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The fourteen Directors of the American Board of Neurological Surgery hope this *Newsletter* has been of interest to you. If you have any questions, advice, or comments, please write to the office or e-mail us at abns@mh.tmc.edu. Notices of change of address are always appreciated, and it is helpful to learn of change of status to retired since assessment statements are sent only to active practitioners. Diplomates overwhelmingly continue to support the Board's commitment to continuing improvement of the certification process and the search for an acceptable MOC process through the voluntary dues program. Thank you.

TRANSITION FROM RECERTIFICATION TO MAINTENANCE OF CERTIFICATION DAVID G. PIEPGRAS, MD IMMEDIATE PAST CHAIRMAN

Background

For the young specialist, completion of post-graduate specialty training remains a landmark that deserves recognition as having achieved a high level of expertise. As early as 1908 the first specialty group, the American Academy of Ophthalmology and Otolaryngology, proposed a process for assessing specialists in their field. In 1917 the nationally recognized Medical Specialty Board of Ophthalmology was established. Otolaryngology followed in 1924 with their program of required training and certification. Neurosurgery incorporated the ABNS in 1940 with the broad aim to encourage the study, to improve the practice, to elevate the standards, to advance the science, and to serve the cause of public health.

As specialty and subspecialty medicine flourished, a need was seen for an umbrella organization to coordinate and facilitate the common purposes and activities of the Boards. That role was met in 1933 by the formation of the Advisory Board for Medical Specialties. In 1970 it was re-organized and incorporated as the American Board of Medical Specialties with the stated mission to maintain and improve the quality of medical care by assisting member Boards in their efforts to develop professional and educational standards for evaluation and certification of physician specialists. The mission statement goes on to state that the intent of certification is to provide assurance to the public that a Diplomate certified by a member Board has successfully completed an approved educational program and evaluation process that assesses the knowledge, skills, and experience required to provide quality patient care in that specialty.

The process of certification is voluntary. For the neurosurgeon it consists of verification of having met basic training, professional, and practice standards. This is affirmed by passage of a cognitive examination on basic knowledge relative to the neurosciences, and finalized through passage of an oral examination confirming the neurosurgeon's possession of fundamental clinical knowledge and sound judgment.

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Recertification

There has been a growing awareness in the medical profession, as well as the public, that initial certification is not enough to assure a high level of care throughout one's career. Over the past several decades there has been a call for periodic recertification of specialists. At the outset recertification was envisioned as an impetus for physicians to keep up with new knowledge. The American Board of Family Practice has issued seven-year time-limited certificates since its inception in 1969; recertification requires an evaluation of office practice and cognitive knowledge, along with Continuing Medical Education (CME) credits. Other Boards followed suit as it became recognized that updating knowledge and basic skills is essential to maintaining high quality patient care. Recertification was affirmed by ABMS policy statements dating back to 1973, and in 1993 the ABMS adopted as policy: "the goal of recertification is to evaluate the continuing competence of a Diplomate in the specialty in which he/she was initially certified". By 1998 most member Boards had recertification in place, primarily based on passing an examination, maintaining licensure, and meeting CME requirements. Neurosurgery was slow to join the movement and had the somewhat ignominious distinction of being the last Board to adopt a plan. The first ABNS ten-year time-limited certificates were issued in May 1999.

Meanwhile expectations were changing. Quality of medical care, incompetent physicians, and consumer protection had become issues of broad concern on a national level. There was growing recognition that a test of factual knowledge every ten years is inadequate to assure a continuum of high level knowledge

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RALPH G. DACEY, JR., MD SECRETARY

The Directors of the American Board of Neurological Surgery have been busy during the past year with several initiatives important to all Diplomates. In this edition of the Newsletter, Drs. David G. Piepgras, Volker K. H. Sonntag, and Arthur L. Day describe some of that work.

Dr. Piepgras, immediate past ABNS Chairman and a member of the executive committee of the American Board of Medical Specialties (ABMS), provides the background and rationale for Maintenance of Certification (MOC).

Dr. Sonntag, ABNS Vice Chairman and chair of the MOC Committee, describes the work of his Committee, its accomplishments, and areas for continued effort.

Finally Dr. Day, ABNS Chairman and immediate past Treasurer, describes the development of NEURO-LOG, improvements in the operations of the Board, and the status of its finances.

VOLKER K. H. SONNTAG, MD CHAIRMAN, MAINTENANCE OF CERTIFICATION COMMITTEE

The MOC Committee continues to be very active, having met several times since the last Newsletter. In association with its Diplomates and organized neurosurgery, the ABNS is working hard to develop a meaningful process that conforms to ABMS standards. The ABNS application for its MOC process has now been submitted to the ABMS.

The four components of MOC consist of:
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DAVID G. PIEGRAS, MD
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and skills. In response to the demand for improvement, task forces, private and presidential commissions, and the Institute of Medicine Committee were formed to examine the quality of health care in the U.S. Dr. Kenneth Shine, President of the Institute of Medicine, challenged physicians by stating that demonstration of competence and verification of performance are the expectations for the future.

MOC

In recognition of the need to satisfy the public, payers, other health care organizations, governmental agencies, and the profession itself, in 1998 the ABMS created the Task Force on Competence to assure that specialists maintain satisfactory up-to-date knowledge and skills throughout the span of their careers. In essence, in the words of then ABMS President Dr. Leo Dunn, “to do what we say we do.” ABMS leadership espoused that recertification programs should transform from a periodic examination and meeting CME requirements to a continuing process of updating and maintaining knowledge and skills through ongoing learning and improvement in practice. In March 2000 ABMS Boards adopted a commitment to evolving their current or planned programs for recertification into programs for MOC.

The MOC movement has gained momentum and been embraced in the policies of not only the ABMS, but also the Accreditation Council of Graduate Medical Education (ACGME) and Association of American Medical Colleges. The expectation is that training and acquisition of knowledge and skills in medical practice will begin in medical school, be enhanced and honed to the specialty in residency, and maintained throughout a specialist’s career.

Admittedly the designation of “competence” has been troublesome for ABMS Boards. All Boards share the belief that their Diplomates possess “requisite or adequate ability or qualities”; however, they and their legal counsels are reluctant, indeed unwilling, to accept the responsibility that the certification process verifies “competence” in all aspects of practice at all times. The Task Force on Competence defined physician competence as follows:

“The competent physician should possess the medical knowledge, judgment, professionalism, and clinical and communication skills to provide high quality patient care.

Patient care encompasses the promotion of health, prevention of disease, diagnosis, treatment, and management of medical conditions with compassion and respect for patients and their families.”

In concert with the ACGME, six general “competencies” have been identified as key elements for the full spectrum of MOC. Thus, although neither the ABNS nor its sister Boards purports to certify competence, it strives to evaluate competence with respect to knowledge and practice. The components, appropriate to the specialty, form the foundation for physician and resident training; the basis for credentialing, both primary certification and future MOC; and the accreditation standards against which residency programs are assessed in their teaching and performance by Residency Review Committees (RRC). They are:

Medical Knowledge: Know and critically evaluate current general and practice specific medical information; understand and incorporate evidence-based decision making.

Patient Care: Improve performance skills, including medical interviews and physical examinations; incorporate a synthesis of clinical data.

Interpersonal and Communication Skills: Communicate effectively with patients and families, other professionals, and team members; maintain comprehensive legible medical records.

Professionalism: Demonstrate self-awareness and knowledge of limits, high standards of ethical and moral behavior, reliability and responsibility, respect for patient dignity and autonomy.

Practice-Based Learning and Improvement: Engage in ongoing learning to improve knowledge and skills; analyze one’s practice to recognize strengths and deficiencies; seek input to improve practice and quality care.

Systems-Based Practice: Promote patient safety within the system; provide value for patients through cost effective care; promote health and prevention of disease and injury; demonstrate effective practice management.

ABNS MOC

The ABNS is giving careful thought and study to the methodology of an MOC program. Certain principles governing the plan are already established, whereas others are just taking shape. The overriding principle is that the process must evaluate the six basic competen-

cies and evolve into a continuous, rather than periodic, process. The ABNS envisions that its primary certification program will remain as it currently functions: verification of credentials, evaluation by peers, review of practice data, and examinations. MOC will necessarily conform to the model adopted by the ABMS with assessment of four components. A proposal for assessment of the first components has been submitted to the ABMS for approval.

For evidence of professional standing, all ABMS Boards will require an unrestricted license to practice medicine. The ABNS will likely also include input from peers and perhaps co-workers and even patients.

Evidence of cognitive expertise will be met by a secure examination, undoubtedly multiple choice, administered at test centers around the country. It is the only part of MOC that will be pass/fail. The Examination Committee, with input from the Extra-Mural Subspecialty Item Writing Committee, is already assembling a bank of questions to generate an examination that will test fundamental knowledge, as well as practice related current clinically valid knowledge. Additionally it will cover information relating to the practice environment, such as quality assurance, safety, ethics, and economic issues. Diplomates will be given the option to be examined completely in general neurosurgery or partially in complex spine surgery or pediatric neurosurgery. The fact that the examination will be practice related should allay fears regarding esoteric question. Also there will be no limit on retaking it.

The requirement for evidence of participation in lifelong learning and self-assessment is challenging. Traditional CMEs will be part of this but less weighty than practice related self-study and analysis. The Self-Assessment in NeuroSurgery (SANS) program holds promise as an important element, as well as valuable in preparing Diplomates for the secure examination.

Involvement in a program for evidence of evaluation of practice assessment has the potential to bring about significant improvement in practice. A web-based analysis of key cases relative to management methods and procedural outcomes will likely be used here.

The ABNS will proceed slowly in developing these programs and look to the cumulative experience of other surgical Boards and the ABMS for direction. Methods for assessment and feedback relative to performance in the six areas will undoubtedly evolve and ultimately

become most meaningful.

Many Diplomates will regard MOC with trepidation or even outright hostility, which is understandable. I reassure you, however, that the ABNS is committed to the program with the realization that “its time has come”, and it is “the right thing to do” for our patients and our specialty. The goal is an MOC process that is not onerous or expensive but, instead, meaningful and enhancing to the practice and competence of neurosurgeons.

VOLKER K. H. SONNTAG, MD
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- Evidence of professional standing,
- Evidence of life-long learning and self-assessment,
- Evidence of cognitive knowledge, and
- Evidence of performance in practice.

Evidence of professional standing is the only component completed at the present time. It will require a full, unrestricted license to practice medicine in all jurisdictions in which the Diplomate practices. The neurosurgeon must also have unencumbered hospital admitting privileges to practice neurosurgery, and a letter of recommendation from the chief of staff of the primary hospital will need to be submitted. Evidence of fulfillment of these requirements must be submitted to the ABNS every two years. The MCO Committee is also working on how individuals who are not practicing full time can participate in the process.

Although not finalized, the following is planned for the other three components.

Evidence of life-long learning and self-assessment will require Diplomates to submit evidence of completion of 100 hours of CMEs over a two year cycle: 40 hours of Category I and 60 hours of Category II or a mix of both. Tracking of credits will be done in conjunction with the American Association of Neurological Surgeons. The component will also include an open book examination to be taken every two years. This will be carried out in conjunction with the Congress of Neurological Surgeons.

Evidence of cognitive knowledge will consist of a secure, web-based examination to be completed every ten years. The examination will consist of 200 questions, with three test modules available: general neurosurgery, spine surgery, and pediatric neurosurgery. For the complex

spine and pediatric examinations, 150 questions will be from general neurosurgery and 50 from the subspecialty.

Evidence of performance in practice will consist of submission of ten key cases by Diplomates every two years. The cases will be selected from a list of procedures covering all subspecialties. In addition, Diplomates will track six months of operative cases. This should help to develop a practice profile for Diplomates and hopefully provide feedback about outcomes, possibly compared to national benchmarks.

The ABNS acknowledges that adopting an MOC program and processes will significantly change professional requirements, which could generate considerable frustration. The Board, however, is committed to making the program accessible, affordable, and professionally enhancing and, thereby, meaningful for Diplomates, patients and the general public. The ABNS welcomes the input of its Diplomates in the MOC process.

ARTHUR L. DAY, MD TREASURER

ABNS yearly revenues are derived from several sources, including the annual membership assessment, fees for written and oral examinations, and return on investments. Yearly expenditures include office expenses (salaries, benefits, rent, and supplies, etc) and the activities of Directors in their various Committee functions (development and delivery of examinations, and development of MOC, etc.). In years past, expenses have generally run slightly lower than revenues, thus enabling the Board to establish a reserve operational fund.

The ABNS is addressing several major issues that have required restructuring of its finances.

1. Meeting frequency and length is one of these. Faced with increasingly complex issues, Directors each year now hold a third meeting, which is regularly scheduled in the winter and dedicated to a specific focus.

2. MOC will require the Board to review practice data from its Diplomates periodically throughout the life of their practices. In order to facilitate this, the ABNS developed a web-based logging system called NEURO-LOG to compile and manage data from residents, primary certification applicants, and MOC candidates.

The goal of the database project was originally to standardize and digitize candidate practice data submission. NEURO-LOG goes beyond this by offering HIPAA compliant technology that merges the ABNS requirements with those of the RRC for Neurological Surgery and creates a seamless system useful from residency to retirement with a similar data submission format for all levels. In addition, once implemented and used for several years, the database should be quite useful in evaluating practice patterns. NEURO-LOG will be released later this summer. It will be supported by DataHarbor and the ABNS office. Details can be found at www.ABNS.org.

3. The Board office has made much needed upgrades in important electronic and communications capabilities in order to prepare for the future and increase its workload.

The fee for the 2003 written Primary Examination was \$410 and currently \$2250 for the oral examination. The yearly contribution asked of actively practicing Diplomats is \$125. These fees, increased by vote in fiscal year 2002, cover the costs of activities as they currently exist but may not take care of future expenses, for instance those associated with MOC and increased legal costs associated with ensuring Diplomate conformity to Board standards.

The ABNS Investment Portfolio is divided equally between equities and bonds. Like all similar funds, it diminished in value over the past few years, but fortunately by the end of June 2003 the Portfolio had recovered substantially. The Board expects that the budget for 2003, as was the case for 2002, will balance (income vs. expenditures) without dipping into reserves.

The fourteen Directors of the American Board of Neurological Surgery hope this Newsletter has been of interest to you. If you have any questions, advice, or comments, please write to the office or e-mail us at abns@tmh.tmc.edu. Notices of change of address are always appreciated, and it is helpful to learn of change of status to retired since assessment statements are sent only to active practitioners. Diplomates overwhelmingly continue to support the Board’s commitment to continuing improvement of the certification process and the search for an acceptable MOC process through the voluntary dues program. Thank you.