



# ABU REPORT

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A Newsletter for Diplomates and Candidates from the American Board of Urology

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## MESSAGE FROM THE PRESIDENT

John F. Kennedy said, "Change is the law of life. And those who look only to the past or the present are certain to miss the future." The United States is a leader in medicine, but this was not the case in the past, and some may argue not the case of the present or future. It was not until the 1920's that "American medical education had evolved from the worst in industrialized civilization to the very best ... the marvel of the industrial world" according to K.M. Ludmerer. This revolution resulted from standardization of medical school curricula and recognition that American medical practice lagged behind medical knowledge. In the 1930's changes in medical education were followed by the formation of examining boards in the medical specialties. The American Board of Ophthalmology was created in 1917, followed by 7 other boards with the Board of Urology in 1935 and American Board of Surgery in 1937, all of which are members of the American Board of Medical Specialties (ABMS). The purpose of these Boards was to improve standards of training and protect the public from 'superficial training and commercialism.' One or more of the current 24 ABMS Member Boards certifies almost 90% of practicing physicians today.



Linda M. Shortliffe, MD  
President

The teaching and practice of medicine in this country has changed and continues to change. Some medical students aspire to become CEO's rather than practitioners, and our children watch Sex in the City rather than Father Knows Best, Marcus Welby, Dr. Kildare or Ben Casey. In 1999, eight medical schools offered MD/MBA dual degrees and by 2004, forty-one did. Professionalism is now a required educational topic as part of the residency curriculum rather than learned by example and practice. Dr. Josef Fischer, Chairman, Department of Surgery, Beth Israel Deaconess Medical Center, Boston MA, wrote "Surgeons: employees or professionals?" He concludes, "We are no longer professionals. Professionals are usually guided by the benefit and welfare of those individuals who the professional must serve ... (and)

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# REPORT FROM THE PRESIDENT

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having been devalued to employees, general surgeons and other surgical specialists do not feel an obligation to do a number of things that professionals do.”

Finger pointing toward ‘change movers’ occurs in many directions. Be it changing medical insurance, developing HMO’s, declining relevance of medical education, rapidity of technological changes, growing entrepreneurial medicine, commercialism, or cost containment, those of us who have practiced at least 15- 20 years will probably agree not just medicine, but practice and patient expectations have changed. Similar to the fate of the airlines after deregulation occurred, it is unlikely that we will return to the way we were.

When I decided to enter urology twenty plus years ago, I saw it as a specialty that managed patients with genitourinary diseases regardless of whether the treatment was medical or surgical. Today students give the same response as reasons for entering urology. The scope of urology is different, however. How many intravenous urograms are performed in this country today as opposed to 25 years ago? How many ureterolithotomies? How many of us learned that beta-blockers should be given to our patients who are at high-risk for coronary events undergoing major abdominal operations? How many of us learned the risks and complications of fluoroscopy? How many have had additional training in transrectal ultrasonography and lithotripsy and laparoscopy? These things and more are part of the new realm of urology and must be for urology to remain the field of medical and surgical management that we entered.

Urology is meant to evolve, and because urologists care for the diseases of the genitourinary tract, we must integrate new areas of medical, surgical, technological, imaging, and pharmacologic options into diagnosing, managing, treating, and preventing problems of the urinary tract. The core of urologic diagnostics, management, and treatment has always involved imaging, pharmacologic manipulation, chemotherapy, endoscopy, and surgery, but each of these modalities has advanced in complexity and scope. Urologic imaging is no longer limited to retrograde pyelography, intravenous urography, and voiding cystourethrograms, but in addition we now must understand and interpret ultrasonography, nuclear renography, computed tomography, magnetic resonance imaging, positron emission tomography (PET), and molecular imaging, and decide the optimal imaging studies for the occasion. Treatment of advanced prostate cancer is no longer limited to diethylstilbestrol (DES) and radiation, but includes new surgical and chemotherapeutic options, hormonal manipulation, radiation, and cyberknife. Our pharmacologic armamentarium for infection, impotence, urinary retention, and incontinence is wider. We must still prepare, however, to treat diseases of the genitourinary tract with medical and surgical means. We are the stewards of the field, and carry a burden of continually learning updated practices and skills.

The landscape into which urology has evolved is reflected in the recent ABU listing of the scope of urology (including but not limited to) these Cognitive Areas: ethics and professionalism, evidence-based medicine, peri-operative care, wound healing/management, adrenal disease, benign renal disease, endocrinology, calculus disease, benign prostate disease, infertility, female pelvic medicine and surgery, geriatric urology, infectious disease, neurourology and voiding dysfunction, urethral and ureteral obstructions, oncology, pediatric urology, renovascular disease, sexual dysfunction (male/female), renal transplantation, trauma, basic genitourinary pathology; and the relevant Diagnostic and Technical Skills: imaging (physics, diagnostic and therapeutic), open surgical skills/techniques, endourology, shock wave lithotripsy, laparoscopy, and urodynamics.”

Proposing how to accommodate core knowledge in the same or shorter training as we conform to residency constraints of 80 or fewer hours per week is a clear and present dilemma. In part for these reasons, there is interest in specialized advanced training and potential ‘subspecialty certification’ in these areas. Such certification will require demonstration of extended study, deeper cognitive knowledge, diagnostic, and technical skills in the area of specialty.

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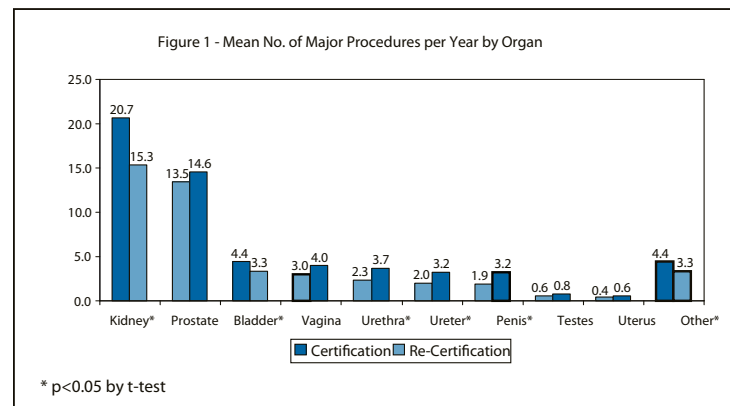
# ELECTRONIC PRACTICE LOGS – VALUABLE AND EFFICIENT OR USELESS AND ONEROUS?

Peter R. Carroll, MD and Peter C. Albertson, MD

Electronic log submission was offered as an option for the 2004 Recertification and the 2005 Certifying Examinations. The electronic logs were generated from billing records and submitted electronically on CD or by Email. The reasons for such changes were to ensure more precise and reliable estimates of candidate activity. It was also felt that it would be easier for candidates for both examinations to submit compared to manual entry. Since 2005, electronic practice logs have become mandatory.

The transition to this form of entry has not been easy for some. Approximately 20% of the candidates cite problems with the process, many small, but some large. This method of entry appears easiest for those in large group or academic practices where information technology support staff can generate them. Smaller practices or older candidates may not have such resources or be as familiar/comfortable with electronic data processing. In addition, those physicians who do not use billing records (i.e. those employed by the Veterans Administration, large HMOs or the military) have to maintain their own logs. Those from other countries, such as Canada, who do not use US billing codes, have to do the same. Luckily this accounts for a small minority of candidates.

The ABU staff continues to work hard to improve the process for our candidates. Each complaint has been logged and a plan to address the complaint, if at all possible, has been generated. The instructions for submission are being revised continually. For those whose software cannot export the data, ABU staff will prepare a data file from a paper submission for a fee. Staff routinely modifies submitted reports to make them compliant. Such changes have resulted in fewer recorded problems for this year's candidates.



Practice log information is useful and will become increasingly critical to urologists as it has allowed accurate and insightful information into contemporary urologic care and, most importantly, the way(s) it is changing. Recent analyses of electronic practice logs were presented, for the first time, at the 2006 AUA Annual Meeting in Atlanta. Although “office urology” accounts for a sizable component of US urologists’ activity, office, outpatient and open surgical procedures are common. Endoscopic procedures account for 62% of all surgical procedures performed, open surgical procedures 19%, outpatient procedures 7% and extracorporeal lithotripsy 9%. Laparoscopic procedures accounted for only 2% of the cases. Such cases were more frequently performed by younger urologists when compared to older urologists (6.2% of the total vs. 1.7%). Urodynamics

of some sort (bladder volume, uroflometry, etc.) accounted for 41% of the procedures done in the office, whereas cystoscopy accounted for 30%. Major open, percutaneous and laparoscopic surgery accounted for a small portion of activity. Renal and prostate procedures predominated. Although few practicing urologists did no major surgery, the average number of such surgery performed was limited for most. (Figure 1) Surgery for benign prostatic hyperplasia, a mainstay of urologic practice for many years, is evolving. Whereas transurethral resection remains the most common method of surgically managing BPH, microwave and laser therapy are increasing common treatment modalities (17%/25% and 10%/14% for certification vs. recertification, respectively). Interestingly, candidates for certification treated just 9 men with BPH surgically, on average, per year, compared to 14 men annually for those undergoing recertification. Clearly medical therapy has had an impact on the number of such surgical cases per year. Manuscripts documenting these changes are being submitted.

The ABU is committed to using such information both strategically and productively. The board will disseminate such information broadly and provide reports on the data to selected parties. This is occurring. Given that urologic practice may not mirror the residency training experience, a multidisciplinary team of urologic leaders, practitioners, administrators, academicians and residency directors have met and will craft a strategic plan aimed at better preparing our trainees for clinical practice, hopefully better serving our patients now and in the future. In addition, the Board provided log data to Dr. Quentin Clemens of Northwestern University for a report he prepared for the AUA Quality Improvement and Patient Safety Committee as the official urology representative regarding the pay-for-performance (P4P) initiative that is being promoted by CMS.

In summary, the ABU recognizes that electronic log submission does place a burden on those undergoing initial certification and recertification. It will work to streamline and make the process more efficient. However, the information gained is both valuable and will be put to good use.

# THE QUALIFYING AND RECERTIFYING EXAMINATIONS: HOW ARE THEY CONSTRUCTED AND WHAT DO THEY TEST?

*Michael O. Koch, MD*

The ABU Qualifying (QE) and Recertification (RE) examinations are constructed by the Joint Examination Committee of the American Urologic Association and the American Board of Urology. The Committee consists of 4 task forces, each composed of three actively practicing urologists with expertise in specific aspects of urology. These task force members are carefully selected by the trustees of the ABU for their commitment to the specialty of urology, their knowledge of their field, their geographic representation, and their ability to complete their workload in a timely and careful fashion. The work of the task forces is overseen by 5 senior members, each of whom has served a minimum of 4 years as a task force member. This group is responsible for constructing your qualification (QE) and recertification (RE) examinations in addition to the residency inservice examination (ISE), the self-assessment study examination (SASP), and the pediatric inservice examination (PISE). In a work-load analysis that I did in 2004, the committee spends 1,548 hours (74 hours per person) each year constructing the QE and RE and 3,089 hours (140 hours per person) on all of the examinations. Committee members receive a total stipend of approximately \$1,500 per year for this effort.

The ABU defines content areas that it believes are core knowledge in urology and each year, the examinations are based upon these defined content areas. While the questions themselves may change each year, the areas and relative proportions of those areas on the examination remain essentially the same. A question starts with an individual task force member who is responsible for drafting a question that is core knowledge, has a single correct answer, and 4 plausible but incorrect answers. Each question must be supported with a current literature source and justifying comment. Each question then passes through a senior member who reviews and corrects the question for content, clarity and grammar. Each task force member composes approximately 50 new questions each year for possible inclusion on the examination.

Two times per year, the full examination committee meets to construct the actual examinations. The QE is composed 2/3's of previously tested and statistically validated questions and 1/3 from newly written questions.

Only the previously tested questions are used in the determination of the score. The RE is composed of all previously tested and validated questions. New questions are vital to maintain the pool of statistically valid questions and to make certain that the examination is consistent with the current practice of urology. Every single question on the examination is then reviewed by a minimum of 10 task force members for validity, clarity, and content. If it is judged to meet all of these criteria and it is also statistically valid, it may be chosen for inclusion on your examination. Each question will have then been reviewed by members with specific expertise in the content area being tested as well as members representing other subspecialties for all of the criteria mentioned. After the entire examination is constructed, the entire examination is then reviewed again, a minimum of 4 times, for its content, its clarity, and its statistical ability to provide the most accurate information about a candidate's ability as a urologist. At this point, every new question on the examination will have been reviewed a minimum of eight times.

The ABU contracts with Measurement Research, Inc. ([www.measurementresearch.com](http://www.measurementresearch.com)) to provide us with professional guidance on the construction of the examinations to be certain that we are composing an examination that has the maximal achievable ability to measure the knowledge base and clinical judgment of a practicing urologist. After each examination is administered, this company conducts an in-depth analysis of the examination to determine the overall reliability of the examination in predicting the knowledge base of the candidate and an analysis of each question on the exam to determine its contribution to the test. After this analysis is complete, the entire examination is reviewed on conference call by the senior leadership and psychometrics consultant and questions which tested poorly or were ambiguous are deleted from the examination before a final assessment of the examination and individual scores are determined.

Each year, the ABU solicits feedback from the examinees about the testing process and the examination. While the comments are generally very favorable with

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## THE QUALIFYING AND RECERTIFYING EXAMINATIONS...

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respect to the testing process and the computerized testing centers have been well received, some candidates still complain that many of the questions are ambiguous, esoteric, or not reflective of their practice. Several explanations are apparent for this. First, it should be recognized that the ABU is certifying its members to practice in all areas of urology including areas such as pediatrics, infertility and others in which many candidates may have chosen not to include in their own personal practice. Nevertheless, since the ABU issues a general certificate and these areas are still considered part of the core content of urology, they must be tested on the examinations. Secondly, in order to construct an examination that achieves its purpose of accurately determining for the board what the capabilities of the candidates are, we cannot include questions which all candidates can answer correctly. An optimal question from a statistical standpoint is one which approximately 65-75% of the candidates will answer correctly. Urologists are a highly accomplished group of individuals who are

accustomed to doing very well on tests and for which questions must be relatively hard to meet the statistical goals over a valid certification examination.

The written examination process used in urology has become a model for other specialty boards to follow. It has been constructed to provide you with an examination that has the utmost ability to test the knowledge base of urologists and be the fairest test possible for the candidate. The board continues to strive to improve the process. This year we have initiated steps to base more questions on published guidelines and we have reduced testing in areas that many urologists tell us they are no longer practicing such as transplantation and pediatrics. Urology is a dynamic evolving field which means that the examination must continue to evolve and we will continue to strive to provide our members with a current and fair examination.

Further information on the testing process can be found on the ABU website at [www.abu.org/certification.html](http://www.abu.org/certification.html).

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## REPORT FROM THE PRESIDENT

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While the American Board of Urology did not invent or ask for 'Maintenance of Certification' (MOC), the concept is in concert with the original mission of the Specialty Boards and allows us to evolve with our specialty. The American Board of Medical Specialties (ABMS) created the concept of maintenance of certification in 1999. The program encompasses recertification and consists of 4 components: 1) Evidence of professional standing, 2) Evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process, 3) Evidence of cognitive expertise, and 4) Evidence of evaluation of performance in practice.

Even though some of the requirements are already in place, two components are new and will require new processes (i.e., 2---evidence of commitment to lifelong learning; and 4--practice evaluation). In my opinion, MOC may be a misnomer, because maintenance fails to construe the process leading to active acquisition of new knowledge and skills acquired since original certification. Indeed, as members of the ABMS, the Trustees of the American Board of Urology are working to develop a MOC process that will allow diplomates to demonstrate their ongoing efforts to advance their expertise in urology as the specialty evolves. As new urologic or urology-pertinent practice guidelines and recommendations are generated, it is planned that practice assessment protocols will allow practitioners to demonstrate their knowledge in areas that they select. This will affirm that board certified urologists are professionals who hold the welfare and benefit of their patients in esteem. We cannot afford to miss our future.

# TRUSTEES AND EXECUTIVE STAFF OF THE AMERICAN BOARD OF UROLOGY

## Winter Meeting 2006



*Back row (from left):* Stuart S. Howards, MD, Executive Secretary; William D. Steers, MD; Paul H. Lange, MD; Ralph V. Clayman, MD; Howard M. Snyder, MD; Timothy B. Boone, MD; Michael O. Koch, MD; Gerald H. Jordan, MD

*Front row (from left):* David A. Bloom, MD; Peter C. Albertsen, MD, Vice President; Mani Menon, MD; Robert C. Flanigan, MD; Linda M. Shortliffe, MD, President; Peter R. Carroll, MD, President-Elect; W. Bedford Waters, MD, Secretary-Treasurer

### *The Board Welcomes . . .*

New Trustees Gerald H. Jordan, MD, and Timothy B. Boone, MD, PhD

Dr. Jordan is currently a Professor in the Urology Department of the Eastern Virginia Medical School and is Chairman of the Devine Center for Genitourinary Reconstructive Surgery at Sentara Norfolk General Hospital in Norfolk, Virginia. He is an innovative leader in the field of genitourinary reconstructive surgery and has made notable contributions to the literature.

Dr. Boone is currently Chairman of the Department of Urology at Baylor College of Medicine and Chairman of the Urology Department and Medical Director of the Urodynamics Laboratories at the Methodist Hospital in Houston, TX. His special interests are neurourology and urodynamics with a focus in incontinence and bladder dysfunction associated with spinal cord injury and neurologic diseases.

### *The Board Thanks . . .*

Dr. Robert Flanigan served as a Trustee of the Board from 2000-2006, and as President from 2005-2006. He also served as Secretary-Treasurer, Chairman of the Executive Committee, Chairman of the Finance Committee, Chairman of the Recertification Committee, Chairman of the Ad Hoc Committee on Pediatric Subcertification, and as a Representative to the

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## THE BOARD THANKS

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American Board of Medical Specialties and ABMS Board of Directors. During his time on the Board, the decision to commence Subspecialty Certification in Pediatric Urology was approved by the ABU and the application process was begun with the American Board of Medical Specialties (ABMS). Dr. Flanigan served as the ABU Representative on the newly re-constructed Board of Directors of the ABMS (and its Executive Committee) and has been very involved in the evolution and development of Maintenance of Certification (MOC) for all medical specialties, including urology. Dr. Flanigan congratulates all of his Co-Trustees and thanks them for their dedication to urology, their great time commitment, energy, and the enthusiasm that they have directed towards the American Board of Urology's efforts to improve urologic clinical care to patients.

Dr. Mani Menon served as a Trustee of the American Board of Urology from 2000 to 2006 and was Vice President from 2005 to 2006. He also served as Chairman of the Nominating Committee, Chairman of the Oral Examination Committee, and ad hoc member of the Committees on Pediatric Subcertification and on Female Urology. He was a member of the Credentials Committee for many years. Dr. Menon was the representative of the American Board of Urology to the American College of Surgeons. He very much enjoyed his time on the Board, the intellectual stimulation and the friendships. He extends heartfelt gratitude to all of his colleagues on the Board, to Dr. Stuart Howards and the exemplary Board Staff.

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## DISCIPLINARY ACTIONS BY THE BOARD

The following doctors had their certification revoked during 2006:

Scott W. Aigner, MD  
Jude T. Barbera, MD  
Julio Castellanos, MD  
Virinder S. Grewal, MD  
Laxmi N. Hedge, MD  
Charles F. Johnson III, MD  
Carlos A. Nazir-Diuana, MD  
Frank J. O'Connor, MD  
Bharaj J. Patel, MD  
Janardhan B. Reddy, MBBS  
Robert F. Seymour, MD  
Charles F. Skripka, Jr., MD  
Joseph A. Spinella, MD  
Joseph K. Wheatley, MD

An explanation of the levels of disciplinary action and manner of notification, appeal and reinstatement are explained in the *Information for Applicants for Recertification* handbook.

# SUBSPECIALTY CERTIFICATION IN PEDIATRIC UROLOGY

by *Stuart S. Howards, MD*

The vast majority (18 of 24) of the member boards of the American Board of Medical Specialties (ABMS) boards provide subspecialty certification. To date, the American Board of Urology has not offered any subspecialty certification. The pediatric urology community has had a longstanding interest in obtaining subspecialty certification from the American Board of Urology.

For many years there have been periodic discussions at meetings of the American Board of Urology as to whether or not it would be advisable to offer a subspecialty certification in pediatric urology. Until recently, these discussions ended with a vote against implementing a pediatric urology certificate. The ABMS requirements for a subspecialty certification include a distinct area of knowledge and ACGME-approved accredited fellowships, or in the case of the American Board of Obstetrics and Gynecology (ABOG), an ABOG-accredited fellowship. Currently there are two subspecialty areas in urology which have accredited fellowships. One is pediatric urology, and the other is female pelvic medicine and surgery which is accredited under the auspices of the ABU and ABOG and regulated by a joint fellowship committee of the two boards.

Obviously there are arguments both for and against subspecialty certification. The opponents feel that this could be divisive for the field of urology, and there is a concern that subspecialty certification creates additional expense and effort for no real advantage. The pediatric urology community is not at all concerned about the latter. Proponents of subcertification have various motivations, including a desire for recognition of their extra training and a sense they would be in a better competitive position as compared with those in other specialties. An example of the latter is the fact that the pediatric urologists feel that they would be better able to compete with pediatric surgeons who do have a subspecialty certificate from the American Board of Surgery.

The ABU has debated this topic at least once every two years for the last 20 years. In 2004, the Board finally voted to proceed with subspecialty certification in pediatric urology. With input from the pediatric urologic community, a proposal was submitted to the ABMS. This proposal was accepted by the COCERT committee of the ABMS which is charged with the responsibility for deciding whether or not a subspecialty application is appropriate. COCERT did require a few minor modifications. These modifications have been implemented. The ABMS gave final approval

to subspecialty certification in pediatric urology at its September 2006 meeting.

Plans are already underway to have a special subcommittee of the ABU/AUA exam committee generate an appropriate examination. This examination will be very similar to the current pediatric inservice exam, which is taken by fellows and many practitioners specializing in pediatric urology. The requirements for individuals who have a majority of their practice in PU and were trained before 1998 will not be required to have an ACGME-approved pediatric urology fellowship since this, in general, was not available before that date. All individuals who completed residency after 1998 will be required to have completed two years of training including an ACGME-approved fellowship in pediatric urology in order to be eligible to apply for subcertification in pediatric urology. In addition, all applicants will be required to submit a case log documenting that the majority of their practice is in pediatric urology and that they perform a significant number of major pediatric urology procedures.

From time to time there has been concern that subcertification in pediatric urology would result in general urologists losing some of their practice. However, review of practice logs submitted to the ABU documents that general urologists currently do almost no major pediatric urologic cases. Therefore, it is quite clear that there will be little change in practice patterns either by general urologists or by pediatric urologists after pediatric urology subcertification is implemented. Another concern that has been expressed is that individuals might be more vulnerable to malpractice suits if they did not have a subspecialty certification. A review done several years ago by Andrew Novick, who was then a member of the Board, revealed that this had not been the case with any of the other subspecialty certificates that have been issued by other boards.

A more complicated and difficult question is how will the ABU and the urologic community react if other subspecialty areas in urology, such as urologic oncology, request subcertification. As mentioned above, general urologists do very little pediatric urology, but they certainly do a great deal of urologic oncology. At this time, urologic oncology does not have ACGME-accredited fellowships. Therefore an application by the urologic oncologists for subcertification is not on the immediate horizon. Nevertheless, it is quite possible that in the future several subspecialty areas in urology will have ACGME-accredited fellowships and may request subcertification.



## ABU TO LAUNCH INTERACTIVE WEB SITE

In late 2006, the ABU will launch a new interactive section of its web site that will serve as the main point of contact for all ABU activities. The web site address will remain the same: [www.abu.org](http://www.abu.org). In addition to providing detailed information on all ABU requirements and processes, the new design will offer many interactive features.

### Username and Password

To access the interactive features, users must login with the username and password assigned by the ABU. Once a user logs in to the interactive website using the username and password supplied by the ABU, he/she will be presented with a page giving him/her the opportunity to change the username and password to something that can easily be remembered. A mailing with your username and password, and instructions on how to access the interactive section, will be sent to all candidates and diplomates when the website is online.

### Personalized Page Reflects Individual's Current Information

One page will display the demographic information the ABU has on file, and will allow the doctor to update his/her primary address, phone, fax, and cell phone numbers, email address, date of birth, birth place, social security number, secondary address and phone numbers. Information on the doctor's medical school, residency, and fellowships will be displayed on another page, with an opportunity for the doctor to update this information. An auto-responder confirmation page listing all updated information will be sent to the email address provided. After the requested changes are reviewed by ABU staff, the changes will be uploaded to the Board database. If there are any questions, a staff person will contact the doctor to verify the correct information. All updated information will also be transmitted periodically to the American Board of Medical Specialties (ABMS).

### Online Applications and Registration Processes

The interactive website will allow doctors to apply for their upcoming Qualifying, Certification, or Recertification processes; submit their practice logs; and access their Maintenance of Certification components online during the period when they are eligible. Online application is optional this year. The ABU will mail usernames and passwords to all candidates and diplomates as they are eligible to enter a process.

Applying for an ABU process will require applicants to review and update their personal contact information; review and update their training and fellowship information; and submit names and addresses of certain individuals the ABU staff will contact for peer review.

The application itself will be completed online. However, there are several items of supporting documentation that must be mailed to the Board office. A printable form will be available to use as a cover sheet to submit this documentation to the ABU. Also, the applicant must print out and sign the signature page and mail the signed page along with the application fee to the ABU office. Once an online application is submitted, the candidate will receive an instant "thank you for applying" email. After the signature page and fees are received, the Board staff will review the application and other documentation and notify the candidate of any missing items. This information will also be available in the candidate's personalized status page on the website.

### Easy Information Exchange

The ABU will use email addresses to notify candidates and diplomates of important updates to the Certification, Recertification, and MOC processes. Additionally, users can update personal contact information, including addresses, phone numbers, and email address. Current contact information will ensure receipt of important correspondence from the Board.

### Your Feedback

The ultimate success of this web site rests entirely on its ability to better serve the Board's diplomates and candidates with information, data and an interactive means of communicating with the ABU. Your input and feedback will be continually solicited to help the ABU discover new ways to use this technology to enhance your relationship with the Board. Email and feedback sections will be provided throughout the site to facilitate this communication. We hope you

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# ABU TO LAUNCH INTERACTIVE WEB SITE

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will find the new website clear and intuitive, the content useful, timely and informative, and the application process straightforward and easy to use.

## Projected Timeline:

**When the website is completed, the ABU will mail usernames and passwords to all candidates and diplomates with instructions on how to access the website. This same information will also be mailed to candidates and diplomates as they become eligible to enter a certification or recertification process.**

**In November 2006**, any doctor who is certified or in the process of becoming certified by the ABU may access and change his personal demographic data and training history.

**On December 15, 2006**, those doctors who are eligible to apply for Recertification will be mailed their usernames and passwords along with instructions on how to access the interactive website and submit their applications and practice logs online. Online application will be optional this year.

**On May 15, 2007**, those doctors who are eligible to apply for their Certifying (Part 2) Examination will be mailed their usernames and passwords plus instructions on how to access the interactive website and submit their applications and practice logs online.

**On September 15, 2007**, application information will be sent to all Residency Program Directors for the residents who will be eligible to take their Certifying (Part 1) Examination in August 2008. At that time, these candidates will be given the instructions on how to access the interactive website and submit their applications online.

A candidate or diplomate may get his/her assigned username and password by submitting a written request on personalized letterhead to the ABU office by mail or fax and the username and password will be mailed to him/her. The candidate or diplomate may also call the ABU at 434/979-0059 and the username and password will be mailed to the address on file with the Board. Or an email request may be sent to [staff@abu.org](mailto:staff@abu.org), including your full name, mailing address, and date of birth or certificate number, and a specific request that the username and password be sent via email reply. Usernames and passwords will not be given over the telephone or fax.

A mailing with your username and password, and instructions on how to access the interactive section, will be sent to all candidates and diplomates when the website is online.

## IN MEMORIAM

The office of the American Board of Urology regrettably reports receiving word in 2004-2005 that the following Diplomates have passed away:

John T. Boaz III, MD	Lawrence Frederick Grey, MD	Russell W. Lavengood, MD	Howard E. Strawcutter, MD
Robert E. Boyd, MD	John T. Harbough, MD	Robert K. Mookini Jr., MD	Gene M. Sweigart, MD
James R. Brown, MD	Kenneth F. Hausfeld, MD	Edward H. Ray Jr., MD	Albert J. Tactac, MD
Donald E. Burke, MD	David C. Henning, MD	Carl L. Sauls, MD	James A. Tremann, MD
Louis R. Devanney, MD	Michael H. Higgins, MD	Joseph W. Segura, MD	Ivan J. Weiner, MD
Joseph B. Dowd, MD	Joseph A. Jacobs, MD	Richard H. Seifert, MD	Jesse L. Williams, MD
John W. Duckett, MD	James J. Jacobson, MD	Arthur M. Smith, MD	

## BROCHURE DESCRIBES CERTIFICATION

Diplomates of the American Board of Urology who wish to make patients aware of their certification and the process of obtaining it may benefit from the brochure: *Your Urologic Surgeon is Certified by the American Board of Urology*. This color pamphlet describes the importance of certification and the training requirements and examinations necessary for certification. It is also available in Spanish.

This brochure is available from the Board office at a minimal cost in quantities of 100, 200 and 500. Please use the form below to place an order. We regret that telephone orders and credit cards cannot be accepted.



### Brochure Order Form

*Please type or print clearly*

Brochures are available only to American Board of Urology certified Diplomates.

Diplomate # (if available): \_\_\_\_\_ Quantity: 100 200 500

\_\_\_\_\_ English / \_\_\_\_\_ Spanish (if not specified, English will be sent)

Name: \_\_\_\_\_

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