A Closer Look at MOC
What Diplomates Need to Know and Do

With the American Board of Surgery’s transition from “traditional” recertification to Maintenance of Certification (MOC), diplomates may have questions about what this means for them. MOC was initiated by the member boards of the American Board of Medical Specialties (ABMS) to respond to growing public concern over health care quality. The ABS is proceeding carefully with the development of its MOC program so it incorporates tools and measures that assist diplomates in providing quality care and in documenting this care to patients, insurers and purchasers. The ABS intends MOC to be a professional development program that gives diplomates the opportunity to self-assess their knowledge, obtain CME of the greatest value to them, and track their performance in practice using outcome measures.

What is MOC?
MOC goes beyond traditional recertification once every 10 years to a program of continuing learning and assessment at more frequent intervals throughout the 10-year certification cycle. All ABMS member boards must participate in MOC, though each can determine its own schedule for implementation.

Why do we need MOC?
The explosive growth in medical knowledge and technology, as well as external pressures for ongoing quality assessment, has made the 10-year “snapshot” evaluations of traditional recertification insufficient. Board certification is considered to be the gold standard in assuring that a surgeon has acquired and sustained a certain level of knowledge, skill and performance. MOC will ensure that board certification remains a recognized, surgeon-defined, standard of excellence.

Am I in MOC?
If you certified or recertified after July 1, 2005, you are now enrolled in MOC. If you have yet to recertify, you will be enrolled in MOC at the time of recertification.

ABS and SVS Establish New Alliance

Following the creation of a primary certificate in vascular surgery and development of new, independent training pathways, the ABS met in December with representatives of the Society for Vascular Surgery (SVS) to address lingering issues regarding the status of vascular surgery.

Last year the SVS formed a new committee, the Vascular Specialty Action Committee, under Jack Cronenwett, M.D., to specifically identify issues of importance to the SVS and vascular surgery. A main concern of this committee has been that the Vascular Surgery Board of the ABS (VSB-ABS) possess autonomy in all decisions pertaining to vascular surgery certification. Although this has been the de facto policy for the last 10 years, the ABS agreed at the December meeting to amend its bylaws to officially recognize the autonomy of the VSB-ABS. The ABS also agreed that the VSB-ABS would provide expert review of clinical issues in vascular surgery for any cases that come before the ABS Credentials Committee for disciplinary action.

In turn, the ABS requested that the SVS officially recognize in its communications and website the role of the VSB-ABS as the sole body responsible for establishing vascular surgery training and certification standards. The ABS also agreed to consider the inclusion of a member of the VSB-ABS on its governing council.

ABS and SVS Establish New Alliance

Dr. Wayne Johnston and Dr. Jack Cronenwett of the SVS discuss the vascular surgery primary certificate at a December 2007 meeting with the ABS.

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The start of 2008 has already seen many developments for the American Board of Surgery. We began the year by welcoming Jo Buyske, M.D., to the ABS office as our new associate executive director. Dr. Buyske will fully take over the position from Robert Rhodes, M.D., in July. Additionally the SCORE curriculum project continues to progress, and we are excited about the impact this project will have on general surgery training and surgery as a whole.

By bringing together the various parties responsible for surgical training in the U.S., we have ensured that SCORE is a collaboration of many minds and surgical specialties. At our January meeting, the ABS directors gave their approval of the SCORE curriculum outline, which prioritizes specific subject areas so that all residents complete their training having received adequate exposure to all of the core areas of general surgery. SCORE’s intent is to move surgical training away from the “see one, do one” approach and instead establish a systematic progression for the acquisition of surgical skills and experience.

Related to SCORE, several ABS directors met recently to tackle which gastrointestinal (GI) surgery procedures and cases should be required as part of residency, and which are more appropriate for fellowship training. The ABS is concerned that the growing popularity of post-residency fellowships in gastrointestinal surgery may indicate that trainees are completing residency without sufficient exposure to essential GI operations. ABS directors will be discussing these concerns in the coming months with the organizations involved in GI fellowships to jointly resolve this issue.

The ABS has also begun the new year forging a new relationship with the Society for Vascular Surgery. The creation of a primary certificate in vascular surgery has dramatically altered the vascular surgery training landscape, and both the ABS and SVS felt that changes were needed in several areas related to board certification to better address this new paradigm. We had a collegial meeting with the SVS in December that I believe augurs a greater level of collaboration between the two organizations, ultimately to the benefit of both vascular surgery and general surgery.

Above all, the ABS is starting 2008 with determination to establish a Maintenance of Certification program that meets the needs of diplomates in the current health care environment. MOC takes effect for diplomates upon certification or recertification after July 1, 2005. The ABS is very aware that diplomates are already facing administrative hurdles imposed by insurers, government entities and quality assessment organizations. The ABS plans to adapt its MOC requirements as new educational tools and technologies become available and aims to make fulfilling MOC a seamless part of a diplomate’s daily practice. We are resolved to building an MOC program that supports diplomates in providing quality care to their patients. As the ABS continues its work toward this goal, we welcome your ideas and feedback.
The ABS convened a meeting last November to examine in depth the rapid growth of gastrointestinal surgery fellowships. Members of the ABS’ General Surgery Residency Committee, Advanced Surgery Education Committee and Gastrointestinal Surgery Advisory Council met to consider the potential reasons residents feel the need to pursue these fellowships and their effect on residency training. The principal outcome of the meeting was that the ABS should work to establish specific standards for the training of residents in GI surgery, including a core set of operations that residents should be competent to perform by completion of residency, to assure that residents obtain sufficient GI surgery experience.

In the course of its work on the SCORE project, the ABS has examined residents’ operative data from recent years which reveal insufficient case numbers for many core GI procedures. Despite laparoscopic procedures becoming fairly common and routine, many appear to still be considered the domain of fellows when they could be done by senior residents. This lack of exposure to laparoscopic cases leads residents to enter fellowships to gain more laparoscopic training, thus continuing the cycle. Residents’ operative data also show a decrease in residents’ participation as second and first assistant, perhaps signifying that residents are also receiving fewer opportunities to observe procedures before performing one themselves. In addition, with the increased supervision that residents now receive, some may pursue fellowships to experience a greater degree of independence without yet being in independent practice.

As a result of the November meeting, the ABS will explore establishing minimum case numbers for certain GI procedures, as well as a certain level of competency in the care of underlying diseases, as a requirement for certification. In specifying certain GI procedures as “must-haves” by the end of residency, the ABS will focus on operations that are common enough for residents to gain adequate experience. The ABS will present the proposed requirements to GI specialty surgical societies for discussion and feedback, and will coordinate its efforts with those of SCORE and its new curriculum outline for general surgery residency. The ABS will also collaborate with the American Board of Colon and Rectal Surgery and the Fellowship Council, both of which are currently developing curriculums for their respective fellowship programs.

### New Certificate in Hospice and Palliative Medicine

This year the ABS will join nine other ABMS member boards in offering a new certificate in hospice and palliative medicine. While each board will use its own application process, the examination will be administered through the American Board of Internal Medicine (ABIM). As the lone surgical board offering this certificate, the ABS will also accept current diplomates from other ABMS surgical boards as applicants for certification.

For the first five years of the certificate, a practice pathway is available for diplomates already involved in hospice and palliative care. For this pathway, a diplomate would have to be able to document at least 800 hours of clinical involvement during the last five years in the subspecialty-level practice of hospice and palliative medicine. The 800 hours must include at least two years and 100 hours of participation with a hospice and palliative care team and participation in the active care of at least 50 terminally ill patients (25 for pediatric surgeons). Diplomates who were certified by the American Board of Hospice and Palliative Medicine may also enter through this pathway, with their certificate serving as documentation of their experience.

A training pathway has also been established, requiring satisfactory completion of a 12-month training program in hospice and palliative medicine. Prior to July 1, 2010, the training program must be affiliated with a residency or fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME). After July 1, 2010, the hospice and palliative medicine program itself must be ACGME accredited.

The computer-based certifying examination will first be held on October 29, 2008, and will be offered every even-numbered year thereafter. The examination developed by the ABIM is a one-day exam approximately 10 hours long given through Pearson VUE testing services. An examination “blueprint” is available from www.abim.org. ABS diplomates will apply for the certificate through the ABS website, www.absurgery.org. Applications must be submitted to the ABS by May 1, with a late application deadline of June 2.
Redefining General Surgery
SCORE Establishes New Curriculum Framework

The Surgical Council on Resident Education (SCORE) met in November 2007 to continue work on a new curriculum for U.S. surgical education. Discussion centered on the curriculum’s educational content, as well as the teaching of specific operative skills at different stages of residency. The ABS has assumed a major role in the curriculum project, which aims to reduce variability in U.S. surgical training and ensure that residents are obtaining sufficient training and education in all aspects of general surgery.

At the meeting, the members of SCORE gave their approval for a content outline that will serve as the basis for the new curriculum. The outline was created by the Association of Program Directors in Surgery (APDS) and the ABS General Surgery Residency Committee to specify the necessary depth and breadth of training in each curriculum area. At the curriculum’s foundation are 28 organ system-based categories, which are further divided into “diseases/conditions” and “operations/procedures.” The diseases/conditions are divided into those for which a resident should be able to provide comprehensive management, and others requiring only focused knowledge related to diagnosis and initial management. Operations/procedures are similarly divided into three categories: “essential-common” (operations frequently performed by general surgeons in which complete competence is required), “essential-uncommon” (not as frequently seen but full competency still required), and “complex” (not commonly done in practice, but general familiarity is necessary).

The curriculum outline was approved by the ABS directors in January 2008. It will be distributed at the APDS annual meeting in mid-April 2008 and posted on the ABS website, www.absurgery.org, at that time. Each year SCORE will seek input from the surgical community at large about the curriculum framework and will review it for its continued relevance to general surgery training, modifying it as necessary as the field of surgery changes. The ABS plans to revise its own definition of general surgery to reflect the outline and to more precisely define the knowledge and skills a certified general surgeon should have.

The second main topic at the meeting was the teaching and assessment of technical surgical skills. The surgical skills curriculum being developed by the American College of Surgeons’ (ACS) division of education and the APDS was presented by Gary Dunnington, M.D., of Southern Illinois University. The skills curriculum includes incremental learning objectives, lesson plans and standards for the teaching and evaluation of residents’ surgical skills. Phase I of the curriculum has been completed and focuses on 20 basic surgical skills, such as inserting a central line, suturing and knot-tying; Phase II will contain 20 common operative procedures broken down into steps; and Phase III will instruct and evaluate residents on team-based skills. SCORE will continue to work with Dr. Dunnington to integrate this project into the new surgical curriculum. In addition to Dr. Dunnington’s presentation, the SCORE group heard talks about the state of skills training and evaluation in Canada and in the U.K., given by Richard Reznick, M.D., and Mr. William Thomas, respectively.

SCORE is also moving forward with the development of a website that will provide residents with educational content organized according to the curriculum outline. A preliminary version of the website is planned for release in July 2008 to a pilot group of residency programs, with the intent of finalizing the website design by end of 2008. Richard Bell, M.D., and Stanley Ashley, M.D., of the ABS are working with the APDS in developing 115 modules by July 2008 that will parallel the subjects in the curriculum outline. The website will mostly use existing content gathered from the ACS, specialty societies, medical publishers and other sources. The website modules are intended to foster multimedia learning and will feature text, diagnostics images, video, step-by-step “walk-throughs” of procedures, and recent journal articles.

For additional information about SCORE, see the News section of www.absurgery.org. SCORE is composed of representatives from the ABS, ACS, APDS, Residency Review Committee for Surgery (RRC-Surgery), American Surgical Association, and Association for Surgical Education.

Dr. Stanley Ashley, chair of the ABS General Surgery Residency Committee, explains the three different categories of procedures in the new curriculum outline.
A Closer Look at MOC (cont.)

(Continued from page 1)

How does MOC work?
The ABS’ MOC requirements run in three-year cycles (a year being July
1 to June 30). At the end of each cycle, diplomates submit information regarding
their MOC activities. If diplomates do not meet the requirements by the
end of a three-year cycle, they will be
given a one-year grace period in which to reenter the program. If they choose
not to reenter, they will be reported as
“Not Participating in MOC” in
response to any inquiries regarding
their certification status. A secure
examination will continue to be
required at 10-year intervals and may
be taken starting three years prior to
certificate expiration, as at present.

So what do I need to do?
There are four parts to MOC, each
with a set of requirements:

Part 1 - Professional Standing
• Maintain a valid, full and unrestricted
medical license;
• Maintain hospital admitting and operat-
ing privileges in the specialty, if clinically
active;
• Submit reference letters every three
years from the chief of surgery and chair
of credentialing committee at the institu-
tion where most work is performed.

Part 2 - Lifelong Learning and Self-
Assessment
• Perform annually at least 30 hours of
Category I and 50 hours overall of con-
tinuing medical education (CME). Over
the course of three years, one-third of
Category I CME must be a self-assess-
ment activity.

Part 3 - Cognitive Expertise
• Successfully complete a secure exami-
nation, which may first be taken as of
three years prior to certificate expiration.
An application and 12-month operative
log (using either the ABS operative
report or ACS case log) will continue to
be required for admission to the exam.

Part 4 - Evaluation of Practice
Performance
• Participate in a national, regional or local
surgical outcomes database or quality
assessment program, including such
programs as NSQIP, SCIP, PQRI or the
ACS case log system (for other accept-
able programs, see www.absurgery.org).
• Not yet finalized: Participate in a patient
communication skills assessment pro-
gram. The ABMS is currently developing
such a program for use by its member
boards.

How will I know when to submit
something?
The ABS will send individual
reminder letters to diplomates when
they are beginning their third (and
eventually sixth and ninth) year of
MOC. This summer the ABS will send
letters to the first group of diplomates
who became enrolled in MOC—those
who certified or recertified in the fall
of 2005 and spring of 2006—and who
will start their third year of MOC in
July 2008.

What will I need to submit?
During
their third year of
MOC, diplomates
will be
required to
log on to
the ABS
website and
enter infor-
mation
about their
MOC activ-
ities. They will be asked to provide
information regarding their medical
license, hospital privileges, CME/self-
assessment hours, and practice assess-
ment activity. Reference letters will
also need to be printed and sent to the
appropriate officials for completion.

For more information about MOC,
visit www.absurgery.org.

MOC Requirements Timeline

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<tr>
<th>Year of Certification or Recertification</th>
<th>Description</th>
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<td>Diplomate initially certifies or successfully recertifies</td>
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| Year 1 MOC | CME (Minimum of 30 hours of Category I, 50 overall every year) |
| Year 2 MOC | CME |
| Year 3 MOC | CME Diplomate submits information via ABS website regarding medical license, hospital privileges, CME/self-assessment, and practice assessment by June 30. Reference letters also to be completed and sent to ABS. |
| Year 4 MOC | Same as year 1 |
| Year 5 MOC | Same as year 2 |
| Year 6 MOC | Same as year 3 |
| Year 7 MOC | Same as year 1 |
| Year 8 MOC | Same as year 2 |
| Year 9 MOC | Same as year 3 |
| Year 8-10 MOC | Secure examination (application and 12-month operative log required) |
Dr. Steven Stain Named Vice-Chair

Steven Stain, M.D., was elected this summer as vice-chair of the ABS for 2008-2009. He will serve as ABS chair in 2009-2010. Dr. Stain is currently the Neil Lempert Professor and Chair of the department of surgery at Albany Medical College in Albany, New York.

A native of Fresno, California, Dr. Stain received his undergraduate and medical degree from the University of California at Irvine, and completed his residency at Los Angeles County/University of Southern California (USC) Medical Center. He then joined the faculty at USC as a clinical instructor while completing a fellowship in surgical critical care. Dr. Stain also trained in hepatobiliary surgery at the University of Berne, Switzerland. While at USC, he became an associate professor and served as director of the general surgery residency program at Huntington Memorial Hospital. In 2000, Dr. Stain was appointed professor and chair of the department of surgery at Meharry Medical College, with a secondary appointment as professor of surgery at Vanderbilt University in Nashville, Tennessee. In 2005, he moved to his current position at Albany Medical College.

Dr. Stain was appointed to the ABS in 2002 as a representative of the Western Surgical Association. He is currently president of the Society of Black Academic Surgeons and is a past member of the board of governors of the Society of American Gastrointestinal and Endoscopic Surgeons. Dr. Stain has also served as program committee chair for the Western Surgical Association, chair of the surgical section of the National Medical Association, and chair of the surgical section of the Southern Medical Association.

ABS and SVS Establish New Alliance (cont.)

(Continued from page 1)

Another issue discussed related to how the ABS defines general surgery. The dramatic change in the nature of vascular surgery over the last 10 years and the increased role of endovascular technologies has resulted in general surgery residents not being trained to treat the full spectrum of arterial vascular disease. Vascular surgery fellowship is now an essential requirement for residents who wish to specialize in this area, and the ABS’ definition of general surgery needed to be updated to reflect this development. An updating of the definition was already in process through the new surgery curriculum outline put forth by SCORE, which was approved by the ABS at its January meeting. The ABS’ definition of general surgery and related publications will be revised in the coming months to reflect the curriculum outline, which features a narrower scope of vascular surgery training in general surgery residency. The ABS and SVS both agreed, however, that this revision is only applicable to future training and certification and does not apply in any way to diplomates already certified.

The ABS and SVS representatives also discussed the representation of vascular surgery on the Residency Review Committee for Surgery of the ACGME. Currently two members of the RRC-Surgery are mandated to be vascular surgeons. While the ABS has no jurisdiction over the RRC-Surgery, it was agreed that the ABS would support the proposal for an additional vascular surgery representative on the RRC-Surgery.

The ABS and SVS plan to implement these resolutions over the next six to 12 months and will keep each other apprised of their progress.

Important 2008 Dates

**Surgery Qualifying Examination**
- Application Deadline: May 1, 2008
- Late Application Deadline: June 2, 2008
- Exam Date: August 14, 2008

**Surgery Recertification Examination**
- Application Deadline: August 1, 2008
- Late Application Deadline: September 2, 2008
- Exam Dates: December 1 – 12, 2008

**Vascular Surgery Qualifying and SCC Certifying Examinations**
- Application Deadline: July 1, 2008
- Late Application Deadline: July 15, 2008
- Exam Date: September 22, 2008

**Vascular Surgery and SCC Recertification Examinations**
- Application Deadline: July 1, 2008
- Late Application Deadline: July 15, 2008
- Exam Dates: September 22 – October 4, 2008
ABMS Appoints New President and CEO

Kevin Weiss, M.D., M.P.H., was hired in December as the new president and CEO of the American Board of Medical Specialties. Dr. Weiss replaces Stephen Miller, M.D., who has retired. Prior to the ABMS, Dr. Weiss was professor of medicine and director of the Institute for Healthcare Studies at Northwestern University’s Feinberg School of Medicine in Chicago. He currently serves on committees for the National Committee for Quality Assurance and the National Quality Forum, and on the American Medical Association’s Physicians Consortium for Performance Improvement. Dr. Weiss was also a member of the Institute of Medicine committees that developed the reports “Crossing the Quality Chasm” and “Identifying Priority Areas for Quality Improvement.” He completed his medical degree at Chicago Medical School and obtained master’s degrees in community health sciences and health services administration from the University of Illinois and Harvard University respectively.

General Surgery Recertification: ACS Case Log Option

Diplomates applying for recertification in general surgery this year will have the option of electronically transferring cases from the ACS case log system to the ABS instead of completing the ABS’ operative experience report. The ABS will post its online application system on its website in early spring, at which time eligible diplomates will be sent letters inviting them to apply for recertification. A link will be posted at that time on the Status of Application page to transfer data from the ACS system to the ABS.

News from VSB-ABS

The VSB-ABS administered the first Vascular Surgery In-Training Examination on February 16, 2008, as a web-based examination to approximately 200 residents. In another examination first, a new computer-assisted format will be used for the 2008 Vascular Surgery Certifying Examination to improve the examination’s use of images in presenting case scenarios. The examination will be held at the offices of the American Board of Obstetrics and Gynecology in Dallas to take advantage of their specially designed exam rooms. This new technology will allow the VSB-ABS to incorporate many more images into the oral examination to better reflect current vascular surgery.

News from PSB-ABS

The Pediatric Surgery Board of the ABS (PSB-ABS) is working with the American Pediatric Surgical Association (APSA) to facilitate the MOC process for its diplomates, particularly for Part 4, Evaluation of Performance in Practice. The APSA Education Committee is currently working on a program similar to NSQIP for pediatric surgeons that would fulfill the Part 4 requirement. The PSB-ABS will also accept participation in other databases (trauma, cancer, etc.) for Part 4, as listed under the MOC section of www.absurgery.org, and is exploring additional options for practice assessment. In addition, the PSB-ABS is creating a pediatric surgery self-assessment examination that diplomates will be able to use toward fulfilling Part 2 of MOC, Lifelong Learning and Self-Assessment.

Clarification Regarding Clinically Inactive Status

The new status of Certified – Clinically Inactive is meant for diplomates who are completely retired, working in an administrative or research capacity or similar situation, and do not treat patients in any capacity or hold hospital privileges. Any inquiry received by the ABS as to the diplomate’s certification status will specify that the diplomate is considered clinically inactive and that this certification status is intended only for diplomates who do not have any involvement in patient management. Diplomates with the clinically inactive status who decide to return to active practice must develop a reentry plan with their institution’s credentialing office for approval by the ABS and fulfill additional requirements based on their particular circumstances. For the full policy, see www.absurgery.org.

New Policy on Credit for Foreign Training

The ABS established a new policy this fall for individuals in ACGME-approved residency programs who wish to obtain credit for past training conducted outside the U.S. and Canada. As part of the new policy, the ABS will no longer provide a preliminary review of an individual’s foreign training. The residency program director is the primary judge of a resident’s proficiency level and should make the request for credit only after having observed the individual as a junior resident for approximately nine months.

Requests for credit must include documentation of past training and all in-training examination (ABSITE) scores, which should be consonant with the level of credit requested. Program directors who wish to advance residents to senior levels (PGY-4 or PGY-5) must have obtained ABS approval prior to the PGY-4 year; otherwise credit for these years will be denied. See www.absurgery.org for the complete policy.
Visitors from the Chinese Ministry of Health visited the ABS office in December to learn more about the board certification process for surgeons in the U.S. Tom Biester and Dr. Robert Rhodes (front row, first and third from left) presented an overview of the ABS’ activities.

The ABS welcomes your feedback! Send your ideas and comments about this newsletter to cshiffer@absurgery.org.