



ABU Report

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

October 2009

MESSAGE FROM THE PRESIDENT

The Changing Face of Urology

Never before has medicine faced greater challenges. The impending health care reform legislation may bring very fundamental changes to the way we as urologists deliver care to our patients. While much of the health care crisis is the doing of health care insurers, hospitals, medical malpractice lawsuits, pharmaceutical companies, and even the public; some of this crisis has been brought on by physicians.

It has been 10 years since the Institute of Medicine published its report on the poor quality of health care in the United States and estimated that there are just under 100,000 unnecessary deaths each year from medical mistakes. Some of these errors are physician related and some are failures of the system. Little has changed since that time. While much of the ongoing health care debate is focused on the *cost* of health care, there is a significant amount of work going on in the area of improving the *quality* of health care. This emphasis on improving quality puts the American Board of Urology (ABU) front and center since insuring the quality of urologic health care is the primary mission of our board. When the ABU makes its decisions, the fundamental question that we ask is whether making such a decision will improve the quality of urologic care.

Since I finished training in 1981, there has been an insidious but perceptible refocusing of time and effort towards the business of medicine and away from the care of the patient. Some of this is out of necessity as reductions in reimbursement for patient care have made it increasingly more difficult to manage a medical office or practice on increasingly limited resources. The ABU is confronted too often with the review of practices where decisions appear to be made for monetary gain rather than patient interest. This is a small percentage of the whole; nevertheless, it is a threat to our fundamental commitment to patient care

and our image with the public. As President Obama was astute enough to point out, the practice of surgery is inherently conflicted where physicians must often choose between treatment options for patients when some of those treatment options are more favorable for the treating physician financially. Even highly ethical and professional urologists may struggle from time to time in sorting through these conflicted treatment decisions.



Michael O. Koch, MD
President

At the summer meeting of the Trustees of the ABU, we endorsed a professionalism and ethics statement originally authored by a joint group from several internal medicine organizations. Dr. Peggy Pearle explains this later in this newsletter. We ask that you read this statement to refresh your enthusiasm for what we stand for as professionals and to guide you with the decisions that each of us makes each and every day.

We also need to ask ourselves what we as urologists can do to improve the quality of the care that we deliver. Maintenance of certification (MOC) was initially designed to insure the public that all urologists were current in their knowledge base and practicing competent urology. The MOC plan of the ABU as originally approved by the ABMS was designed to be minimally disruptive to hard working urologists but still insure the public of the quality of urologic care. Various components of MOC examine the diplomates' clinical practice, knowledge base and professionalism.

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Message from the President

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As we move forward we need to consider more creative and meaningful ways that we can improve the quality of care that we deliver. Some boards have done amazing things working with their diplomates to improve quality. One example is the American College of Cardiology who mandated registries to analyze impediments to rapid treatment of myocardial infarctions. This project resulted in profound decreases in the time from presentation to treatment after myocardial infarction and has saved countless lives. Other similar projects have been done by pediatric organization which resulted in dramatic improvements in the care of children with cystic fibrosis and childhood asthma. The ABU is now examining the possibility of similar programs in urology to improve the care of our patients. Some of these programs might someday fulfill MOC requirements for practice based learning and if done correctly bring meaningful improvements to clinical care of urology patients.

Another step we can take to improve the quality of care of urology is to improve the quality of our training programs. Urology is blessed with an exceptional group of young people who seek to train in our field. While most of our training programs are outstanding experiences in surgical and clinical experience, in the future they will have to be more. Medicine is rapidly evolving to a point where we will all need to practice in integrated health care systems

which communicate effectively and provide highly efficient and effective care.

The concept of *systems* will be increasingly emphasized in the upcoming years of health care reform. Consequently, we need to insure that our residents are not only skilled surgeons who behave in a highly professional manner but also that they can communicate effectively and continuously improve their own and their system's outcomes. In January, the ABU will embark on a 1-2 year project to more clearly define those outcomes that all residents must achieve at each level of practice to continue in training. This project is co-sponsored with the ACGME and is called the *Milestones project*. Dr. Mike Ritchey has written an article in this newsletter to more fully explain this project. Someday, the milestones established in this project should be able to mesh with ABMS MOC requirements and will set the standard for urologic care.

There are many ways that the trustees of the ABU are examining to improve the quality of urologic care in our country and there are probably many more that we should consider. The ABU looks for a balance between what MOC requirements offer in terms of improving health care with the requirements that they place on already over-burdened and over-worked urologists. We value your support for improving urologic care and your commitment to the care of your patients. ■

Significant Changes to ABU Policies Affecting Urology Training

At their recent meeting, the Trustees of the American Board of Urology made two important policy changes affecting urology residency training. It is critical that department Chairs and Program Directors understand these policies and communicate these changes to residents. The former leave of absence policy stated that time away from clinical residency could not exceed fifteen percent (15%) of the clinical residency training period and not more than twenty percent (20%) of the chief resident year. The former resident transfer policy stated that a resident must petition the Board in advance for approval of a transfer and submit letters of acknowledgment and approval from both program directors. The new policies are outlined below:

NEW Leave of Absence Policy

Each program may provide sick leave and vacation leave for the resident in accordance with institutional policy. However, a resident must work forty-six (46)

weeks each year of residency; that is, one year of credit **must** include at least forty-six weeks of full-time urologic education. Vacation or leave time may not be accumulated to reduce the total training requirement. If a circumstance occurs in which a resident does not work the required forty-six weeks, the program director must submit a plan to the ABU for approval on how the training will be made up, which may require an extension of the residency.

NEW Residency Transfer Policy

A resident may only transfer once during the urology portion of training and the last two years of residency training must be spent in the same institution. A resident who wishes to transfer must notify the ABU in writing six months in advance of the transfer and copy the current Program Director and DIO. The Program Director from the recipient program must send a letter to the ABU verifying there is an appropriate residency slot in the program for the resident to fill. ■

The Board Welcomes...

New Trustees: Michael L. Ritchey, MD, and Peter N. Schlegel, MD.

Dr. Ritchey, a native of Louisiana, is a graduate of Louisiana State University School of Medicine. He completed his Urology residency at Wilford Hall USAF Medical Center and fellowship at the Mayo Clinic. He has held faculty positions in urologic surgery at University of Michigan and University of Texas Health Science Center where he served as Chairman of the Department of Urology. He is currently a Professor of Urology at the Mayo Clinic Arizona. He is past Chairperson of the Section of Urology of the American Academy of Pediatrics, and past Chair of the AUA/ABU Examination Committee. He is currently the Chief of Surgery at Phoenix Children's Hospital.

The Board Thanks ...

W. Bedford Waters, MD and David A. Bloom, MD

Dr. W. Bedford Waters served as a Trustee of the American Board of Urology from 2003-2009, as President from 2008-2009. He also served as Secretary-Treasurer, Chair of the Executive Committee, Chair of the Recertification Committee, Finance Committee, Oral Exam Committee, and representative to the American College of Surgeons. Dr. Waters was instrumental in developing the framework and policy for the Board's maintenance of certification program (MOC), spending countless hours working with ABU staff to implement the program by the 2009 launch date. He is honored for the opportunity to serve on the Board and thanks his fellow Trustees for their confidence and trust in electing him to lead the ABU. He thanks the Trustees for their dedication, hard work, and clear perception in addressing some difficult issues. He thanks the ABU staff for their tireless energy and hard work. He also thanks Dr. Stuart Howards, Executive Secretary, for his advice, leadership, judgment, and friendship. Dr. Waters will continue his service to the ABU for an additional three years as Chairman of the Maintenance of Certification Committee, a new non-voting Trustee Emeritus position.

Dr. Schlegel is Chairman of Urology at Weill Cornell Medical College and Urologist-in-Chief at New York Presbyterian Hospital in New York, NY. A native of New England, Dr. Schlegel received his A.B. degree from Hamilton College in Clinton, NY, and his M.D. from the University of Massachusetts before training in general surgery and urology at Johns Hopkins Hospital in Baltimore. He has contributed over 200 original manuscripts and book chapters to the urologic literature. Dr. Schlegel has served as Task Force Chair and senior consultant to the AUA/ABU Examination Committee, is on the Editorial Board of the Journal of Urology and has served as President of numerous societies, including the Society of Reproductive Surgeons, Society for the Study of Male Reproduction, Society of Reproductive Medicine and Urology, as well as the Board of Directors of the American Society of Reproductive Medicine. ■

Dr. David A. Bloom served as a Trustee of the American Board of Urology from 2003-2009, as Vice-President from 2008-2009. He also served on the Executive Committee, Bylaws Committee, Policy Committee, Finance Committee, and Publications and Research Committee. Dr. Bloom chaired the Credentials Committee and the Nominating Committee. He also served as the ABU representative to the American Board of Medical Specialties and was appointed to the ABMS Board of Directors during his ABU tenure. Dr. Bloom said of his time as a Trustee of the American Board of Urology: "Service on the American Board of Urology was the highlight of my career. I came to cherish the concept of board certification and the idea that the Board seems to have two responsibilities. The first of these is to serve the interests of the public by establishing and monitoring standards of education and practice of urology. It is the interest of the public that we serve primarily in those processes. Secondly, and this is not largely acknowledged, the Board oversees the scope of practice of urology that defines the specialty and works to chart a course for the future with other professional organizations, keeping the public trust central in its vision. Urological practice has been recognized as a distinct entity since the time of Hippocrates and is unlikely to disappear no matter what the socioeconomic or technology challenges might be, yet urology needs a parent organization that serves the public first and the specialty itself second." ■

Diplomate and Candidate Feedback

The American Board of Urology welcomes comments from Diplomates and Candidates on the issues raised in the *ABU Report* or any other issues affecting the practice of urology or certification processes. Please mail your comments to Dr. Stuart S. Howards, Executive Secretary, American Board of Urology, 2216 Ivy Road, Suite 210, Charlottesville, VA 22903, or fax your comments to 434/979-0266.

Pediatric Subspecialty Certification

By Barry A. Kogan, MD

The American Board of Urology is currently in its third cycle of the Pediatric Subspecialty Certification Examination (PSCE). The eligibility criteria are quite specific, requiring completion of a two year ACGME or RCPS(C) approved pediatric urology residency (after July 1998), a one year ACGME or RCPS(C) approved pediatric fellowship (prior to July 1998), or at least a ten-year period of pediatric urologic practice.

It is important to recognize that 2009-2010 is the last examination cycle in which those Pediatric Urologists who completed a fellowship before January 1, 1998 (or have been in Pediatric Urology practice for 10 years without a fellowship) will be eligible to apply without completing a new two-year ACGME or RCPS(C) accredited fellowship. It is also necessary for the candidate to have a significant practice in Pediatric Urology.

The previous requirement for eligibility for subspecialty certification in pediatric urology was that a minimum of 75% of the candidate's practice is dedicated to pediatric urology with a significant number of major pediatric surgical cases. The Board recently added

possibility for admission to the process with a minimum number of pediatric cases, excluding minor cases such as circumcision, as determined by the Board.

The results of the first two examinations have shown the pediatric urology community to be very "able" regarding their knowledge base. In 2008, one hundred seventy four of the one hundred seventy six candidates taking the examination passed and in 2009, all forty-six candidates who sat for the examination passed.

The next examination will be administered electronically in June 2010 at select Pearson VUE test centers nationwide. For those individuals just completing approved fellowships, it is important to note that after 2010, the exam will only be given every other year (2010, 2012, 2014, etc).

An application for the 2009-2010 PSCE process is available on the ABU website www.abu.org or by contacting the Board office at 434/979-0059. The deadline for application was September 15, but applications with a late fee may be submitted by October 1. If you wish to submit an application after this date, please call the Board office at 434-979-0059. ■

Trustees and Executive Staff of the American Board of Urology Winter Meeting 2009



Back row (from left): Peter N. Schlegel, MD; Gerald H. Jordan, MD; Michael L. Ritchey, MD; Margaret S. Pearle, MD; Timothy B. Boone, MD; Barry A. Kogan, MD; Robert R. Bahnson, MD; John B. Forrest, MD

Front row (from left): William D. Steers, MD; Paul H. Lange, MD; Michael O. Koch, MD; W. Bedford Waters, MD; David A. Bloom, MD; Stuart S. Howards, MD; Ralph W. Clayman, MD

Code of Ethics

By Margaret S. Pearl, MD

The American Board of Urology is committed to the principle that patient welfare is preeminent. This principle presupposes a responsibility to the patient that transcends personal gain and thereby engenders both individual patient and public trust. It is the cornerstone of the ethical and moral framework by which the physician is bound.

The physician-patient relationship, however, is part of a more complex social network that also includes relationships within the profession and society as a whole. A variety of societal forces increasingly conflict with the responsibility of physicians to their patients and the public. Rapidly advancing technologies, relationships with commercial entities, increased demands for documentation, rising health care costs, declining reimbursement, and increasing patient autonomy place conflicting demands on the physician and potentially lead to compromise of patient welfare. Urologists, in particular, are faced with technological advances that demand increased training but also offer increased opportunity for entrepreneurialism. From this perspective medicine is viewed as a specialized personal service at variance with public responsibility and one that belies the trust instilled in the physician

As a consequence, there has been a call for a renewed commitment to professionalism. A number of organizations have attempted the development of a code of ethics and professionalism that sets forth principles and responsibilities the physician can consult for guidance when confronting an ethical dilemma. In these documents, a number of qualities or virtues are repeatedly espoused, including justice, honesty, competence, impartiality, preservation of patient confidentiality, patient autonomy, and unbiased medical care. To address this need, representatives from the American Board of Internal

Medicine Foundation, the European Federation of Internal Medicine and the American College of Physicians-American Society of Internal Medicine collaborated on the Medical Professionalism Project which was charged with developing a charter that provides a basic set of tenets for ethical and professional behavior.¹ The group intended to create a document that is applicable across medical and surgical specialties, healthcare systems, and cultures. To that end, they set forth three Fundamental Principles and a set of ten core commitments that serve to guide the professional and ethical conduct of physicians.

Although this Charter has met with widespread enthusiasm, it has not been uniformly endorsed by all physician groups; indeed it has been criticized for emphasizing a duty-based ethic (that is, duty to those around us), rather than a virtue-based ethic (which focuses on individual traits of human character).² Likewise, some have objected to the emphasis on achieving “competence” rather than encouraging excellence, and to the contractual tone of the document that implies an inherent basis of mistrust.³ While these criticisms may be valid, the document serves as a starting point for a conversation about professional responsibility and provides a framework for moral, ethical and professional conduct. The American Board of Urology endorses the Physician Charter and encourages and expects the urologic community will uphold the commitments which support the fundamental principles set forth by the document. ■

References

- ¹Medical professionalism in the new millennium: A physician charter. *Ann Int Med*, 136: 243-246, 2002.
- ²Doukas DJ: Where is the virtue in professionalism? *Cambridge Quarterly of Healthcare Ethics*, 12: 147-154, 2003.
- ³Swick H, Bryan CS, Longo LD: Beyond the Physician Charter. Reflections on medical professionalism. *Perspectives in Biology and Medicine*, 49: 263-275, 2006.

In Memoriam

The office of the American Board of Urology regretfully reports receiving notification in 2008 – 2009 that the following Diplomates have passed away.

Rodney A Appell MD	Ruben F Gittes MD	Donald J McKenzie MD	Joseph E Twidwell MD
Thomas W Ayres MD	James F. Glenn MD	Lawrence Scott Miller MD	Damir Velcek MD
Paul L Bessette MD	Guillermo P Gonzales Jr MD	Louis Rafael Molina MD	John A Whitesel MD
Douglas S Dahl MD	William V Hall MD	Barry N Nocks MD	Warren S Witus MD
Mohammed E Darwish MD	Earl Haltiwanger MD	Donald R Pohl MD	Sam M Yamamoto MD
Richard M Delnay MD	John F Hensleigh MD	Josef Richter MD	John G Young MD
John G Feminella MD	Lowell R King MD	Samuel H Rothfield MD	Mahmood A Zia MD
Richard A Finegold MD	Charles A Lattanzi MD	Frank Woodson Smyth MD	William M Zurich Jr MD
Jack N Gersensfeld MD	Ben D Massey Jr MD	Andrew Sporer MD	
David J Gillis MD	Timothy M McCormick MD	Lucian L Tatum Jr MD	

American Board of Urology Finances

By Stuart S. Howards, MD

Below are some important facts about the finances of the American Board of Urology:

- The ABU had an operating budget deficit for the last five years.
- During the previous eight years, the operating budget was close to breaking even.
- Without voluntary dues contributions, there would have been a deficit almost every year.
- The ABU, like any other individual or organization (except the U.S. Government) cannot permanently have an operating deficit.
- Trustees elected to serve the American Board of Urology spend an average of three weeks per year for six years working for the Board with no compensation.
- The charge for recertification was \$1,350, or a tax-deductible \$135 per year.
- Because of the operating deficits and a very sizeable increase in expenses due to a large ABMS fee increase and the cost of implementing MOC, the Board initiated a \$200 annual certificate fee and eliminated the \$1350 charge.

The Board office operates in very cost efficient manner. Any Diplomate who is interested is welcome to come to the office and review the books.

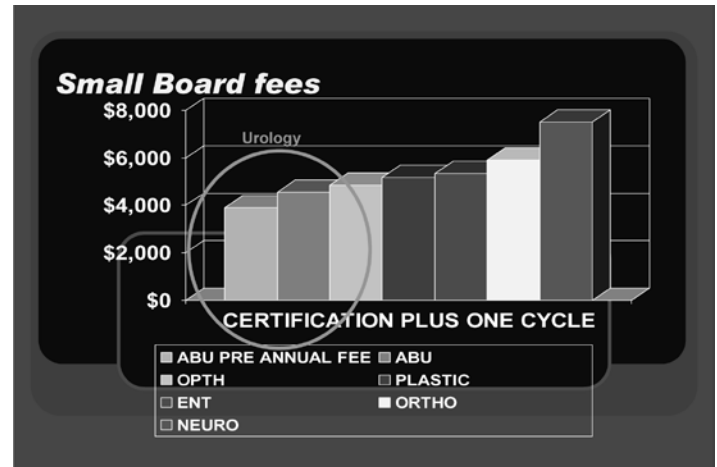
Incidentally, it is important to note that the new costs for providing subspecialty certification in pediatric urology are entirely covered by pediatric urologist certification fees.

The chart illustrates the current fee for certification and one cycle of recertification for the small ABMS surgical boards.

ABU Statement on Billing for Unnecessary Tests

The ABU certification and recertification/MOC processes include practice log reviews. These reviews examine the breadth, volume, and patterns of practice. Recently, a practice has been identified where some urologists order tests which are of limited value for most patients. We are aware the technology of diagnostic medical testing provides multiple results as part of diagnostic panels. In some cases, there appear to be tests reported as part of a panel which are billed separately in addition to the base cost of the panel. When office testing is done, documentation of the indications for the test, the result, and the therapeutic value/plan for the patient is necessary. However, the practice of ordering and billing for a test, only because the result is part of a panel, is not considered proper administration of urologic care. ■

Note that the first bar represents the ABU fees before the change from a \$1350 charge for the recertification examination. The second bar shows the ABU fees after implementation of the annual certificate fee. Notice that the fees for the ABU still remain lower than any other surgical board.



The Trustees of the ABU are very appreciative of the exceptional compliance of the Diplomates with this new fee schedule, the results of which are detailed below:

- 5,470 of the 5,756 (95%) ABU Diplomates with time-limited certificates paid the 2009 annual certificate fee as of August 15, 2009. The 292 new Diplomates of the Class of 2009 were not invoiced. They will receive their first invoice in January 2010.
- All current Recertification candidates paid the 2009 annual certificate fee.
- 1,682 (42%) of non-retired Diplomates with time-unlimited certificates voluntarily paid the \$200 fee. ■

Examination Results

294 candidates sat for the computerized Qualifying (Part 1) Examination in August 2009. Of these, 91 percent, or 267 passed.

251 candidates sat for their oral Certifying (Part 2) Examination in February 2009. Of these, 93%, or 233 passed.

452 candidates sat for the computer-based Recertification Examination in October 2008, and 442, or 92% passed.

46 candidates sat for the second Pediatric Subspecialty Certification Examination, and 46, or 100% passed.

Milestones Project for Urology Residency Training

by Michael L. Ritchey, MD

Recent graduates and faculty of urology training programs are familiar with the changes instituted by the ACGME (Accreditation Council for Graduate Medical Education) in residency training over the past decade. In 2001, the ACGME introduced the competencies to measure resident training (Table 1). This was the first step in the building of an outcomes based accreditation process. When this was introduced, the ACGME expected that the individual specialties would develop metrics to measure outcomes in these competencies. The best metric tools would then be adopted by other institutions to use in their programs. They have not materialized as expected and incorporation into the actual training of residents has varied among institutions.

Currently most programs are reviewed every four to five years. They predominantly review the systems and processes that are set in place for education. They look at conference schedules, attendance at conferences, papers published, number of faculty per resident, duty hours, etc. The RRC (Residency Review Committee) uses this information to assess the quality of the overall experience for the residents in training.

The ACGME now hopes to revise the process of accreditation to a truly outcomes based system. The ACGME proposes to change the measurement of resident performance to evaluate residents at key points during their progression in the program. The residents will be required to meet competencies appropriate for the given specialty and for their postgraduate training year. The progress in meeting these competencies will be reported to the RRC at much more frequent intervals, allowing the RRC to track the progress in training of residents individually at multiple points in time. It is expected that the resident will demonstrate an appropriate level of competency as they progress through the residency program and pass “**milestones**” each year until they have reached the level at which they can graduate from the training program and move on into practice. Implicit to the success of this program is the development of reliable measurement tools to assess each of the competencies. These tools will allow program directors to review the progress of their own residents and programs and will allow

the ACGME to compare programs and potentially conduct site visits less often.

The American Board of Urology is also being asked by the ABMS (American Board of Medical Specialties) to address competency of practicing urologists. The Board has developed a MOC (maintenance of certification) process to perform these functions. For many years now, urologists have been required to take an exam to complete the process of recertification. The latter specifically addresses medical knowledge which is only one of the six competencies.

The Board does also review surgical logs and peer review of candidates who are candidates for recertification. This provides the ABU with additional information regarding the candidate’s patient care and professional performance. The ABMS is now endeavoring to increase the scope of the MOC process. The committee on maintenance of certification (COMMOC) of the ABMS is proposing that specialty boards obtain more detailed evaluation of candidates based on communication skills and professionalism. Tools will be developed to accomplish these tasks. It is probable that state medical boards will begin to adopt similar processes for maintenance of licensure in the future. This is being pushed significantly at the federal level under the umbrella of improving patient safety and quality of health care.

Monitoring of practice based learning via CME activity and self assessment will also be part of the future MOC process.

The trustees of the American Board of Urology believe that it is in the best interest of urologists that we fully engage in these processes to help define what standards and what measurement tools are appropriate for urology. The ACGME is piloting several specialties for development of milestones and urology is the fourth specialty tasked to begin this project. The RRC, American Board of Urology and the other stakeholders are developing a committee to determine how to implement the milestones project. This committee will define and determine how to use milestones both in residency training and for maintenance of certification. This committee will have representation from the RRC, ABU, ACGME, AUA and American College of Surgeons. This process will take place over the next two years. Utilizing the expertise of these organizations will enable development of the tools needed to measure these “milestones”. ■

Table 1 – Competencies

1. Patient Care
2. Medical Knowledge
3. Practice Based Learning
 - A. Practice assessment protocols
 - B. Best evidence
 - C. Self assessment
4. Communication Skills
 - A. Peers
 - B. Medical records
5. Professionalism
 - A. Ethics
 - B. Compassion to patients
 - C. Conflict of interest
 - D. Accessibility
 - E. Confidentiality
6. Systems-based Practice
 - A. Multiple care systems
 - B. Recognize system error
 - C. Cost-effective care.

ABU Maintenance of Certification (MOC) 2009

The 2009 ABU MOC class consists of 255 Diplomates who certified in 2007. Applicants were required to pay the newly implemented \$200 Annual Certificate Fee; complete an online application form; submit a copy of their current, unrestricted medical license; and complete a two-part online Practice Assessment Protocol (PAP) in compliance with established deadlines to avoid late fees. The online components of MOC have functioned well and in cases where a Diplomate encountered problems, ABU staff quickly resolved these.

In April 2010, all Diplomates who completed initial certification, recertification, or pediatric urology subspecialty certification in 2008 will be mailed application information for completing the required Level 1 of MOC. Charts showing MOC Levels 1-4 requirements and implementation dates appear at right.

The American Board of Urology staff will assist Diplomates in every way possible to meet deadlines and requirements of MOC using application mailings, email reminders, and postings on the ABU website. Non-compliance with deadlines may result in late fees or revocation of certification; therefore, current contact information provided by Diplomates is essential in order for ABU staff to communicate critical information and deadlines. If you are uncertain about the status of your mailing address and email address information, please contact the Board office to verify. **The American Board of Urology does not have access to address updates made with the American Urological Association; therefore, it is the responsibility of the Diplomate to insure the ABU has current contact information. The Board will not waive late fees incurred due to an outdated mailing address. ■**

MOC REQUIREMENTS

Requirements	Level 1 (year 2)	Level 2 (year 4)	Level 3 (year 6)	Level 4 (years 7-9)
Complete application online	yes	supplemental application	supplemental application	supplemental application
ABU office verify licensure	yes	yes	yes	yes
ABU office complete peer review		yes		yes
Candidate: Complete online Practice Assessment Protocol	yes	yes	yes	yes
Candidate: Submit documentation of 90 hours of CME		yes		yes
Candidate: Submit 6 month electronic practice log				yes
Candidate: Computer-based closed-book exam				yes

MOC ENTRY TIMELINE

CERTIFICATION PROCESS					
Certification Exam Year	Certificate Expires	Year for Level 1 (year 2)	Year for Level 2 (year 4)	Year for Level 3 (year 6)	Year for Level 4 (years 8-9)
2007	2017	2009	2011	2013	2015-2016
2008	2018	2010	2012	2014	2016-2017
2009	2019	2011	2013	2015	2017-2018
2010	2020	2012	2014	2016	2018-2019
2011	2021	2013	2015	2017	2019-2020
2012	2022	2014	2016	2018	2020-2021
2013	2023	2015	2017	2019	2021-2022
2014	2024	2016	2018	2020	2022-2023
2015	2025	2017	2019	2021	2023-2024
2016	2026	2018	2020	2022	2024-2025
2017	2027	2019	2021	2023	2025-2026
RECERTIFICATION PROCESS					
Current Certificate Expires	Recertification Exam Years	Year for Level 1 (year 2)	Year for Level 2 (year 4)	Year for Level 3 (year 6)	Year for Level 4 (years 7-9)
2008	2007	2010	2012	2014	2016-2017
2009	2007-2008	2011	2013	2015	2017-2018
2010	2007-2009	2012	2014	2016	2018-2019
2011	2008-2010	2013	2015	2017	2019-2020
2012	2009-2011	2014	2016	2018	2020-2021
2013	2010-2012	2015	2017	2019	2021-2022
2014	2011-2013	2016	2018	2020	2022-2023
2015	2012-2014	2017	2019	2021	2023-2024
2016	2013-2015	2018	2020	2022	2024-2025
2017	2014-2016	2019	2021	2023	2025-2026
2018	2015-2017	2020	2022	2024	2026-2027

Non-Compliance	Sanction
No annual certificate fee by April 1	\$200 late fee
No application or license by June 1	\$200 late fee
No PAP initiated by August 1	\$200 late fee
Requirements not completed by Dec. 1	Possible revocation of certificate

2010 Important Dates and Deadlines

January	Annual Certificate Fee Invoices mailed
April 1	Annual Certificate Fees due
June 1	Deadline for Annual Certificate Fee (with \$200 late fee)

Qualifying (Part 1) Process

September 10	Applications mailed
November 1	Deadline for applications (Dec 1 + \$750 late fee)
March 1	Program Director's evaluation form due
July 29 or 30	Examination given at Pearson VUE Testing Centers



Certifying (Part 2) Process

February 19-20	Oral Examinations in Dallas, TX
May 10	Applications mailed
July 1	Deadline for applications and documentation (August 1 with \$750 late fee)
September 1	Practice log deadline (Sept. 15 + \$750 late fee)

Recertification Process

December 1, 2009	Applications mailed
February 1	Deadline for applications and documentation (Feb. 15 with \$750 late fee)
March 15	Practice Log deadline (March 31 + \$750 late fee)
August 2	Deadline for CME documentation
October 6, 7 or 8	Examination at Pearson VUE Testing Centers

Pediatric Urology Subspecialty Certification Process

June 4 or 10	Examination given at Pearson VUE Testing Centers
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Maintenance of Certification (MOC) Process

April 1	Application letters mailed
June 1	Deadline for completing online MOC application (July 1 + \$200 late fee)
June 1	Deadline for medical license documentation (July 1 + \$200 late fee)
August 1	Deadline for completing Part A of online Practice Assessment Protocol (\$200 late fee after August 1)
November 1	Deadline for completing Part B of online Practice Assessment Protocol (\$200 late fee after November 1)

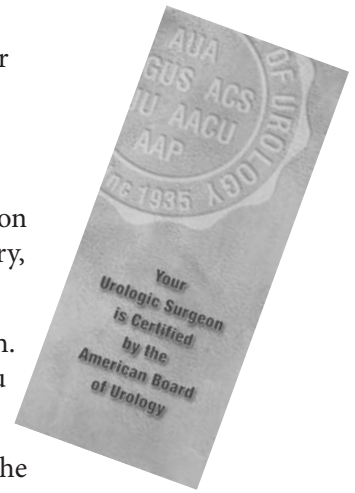
Brochure Describes Certification

Diplomates of the American Board of Urology who wish to make patients aware of their certification and the process for obtaining it may benefit from the brochure: *Your Urologic Surgeon is Certified by the American Board of Urology*.

This new brochure includes sections on The Importance of Board Certification, Maintenance of Certification, and Pediatric Subspecialty Certification and a detailed illustration of the urinary system. A sample will be mailed with the annual certificate fee invoice in January, or you may request a sample by contacting the Board office at 434/979-0059.

There are limited quantities of the previous brochure available in English and in Spanish. (The new brochure is currently only available in English.) Please note on the order form if you are ordering the previous brochure.

Brochures may be ordered from the Board office in quantities of 100, 200 or 500 using the order form below. 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

Name: _____

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