Outline

- ABS Structure and Role
- Examination Development and Scoring
- MOC
- Residency Redesign/Evaluations
The ABS Today

- Approximately **30,000** diplomates with current ABS certificates
- **92%** are meeting MOC requirements
- ABS includes representation from **39** surgical societies, plus **3** at-large directors and one public member
- All ABS board members are in active practice and must participate in the ABS MOC Program
ABS: Mission Statement

The American Board of Surgery serves the public and the specialty of surgery by providing leadership in surgical education and practice, by promoting excellence through rigorous evaluation and examination, and by promoting the highest standards for professionalism, lifelong learning, and the continuous certification of surgeons in practice.
ABS Leadership: 2016-2017

Dr. John Hunter, Chair

Dr. Mary Klingensmith, Vice Chair

Dr. Spence Taylor, Vice Chair-Elect

Current Focus:

- Improving the ABS MOC Program so it is more valuable to diplomates
- Improving surgery training to better prepare graduating residents for practice
The VSB-ABS

Dr. Vivian Gahtan, Chair

- VSB of the American Board of Surgery (VSB-ABS) founded in 1998
- Defines all requirements and processes related to vascular surgery examinations and certification
- Members are nominated from APDVS, SCVS, SVS and VESS, and now 5 Regional Societies for one 6-year term
ABS Support of VSB

- Approved 50% Expansion in VSB Membership

- Supported Approval of Independent Independent 2-Year Fellowships @ RRC-S // ACGME
ABS Mission & Associated Organizations

- To conduct examinations of acceptable candidates who seek certification or maintenance of certification by the board
- To issue certificates to all candidates meeting the board's requirements and satisfactorily completing its prescribed examinations
- To improve and broaden the opportunities for the graduate education and training of surgeons

**Umbrella organization**
For 24 member Boards

**RRC**
Develops and enforces the training program requirements for all ACGME accredited surgery residencies in the United States

**APDVS**
Addresses the educational, regulatory, and financial issues which impact on vascular surgical education.

**THE MATCH**
Provides an orderly and fair mechanism for matching the preferences of applicants for U.S. residency positions
Examination Development and Scoring

QE / MOC / VSITE: **Key Validation**

<table>
<thead>
<tr>
<th>P value</th>
<th>(Difficulty of the item)</th>
<th>R value</th>
<th>(Discrimination between the most and least knowledgeable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 or higher</td>
<td>Easy item</td>
<td>.00 or lower</td>
<td>Poor discriminator</td>
</tr>
<tr>
<td>50 - 85</td>
<td>Desirable range</td>
<td>.00 - .15</td>
<td>Weak discriminator</td>
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<tr>
<td>35 or lower</td>
<td>Difficult item</td>
<td>.25 or higher</td>
<td>Good discriminator</td>
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Item 151

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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<tr>
<td>Lo</td>
<td>23</td>
<td>12</td>
<td>12</td>
<td>23</td>
<td>31</td>
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</tbody>
</table>

Total Group P = 0.29
CRE = -0.01
2003 = 0
VS CE Grading Change

- **5 Point System**: (6, 5.5, 5.0, 4.5, 4.0)
- **3 Point System**: (3, 2, 1)

- **Room Grades**
  - $2 \times 3 = 6$

- **Case Grades**
  - $4 \times 2 = 8 \times 3 = 24$
FROM THE EDITOR:

MOC: Maintenance of confusion

BY RUSSELL SAMSON, MD
MEDICAL EDITOR, VASCULAR SPECIALIST

I was an unusual patient, but I was confident I could handle it. After all, I had just passed the recertification examination (for the third time), and I was current with the literature. The patient had familial Drabek syndrome, and though she was the first with that condition that I had encountered in 36 years of practice, I knew everything about the disease. I had read about the disease in the American Board of Surgery (ABS) yearbook and was familiar with the treatment. The patient had type IV osteosarcoma, and although I had never seen such a case before, I was confident I could handle it.

As the surgery lasted, I found myself re-examining my knowledge and skills. The patient was a 25-year-old woman who presented with a 3-month history of pain in the right leg. She had undergone chemotherapy for osteosarcoma and was now scheduled for a second surgery. I had reviewed the patient's medical records and was confident in my diagnosis and treatment plan.

I had to make a decision quickly. Was it (a) biopsy or (b) continue medical management? I had to choose the right option. The patient's pain was (b) in question 58. VESAP 3, but what had I read in Rutherford's textbook? I had reviewed the patient's medical records and was confident in my treatment plan.

As the surgery continued, I realized the importance of being current with the literature. The patient had type IV osteosarcoma, and although I had never seen such a case before, I was confident in my diagnosis and treatment plan.

Hopefully you will realize that this embarrassing tale never occurred. Nor are the references to VESAP and Rutherford real. So where are we going with this?

Many have questioned the necessity of recertification examinations for the Maintenance of Certification (MOC). Whatever your viewpoint, it is my contention that the recent recertification examinations require vascular surgeons to memonize trivia that has little bearing on daily practice. Certainly, patients have the right to expect their vascular surgeons to remain current. The surgeon should also have a broad practical knowledge such that the patient will receive a treatment in keeping with appropriate guidelines. But does this also imply that the vascular surgeon should have an in-depth knowledge of rare conditions which most will address in a lifetime of practice? Medical students of today are actually taught the means to rapidly obtain relevant information from the Internet. So why can't the surgeon also be permitted electronic access to the current literature? Examinations that rely on memorized knowledge are anachronisms developed originally to an era when the knowledge base was limited and when access was scarce.

Today there are almost daily paradigm shifts as information expands exponentially. Rutherford's textbook is now over 2,000 pages and takes up two volumes. The JVS is published monthly in three sections with hundreds of pages, not to mention the presence of other major vascular journals. When I first certified there was no such procedure as an endovascular approach. The only treatment available were endarterectomy and bypass. The no-stitch era was a far-off dream. Today we have endovascular grafts, and the next generation is looking forward to new procedures that develop as they are taken off by the Board examinations.
TO THE BARRICADES! THE DOCTORS’ REVOLT AGAINST ABIM IS SUCCEEDING!

By Kurt Eichenwald

Dr. Jones has been a physician for decades. His hundreds of online patient reviews are overwhelmingly positive, with an average of just under five stars and notes that he is caring and attentive. Based on those assessments, it’s clear he is the kind of physician who focuses on quality patient care and one of America’s best surgeons.

Unfortunately, as a single father with a disabled child, Dr. Jones can’t manage his practice, care for his family, and study for the certification exam administered by the American Board of Internal Medicine. The test purportedly ensures doctors’ competence, but, like many physicians, Dr. Jones says the questions often have nothing to do with what he sees in his practice and are little more than a game of medical Trivial Pursuit. Dr. Jones can’t afford the thousands of dollars for study guides and classes to learn obscure, often irrelevant information, and has no time to review the material every night for months. He fails the test, so his hospital will no longer allow him to admit patients because he couldn’t answer questions about diseases he will never encounter.

On March 13, 2014, an online petition was launched requesting that the American Board of Internal Medicine (ABIM) recall recent changes to its Maintenance of Certification (MOC) process. As of this writing, the petition had obtained 50,000 signatures, representing an average signing rate of approximately 500 signatures per day since the ABIM MOC petition was first established.

The ABIM MOC petition calls for a rollback of recent changes to MOC and advocates for a return to “a simpler pathway consisting of a recertification test every ten years.” This effectively makes the more moderate and MOC position compared with others advocating for:

- Elimination of all MOC requirements, including secure, high-stakes exams;
- Aid and the right to obtain a license, as well as continued board certification;
- Establishment of competing certification boards.

One commentator on the ABIM MOC petition stated, “ABIM MOC is a program that must go. Even the current tests every ten years (items 1 and 2) for MOC are unnecessary, commercial, and of questionable relevance for demonstrating professional competence.”
MOC: Criticisms

- Onerous
- Expensive
- Not relevant to my practice
- No evidence of benefit
- Complex and confusing
- Patients don’t care
Why ABS MOC?

- Establishes a national program for maintaining knowledge and skill in practice
- Documents the ongoing commitment of surgeons to professionalism, lifelong learning, and quality patient care
- Gives the surgical community a proactive position in the healthcare quality debate, using surgeon-developed metrics and reporting methods

As of 2015 exam, 2,297 diplomates have recertified at least once in vascular surgery, 1,066 twice, and 120 three times
MOC: The Patient’s Voice

“Check Certification” feature on ABS website receives hundreds of visits per day.
MOC: Regulatory & Patient Groups
MOC: Income

![Graph showing income with and without board certification.](Medscape Physician Compensation Survey, 2013)
MOC: MIPS

MIPS
CPIA Component
(Clinical Practice Improvement Activities)

• Point system
  • 60 points for full credit - partial credit possible
    • Each HIGH value activity = 20 points
    • Each MEDIUM value activity = 10 points

• Examples MEDIUM value activities
  • “Participation in Maintenance of Certification Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program.”
PDK/Gallup Poll Finds Strong Public Support for Board Certification for Teachers

September 16, 2014
News Releases
Arlington, VA

ARLINGTON, Va. — More than 80 percent of Americans agreed that teachers should achieve Board certification in addition to being licensed to practice, similar to professions like law and medicine, according to results from a national poll by PDK International and Gallup released today. The statement garnered the most positive overall response from respondents among the survey questions included in the 46th annual Poll of the Public’s Attitudes Toward the Public Schools, published in the October issue of Kappan.

In addition, 70 percent agreed that “new teachers should spend at least a year practicing under the guidance of a certified teacher before assuming responsibility for their own classrooms.”

These two poll findings support National Board President and CEO Ron Thorpe’s call in the September issue of Kappan to create a universal one-year medical residency model for teachers that builds a pipeline of preparation and support leading to Board certification. Responding to the survey’s findings, Thorpe said:
## MOC Results: Vascular

<table>
<thead>
<tr>
<th>Year</th>
<th>Pass Rate</th>
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<tbody>
<tr>
<td>2011</td>
<td>94%</td>
</tr>
<tr>
<td>2012</td>
<td>95%</td>
</tr>
<tr>
<td>2013</td>
<td>97%</td>
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<tr>
<td>2014</td>
<td>94%</td>
</tr>
<tr>
<td>2015</td>
<td>94%</td>
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MOC Results: Vascular

Failure Rate by Cohort

- 10-Year
- 20-Year
- 30-Year
MOC: Work in Progress

- Years Cycle
- Reduced Self-Assessment Requirement
- Modular Exams
- Life-Long Learning Alternatives
- Alternative Payment Options
Resident Training

Entrustable Professional Activities

Units of professional practice (tasks) that may be entrusted to a learner to execute unsupervised, once he or she has demonstrated the required competence

Enables a shift of focus from individual competencies to the work that must be done
Resident Training

For most EPAs, multiple competencies are required

<table>
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<tr>
<th>Competency</th>
<th>EPA1</th>
<th>EPA2</th>
<th>EPA3</th>
<th>EPA4</th>
<th>EPA5</th>
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<tr>
<td>Patient care</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Medical knowledge</td>
<td>+</td>
<td>+</td>
<td>++</td>
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<tr>
<td>Interpersonal skills &amp; communic.</td>
<td>++</td>
<td>++</td>
<td>++</td>
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<tr>
<td>Professionalism</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>++</td>
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<td>Practice-based learning &amp; improv.</td>
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<td>++</td>
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<td>System-based practice</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>++</td>
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</table>

Assessment based on EPAs

Competencies inferred
Resident Training

Growth of competence over time

- expert
- proficient
- competent
- advanced
- novice

Ready for unsupervised practice

Dreyfus & Dreyfus 1986; ten Cate et al, 2010
QUESTIONS?