



As Chairman of the American Board of Neurological Surgery, it is my honor to provide a report on the recent activities of the Board. This column will focus on

the Board's position regarding "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety", a report from the Institute of Medicine calling for further duty hour restrictions. Then, we turn our attention to NeuroPoint Alliance, and the appointment of new ABNS Directors and Officers.

Duty Hour Restrictions

A core mission of the ABNS is to certify individuals in the practice of neurological surgery. A core mission of the Residency Review Committee for Neurological Surgery is to accredit neurosurgical residency training programs. Both the ABNS and RRC are concerned about the recommendations in the IOM report with its proposal for further restriction of duty hours. Organized neurosurgery, composed primarily of the ABNS, American Association of Neurological Surgeons, Congress of Neurological Surgeons, Society of Neurological Surgeons, and RRC, responded to the Accreditation Council for Graduate Medical Education discussions about the report and its implementation. Emphasizing what is well known to individual neurosurgeons, organized neurosurgery's letter to Dr. Thomas J. Nasca, Chief Executive Officer of the ACGME, points out that the practice of neurosurgery is unique in the following ways:

- The scope and breadth of neurosurgical diseases require a diverse set of surgical skills without substantial overlap by other specialties.
- Neurosurgeons lack meaningful counterparts in other specialties who can provide similar care in their absence.
- The diversity of operations demands that during residency neurosurgeons gain exposure to the range of normal post-operative recovery, as well as recognition of untoward, immediate post-operative complications.

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ABNS NEWSLETTER

NUMBER 27

AMERICAN BOARD OF NEUROLOGICAL SURGERY

2009

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, interpretation of imaging, 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 purposes of the American Board of Neurological Surgery are to:

- a) Review the credentials and practice experience and conduct examinations of eligible candidates who seek certification by the Board;
- b) Issue Certificates to those individuals who meet the Board's eligibility requirements and satisfactorily complete its examinations, thereby conferring Diplomate status;
- c) Implement and administer a program for Maintenance of Certification; and
- d) Issue new time-limited Certificates to Diplomates who successfully complete the Board's MOC program, upon expiration of their time-limited Certificates.

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



MOC is rapidly becoming a fact of life for many Diplomates. The ABNS continues to invest significant financial and human resources into the

implementation and further development of this critical and key aspect of our professional lives.

As of the last meeting of the Board in May 2009, there are 1196 participants in MOC. A total of 1294 Diplomates hold ten-year time-limited certificates and are eligible to begin the process. Seventy-four Diplomates are voluntary enrollees.

The goal of MOC is to foster excellence in patient care. The ABNS program reflects the

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The fourteen Directors are selected from nominations submitted by the

- American Academy of Neurological Surgeons (1),
- American Association of Neurological Surgeons (4),
- Congress of Neurological Surgeons (4),
- Neurosurgical Society of America (1), and
- Society of Neurological Surgeons (4).

Each Director serves a six-year term and then moves as a former Director to the Advisory Council for another six years. Among many responsibilities, Directors' primary tasks 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 examinations, and development and administration of the various components of MOC.

Residency Training

Residents in training totaled 1136 in 99 programs during the 2008/2009 academic year. One hundred forty-two (13%) were women. One hundred thirty-two residents finished training in 2008.

The 2009-2010 academic year was the first time neurosurgery used the National Residency Matching Program. The results of the match show that neurosurgery remains competitive. Eighty-two percent of U.S. senior medical students were able to obtain positions. The average USMLE score continued to rise among applicants; for Part I it was 239 this year.

The Board conducts a post-residency survey at the time candidates arrive to take the oral examinations. This assures a higher compliance rate than a mailed survey. In November 2008 it had 73 participants. Thirty-one completed a post-residency fellowship; 14 completed enfolded fellowships, and 28 participated in no fellowship program. The most popular post-residency fellowships were spine, pediatrics, and endovascular. The most common enfolded fellowship was spine, followed by endovascular.

One of the priorities of the ABNS over the last few years has been residency redesign. Changes in the requirements for neurosurgical training have been approved by the ABNS and RRC and were implemented July 1, 2009, for this academic year. The new training requirements are as follows:

1. The PGYI year is under the direction of the neurosurgical residency program.
2. Total neurosurgical training for ABNS certification is 72 months in length (including PGYI).
3. 42 months of clinical neurosurgical training are required.
4. The PGYI year may include six months or less of neurosurgery, which will count toward the 42 months.
5. At least 3 months of neurology are required and may be taken any time within the first three years.
6. Either enfolded advanced clinical training, research, or both are allowed for one or two years.

The Primary Examination was administered to 636 examinees on Saturday, March 28, 2009. Two hundred nine candidates took it for credit toward certification and 427 for self assessment. The test was administered at 96 test centers throughout the country. There were 375 items, approximately 60% of which were newly written questions or revised old ones. Thirty were reviewed by the Written Examination Committee and 8 deleted, leaving 367 items for scoring. The failure rate was 16%, which is quite comparable with recent years.

The third MOC Cognitive Examination was held in March at the same time as the Primary. One hundred forty-two examinees took it, a significant increase from the 76 examinees in 2008 and 27 in 2007. All but one Diplomate passed.

Diplomate Numbers

There are currently 3540 actively practicing Diplomates of the ABNS. Including 1517 retired Diplomates, a total of 5057 neurosurgeons are certified by the Board at the present time. During the last twelve months, the ABNS has not revoked or suspended any certificates; however, two were put on probation.

Eighty-four candidates were examined at the November 2008 oral examinations; ten failed. In May 2009, 71 candidates were examined, and 12 failed. 🍷

- Neurosurgical operations are long and technically demanding; the average operating time, four hours, doubles other fields.
- Neurosurgeons face a substantial outpatient load and a unique workforce demand, including staffing trauma centers and taking care of emergency neurosurgical cases.

Organized neurosurgery believes it would be virtually impossible for a typical neurosurgical residency program to be in compliance with the proposed IOM duty hour rules while maintaining appropriate patient care and resident education activities. Under one model, a hypothetical program would be in violation and have to sacrifice 80 hours of program activity each week. The negative effects of the proposed regulations far outweigh possible benefits:

- The number of risky patient hand-offs would be increased, with a resulting lack of patient continuity of care.
- Clinical experience and educational opportunities would be decreased.
- The hierarchical nature of neurosurgical training would be flattened, inhibiting a resident's growth into a capable and mature neurosurgeon, instead leaving him or her ill-equipped for independent practice.
- Trust between attending physicians and residents would be eroded, impairing residents' experience in the operating room.

Organized neurosurgery recommends that the ACGME follow its present plan of analyzing the impact of the current work-hour restrictions by carrying out proposed pilot projects that emphasize flexibility and recognition of the differences between medical and surgical specialties. It further suggests that the ACGME is the appropriate institution to monitor and oversee resident training and education, including setting and enforcing resident duty hour rules.

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TAE SUNG PARK, MD
BOARD OF DIRECTORS,
AMERICAN BOARD OF
MEDICAL SPECIALTIES



I am pleased to update you on the recent activities of the ABMS. The organization consists of 24 member Boards and oversees physician certification and

MOC. Its mission is to maintain and improve the quality of medical care by assisting Boards to establish standards. It coordinates the activities of the Boards and provides information to the public, government, and profession organizations concerning issues involving certification.

For 75 years the Board Certification movement has been a key motivating factor in achieving a higher quality physician workforce. It serves as the primary self-regulation of physician accountability. There has been, however, a clear erosion in the public's trust of the ability of our profession to manage itself through self-regulation. Over the past few years, a consumer/purchaser movement to oversee physician accountability has rapidly emerged. More recently, self-regulation has been affected by government regulation. An example is the establishment of the Physician's Quality Reporting Initiative by CMS. Such government regulations and mandates will likely increase in coming years.

New ABMS Initiative

A goal of the ABMS is to enhance public trust in physician certification and provide national leadership for healthcare quality, patient safety, and physician accountability in the changing healthcare environment. Consequently, it has launched an ambitious new initiative called "Enhancing the Public Trust". One focus is to streamline and enhance the value of MOC. What this means is that all Diplomates with time-limited Certificates must participate in MOC, and the standards for it will undergo substantial periodic modifications.

New PQRI Requirement under Senate Finance Committee Health Care Policy Option

Under this program, eligible physicians could receive PQRI incentive payments for two successive years if they

- 1) Participate in an ABMS sponsored MOC program and
- 2) Complete a qualified MOC practice assessment (Component IV, Evidence of Performance in Practice).

An initial assessment of a participant's practice would be designed to demonstrate the physician's ability to use best evidence and practices in comparison to peers and national benchmarks, along with apply best evidence and consensus recommendations in order to improve quality of care. If MOC is included in the legislation for healthcare reform, the value of certification will be enhanced. MOC participants who collect performance measures for MOC will be able to use the data for multiple purposes, such as PQRI, plan rewards, and recognition programs.

Standardized Surveys of Patient Experience with Medical Care – Consumer Assessments of Health Care Providers and Systems

The Senate Finance Committee policy options require that MOC programs include a survey of patients' experience with care. The Agency for Healthcare Research and Quality has developed CAHPS for insurance plans and hospitals. Although it is not currently an MOC requirement, there is increasing external pressure to include it. The ABMS is developing a CAHPS tool, and ABNS Diplomates will likely be required to use a surgical version in the near future.

Aligning MOC with Maintenance of Licensure

Most patients assume licensed physicians are keeping current with the latest information and technology in their fields of practice. A goal of State medical licensing boards is to assure the public that their expectations are being met. Accordingly, the Federation of State Medical Boards is developing a policy model for States to require physicians, as a condition of re-licensure, to demonstrate their continuing competence. Since numerous complex issues are involved, it will take years to resolve. Representatives of the ABMS member Boards, National Board of Medical

Examiners, and FSMB will hold a workshop in November 2009 to explore the issues.

ABMS Position on IOM Report on Resident Work Hours

The ABMS presented the concerns of its member Boards to the ACGME regarding the IOM report in December 2008. The ABMS is concerned that further restriction of resident duty hours may constrain trainees' ability to achieve competence and preparedness for practice in community settings. Furthermore, it would not improve patient safety, patient care, or resident welfare. The ABMS made several recommendations, including:

- 1) Flexibility in implementing resident duty hours and scheduling standards since one size does not fit all specialties or programs,
- 2) Further research about current residency duty hours using prospective specialty-related outcome studies.
- 3) No further reduction in residency duty hours or constraints on work schedules until the impact of the 2003 reduction has been better studied,

Recognition of Focused Practice through MOC programs

The American Board of Internal Medicine presented a proposal in 2007 for an RFP in Hospital Medicine through MOC. Initially the concept appeared to have advantages over subspecialty certification through the ACGME. At the ABNS Winter Directors Meeting in 2008, Directors examined the pros and cons of RFP in various subspecialty areas. After comprehensive discussion, they decided against pursuing it for any subspecialty. The ABMS held a workshop in December 2008 to study the issues. Participants included representatives from member Boards and external stakeholders. At the workshop, more issues were raised. It is a fact that some physicians choose to focus their practices within their certified area, and RFP was seen as most benefit to those Diplomates who have chosen to do so. Workshop participants had a number of concerns, included the question of what patients and society need, the possibility of RFP limiting the scope of a physician's practice, its impact on small and rural hospitals, and complexities it might add

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to credentialing, privileging and contracting issues. Three unintended consequences might be public confusion, increased fragmentation of general medicine by placing emphasis on subspecialization, and increased risk for physicians who focus their practices but do not have an RFP designation. The ABIM plans to launch a demonstration project to measure outcomes and effectiveness. It has submitted a proposal for a pilot program for Hospital Medicine. 🍷

NELSON M. OYESIKU, MD
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realities of current neurosurgical practice. Emphasis is on core knowledge and practice common to all neurosurgeons. Directors realize, however, that Diplomates often concentrate their energies in subspecialties areas. Consequently, the MOC process permits them to emphasize their areas of expertise when devoting time to CME activities: logging Key Case information, completing one of the three SANS examinations, and selecting a module for the Cognitive Examination.

The ABMS on March 16, 2009 approved universal standards for MOC that reverberate through its member Boards. The program has four basic **Components**:

- I. Evidence of Professional Standing
- II. Evidence of Lifelong Learning and Self-assessment
- III. Evidence of Cognitive Knowledge
- IV. Evidence of Performance in Practice

Incorporated into the Components are six **Competencies**:

1. Communication and Interpersonal Skills
2. Medical Knowledge
3. Patient Care
4. Practice Based Learning and Improvement
5. Professionalism
6. Systems Based Practice

This Newsletter provides an update for Diplomates regarding recent events and changes, plus the status of the four Components.

Professional Standing

Currently in order to satisfy this Component, Diplomates are required to hold an unrestricted license to practice medicine and surgery in their jurisdiction. The Questionnaire sent to each participant's Chief of Staff has been substantially streamlined, making the process less onerous and more efficient by dispensing with unwanted items.

Two other requirements planned for this Component are the Consumer Assessment of Health Providers and Systems and a Peer Communication Survey. Both measure and report as part of the Communication and Interpersonal Skills Competency. CAHPS measures patient perception of physician performance in communication and interpersonal skills. PCS performs the same function for healthcare providers. Both will most likely be required once in each three-year mini-cycle. At this time, they are considered developmental standards, which means ABMS Boards are allowed time and flexibility to determine which instrument and yardstick is most appropriate for their Diplomates. Most of the surgical Boards, being similar in character, have combined to produce a CAHPS and PCS that will better serve the needs of surgeons. Both tools are also Components of Part IV, Performance in Practice.

Lifelong Learning and Self-assessment

This requires the accumulation of a total of 150 Continuing Medical Education credits. Sixty must be neurosurgical Category I credits. The remaining 90 may be Category I or Category 2, 30 of which may be non-neurosurgical. These are accrued and tracked on a three-year cycle. All verified Category I CMEs are reported to the AANS, which logs them for the ABNS. Category 2 credits are entered at MyMOC by participants.

A second aspect of this Component is the Self-Assessment in Neurological Surgery examination. Recognizing the fact that Diplomates engage in subspecialty practice, the CNS, which developed and updates SANS, now has three examinations available

for MOC: General Neurosurgery, Pediatric, and Spine. This feature tailors the requirement to the reality of practice. All three examinations consist of 250 questions and award 24 CME credits. Spine offers nearly 70 questions focused on spinal disorders and treatments, while the remaining questions cover all areas of neurosurgery. Pediatric SANS places its emphasis in over 80 questions on pediatrics. The General SANS material has a broad range of neurosurgical topics covering all areas of practice. Each question is accompanied by a peer-reviewed expert critique and hyperlinks to peer-reviewed literature. A fourth examination, SANS Competencies, is excellent. It does not, however, fulfill this aspect of MOC. It has 100 questions and awards 10 CME credits.

The third aspect is a Patient Safety Improvement Program. This self-assessment tool is currently in the developmental stage, although it will soon become mandatory. The ABMS has a PSIP, but member Boards may develop specialty specific modules. One likely scenario for the ABNS is a web-based downloadable multimedia tool, for instance an audio file, PDF, Webinar, or video file. When the module has been completed, participants will be directed to a brief quiz, given an evaluation, and led to an interactive form for claiming CME credits. The module may be developed by the neurosurgical professional societies with ABNS oversight. Approval by the ABMS Committee on Oversight and Monitoring of Maintenance of Certification would then be sought. Examples of possible topics are:

1. Communication of critical results such as labs, imaging, and surgical findings
2. Discharge communication
3. Hand hygiene and sterile technique
4. Patient positioning in order to avoid injury to the nerves and skin
5. Preoperative medications: screening, interactions, and high alert medications
6. Wrong side/site surgery; How to get it right and avoid missteps

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Cognitive Knowledge

The third Cognitive Examination was administered in March 2009. The web based Examination is well tolerated and easy to administer. The Board has no plans for changes in the near-term.

Performance in Practice

The most important tool here is Key Case reporting. Diplomates select a Case from a list of fifteen and log data from ten recent consecutive cases of that type. The information, including outcomes, is self-reported by participants on 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 the Diplomate receives feedback on his or her cases, as well as a comparison to the collective results of all Diplomates who selected the same Case. Once a Case has been selected, it is used for all three mini-cycles in a ten-year cycle. Thus, participants can compare their own outcomes and see their improvement over mini-cycles. The Key Cases, like SANS and self-reporting of Category II CME credits, are accessed and completed at MyMOC on the ABNS website, www.abns.org.

In response to requests of Diplomates, the MOC Committee is developing additional Key Cases. A Ventricular Peritoneal Shunt is in an advanced stage of development and will debut soon. Two other Cases are at an earlier stage of development, Lumbar Stenosis and Cervical Spine Trauma. The Committee also provides review of ad hoc Key Cases for Diplomates with unique or special practices not suited to the current Key Case list. For example, in the past year three sets of paper data have been reviewed: surgery for intramedullary tumor, piriformis syndrome, and surgery for acoustic neuroma

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 require-

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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' Certificates in various circumstances. All of these are voted on by the full Board. I have been chair of the Committee for the past few years and during that time seen a rise in the number of cases coming before us for review each year. Dr. Craig A. Van Der Veer now takes over this responsibility. He and the Committee will likely continue to see this increase. The ABNS always endeavors to protect the public and enhance the profession of neurosurgery.

States Medical Licensing Boards are increasingly taking disciplinary actions and imposing various levels of restrictions on licenses. Every case brought to the attention of the ABNS 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. Notwithstanding, since practices vary from state to state, Directors must try to take a broader view in determining what a particular State defines as probation. The ABNS then acts accordingly, usually paralleling the action of the State, in each individual circumstance. In some instances the ABNS will place a Diplomate's Certificate on probation while allowing the individual to continue to hold him or herself out as certified (although the action must be reported to State licensing authorities, hospitals, and insurers). In other circumstances, particularly when the State has suspended a license, the ABNS will suspend the Certificate. Once State restrictions have been lifted, the Diplomate may apply to the ABNS for an end to the probation or suspension. Ordinarily at that time, even Diplomates

with non-time-limited Certificates will be given time-limited Certificates and required to participate in MOC. Similarly, the ABNS may require a Diplomate to participate in MOC if, for example, a State reprimands him or her for multiple wrong side/site surgeries, even though the State might not take action.

Several specific topics were discussed at the May 2009 Board meeting.

1. Multiple cases of Diplomates with problems were reviewed. Six led to letters of concern. In one instance the ABNS issued a letter of concern and converted the Certificate to time-limited requiring participate in MOC. Three other Diplomates were sent requests for additional information, which will be further reviewed at the fall Board meeting.
2. Three hearings were held. The first was an issue concerning quality of care and lack of response to the Board's queries. A letter of concern was sent and the Diplomate asked to keep the ABNS informed as to any actions by his hospital and/or State. The second involved multiple cases with bad outcomes that had prompted the State to place the Diplomate's license on what the ABNS considered probation. After review, Directors voted to place the Diplomate's Certificate on probation co-terminus with the State action. It will be converted to a time-limited Certificate requiring the individual to enter MOC. The third involved three wrong site/side surgeries for which the Diplomate's license was put on probation. Directors put the Certificate on probation coterminus and converted it to a time-limited Certificate requiring participation in MOC.
3. Multiple candidates applying to take the oral examinations had rotations outside their sponsoring institution without prior approval of the ABNS. It was decided that, after each such incident, the ABNS will notify the program director of the infraction and send a copy of the letter to the Residency Review Committee for Neurological Surgery and the program's Graduate Medical Education office. 🍷

We oppose the IOM's proposal for a "complementary oversight role for both the Centers for Medicare and Medicare Services and the Joint Commission."

The production of well-trained neurosurgeons requires the following:

- Technical mastery, which requires many hours to achieve; appropriate duty hour standards are needed so as not to interfere with residents obtaining the necessary operative experience.
- Graduated and supervised responsibility throughout the evolution of the residency training period.
- Development of effective, personalized, fatigue management strategies.
- Professional and surgical ownership; since patients expect their neurosurgeons to be present throughout the surgical encounter, residency training must permit this without the imposition of duty hour restrictions, especially in the chief or senior residency years.

Neurosurgical training currently takes up to seven years. Further duty hour restrictions may require extending the clinical time. Prospective residents might be unwilling to train for longer periods; therefore, the recruitment of high-quality, talented medical students to the field could be compromised. Organized neurosurgery recommends there be no further reduction in duty hours for neurosurgical residency programs. In addition, the schedule within the 80-hour week should be more flexible in order to help residents internalize the importance of continuity of care and taking personal responsibility for patients. Duty hour standards should vary according to the level of training in order to allow senior residents to assume a greater degree of responsibility for patient care as they prepare for independent careers. To this end, organized neurosurgery recommends a paradigm for graduated responsibility and work hours as follows:

PGY 1 – 3: Residents taking in-house call ("first contact" for patient care)

- 88 hour weeks, averaged over 4 weeks
- 1 day in 7 off duty, averaged over 4 weeks
- 10 hours off between duty shifts
- In-house call (24-hour shift) may be followed with up to 10 work hours in order to permit residents to attend in the operating room, participate in didactic activities, and maintain continuity of care.

PGY 4 – 5: Residents in a supervisory role, not taking in-house call (by definition, not "first contact" for patient care)

- 88 hour weeks, averaged over 4 weeks
- 1 day in 7 off duty, averaged over 4 weeks

PGY 6 (last year of training):

Senior resident

- 1 day in 7 off duty, averaged over 4 weeks

NeuroPoint Alliance LLC

As noted in a press release by the American Board of Medical Specialties, recent news reports have highlighted the importance of physician credentials and ensuring that they meet high standards in their chosen areas of practice. While certification remains a voluntary process, it is viewed by hospitals, insurance companies, state and national agencies, and increasingly by patients as essential documentation of a doctor's training, competence, and commitment to lifelong learning.

The ABNS has developed a sophisticated Maintenance of Certification process under the leadership of several Directors who have chaired the MOC Committee. Dr. Volker K. H. Sonntag developed the initial process and submitted the plan to the ABMS. Dr. H. Hunt Batjer took over the ABMS approval process and developed more specifics for the program. The current chair is Dr. Nelson M. Oyesiku. They all worked to facilitate fulfilling the commitment to obtain and document lifelong learning.

While there are many aspects to being a neurosurgeon, patient care is at the heart of practice. Documentation of care is part of training and now of practice. In an effort to facilitate collection of patient care data and allow an opportunity for reflection and improvement, the Board developed an impressive online database for patient care logging through Key Case modules.

The AANS, ABNS, and CNS recognize the advantages of allowing neurosurgeons to use a single, consistent data entry system for collecting patient care information for the many agencies that will ultimately request it for documentation of commitment to lifelong learning. As a result, the AANS and CNS formed NPA, which has a license agreement with the ABNS to collect data on neurosurgical practice.

NPA will work with practicing neurosurgeons, and federal, pay-for-performance and quality improvement programs, clinical investigators, neurosurgical device manufacturers, and others who need the highest quality clinical data about neurosurgeons, their patients, practices and opinions. Neurosurgeons will have the opportunity to participate in projects offered by NPA and at the same time can reliably submit their data for MOC, and federal and pay-for-performance programs, etc. Services NPA will provide to individual neurosurgeon and neurosurgical organizations include the ability to perform sophisticated surveys, facilitate completion of studies from concept to protocol, provide clinical trial management expertise, and offer data management. This will be done through the use of an internet-based system with a wide range of data management tools. NPA clients will be able to collect data related to neurosurgical practice, for example experimental clinical trials, observational studies, registries, practice expense, and practitioner surveys. Ultimately, NPA will provide direct benefit to neurosurgical patients by allowing identification of the best practices of neurosurgical care.

Strategic Planning

Three years ago, the ABNS, under the direction of Dr. A. John Popp, undertook a broad strategic planning process. Each year since

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WARREN R. SELMAN, MD
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then, Directors have designed time to address the three areas highlighted by that process. At their January 2010 meeting, Directors will review the goals and objectives recognized in 2006 in an effort to ensure that the Board is meeting the objectives of its core mission.

New Appointments

At the ABNS meeting in May 2009, Drs. M. Sean Grady and Robert L. Martuza 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. Robert E. Harbaugh and Frederick B. Meyer. Officers for 2009–2010 are Dr. Warren L. Selman, Chairman, and Dr. Paul C. McCormick, Vice Chairman. Dr. Matthew A. Howard, III will serve as Treasurer, and Dr. Daniel L. Barrow will continue to serve as Secretary.

The work of the Board is shared among the fourteen Directors who serve on multiple Committees: Bylaws, Credentials, Educational Requirements and Subspecialization, Finance, Maintenance of Certification, Oral Examination, Professional Practice Data and Technology, and Written Examinations. The work of the Committees continues throughout the year. Directors and Officers devote at least a month out of each year to Board activities. All serve without compensation.

You may visit the ABNS website to learn more about the Board. As always, we welcome your input. 🍷

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ments 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. 🍷

PAUL C. MCCORMICK, MD TREASURER



The current financial status of the American Board of Neurological Surgery remains stable. Modest operational deficits were incurred in fiscal years 2007 and 2008 due primarily to the costs associated with development and implementation of the MOC program, as well as ongoing maintenance costs of our NeuroLog online data management system for candidate practice data and Key Cases. Specific expenditures include the now operational fifteen Key Cases and the addition of a permanent full-time employee in the Houston office. The ABNS projects a modest operational surplus for the 2009 fiscal year. Any recognized net income will be added to the reserve fund.

annual Diplomate assessment, which now accounts for just over 50% of ABNS annual revenues, covers general and administrative costs, including personnel and space, professional and liability fees, most MOC costs, the Winter Directors Meeting, and ongoing data management and web hosting.

The assessment is voluntary for Diplomates with non-time-limited certificates (pre-1999) who are not participating in MOC but mandatory for Diplomates with time-limited Certificates. It has remained at \$275.00 since 2006. The 2008 remittance rate for the voluntary assessment was 81%, compared with 75% from 2007.

The reserve fund is intended to be maintained at 125% to 150% of annual ABNS operating expenses. It is currently invested in a professionally managed diverse portfolio of cash, equity, fixed income, and alternative strategies. Preservation of capital and annual returns that meet or exceed the appropriate S&P bench-

2009 ABNS FEE STRUCTURE

Annual Diplomate Assessment	\$ 275.00
Primary Examination Fee	\$ 475.00
MOC Written 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

The ABNS financial model is based on a calendar year and utilizes cash based accounting methods. The financial structure of the Board is relatively simple in that fees are adjusted to match each activity's expenses. ABNS activities include the preparation and administration of the Primary and MOC Cognitive Examinations in conjunction with the NBME, assessment of qualifications and requirements for certification, administration of the oral examination for certification, and management of the MOC program. Current fees for these activities are listed here. The

marks are the investment goals. While asset values declined in fiscal year 2008, the average annual rate of return in the previous five years (January 1, 2003 through December 31, 2007) is 11.03%. ABNS finances are monitored by a certified accountant who does comprehensive annual reviews and periodic formal audits. 🍷

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www.abns.org

E-MAIL: abns@tmhs.org
abns.moc@tmhs.org

(713) 441-6015
HOUSTON, TEXAS 77030-2701
6550 FANNIN STREET
SMITH TOWER SUITE 2139

THE AMERICAN BOARD OF
NEUROLOGICAL SURGERY

CURRENT DIRECTORS AND
THEIR SPONSORING
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Neurosurgical Society of America
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American Association of Neurological Surgeons
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