

M. SEAN GRADY, MD
CHAIRMAN



I am pleased to provide a report on the activities of the American Board of Neurological Surgery for 2008. This column will focus on:

- Ongoing implementation of the Board's Strategic Plan,
- Update on the Institute of Medicine's Committee on resident work hours, and
- Maintenance of Certification.

Strategic Plan

In 2006 the ABNS developed a series of strategic initiatives that would form the basis of its activities for the next five years. Updated reporting on them is an important part of the Board's responsibilities to Diplomates. They are:

- Finance,
- Information Technology, and
- Residency Education and Subspecialization.

Much has been accomplished on all three.

Thus, after reflecting on the initiatives and programs involved, the Executive Committee has cancelled the 2009 Winter Directors Meeting that traditionally serves as a strategic retreat. In the view of the Board, there are currently no urgent imperatives. In addition, Directors are very cognizant of their responsibility in using the resources derived from Diplomates.

Finance

The ABNS was very concerned in 2006 about the cost of MOC since it would increase the work of the Board by 30%. Adjustments made in the assessment structure and the elimination of the residency database have made significant inroads into assuring a balanced budget (see the report from Dr. Paul C. McCormick, ABNS Treasurer). Current database costs include development of Key Cases used as a part of MOC. The case collection system is maintained by Outcome Sciences, but the actual tool by which cases are collected and compared is the intellectual property of the Board. There may be oppor-

Continued on page 2

ABNS NEWSLETTER

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AMERICAN BOARD OF NEUROLOGICAL SURGERY

2008

NEUROLOGICAL SURGERY

is a discipline of medicine and the specialty of surgery that provides the operative and non-operative management (i.e. prevention, diagnosis, evaluation, treatment, critical care, and rehabilitation) of disorders of the central, peripheral, and autonomic nervous systems, including their supporting structures and vascular supply; the evaluation and treatment of pathological processes that modify the function or activity of the nervous system, including the hypophysis; and the operative and non-operative management of pain. As such, Neurological Surgery encompasses the surgical, non-surgical, and stereotactic radiosurgical treatment of adult and pediatric patients with disorders of the nervous system: disorders of the brain, meninges, skull, and skull base, and their blood supply, including the surgical and endovascular treatment of disorders of the intracranial and extracranial vasculature supplying the brain and spinal cord; disorders of the pituitary gland; disorders of the spinal cord, meninges, and vertebral column, including those that may require treatment by fusion, instrumentation, or endovascular techniques; and disorders of the cranial, peripheral, and spinal nerves throughout their distribution.

The broad aim of the

AMERICAN BOARD OF NEUROLOGICAL SURGERY

is to encourage the study, improve the practice, elevate the standards, and advance the science of neurological surgery, and thereby to serve the cause of public health.

DANIEL L. BARROW, MD SECRETARY



The primary, core role of the American Board of Neurological Surgery is certification of young neurosurgeons. The ABNS also plays an important role in residency training by establishing the requirements a resident must meet in order to become certified. More recently, the institution of Maintenance of Certification has added additional responsibilities. Directors' increasing commitments and expanding responsibilities have resulted in the establishment of a close linkage with a number of other important organizations, including the Accreditation Council for Graduate Medical Education, Residency Review Committee for Neurological Surgery, American Association of Neurological

Continued on page 2

TAE SUNG PARK, MD CHAIRMAN, EDUCATIONAL REQUIREMENTS AND SUBSPECIALIZATION COMMITTEE

I am pleased to update you about the Board's ongoing deliberations on recognition of subspecialties within neurosurgery.

Directors recognize that subspecialization in neurosurgery is a reality. At their 2007 Winter Meeting, they reviewed the pros and cons of recognizing subspecialties. A resolution was passed stating that subspecialty certificates will not be issued, but Recognition of Focused Practice for Diplomates in certain subspecialties through the Maintenance of Certification process will be considered. At the 2008 Winter Meeting, the option of a

Surgeons, Congress of Neurological Surgeons and AANS/CNS Subspecialty Sections, American Board of Medical Specialties and its member Boards, Federation of State Medical Boards, National Board of Medical Examiners, and Society of Neurological Surgeons.

The fourteen ABNS Directors are selected from nominations submitted by the American Academy of Neurological Surgeons, American College of Surgeons, Neurosurgical Society of America, AANS, CNS, and SNS. Each Director serves a six-year term, and then moves to the Advisory Council for another six years. The vital responsibilities of Directors include review of candidate practice data, review of applications for initial certification, development of questions for the Primary and MOC Cognitive Examinations, administration of oral examination, and development and administration of the various components of MOC.

Residency Training

Nine hundred twenty-five residents were training in 97 programs during the 2007/2008 academic year. One hundred twenty-seven (14%) were women. Sixty-three of the 97 training programs the United States have at least one woman. One hundred forty-four residents finished training in 2007. The RRC has been progressively increasing the number of training slots and approved two new programs.

The results of the 2008 Match show that neurosurgery remains competitive with 88% of U.S. seniors able to obtain positions. One hundred seventy-nine positions were offered and 173 filled; the remaining 6 were filled within 48 hours. Over the past several years, neurosurgery resident applicants' scores on the USMLE Part One have risen to the present average of 236.

The ABNS conducts a post-residency survey of residents finishing training to determine whether they go on to fellowships or straight into practice. The response rate in 2007 was 63 of 144 finishing trainees. Thirty-seven went on to fellowship training (12 vascular, 9

spine, and 9 pediatric), while 26 went into practice (14 partnership, 11 academic, 7 hospital). In order to obtain a more accurate view, candidates for oral examination will be surveyed at the conclusion of their examination. This should provide a better picture of the actual activities of neurosurgeons in the first three to five years following training.

Beginning in the 2008/2009 academic year, neurosurgery will change from the San Francisco Match to the National Residency Matching Program. This means neurosurgery residency applicants will only apply to one match and their entire training will be under the direction of a neurosurgical Program Director. More information about the NRMP and its process is available at www.societyns.org.

One of the priorities of the ABNS over the last few years has been residency redesign. Changes in the requirements have been approved by the ABNS and RRC, and more recently by the ACGME. They will be implemented July 1, 2009, in order to coordinate with the NRMP.

The March 2008 written Primary Examination, which must be passed before completing residency training, contained 375 questions. It was taken by 617 examinees, 198 of whom took it for credit toward certification. The failure rate was 14%. Since the internship year is now under the control of neurosurgery residency Program Directors, interns were allowed to take the Examination for the first time in 2008.

The second MOC Cognitive Examination was held in March at the same time as the Primary Examination. Seventy-six Diplomates took it; 52 took the general examination, 21 the spine module and 3 the pediatric. In conjunction with a standard setting exercise done by the Written Examination Committee and the NBME, a minimum passing score of 73% was established. All examinees passed.

Diplomate Numbers

Seventy-two candidates were examined at the November 2007 oral examinations; the failure rate was 19%. In May 2008, 74 candidates were examined, and the failure rate was 18%. During the last 12 months, the ABNS has

revoked two certificates and suspended one other. Currently, there are approximately 3400 ABNS certified neurosurgeons in practice, an all-time high. About 39% hold time-limited certificates and must participate in MOC. 🍷

tunities to license the technology and provide an offset for the costs of maintaining the system as pay for performance and other processes are implemented by insurers.

Information Technology

In 2006 there was significant concern that the clinical database maintained by the Board was becoming increasingly complex and costly. It served to collect operative cases for both initial certification and residency training. An alternative system for resident case logging developed by the Accreditation Council for Graduate Medical Education was being utilized by a number of surgical Residency Review Committees at that time. Consequently, the ABNS voted to transfer the responsibility for residency data to the RRC for Neurological Surgery and ACGME, which are responsible for insuring case volume in residency programs. Furthermore, the Board found that resident operative data, which for years was submitted as part of the application for initial certification, was no longer being utilized in making decisions about candidates' credentials. In May 2007 the Regulations were changed, and resident cases are no longer required to be submitted to the ABNS.

Residency Education and Subspecialization

The focus of the 2008 ABNS Winter Directors Meeting was Residency Redesign and Recognition of Focused Practice through MOC. In July and November 2007, the Society of Neurological Surgeons sponsored Educational Summit meetings attended by members of all the major neurosurgical organizations involved with residency training. As a result of these, plus discussions and deliberations by the Board, the following recommendations for resident training were made to the RRC.

WARREN R. SELMAN, MD
WEBSITE & MyMOC
COORDINATOR



The mechanism for initiating and continuing the Maintenance of Certification process is found on the ABNS website, www.abns.org.

The process for Diplomates with time-limited certificates who need or wish to participate in the program, is the same.

Diplomates are assigned a user name, which corresponds to their email address used by the AANS for the purpose of CME tracking. The password, if forgotten, can be obtained from the MyMOC website by clicking on the Email my Password button. Diplomates encountering any difficulty can always obtain personal attention for problem-solving by e-mailing the Board at abns.moc@tmhs.org.

After successfully logging on to MyMOC, Diplomates will find the on-line application. A checklist is available on the website in pdf format. You might want to print this out to review prior to starting. The application has been designed for ease of entry. If all the information noted on the checklist is available, it can be completed in approximately thirty minutes. The website will remain a central place for Diplomates to monitor their progress in MOC throughout each ten-year cycle.

One requirement of Lifelong Learning and Self Assessment is the completion of 150 CME credits during each three-year mini-cycle. Category 1 credits, which are neurosurgery oriented and require verification, are tracked by the AANS for the Board. Guidelines for acceptable Category 2 credits

are located at MyMOC as well. These are self-reported and self-entered per the instructions also found there. Thirty Category 2 credits may be non-neurosurgery oriented.

Another component of MOC is successful completion of the Cognitive Knowledge Examination. It is taken in the 8th, 9th and/or 10th year of the ten-year MOC timeframe. The Examination is given in the spring at residency training programs at the same time as the Primary Examination. It consists of 200 multiple choice questions covering thirteen disease oriented categories: anatomy, anesthesia, congenital, core competencies, degenerative, functional, general clinical, infection, neurology, pain, trauma, tumor, and vascular. All questions are based on conditions that will be familiar to most practic-

ing neurosurgeons. Diplomates may elect to take all 200 questions in General Neurosurgery, or 150 in General Neurosurgery plus 50 subspecialty questions in either Spine or Pediatric Neurosurgery. Preparation for the Cognitive Examination is enhanced by completion of the SANS Examination during each three-year mini-cycle. That is available to all MOC participants free of charge from the Congress of Neurological Surgeons on the MyMOC Website.

The following table lists the number of participants with time-limited certificates enrolled in the MOC process as of October 1, 2008. Of note is that 49 Diplomates have voluntary enrolled, and another 72 have asked to be placed in the process. 🍷

Year Certified	Number Certified	Current 3-year Mini-Cycle	Number Participating	Number Not Yet Participating
1999	128	3 yr - 3rd mini-cycle	119	9
2000	124	2 yr - 3rd mini-cycle	88	36
2001	120	1 yr - 3rd mini-cycle	65	55
2002	143	3 yr - 2nd mini-cycle	122	21
2003	152	2 yr - 2nd mini-cycle	95	57
2004	139	1 yr - 2nd mini-cycle	49	90
2005	145	3 yr - 1st mini-cycle	126	19
2006	128	2 yr - 1st mini-cycle	74	54
2007	121	1 yr - 1st mini-cycle	31	90
2008	61	Start in 2009		
TOTAL	1261	-		

NELSON M. OYESIKU, MD CHAIRMAN, MAINTENANCE OF CERTIFICATION COMMITTEE



Although many ABNS Diplomates have entered the Maintenance of Certification process and are cycling through, others are considering the

program or waiting to enter. The Board has disseminated information in various forums to its Diplomates to keep them abreast of developments. In this Newsletter we will reconsider the purpose of MOC, review one of the key components – Key Cases and, provide a brief update.

Why MOC?

The public, payors, health care organizations, and governmental agencies all support periodic recertification of specialists. In 1998 the American Board of Medical Specialties created the Task Force on Competence to assure that all certified specialists maintain satisfactory, up-to-date knowledge and skills throughout their careers. In March 2000 all ABMS member Boards, including the ABNS, committed to developing an MOC program or modifying their current programs for recertification into MOC. ABNS Directors became committed to making available to Diplomates a meaningful and practical plan that would take into account the concerns of Diplomates and the needs of the public, plus meet the standards of neurosurgery and those established by the ABMS. Since neurosurgeons may soon be required by regulatory bodies to participate in an MOC process, development of a program has been unanimously endorsed. Training and acquisition of knowledge and skills in medical practice now begin in medical school, are enhanced in residency, and maintained throughout a neurosurgeon's career.

Goals of MOC

The goal of MOC is to foster excellence in patient care. Through its MOC program, the ABNS encourages and stimulates continuing education in the practice of neurosurgery. It supports its Diplomates in life-long learning and self-assessment. It provides assurance to patients and their families, payors, funding agencies, and the general public that Diplomates maintain and continually improve their knowledge and practice of neurosurgery, keeping current with changes in the field. In the future, MOC will provide an avenue for compliance with State and hospital requirements, which are expected to include either participation in an MOC program or periodic re-examination by a medical board.

The program reflects the realities of current neurosurgical practice. Emphasis is on core knowledge and practice common to all neurosurgeons. Directors realize that neurosurgeons often concentrate their energies in subspecialties areas. Consequently, the process permits them to emphasize these areas of expertise when devoting time to CME activities, logging Key Case information, and selecting a module for the Cognitive Examination.

The MOC program has four basic components:

1. Evidence of Professional Standing
2. Evidence of Lifelong Learning and Self-assessment
3. Evidence of Cognitive Knowledge
4. Evidence of Performance in Practice

Within this framework, the ABNS program has integrated the following requirements:

- Chief of Staff Questionnaire
- Unrestricted Hospital Privileges
- Unrestricted License to Practice Medicine
- CME Hours, both Category 1 and Category 2
- Key Case Analysis
- Self-Assessment in Neurological Surgery (SANS examination)
- Cognitive Examination

Key Cases

MOC participants select a type of case from a list of fifteen and submit the details from ten recent, consecutive cases of that type. Once a Key Case has been selected, it is used for all three mini-cycles in a ten-year cycle. The Cases are accessed and completed at MyMOC on the ABNS website, www.abns.org. The information, including outcomes, is self-reported by participants on the standardized module questionnaires. As participants log their data, references to relevant literature pop up, thus providing a significant educational aspect. Once completed, Key Case participation is validated, and Diplomates receive feedback on their own cases, as well as anonymously compare theirs to the collective results reported by other Diplomates who selected the same Key Case. Thus, they can track their outcomes and compare them to others, plus see the extant literature. In addition, they can see their own improvement from one mini-cycle to the next.

Directors chose fifteen cases that represent the most common diagnoses seen and procedures performed by neurosurgeons. They then developed reporting modules for each one. The data collected is tailored for relevancy, but the concept is the same. The information is standardized into three areas: history, treatment, and outcome. Great care is taken to protect the anonymity of patients.

The list of Key Cases currently consists of:

1. Anterior Cervical Discectomy and Fusion
2. Chiari Decompression
3. Clipping of Supratentorial Aneurysm
4. Craniotomy for Newly Diagnosed Glioma
5. Craniotomy for Temporal Lobectomy for Mesial Temporal Sclerosis
6. Endovascular Embolization of Anterior Circulation Aneurysm
7. Lumbar Discectomy
8. Management of Head Trauma
9. Management of Low Back Pain
10. Radiosurgery for Brain Metastasis
11. Release of Tethered Spinal Cord
12. Removal of Cerebral Hematoma
13. Surgery for Pituitary Tumor
14. Surgical Treatment of Trigeminal Neuralgia
15. Ulnar Nerve Decompression.

ABNS Directors believe the Cases will provide maximal benefit to this aspect of MOC. The process is straight forward and not onerous to participants.

The Board is always receptive to suggestions for improving and streamlining its MOC process. As of May 2008, there were a total of 900 participants out of 1352 eligible Diplomates. Voluntary enrollees at various stages of completion are between 60 and 100.

All 27 examinees passed the first Cognitive Examination in March 2007. Similarly, all 78 examinees passed at the second Examination given in March 2008.

Diplomates participating in MOC are advised to track their progress closely at MyMOC and adhere to all deadlines for completion of requirements. Although they may petition the Board for exemptions from particular requirements or extensions of time, such exceptions and extensions will be granted only in rare cases. Only under compelling circumstances will they be considered, not in the normal course of events in which an individual simply missed a deadline or is "unable" to complete requirements within the mandated time frame. 🍷

ROBERT L. MARTUZA, MD CHAIRMAN, CREDENTIALS COMMITTEE



The ABNS Credentials Committee is charged with determining and recommending to Directors the eligibility of all candidates who apply for oral examination and initial certification, plus recommending disciplinary actions against Diplomates in various circumstances. All of these are voted on by the full Board.

With regard to disciplinary actions, we have increasingly seen States impose "probation" on licenses. In some States, a Diplomat with a license on probation is allowed to continue to practice. In these circumstances the ABNS will typically place the individual's Certificate on probation, while allowing the Diplomat to continue to hold him/herself out as certified (although he or she must report the action to State licensing authorities, hospitals, and insurers). Other States do not allow continued practice during the period of probation, effectively suspending the license. Here, the Board will usually suspend the Certificate. Once restrictions are lifted, Diplomates may apply for an end to the probation or suspension. Ordinarily, even Diplomates with non-time-limited certificates will then be given time-limited Certificates and must participate in Maintenance of Certification. Similarly, the Board will require a Diplomat to participate in MOC if, for example, a State reprimands him or her for multiple wrong site surgeries but does not take action against a license.

At their May 2008 meeting, Directors held a hearing to consider a candidate who started residency training in Canada in 1996. As a first year resident, he signed a letter acknowledging that he would need to have an FRCS(C) before applying for ABNS certification. He subsequently failed to achieve an FRCS(C) and requested a waiver of the requirement. The waiver was denied. Directors also discussed a Diplomat whose

medical license was placed on probation in 2006 but the action reversed the same year; he now has an unencumbered license. The Directors voted to take no action. Nine reviews involved:

- 1) Issues requiring conversion of non-time-limited Certificates to time-limited (which requires MOC participation),
- 2) Diplomates who accept the option of signing a letter of retirement from the practice of neurosurgery in lieu having their Certificates revoked, and
- 3) Letters of concern.

The Committee recommended and Directors voted affirmatively that a Diplomat with no active license be allowed to sign the retirement letter. Another Diplomat had multiple instances of unacceptable surgical outcomes that prompted a review of licensure by his State Board of Medicine, which imposed sanctions consistent with what the ABNS considers probation. Directors voted to place his Certificate on probation coterminous with the State sanctions. Once these are lifted, the individual will be required to enter MOC. In two cases Diplomates had been issued letters of concern by their State Boards for a single instance of wrong site/side surgery. Directors voted to issue letters of concern to them.

Every case brought to the Board's attention is considered on its individual merits. In general, however, recognizing that States are in a better position to conduct thorough investigations, Directors vote along the lines of the actions taken by the licensing authorities. The ABNS always endeavors to protect the public and enhance the profession of neurosurgery. 🍷

- 1.) Neurosurgical training is a minimum of 72 months in length, including the PGY-1, which is now under the complete control of the neurosurgical Program Director.
- 2.) 42 months of core clinical neurosurgery are required during the 72 months, including 12 months as senior most resident.
- 3.) The PGY-1 must include a minimum of 3 months of fundamental clinical skills training (trauma, critical care, and other rotations as designed by the Program Director) and may include up to 6 months of neurosurgery (which will count toward the 42 months required).
- 4.) 3 months of clinical neurology must be taken during the first three years, preferably during the PGY-1.

Program Directors will determine the format of training, which should be tailored to the individual residents. The fundamental change is that the PGY-1 is no longer a transitional year but instead has become part of the over-all neurosurgical training experience. The recommendation was carried forward by the RRC through the ACGME approval process, and the changes will go into effect July 1, 2009.

Also at the Winter Meeting, Directors decided not to pursue activities involved in Recognition of Focused Practice through MOC. It will, however, follow the development of any such program that may be established at the level of the American Board of Medical Specialties.

Institute of Medicine Committee on "Optimizing Graduate Medical Trainee Hours and Work Schedules to Improve Patient Safety"

This Committee was formed in late 2007 and has held four meetings to date. The scope of its mandate is to review current evidence on medical resident schedules and health care safety in order to develop strategies to enable optimization of work schedules and improve safety. The Committee has heard evidence on the relationships between work schedules and performance, safety and evidence of sleep fatigue, from other health care professionals and other industries, as well as the experiences

in Europe and Australia. The sponsor is the Agency for Health Care Research and Quality; there is significant concern that a political agenda is behind this particular sponsorship. The ABNS is concerned that duty hours will be substantially reduced to 56 hours per week. The Committee should produce its draft report in September 2008 with publication in March 2009.

At the March 2008 meeting of the IOM Committee, Dr. H. Hunt Batjer, ABNS chairman, represented the ABNS and Society of Neurological Surgeons to provide testimony outlining the consequences of implementing the 80 hour work week in 2003 and the major adverse effects on patient safety that a 56 hour work week would create. Testimony provided by the ABMS, American Association of Medical Colleges, American College of Surgeons, and ACGME strongly supported the ABNS position:

Further reduction of duty hours would have a major negative impact on public health and safety.

It appears that the IOM will not likely recommend any further reduction in duty hours and may recommend that these matters should rest with the ACGME. Notwithstanding, it may recommend that no work session last longer than 16 hours based on sleep physiology studies. Of particular note is that there has been substantial recognition that specialty training varies significantly and the individual specialty societies may be in the best position to determine what is acceptable training.

Neurosurgery has stood out as unique amongst the surgical specialties by its commitment to education and training outstanding neurosurgeons for the public health. During this process, the interactions by the ABNS with other organizations, such as the AAMC, ACGME, ACS, and ABMS, have demonstrated the commitment of organized neurosurgery to education and professionalism.

Maintenance of Certification

Implementation of the ABNS MOC program began in January 2006. Diplomates with time-limited certificates, first issued in 1999, should all be participating now in order to

continue to be certified. Individuals who were certified in 1999 will lose their certification status December 31, 2009, unless they are currently participating in MOC. Nine Diplomates are presently in this category and at risk of no longer being Board Certified. Similarly, all Diplomates certified in 2002 and 2005 should be completing a three-year mini-cycle. Those not in compliance will be required to pay a substantial penalty in order to enter into the next cycle.

Several problems have been brought to the attention of the MOC Committee. These include physicians without hospital privileges who are required to be part of the process. A list of such matters and guidelines on how they are to be handled will be developed. This may result in modification of the MOC program, which would have to be approved by the ABMS.

MOC is expanding on a national basis as a result of a variety of different efforts, including pay for performance, hospital credentialing, and maintenance of licensure by state medical boards. CareFirst, a Blue Cross/Blue Shield insurance program in the Maryland region, has indicated that it would use participation in neurosurgery MOC as an indicator of quality. It is willing to increase reimbursement by 7% to neurosurgeons participating in MOC.

Directors

At the May 2008 Board meeting, Drs. Batjer and Kim J. Burchiel MD completed their six years of leadership as Directors. Each will now serve an additional six years on the Advisory Council. Newly elected Directors are Drs. Karin M. Muraszko and David W. Roberts, both nominated by the SNS. Officers for 2008-2009 are Dr. Grady, Chairman, and Dr. Robert L. Martuza, Vice Chairman. Dr. Paul C. McCormick continues as Treasurer, and Dr. Daniel L. Barrow started his term as Secretary in June. All Directors serve without compensation, taking at least one month out of the year for Board business. 🍷

TAE SUNG PARK, MD

Continued from page 1

reviewed by the Directors, along with members of the Advisory Council and invited guests.

The discussion focused on three subspecialty areas that might be amenable to such a program.

Drs. Robert L. Solomon and B. Gregory Thompson, Jr. reviewed responses from the AANS/CNS Cerebrovascular Section. There was a sense that endovascular neurosurgeons favor an RFP, while cerebrovascular surgeons are opposed. Directors questioned whether a single RFP for cerebrovascular neurosurgery would be sufficient, one of the requirements being the capability of the neurosurgeon to perform all procedures necessary to treat cerebrovascular disease: i.e. endovascular techniques, microsurgery, and radiosurgery. The consensus was that at this particular time it would not be necessary to practice in all areas in order to hold a RFP should one be developed.

Dr. Charles L. Branch Jr. reported from the Spine Section, which is broadly concerned that a RFP would be divisive. Since spine neurosurgery is the major component of the practice of neurosurgery, a general Certificate should suffice to recognize individuals who undertake spine surgery practice. He concluded his discussion by recommending against a RFP.

Dr. Marion L. Walker described the present requirements for certification by the American Board of Pediatric Neurological Surgery. Dr. R. Michael Scott further reviewed ABPNS activities, and its certification and MOC processed. A significant issue for them is that Canadian residency training is accepted for certification by the ABPNS, but no longer accepted by the ABNS. This would be a roadblock in moving forward with an ABNS RFP of pediatric neurosurgery.

Dr. Paul C. McCormick outlined the cost of setting up a RFP program. Much of the infrastructure for MOC would not need major modification; however, a more inclusive and detailed case log might be needed. That cost could be \$200,000 to \$300,000 per year.

At the conclusion of these discussions, Directors voted against undertaking Recognition of Focused Practice through the MOC process at this time. Nonetheless, the ABNS will send a letter to the American Board of Medical Specialties to determine what the requirements might be to institute the program. 🍷

PAUL C. MCCORMICK, MD TREASURER



The financial structure of the ABNS is relatively simple in that fees are adjusted to match each activity's expenses. Board activities include the preparation and administration of both the written Primary and web based Cognitive Examinations in conjunction with the National Board of Medical Examiners, assessment of qualifications and requirements for certification, administration of oral examinations, and development and management of the Maintenance of Certification program. Current fees for these activities are listed below. The annual Diplomate assessment, which now accounts for just over 50% of annual revenues, covers general and administrative costs, including personnel and office space costs, professional and liability fees, most MOC costs, Winter Directors Meetings, and ongoing data management and web hosting charges.

The Board has invested nearly one million dollars since 2002 in the development and implementation of the MOC program. This includes a customized online database cur-

rently utilized for Key Cases, as well as candidate practice data for initial certification. It is hoped that this data platform may also be utilized for pay for performance (i.e. comparative effectiveness), credentialing, maintenance of licensure, and liability coverage purposes in the future. The investment was financed through the ABNS reserve fund and an increase in the annual assessment of actively practicing Diplomates from \$125.00 to \$275.00 in 2006. The assessment is voluntary for Diplomates holding non-time limited certificates (those certified pre-1999) who are not participating in MOC. It is mandatory for Diplomates certified in 1999 and later, all of whom hold time-limited Certificates, and for non-time-limited Certificate holders who have chosen to participate in MOC. The remittance rate for the voluntary assessment for 2007 was about 75%. Directors have voted not to raise the assessment in 2009.

The reserve fund is maintained at 125% to 150% of annual operating expenses. It is currently invested in a professionally managed diverse portfolio of cash, equities, fixed income, and alternative strategies. Preservation of capital and annual returns that meet or exceed the appropriate S&P benchmarks are the investment goals. Total return for 2007 was 7.62%, compared to 6.39% for the 60% S&P 500 and 40% LBIGC benchmarks.

ABNS finances are annually monitored by a certified accountant and a triennial audit is performed. The next audit is scheduled for the year 2008. 🍷

2008 ABNS FEE STRUCTURE

Annual Diplomate Assessment	\$ 275.00
Primary Examination Fee	\$ 475.00
MOC Cognitive Examination Fee	\$ 800.00
Submission of Completed Application for Oral Examination and Certification Fee:	
Years 1 through 3 post residency	\$ 500.00
Year 4	\$ 1000.00
Year 5	\$ 2000.00
Oral Examination Fee	\$ 2500.00

rently utilized for Key Cases, as well as candidate practice data for initial certification. It is hoped that this data platform may also be utilized for pay for performance (i.e. compara-

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