**Meeting Summary**

**American Board of Surgery**

**June 22-25, 2013**

**1. Meeting and Membership**

The Board met in Philadelphia from June 22-25, 2013. The directors’ meeting was chaired by Dr. Thomas Cogbill. He began by noting the new directors who were elected to the Board in January:

Dr. Roxie Albrecht – Southwestern Surgical Congress

Dr. Mark Allen – American Board of Thoracic Surgery

Dr. William Chapman – American Surgical Association

Dr. Dai Chung – Society of University Surgeons

Dr. Vivian Gahtan – Society for Vascular Surgery

Dr. K. Craig Kent – American Surgical Association

Dr. Anne Rizzo – At-Large Director

The following directors are completing their terms at this meeting:

Dr. L. D. Britt – American Surgical Association

Dr. Thomas Cogbill – At-Large Director

Dr. B. Mark Evers – Society of University Surgeons

Dr. V. Suzanne Klimberg – American Surgical Association

Dr. Joseph Mills – Society for Vascular Surgery

Dr. John Potts – Southwestern Surgical Congress

Dr. Cameron Wright – American Board of Thoracic Surgery

**2. General Issues**

A. Strategic Planning Meeting

The ABS conducted a strategic planning meeting to review current policies and project the most important activities we need to focus on in coming years, which was held for two days in March 2013. The conclusions of this session were the following goals, ranked in priority order, with the action plans appended.

A. Strengthen MOC

To be addressed at retreat and subsequently by the MOC Task Force chaired by Dr. Cofer.

B. Strengthen SCORE

Continue with current organization, SCORE Executive Committee, and current plans

C. Improve General Surgical training

Continue to address within GENSAC in regard to three different areas of training

D. Identify, implement and validate broader measures of competence in the certification process

Referred to General Surgery Residents Committee (GSRC) for discussion and recommendations

E. Optimize director time and skills

Assign to Dr. Buyske to develop specific plans and improvements

F. Succession Planning

Assign to Dr. Lewis to develop plan

G. Define uniform oversight process for post-residency fellowships

Refer to Advanced Surgical Education Committee (ASEC) to discuss and develop further plans

Action plans were developed for each will be implemented during the coming year.

B. SCORE Status and Plans

The SCORE website continues to do well, with subscription renewals increasing to 95% of allopathic surgical residencies and about 50% of osteopathic surgical residencies in the 2013-14 year. The vendor for the website was changed this year to Silverchair, and the transition was made on March 1, 2013, with no significant problems. The new website will increase the flexibility of program directors to make curriculum assignments, and of residents to carry out self-assessment of their knowledge and to compare themselves to their peers. The website also has improved navigation and search features and is much more contemporary in its look and user experience.

A study was done by the Johns Hopkins School of Public Health of the use of SCORE versus the residency teaching program of the Royal College of Surgeons in Ireland, School for Surgeons, in a number of surgical residencies in Africa, and both programs were reviewed very highly in regard to their effectiveness.\* Regular international subscriptions to SCORE number about a dozen programs.

The number of learning modules currently completed on SCORE is approximately 550, and 100 additional modules are in preparation and will be put on the site by June 2014. This will complete the full build-out of SCORE modules, such that the website will have modules covering all of the subjects listed in the SCORE curriculum. During the past year the American Society of Transplant Surgeons selected 22 modules from their comprehensive learning program in transplant surgery – Transplant Academic Universe – that are particularly relevant to surgical residents and provided these at no charge by linkage to SCORE so that the material is available to residents on transplant rotations.

The Pediatric Surgical Board has asked that modules be added to SCORE for the use of fellows in pediatric surgical fellowships, and this is in progress. The PSB developed 25 new modules in phase I of this program, and these will be loaded onto SCORE in the next two months. There are an additional 20 more advanced modules which will be completed during the remainder of the year and subsequently added. All of this material, while targeted principally at pediatric surgical fellows, will be available to surgical residents using the program.

\*SD Goldstein, D Papandria, A Linden, G Azzies, E Borgstein, JF Calland, S Finlayson, P Jani, M Klingensmith, M Labib, F Lewis, M Malangoni, E O’Flynn, S Ogendo, R Riviello, F Abdullah. *Innovative approaches to educating the global surgical workforce: A pilot comparison of online curricula for use in low- and middle-income countries.* JAMA Surgery, in press.

C. Developing Board Certification Standards for Singaporean Surgical Residencies

The Ministry of Health of Singapore determined approximately five years ago that they wanted to change the accreditation and board certification system there from the British model to the American model. The first phase of this was to engage the Accreditation Council for Graduate Medical Education (ACGME) to develop accreditation standards that would be applicable in international venues. This effort was completed three years ago, and has resulted in ACGME-I , which provides accreditation standards to any foreign countries which want to emulate the standards in place in the US.

The follow-on to this is to develop certification standards across a range of medical specialties that will allow individual graduates of the Singaporean programs to become board certified. The American Board of Medical Specialties has been overseeing the development of these programs, and to date several boards, including the American Board of Internal Medicine and American Board of Pediatrics, have concluded agreements with the Ministry of Health to grant board certification (international) to graduates who complete the ACGME-I accredited programs.

The ABS declined to be involved in this at the outset, but we have recently been approached by the ABMS with a request that we reevaluate our position. Dr. Joseph Cofer, current Chair of the ABS, and Dr. Jo Buyske, Associate Executive Director, will therefore visit Singapore later this year to evaluate the details of the training programs there and determine whether we can move ahead in providing board certification to the graduates of the surgical programs there which are accredited.

D. MOC Task Force

The number one priority out of the Strategic Planning Initiative described earlier was to strengthen the criteria for Maintenance of Certification, particularly in the area of Performance in Practice (Part IV). In order to address this comprehensively, Dr. Cogbill created the MOC Task Force, to be chaired by Dr. Cofer, and this group will begin meeting this summer to examine the ways in which MOC can be strengthened for individual surgeons.

E. Reentry to Certification for Diplomates with Lapsed Certificates

The ABS has revised its policies in regard to recertification for diplomates who allow their certificate to lapse at the end of the present ten-year cycle by failing to apply for recertification and take the recertification examination. In the past such diplomates could regain certification by reapplying, and retaking and passing the recertification examination without additional requirements. At this meeting the ABS determined that diplomates who allow their certificate to lapse, in addition to present requirements, should be required to pay a penalty of $900 in addition to the examination fees, and to have mandatory audits of their compliance with maintenance of certification standards during the subsequent three-year MOC cycle. These changes will take effect in July 2014.

**3. Resident Issues**

A. Completion of Milestones Project

The “Next Accreditation System” of the ACGME, to be progressively implemented in US residencies to replace the current accreditation system, requires that each specialty develop a set of “milestones” which will be used by residency programs for self-assessment of their educational efforts, and to subsequently be used by the ACGME to judge the adequacy of each training program for continuing accreditation. Each specialty will develop these milestones with joint committees of the ACGME and the specialty boards in each area, in order to provide comprehensive assessment of resident performance.

The ABS and ACGME have had such a joint committee operating for the past several years, and this committee finalized the development of a set of milestones for use by surgical residencies approximately a year ago. These milestones were evaluated in a beta trial during the last academic year, and were then modified based on feedback from the trial and put into final form in the spring of this year. These finalized milestones are now available for use by surgical residencies generally, beginning with the current academic year. They will be mandatory for all residency programs starting July 2014, for subsequent ACGME accreditation.

B. General Surgical Advisory Council

The General Surgery Advisory Council (GENSAC) was created by the ABS one year ago on an ad hoc basis with a two-year lifespan, after which it would either be sunsetted, or would be made a permanent part of the structure of the ABS, depending on its perceived utility at the end of that time. During the year the committee has had two in-person meetings and one conference call, and has focused its efforts on three areas related to resident training: pre-residency medical school education, residency training, and post-residency fellowship training.

In regard to medical school education, the committee feels strongly that the training of medical students has deteriorated significantly in the last decade, as medical students have been removed from “acting internships” and any type of night call. There is very little realistic participation in the care of patients today in which medical students are given any direct responsibility, and it has become largely a spectator experience. The result is that students enter internship without basic skills in patient care, both procedural and cognitive. Many residencies have found it necessary to establish a “boot camp” during the first week or month of residency in which many of these basic skills are taught, although in most programs interns acquire these in a non-structured and ad-hoc way.

In recognition of this, the American College of Surgeons has developed over the past few years a comprehensive curriculum for teaching these fundamental skills over a six-week period, and has recommended that this curriculum be implemented by medical schools for senior medical students in April or May of their senior year, after the results of the match are known. The course has been made available without charge by the ACS, and it has been designed to allow significant flexibility in implementation by individual schools to meet their own perceived needs. After careful evaluation of this material, GENSAC prepared a joint statement for both the ACS and ABS to endorse, which strongly supports the adoption of this curriculum on a universal basis by medical schools, in order to provide improved and more uniform preparation of medical students for entering internship.

The second area of discussion has been residency itself, and GENSAC has taken the position that one of the most important early issues in residency training is to get residents in the first two years of training into the operating room on a more frequent basis. The demands of ward work and basic administrative needs in patient care have become so extensive that interns and second-year residents today spend the majority of their time pursuing minimally educational activities that preclude their involvement in the OR, and as a result fail to grasp the essential nature of what surgery involves early in their training and choose to switch fields because they find it so unrewarding.

As a result of this, GENSAC recommended to the ABS directors that they adopt a resolution that requires residents at the end of the PGY-2 year to have documented participation in 250 operations either as operating resident or first assistant. This was passed unanimously by the ABS and will now go to the RRC for Surgery for discussion and action.

A second resolution of GENSAC was for the ABS to create a resident advisory group which would be created to provide input to the Board in regard to its policies, and to advise on issues that are directly relevant to resident training. The details of the constitution of this group were left to the Executive Committee to define, and it is anticipated that this will occur during the coming year.

C. Endoscopy Curriculum

As a result of conflicts with the medical gastrointestinal societies over the competence of surgical residents in performing upper and lower GI endoscopy, the Gastrointestinal Surgery Advisory Council (GISAC) has collaborated with SAGES (Society of American Gastrointestinal and Endoscopic Surgeons) and the ASGE (American Society for Gastrointestinal Endoscopy) during the last two years. This group has developed a comprehensive curriculum in the performance of endoscopy, which has been endorsed by the ABS and is currently established as a requirement for residents completing residency as of June 2018 and forward. This includes completion of the Fundamentals of Endoscopic Surgery, a new teaching and testing standard developed by SAGES in regard to the technical performance of GI endoscopy.

There has been significant concern on the part of program directors that this requirement, both in regard to direct cost and resource requirements, will be hard to meet, particularly for larger residency programs. GISAC discussed this in detail at the June meeting, and while acknowledging the difficulty which has been raised by program directors, felt it was essential that these standards be implemented in order to assure that surgical residents indeed do acquire the needed skills. It was noted that over a long period of time the performance of endoscopy by surgeons in practice is always among the top five most common procedures performed. It was therefore felt that this constitutes a core area of general surgical training today, and that validated competency is necessary for residents at graduation.

D. Survey of Graduating Residents and Fellows

There has been considerable discussion over the last two years in multiple forums about the perceived deficiencies in performance of graduating surgical residents, and discussion about the need for an additional sixth year of training or of a mandatory fellowship as a general requirement. Since 80% of graduating residents enter post-residency fellowships, only 20% of residents do not complete at least a sixth year of training.

The ABS is commissioning a survey, to be done over the remainder of this year, of two groups of residents: those who complete five years of training and enter practice directly, and those who pursue fellowships for a sixth year or more. Residents who have graduated during the last 3-5 years in both groups will be surveyed.

The purpose of this is to explore more fully exactly what the differences are in attitude and experience of these two groups, and what their feedback is after entering practice. It is hoped that results of this survey will be available by the January 2014 meeting to better inform any future actions in regard to training.

**4. New Officers**

Dr. Joseph Cofer assumed the position of Chair of the ABS at the conclusion of the meeting, with Dr. David Mahvi moving to Vice Chair. In subsequent summer elections Dr. Stephen Evans was elected as the Vice Chair Elect for the coming year.

**5. Necrology**

The Board was notified that Dr. John M. Beal, Jr. died June 3, 2013. He was elected as a member of the American Board of Surgery in 1965, and served as Chairman of the Board 1970-1971.

**AMERICAN BOARD OF SURGERY**

**SUMMARY OF 2012-2013 EXAMINATIONS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Examination** | **# of**  **Examinees** | **#**  **Pass** | **#**  **Fail** | **Pass**  **Rate** | **Fail**  **Rate** | **Total #**  **Diplomates** |
| Qualifying | 1,356 | 1,074 | 282 | 79.2% | 20.8% |  |
| Recertification | 1,825 | 1,758 | 67 | 96.3% | 3.7% | 21,627 |
| Vascular Surgery QE | 123 | 111 | 12 | 90.2% | 9.8% |  |
| Vascular Surgery Rct. | 216 | 205 | 11 | 94.9% | 5.1% | 2,050 |
| Surgical Principles Exam | 35 | 21 | 14 | 60.0% | 40.0% |  |
| Surgical Critical Care | 179 | 154 | 25 | 86.0% | 14.0% | 3,114 |
| SCC Recertification | 173 | 169 | 4 | 97.7% | 2.3% | 1,478 |
| Pediatric Surgery QE | 37 | 34 | 3 | 91.9% | 8.1% |  |
| Pediatric Surgery Rct. | 51 | 49 | 2 | 96.1% | 3.9% | 793 |
| Hand Surgery | 18 | 12 | 6 | 66.7% | 33.3% | 279 |
| Hand Surgery Recert. | 14 | 14 | 0 | 100.0% | 0% | 153 |
| Hospice & Palliative Care\* | 44 | 36 | 8 | 81.8% | 18.2% | 62 |
| Vascular Surgery ITE | 407 | --- | --- | N.A. | N.A. |  |
| Pediatric Surgery ITE | 109 | --- | --- | N.A. | N.A. |  |
| ITE – Junior Level | 4,154 | --- | --- | N.A. | N.A. |  |
| ITE – Senior Level | 4,018 | --- | --- | N.A. | N.A. |  |
| ITE – International | 274 | --- | --- | N.A. | N.A. |  |
| ITE – D.O. | 132 | --- | --- | N.A. | N.A. |  |
| Certifying\* | 1,396 | 1,115 | 281 | 79.9% | 20.1% | 59,548 |
| Vascular Surgery CE | 132 | 106 | 26 | 79.5% | 20.5% | 3,345 |
| Pediatric Surgery CE | 39 | 34 | 5 | 87.2% | 12.8% | 1,233 |
| **TOTAL** | **14,732** |  |  |  |  |  |

N.A. = Not applicable.

5,638 examinees, excluding the ITE, VSITE and PSITE.

\*Certifying Examination totals for 2012-2013 academic year