Message from the President

CME and Certification: Exploring the Difference

“...I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of body as well as the infirm...”

Hippocratic Oath

The relationship between medicine and society has been often described as a “social contract”1. This relationship is founded on the premise that physicians are rewarded in terms of economic benefit and social reward in return for contributing to society through safe, competent and ethical healthcare. Up until now, this “contract” was relatively simple, as patients (or insurers) were responsible for paying for the services rendered. The opportunity to demonstrate altruism through indigent care, education or public service was more clearly defined to practicing physicians.1 Today, as the economics of healthcare change and multiple regulations are requiring more physician time away from direct patient care, this relationship is clearly changing. So, what are our obligations to the public (our patients)? How do we uphold our special obligations to the public, in light of the rapid changes in our healthcare environment? Today, clinicians face more uncertainty than ever surrounding the economics of their practice, while being deluged by electronic health record mandates, hospital regulations, institutional requirements, licensing requirements and continued certification. Plus, all of these regulations are enforced by different organizations with little coordination or communication between them. It’s clear that physician morale is lower and frustrations are higher than ever, particularly in urology. Urologists are considered some of the “most burned out” medical specialists and are significantly dissatisfied with our current MOC (Maintenance of Certification) process. Over 80% expressed that the current CME (Continuing Medical Education) requirements were satisfactory to continue their medical education1 – but, does it meet our public obligation?

It is important to emphasize that the mission of the American Board of Urology (ABU), as a surrogate to the American Board of Medical Specialties (ABMS), is for the benefit of the public. Our mission is to insure the safe and ethical practice of urology through a process of accreditation. This process involves completing an accredited training process (which few seem to question) and certification via a process of examination to determine the skills and competence of urologists. The examination process itself also engendered little debate until Recertification was followed by MOC. Weighing all of these factors with our public obligation, many would contend that our current method of continuing education does not meet the needs of all constituents. Many professions (law enforcement, emergency technicians, airplane pilots, certified drivers, etc.) all require periodic confirmation of competency in order to maintain licensure (not just certification, but the ability to practice). The public generally expects a process where his/her physician has demonstrated and maintained competence. In fact, when asked what factors are most valued in their physicians, Board Certification ranks equally or higher than interpersonal skills as the most important attribute of their physicians1.

The Accreditation Council for Continuing Medical Education (ACCME) develops and promotes standards for quality CME utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities. Most commonly, physicians obtain CME credit through didactic lectures, seminars and on-line activities. Continued on page 2
These activities have been organized around the core competencies introduced by the Accreditation Council for Graduate Medical Education (ACGME) and ABMS and all have demonstrated educational effects in the evidence-based choices of physicians, emphasizing the role of CME in facilitating and reinforcing evidenced-based decision making\(^1\). However, in many instances, these activities do not meet the standards of examination (required for certification) nor the expectation of the public to demonstrate continued competence. To fulfill our public obligation, we must strive to achieve these goals. To date, the ABU has been very active toward our goal of weaving relevant, efficient and effective educational activities into our evolving process of MOC. Over the past year, we have actively engaged our Diplomates to assist in improving MOC. We continue to incorporate many changes to make this process more relevant to individual practice while maintaining our certification standards. Each Board has the capacity to modify the MOC mandate, and the ABU has been diligent in doing so. We have established communications with the AUA and others regarding the development of educational materials that are “MOC Compliant”\(^2\). It is our hope that these materials will facilitate obtaining CME and MOC credit simultaneously. Recently, the ACCME, American Board of Internal Medicine (ABIM) and (ABP) have created MOC compliant CME processes. There are newer methods of “passing standards” being instituted that insure participation and proficiency on an individual basis. In addition, a mechanism of feedback with the physician is insured to measure the impact on clinical practice. It is our hope, as our activities evolve into these areas, to continue to transform MOC into a more meaningful experience for all certified urologists.

A laudable goal is to transform our present process of participation in CME and MOC, given regulatory requirements, away from quality assurance to a process of Continuous Professional Development (CPD)\(^1\) in which clinicians want to participate (because there is value). Largely based on practice-based learning improvement, the first step is to use tools to review data regarding current practice and patient outcomes and compare it to normative data. From these, “gaps” in practice compared to normative data are identified, and the physician then enrolls in CPD programs to address these gaps. The final step involves reassessment of practice by re-evaluation. There are numerous tools and educational opportunities that allow us to achieve these goals. The next step is to continue our ongoing dialogue to improve the experience for physicians, in the most efficient manner possible, while fulfilling our solemn obligation to the public.

J. Christian Winters, M.D., F.A.C.S.

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The Board Welcomes…
New Trustees: Eila C. Skinner, M.D. and Joel B. Nelson, M.D.

**Dr. Eila Skinner** is the Thomas A Stamey Research Professor of Urology and Chair of the Department of Urology at Stanford University. Obtaining her undergraduate degree from Stanford and her medical training from Keck USC School of Medicine, she completed a residency in Urology at LAC+USC Medical Center, and a fellowship in Urologic Oncology at the Norris Cancer Center at USC. She was on the faculty in the Department of Urology at the Keck USC School of Medicine from 1990 through 2012, where she also served as residency program director for over 10 years. In 2012, she was recruited to Stanford University to become Chair of the Department of Urology. Dr. Skinner is a member of several national organizations, including the Society of Urologic Oncology, Society of University Urologists, American Association of Genitourinary Surgeons, Clinical Society of Genitourinary Surgeons, and Society of Women in Urology. She has been a member of a number of committees at the American Urology Association including the Science and Quality Council, the Core Curriculum Committee, and the Guideline Committee on non-muscle invasive bladder cancer. Dr. Skinner’s primary clinical and research focus has been in the surgical treatment of locally advanced bladder cancer, bladder reconstruction and continent urinary diversion. She has active ongoing clinical trials in the treatment of bladder cancer and other urologic malignancies. Dr. Skinner is married to Tom Sadler and they have three children, the eldest of whom is currently a resident in urology training.

**Dr. Joel B. Nelson** was nominated to be a trustee of the American Board of Urology by the American Urological Association. His term extends from February 2016 – February 2022. He is the Frederic N. Schwentker Professor and Chair of Urology at the University of Pittsburgh School of Medicine and Senior Medical Director of the University of Pittsburgh Physicians. Dr. Nelson received his undergraduate degree in philosophy from the University of Pittsburgh and M.D. from Northwestern University Medical School. He trained in urology at Northwestern and completed an American Foundation of Urologic Disease Fellowship at the James Buchanan Brady Urological Institute at Johns Hopkins. In 1996, he joined the Department of Urology at Johns Hopkins and was named Director of Urologic Oncology at Johns Hopkins Bayview. In 1999, Dr. Nelson was appointed Chair of the newly formed Department of Urology at the University of Pittsburgh. His clinical and academic interests are focused on prostate cancer. Administratively, he oversees the 2800-member faculty practice plan of the University of Pittsburgh Medical Center. Dr. Nelson is a Diplomate of the American Board of Urology, certified in 1998 and recertified in 2008. He is a member of the American Urological Association, Society of Urological Oncology, Society of Basic Urological Research, and American Society of Clinical Oncologists. He is a past President of the Northeastern Section of the American Urological Association. He is a member of the American Association of Genitourinary Surgeons, the Clinical Society of American Association of Genitourinary Surgeons. Dr. Nelson is married to Elizabeth “Liz” Nelson and they have three children: Micah, Asa and Adlai. Everyone in the family has run at least one marathon; for some, it will always be one.

American Board of Urology Trustees 2016-2017

Front Row (from left): Fred E. Govier, M.D., Gerald H. Jordan, M.D., J. Brantley Thrasher, Ian M. Thompson, Jr., M.D., J. Christian Winters, M.D., Kevin R. Loughlin, M.D., H. Ballentine Carter, M.D.


ABU Report 2016
The Board Thanks...
Ian M. Thompson, M.D. and J. Brantley Thrasher, M.D.

Dr. Ian M. Thompson Jr. served as a Trustee of the American Board of Urology from February 2010 until February 2016 and was its President from 2015-2016. He also served as Chair of the Executive Committee, Secretary-Treasurer, Chair of the Pediatric Subspecialty Committee, Chair of the Publication and Research Committee, and member of the Recertification Committee, the Oral Examination Committee, the Policy Committee, and the Nominating Committee. Of his term as a Trustee, Dr. Thompson stated, “It was a privilege, these past years, to serve the American Board of Urology. I am most humbled by the legacy of the remarkable Trustees over the years who committed so much time and provided their personal guidance to our specialty. We are looked upon as one of the most forward-thinking specialties in Medicine, one that has the highest level of commitment to both our patients and to the American public. As I watch over the professional development of those who will follow us, I am completely confident that this legacy of service will continue.”

Dr. J. Brantley Thrasher served as a Trustee of the American Board of Urology from February 2010 until February 2016 and as Vice President from 2015-2016. He served on the Executive Committee and served as Chair of the Nominating Committee, the Recertification Committee, and the Finance Committee. He also served on the FPMRS Subspecialty Committee and the RRC Committee. Regarding his service to the ABU, Dr. Thrasher had this to say, “I know that I have told several folks at the ABU that I enjoyed my time with the ABU more than anything else in organized medicine. I have been on the AUA BOD, the RRC, the fellow selection committee of the ACS, the AJCC, the SUO, the SUCPD and many committees for the AUA. I always felt that the most productive work that I did in all of those services was the work as a Trustee of the ABU. I found the organization to be very well organized, the staff extremely capable and professional and the other Trustees were all outstanding. We tackled very difficult problems and controversial issues but always came to consensus. In summary, my 6 years as a Trustee of the ABU were the most rewarding years of my urology career, so far, and if the opportunity arises, I would love to work with the ABU again.”

New ABU Website and Portal

The American Board of Urology has contracted with Virginia-based Immerge Technologies, a web design and software development agency, to develop a new ABU website with a Diplomate portal. This work will not only enhance the public image of ABU, but will also provide much needed technology tools for Diplomates and for partner organizations. The new system will provide candidates and Diplomates a means of accessing personalized, “real time” information about the specific certification processes in which they are involved. Features include web-based interfaces to handle new candidate certification, peer review, log submissions, subspecialty certification, and more. In addition to allowing applicants to know their status in a given process, the portal will provide electronic document storage and secure payment capabilities by credit card. The nearly three-year project is scheduled to launch in the first quarter of 2017 and represents hundreds of hours of work by both ABU staff and the development team at Immerge. The end product will be a tool that will know and present to Diplomates just what is needed, streamlining application and renewal processes for the 21st century.

Check out our new website! www.abu.org
1985 was a watershed year for the ABU and for me personally. It was the first year that the ABU began issuing time-limited certificates and the year that I was certified. Urologic practice has changed dramatically in the past three decades. If, like Washington Irving’s Rip Van Winkle, a urologist had been placed in a potion-induced sleep, upon awakening from such somnolence, he/she would be incredulous regarding the changes in practice.

In 1985, the utilization of nerve-sparing radical prostatectomy was still in its nascent stages and although PSA had been discovered, it was not widely used clinically. A robot was something seen in science fiction movies. Drugs such as 5 alpha reductase inhibitors, PDE 5 inhibitors, and many of the current anti-incontinence and oncology medications were not yet available in the clinical setting. Although IVF had been described some years earlier, the full array of the current ART procedures were still theoretical, rather than a clinical reality.

Urologic imaging was rather rudimentary then and the further application of CT, MRI and ultrasound were still evolving. Pediatric urologists were developing a new era of reconstructive procedures. Many cases of urolithiasis were still treated with open surgery and ESWL, PCNL and ureteroscopy were not universally embraced.

There should be little wonder that with these fundamental changes in urologic care, that the need for monitoring of life-long learning became apparent. The American Board of Medical Specialties mandated Maintenance of Certification in 2002 and, in 2007, the ABU joined the 23 other member boards in the MOC process. Although the introduction of MOC was met with angst by some urologists, as the process matured, the majority of urologists came to see its value. The goal of the ABU trustees has been to make the process useful, fair and not onerous. The MOC process is not immutable and the trustees welcome Diplomate feedback.

The Future

I think the future of urology is robust. Urology, unlike some specialties, continues to attract the best and the brightest. As anyone who has had the opportunity to interview current urology resident candidates will attest, their qualifications are impressive.

If a modern Rip Van Winkle again imbibed a somnolent potion, one can speculate what he/she would observe upon awakening in thirty years. The confluence of scientific investigation, advances in technology and the quality of urologic trainees forecasts daunting advances in the years ahead.

It has been a privilege to serve as a Trustee. The Charlottesville staff is superb and I am continually impressed by the talent and judgment of my fellow trustees. My wife, Christine, and I have been extremely fortunate to share our ABU experience for the past six years with our close friends, Gay and Chris Winters. Finally, Gerry Jordan is a rare blend of knowledge, judgment and leadership. It has been an honor to serve under Gerry. Thanks to you all for this special opportunity to serve as an ABU Trustee.

The purpose of the American Board of Urology is:

1. To improve the quality of urologic care
2. To establish and maintain high standards of excellence in the specialty of Urology and its approved subspecialties
3. To encourage the study, and advance the cause of Urology.
4. To evaluate specialists in Urology who apply for initial and continuous certification and urologists in approved subspecialties who apply for subcertification.
5. To grant and issue to qualified physicians certificates of special knowledge and skills in Urology and approved subspecialties, and to suspend or revoke same
6. To serve the public, hospitals, medical schools, medical societies, and practitioners of medicine by furnishing lists of urologists whom it has certified to the American Board of Medical Specialties and the American Medical Association.
ABU Examination Statistics

2016 Qualifying (Part 1) Examination
324 candidates sat for the 2016 Qualifying (Part 1) Examination on July 14 and 15 at Pearson VUE Test Centers across the country. 313 candidates (97%) passed and 11 candidates (3%) failed. The 2017 Qualifying (Part 1) Examination is scheduled for July 13 and 14.

2016 Certifying (Part 2) Examination
311 candidates challenged the February 2016 Certifying (Part 2) Examination in Dallas, TX. 291 (94%) passed and were certified while 20 (6%) failed. The Board uses the multi-faceted Rasch model and the Fair Average for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. The candidates were scored on four clinical skill categories: diagnosis, management, follow up, and overall ability. The Board believes this scoring methodology results in increased statistical reliability. The 2017 Certifying (Part 2) Examination is scheduled for February 24-25.

2016 Female Pelvic Medicine and Reconstructive Surgery Examination
A total of 56 candidates (urologists and gynecologists) sat for the 2016 Female Pelvic Medicine and Reconstructive Surgery (FPMRS) Subspecialty Certification Examination on June 24 at Pearson VUE Test Centers across the country. The pass rate on the examination was 86%. Like general urology certificates, all subspecialty certificates issued are ten-year time limited certificates and subject to MOC. The next FPMRS examination will be administered on June 27, 2017.

2016 Pediatric Subspecialty Certification Examination
28 candidates sat for the 2016 Pediatric Subspecialty Certification Examination (PSCE) on October 21 and 28 at Pearson VUE Test Centers across the country. 27 (96%) candidates passed the exam and 1 candidate (4%) failed. The pass rate was consistent with previous years. Like general urology certificates, all subspecialty certificates issued are ten-year time limited certificates and subject to MOC. The next PSCE Examination will be administered on October 17 or 23, 2017.

2016 Recertification Examination
303 Diplomates sat for the Recertification Examination on October 21 and 28 at Pearson VUE Test Centers across the country. 270 (89%) Diplomates passed and were recertified and 33 (11%) failed. The recertification process, as it currently exists, will be discontinued by 2019 when the last class of Diplomates who originally certified before 2007 recertifies and Maintenance of Certification is fully implemented. The next Recertification Examination will be administered on October 17 or 23, 2017.

2016 Maintenance of Certification (MOC) Examination
383 (305 General Urology, 78 Pediatric) Diplomates completed Level 4 MOC requirements in 2016, including the MOC examination at Pearson VUE Test Centers, on October 21 or 28. 362 Diplomates (95%) passed and maintained their ABU certification and 21 Diplomates (5%) failed. 305 Diplomates sat the general urology examination, of which 286 (94%) passed and 19 (6%) failed. 78 Diplomates sat the pediatric urology examination, of which 76 (97%) passed and 2 (3%) failed. With three years given to complete MOC Level 4 requirements, Diplomates have three opportunities to pass the examination if they enter MOC at their first opportunity. The next MOC Examination will be administered on October 17 or 23, 2017.

In Memoriam
The office of the American Board of Urology regretfully reports receiving notification in 2016 that the following Diplomates have passed away:

Edwin Darracott Vaughan, Jr., M.D.
Elbert H. Goodier, III, M.D.
Arthur C. Pinto, M.D.
Dwayne Allen McQuitty, M.D.
George Egri, M.D.
Karl Sturge, M.D.
Suhayl S. Kalash, M.D.
Maintenance of certification is required for all Diplomates with certificates issued after January 1, 2007. These include certificates of Urology for the subspecialties of Pediatric Urology and Female Pelvic Medicine and Reconstrcutive Surgery (FPMRS). MOC is a mandate of the American Board of Medical Specialties (ABMS). The different parts of MOC are Professional Standing (Licensure and Peer Review), Lifelong Learning and Self-assessment (CME), Cognitive Expertise (Examinations) and Practice Performance (Outcomes and Quality Improvement). The MOC process is an evolving one and the ABU continues to make changes to improve our program. Upcoming changes in 2017 are primarily related to Examinations and Quality Improvement.

In 2017, the ABU will return to a modular examination for MOC. This exam will continue to be constructed from questions based on clinical scenarios and avoid basic science. There will be five modules: Core/General Urology, Oncology (includes urinary diversion), Andrology/Infertitlity/Erectile dysfunction, Female Urology/Incontinence/Voiding dysfunction, and Calculi/Obstruction/Endourology/Laparoscopy. All Diplomates will be required to take the Core/General Urology module plus one specific content module of their choosing. The core module will incorporate questions based on the AUA guidelines where possible. The ABU felt that a core general urology module is needed for all urologists. Many subspecialists practice in large group practices or academic programs and provide call coverage. Therefore, some knowledge of the entire scope of urologic practice may be required on occasion.

Diplomates with subspecialty certification in pediatric urology will take a pediatric MOC exam. These Diplomates will take the same exam as the candidates for initial certification in pediatric urology. Other Diplomates practicing a significant amount of pediatric urology who do not have a subspecialty certificate will be offered the opportunity to take the pediatric MOC exam rather than the modular exam. Their practice logs will need to confirm that 75% of their practice is pediatric urology. Future FPMRS subspecialty recertifing Diplomates will also take a separate MOC exam in the future. Both the pediatric and FPMRS exams will have 30% of the items pertaining to general core urology, e.g. calculi, infection, obstruction, urinary diversion. Thus, these exams allow for maintenance of both the primary certificate and the subspecialty certificate with one exam process.

We will continue to identify those Diplomates who fail the MOC exam. However, due to the smaller number of exam items on the modular exam, we will identify a second group of Diplomates one Standard Error of Measurement (SEM) above the “pass point” for the exam. These will be designated as a “conditional pass” group. The latter group would be required to complete additional CME in the areas where they demonstrated low scores. After successful completion of the designated CME activity, they would continue in MOC and the condition of their pass will be lifted. The “failed” Diplomates that score below the “pass point” will also need to participate in CME activities in their areas of deficiency and those will be discussed with each Diplomate. The “failed” Diplomates will then retake the MOC exam within the next 2 years, retaking the same modules as taken in their initial exam. Those Diplomates who fail the exam on the second attempt will be offered an oral examination in Dallas the following year. This oral examination will be structured toward the urologist in practice and not like the Certifying (Part 2) Examination with which all are familiar. Going forward, it will also become necessary for all Diplomates to take the MOC exam in year 7 of the MOC cycle. This allows all to have 3 “exam” attempts before expiration of their certificate.

Practice performance or quality improvement is a key element of Level 4 MOC. In the past, we have required all our Diplomates to complete Practice Assessment Protocols (PAPs) at each level of MOC. The ABU develops PAPs based on AUA practice guidelines and best practice statements. The ABU also requires submission of a practice log at the end of the MOC cycle as the primary means to complete this requirement. This will continue to be an integral part of our MOC process. However, the ABU will begin allowing other Level 4 activities or practice improvement projects to be used for MOC credit. The ABU participates in the ABMS Multispecialty Portfolio program which has many sponsoring institutions. ABU Diplomates can participate in approved projects and the ABMS Portfolio program will notify the ABU when Diplomates complete such practice improvement projects. Credit can be given to exempt Diplomates from other required Level 4 activities, e.g. PAPs.

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The ABU will be adding additional MOC Level 4 activities over time. One recent addition is the Michigan Urological Surgery Improvement Collaborative (MUSIC), a physician-led quality improvement program started in 2011 which enrolls the majority of urologists in Michigan. The board will continue to evaluate other registries for Level 4 credit that demonstrate opportunity for improvement in medical practice.

The American Board of Urology is very interested in feedback from our Diplomates with regards to the MOC program. We are, in fact, charged by the ABMS to solicit that feedback. Most of the changes that are being implemented have resulted from constructive commentary offered by our Diplomates. Additionally, before change is made, further discussion is accomplished with the Diplomates in order to avoid unintended consequences. The ABU seeks to establish an MOC program that certified urologists regard as helpful in allowing them to retain their high level of competency and provide them MOC credits for activity they are already performing.

Voluntary Contributors

The Trustees of the American Board of Urology wish to express special thanks for the following retired Diplomates who were gracious enough to pay the $200 annual certificate fee:

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The Trustees would like to express sincere appreciation to the following Diplomates with time-limited certificates who made voluntary contributions in excess of the annual certificate fee:

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Richard L. Zobell, MD

The Trustees want to thank the following retired Diplomates for their monetary support of the Board in 2016:

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The Trustees gratefully acknowledge the generosity of the following Diplomates with time-unlimited certificates who made voluntary contributions to the Board:

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Brendan M. Fox, MD

Larry I. Frank, MD
Richard A. Fraser, MD
Neil R. Friedman, MD
Martin D. Fritschain, MD in honor of Dr. Arthur Evans
Nelcar M. Gadrinab, MD
David C. Ganch, MD
Peter J. Garbeff, MD
Sverrir O. Georgsson, MD
Ronald Peter Glinski, MD MBBS
Kenneth A. Goldberg, MD
Robert L. Goldman, MD
Robert P. Gossett, MD
John Elbert Greene, MD
William P. Griggs, MD
Jerold Grubman, MD
Rudy I. Haddad, MD
M. Ramzy Hajmurad, MD
Craig W. Hamilton, MD
Sammy A. Hamway, MD
Gary F. Harne, MD
Randy D. Hassler, MD in memory of Carl Weber, Jr MD

Michael Scott Hay, MD
George P. Hemstreet, III MD MBBS
Terry W. Hensle, MD
Harry W. Herr, MD
W. Howard Holl, III MD
John D. Holstine, MD
Mohammad J. Iqbal, MD
David Jacobs, MD

Continued on page 10
The processes of Certification, Recertification, Subspecialty Certification, and Maintenance of Certification (MOC) have become increasingly complex, requiring significant exchanges of information between the American Board of Urology and its Diplomates. For many reasons, standard mail, telephone calls, and faxes have become inefficient. The cost involved is significant for the Board, having the potential to influence fees.

It is imperative that the American Board of Urology has current, accurate mailing and electronic contact information for all Diplomates, including those with time unlimited certificates, those in recertification, those in subspecialty certification, and those in MOC. **It is the obligation of the Diplomate to maintain that information with the ABU.** Failure to do so compromises the Board’s ability to convey important information to the Diplomate and jeopardizes currency in MOC, recertification, or certification. Diplomates are required to verify their contact information annually and if one’s information changes, the ABU must be notified. A lapse in this information could ultimately result in the certificate revocation.

**ABU Change of Address Policy**

The ABU Change of Address Policy requires Diplomates to maintain current, accurate contact information with the American Board of Urology. This is crucial for the Board to convey important information to its Diplomates and to ensure currency in various certification processes. Diplomates are responsible for verifying their contact information annually and notifying the ABU of any changes. Failure to maintain this information could lead to certificate revocation.

**ABU Report 2016**

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Not sure if the ABU office has your current address?
Complete and fax this form to 434-979-0266, email to staff@abu.org, or mail to:
American Board of Urology  600 Peter Jefferson Parkway  Suite 150  Charlottesville, VA  22911

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ABU Brochure Available on USB Flash Drive

The American Board of Urology brochure, Your Urologic Surgeon is Certified by the American Board of Urology is now available on USB Flash Drive. For a one-time fee of $150, Diplomates may purchase the brochure as a printable file on a reusable 1G flash drive bearing the ABU logo.

ABU Brochure on USB Flash Drive Order Form

Please type or print clearly

Complete the form and return to the ABU office with a check or money order in the amount of $150.00 payable to the American Board of Urology. Virginia residents must add 5% sales tax ($157.50).

Name: ____________________________________________

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City: _____________________________________________  State: ____________  Zip Code: ________________

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600 Peter Jefferson Parkway
Suite 150
Charlottesville, VA 22911