



ABU Report

Published by the American Board of Urology
A Member of the American Board of Medical Specialties (ABMS)

Issue No. 15

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

October 2007

Message from the President

United States medicine (including urology), the patient population it serves and the political and social environment we live in are changing at a rate and in a direction many neither appreciate nor support. Healthcare is a top issue both for the US population and the political candidates who seek to lead it. Our field and the organizations representing urology, including the American Board of Urology (ABU), are a small but important part of US medicine. The ABU's primary functions, different than other organizations in our field, are to ensure *appropriate training* of urologists and *quality care* for the population served by our specialty. I believe many in our specialty do not understand that the board's *primary* responsibility is to ensure the public good rather than urologists' economic or social welfare. The latter are *secondary* goals, which should naturally follow based on achievement of the primary goals.

Trustees of the ABU are dealing with many issues simultaneously, as they should given the magnitude of the board's responsibility and the multitude of contemporary issues it currently faces. These include maintenance of certification (MOC), subspecialty certification, a core urologic curriculum (in conjunction with many including the AUA), case (number and scope) standards for initial certification, and board certification of certain foreign-trained physicians to name a few. Some of these issues are generated internally and others, such as MOC, are mandated by those outside of the field. The board needs to comply with these later issues and draft and execute a program, which serves the initial intent of the process, but, hopefully, limits unnecessary burden on our diplomates. It should also be noted that ABU trustees also attend to the regular and ongoing business of the board including oral board examination preparation, certification, credentialing, etc.

Subspecialty certification is a concept favored by most, if not all, urologic subspecialties. Pediatric urologists

have for many years been lobbying effectively for a subspecialty in pediatric urology. Essentially such certification recognizes the unique, specialized and additional training of such subspecialists and an ongoing commitment to serve a unique patient population.

The primary drivers of a subspecialty certification, from the board perspective, are the impact of specialized training on the quality of care to a unique, complex and very focused population of patients; and the recognition of the now substantive training required to gain such certification. The ABU recently approved this process for pediatrics after many years of deliberation and revision of the concept. The process is not trivial for those who wish to receive subspecialty certification, as it involves at least 2 years of additional training (clinical and academic), passage of a certification examination unique to this subspecialty, case logs reflecting that at least 75% of the applicant's patient population are children, and ongoing MOC unique to the subspecialty. The ABU is not unique in granting subcertification. Indeed of the 25 boards listed by the American Board of Medical Specialties (www.abms.org) only 5 (neurosurgery, thoracic surgery, colon and rectal surgery, nuclear medicine and ophthalmology) do not have such recognitions. Large specialties such as pediatrics and internal medicine have 20 and 18, respectively. However a roughly similar-sized board to ours, otolaryngology, has 4.

The process of subspecialty certification is not over, but is really just beginning as other subspecialty groups, most notably urologic oncology and female urology and



Peter R. Carroll, MD
President

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neurourology, are rapidly preparing for a similar process. Others will follow. Although other boards have successfully and without apparently harming the general practitioner of the subcertification, the ABU clearly recognizes that such fractionalization of the field has to be considered carefully. The trustees clearly have concerns that the issuing of subspecialty certificates could have an impact on referral patterns, credentialing at the hospital level, and marketing which could disadvantage urologists who have not been similarly recognized. Pediatric urologic care is a small component of most urologists' practices. This is not the case when one considers urologic oncology and voiding dysfunction which are major drivers of both out- and inpatient care for the majority in our field. *The board has been clear to state that subspecialty certification does not mean that fully trained and certified urologists can be prevented, at any level, from evaluating or treating patients*

with urologic disorders related to a subspecialty. Indeed, the Board maintains that all certified urologists are qualified to evaluate and treat all patients with urological disorders.

The process of recognizing subspecialty training will be refined and evolve over time. Some have argued that more specialized training be moved earlier into the educational process, at the residency level. The entire postgraduate educational process is being considered carefully by all specialties, including urology, as well as governmental agencies and even those entering or completing medical school. Current ABU trustees as well as those who follow are committed to ensuring that urological training meets the demands of our society, its technology and the patients it serves. We welcome the active participation of all urologists in meeting this objective. ■

Trustees and Executive Staff of the American Board of Urology Winter Meeting 2007



Back row (from left): Paul H. Lange, MD; David A. Bloom, MD; Michael O. Koch, MD, Secretary-Treasurer; Ralph V. Clayman, MD; Gerald H. Jordan, MD; William D. Steers, MD; Timothy B. Boone, MD; Stuart S. Howards, MD, Executive Secretary

Front row (from left): Barry A. Kogan, MD; Howard Snyder, MD, Vice President; Peter R. Carroll, MD, President; Linda M. Shortliffe, MD; Peter Albertsen, MD; W. Bedford Waters, MD, President-Elect; John B. Forrest, MD

How are Trustees Selected to Serve on the American Board of Urology?

The American Board of Urology is organized to encourage study, improve standards, and promote competency in the practice of urology. The activities of the Board in fulfilling its mission are directed by twelve trustees who are nominated by various urologic societies.

There are six societies including The American Urologic Association (AUA), the American College of Surgeons (ACS), The Society of University Urologists (SUU), The American Association of Genitourinary Surgeons (AAGUS), and the American Academy of Pediatrics (AAP), and the American Association of Clinical Urologists (AACU) which nominate urologists to serve on the American Board of Urology. Several of the nominating groups are allocated more than one nominee in the six year cycle.

Each year two of these societies submit a list of candidates to the ABU. The current trustees must select one

new trustee from each list during the summer meeting of the Board. The chosen nominees officially become trustees at the adjournment of the winter meeting the following February, when the two senior trustees conclude their terms.

The trustees consider many criteria during their discussion of the nominees including integrity, stature in the field of urology, willingness to serve, a reputation for timely performance of assigned tasks, and the ability to work with a group. The trustees are also sensitive to issues such as the diversity of the board as a whole.

Each trustee serves one six-year, non-renewable term. Trustees dedicate approximately three weeks per year for each of the six years they serve to working for the Board, without any compensation except for the reimbursement of work related expenses. They are required to attend two

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The Board Welcomes...

New Trustees: John B. Forrest, MD, FACS, and Barry A. Kogan, MD

Dr. Forrest did his residency at the University of Virginia and a fellowship in urologic oncology at Memorial Sloan Kettering Hospital in New York. He is currently in private practice with Urologic Specialists of Oklahoma, Inc., in Tulsa, OK, and is a Clinical Associate Professor of Urology at the University of Oklahoma Health Science Center -Tulsa. He serves as Vice Chairman of the AUA Practice Guidelines Committee. Dr. Forrest has a special interest in urologic oncology and interstitial cystitis.

Dr. Kogan completed his residency at the University of Michigan and a fellowship in pediatric urology at the University of Liverpool, England. He is currently Chief of the Division of Urology and the Urology Residency Program, and Professor of Urology and Pediatrics at Albany Medical College. He practices at the Urological Institute of Northeastern New York. Dr. Kogan has had a distinguished career as a pediatric urologist and researcher in pediatric urology. ■

The Board Thanks ...

Dr. Linda Dairiki Shortliffe served as a Trustee of the Board from 2001-2007, and as President from 2006-2007. She also served as Secretary-Treasurer, Chair of the Executive Committee, Finance Committee, Credentials Committee, and as a Board representative

to the Urology Residency Review Committee of the ACGME (2003-2009). During her service on the Board issues of subspecialty certification (SC), maintenance of certification (MOC), and training evolved. Modifications to qualifying and certifying processes occurred. She was impressed by and grateful for the commitment, integrity, and friendship of her fellow Trustees. Dr. Shortliffe thanks the tireless Dr. Stuart Howards and staff for their support in all activities of the Board. She thanks the AUA and past and present Trustees for allowing her the opportunity to provide service to urology in this way.

Dr. Peter Albertsen served as a Trustee of the American Board of Urology from 2001 to 2007 and was Vice President from 2005 to 2006. He served as Chairman of the Nominating Committee and Chairman of the Oral Exam Committee from 2005 to 2006, and served on the Recertification Committee and the ad-hoc Committee on Pediatric Subcertification for several years. He also served on the Finance Committee of the American Board of Medical Specialties and represented the Board on the Residency Review Committee of the ACGME. Dr. Albertsen enjoyed working with his fellow trustees on several important projects including the implementation of electronic practice profiling, restructuring of the Board certification requirements, and the decision to award a subspecialty certificate in the field of pediatric urology. He thanks his fellow trustees for their commitment to the field of urology and their efforts to ensure that patients receive care from competent and professional clinicians. ■

Maintenance of Certification Update

by Dr. Stuart S. Howards

The most common questions and criticisms the American Board of Urology (ABU) receives from urologists relate to maintenance of certification (MOC) and the charges for recertification. Before discussing these issues it is important to clarify that the ABU was established as a non profit organization in 1934 with a mandate to protect and inform the public, which is the mandate of all American Board of Medical Specialties (ABMS) organizations. The functions of the ABU are to certify that urologists have satisfied all of the steps the ABU considers necessary to practice urology, and to inform the public, hospitals and other third parties of certification status. In that regard the ABU is different from the AUA, which is a membership organization with a goal to serve and educate urologists.

ABU Finances

The ABU had operating budget deficits of \$119,000 in 2005 and \$107,000 in 2006. During the previous 8 years the operating budget was close to breaking even. Without voluntary dues there would have been a deficit almost every year. Like any other individual or organization (except the United States government), the ABU cannot permanently have an operating deficit. The endowment of the ABU as of December 31, 2006 was \$2,365,391. It should be noted that the trustees of the American Board of Urology spend an average of 3 weeks each year away from their practice for the 6 years working for the Board with no financial compensation. The charge for recertification is \$1,250. Therefore, the cost to a urologist to maintain certification amounts to a tax-deductible \$125 per year.

Grandfathered Diplomates

Urologists certified before 1985 are not required to be recertified because the ABU and ABMS lawyers have advised the Board that it has a contract with these urologists which cannot be unilaterally revoked, i.e. it cannot legally require them to recertify or enter into the MOC process. This issue will disappear with time. There are currently 10,291 certified urologists, and of these 2,447 (24%) are younger than 66 years without a time limited certificate. An unknown number of these diplomates are retired or deceased. By the time MOC is fully implemented there will be 7 certified urologists (0.01% of the total) without time limited certificates who are younger than 66 years.

MOC Status of Other ABMS Boards

As of September 2006 all 24 ABMS medical specialty organizations had ABMS approved MOC plans in place. All 24 Boards have either already implemented MOC or will implement MOC in 2007 and 2008.

Initiation of MOC

Starting in 2007 all diplomats of the ABU who are certified or recertified in that year will enter into the MOC process. Thus, those certified or recertified in 2006 will not enter into the process until their certification expires in 2016.

Outcome if the ABU Refused to Implement MOC

If the ABU refused to implement MOC it would be expelled from the ABMS, which would mean that it would no longer be a legitimate ABMS organization. Its diplomates would not be able to join the staff of most hospitals and they would be excluded from payment by some third parties. It would also create potential problems for current diplomates with their state medical board. The Federation of State Medical Boards (FSMB) passed a resolution to support maintenance of licensure in 2004 which includes self-improvement and monitoring components. In 2005 the FSMB decided to initiate a program for continuous monitoring of physician competence based on the individual's practice. The model legislation is planned for early 2008, and it is almost certain that if a physician is in compliance with ABMS MOC he or she will not be required to undergo any additional testing or evaluation by the state medical board.

Other Potential Advantages of MOC

There are additional potential advantages of MOC for urologists. The pay for performance program of the Centers for Medicare and Medicaid will most likely accept ABMS MOC as proof of performance. The New York Times reported in 2006 that the American Medical Association (AMA) signed a pact with Congress to develop measures of quality for physicians, and it is likely that MOC will serve to document quality for the AMA as well. In addition, several insurance companies plan to offer reduced malpractice rates for physicians active in MOC. ■

Report on the Urology Core Curriculum Task Force

by John B. Forrest, MD

On April 1st and 2nd of 2006 a meeting entitled “The AUA Future of Urologic Residency Strategic Planning” was held at The AUA headquarters in Linthicum, Maryland. The meeting was convened in response to concerns from several quarters that current urologic training may not well serve future urologic practice needs. Multiple groups were represented at this meeting including the AUA, American Board of Urology, the Residency Review Committee, American Association of Clinical Urologists and the American Council for Graduate Medical Education.

Multiple topics were discussed at this meeting under the very able leadership of Dr. John McConnell. These topics included length of training, composition of residency training, fellowship training, factors influencing medical students’ attraction to urology, and urologic residency curriculum design.

One of the conclusions of this group was to proceed with a working group to design a standardized core curriculum for urologic residency training. A task force for this purpose was convened in Anaheim during the 2007 AUA annual meeting. Represented groups were similar to the groups at the original strategic planning meeting. After lengthy in-depth discussions, multiple actions were initiated including subcommittees to develop the breadth of the project, an editorial oversight group, development of a panel of educators and consultants to assist with core curriculum development, and involving the urologic subspecialty societies in curriculum design.

In regard to the length of training, the panel felt that close scrutiny must be paid to the length of time required

for urologic training particularly if the individual elects to pursue fellowship training. This view is driven by the absolute time required for urologic training including fellowship tracts and the financial debt accumulated during that time. However, it was felt that the pre-urology general surgery training is essential whether it is one or two years. These discussions also dovetailed with innovative methods to merge the final year of urologic training (chief residency) with fellowship training. For example, if a chief resident wished to pursue fellowship training in pediatric urology, the Chief Residency year would be heavily weighted toward pediatric urology. These years would then count as one of two years required for a Pediatric Urology Fellowship and subsequent certification. Obviously, this is a complex issue involving funding, certification, and inter-institutional cooperation and coordination.

All of these strategic urologic training issues are occurring against the current backdrop of urology being one of the most attractive and competitive surgical subspecialty residencies. Previous studies have clearly demonstrated that our mix of surgery, procedural urology, and medical management contributes to urology remaining an attractive option for bright medical students.

Each issue discussed will be enacted only after very careful thought relative to the benefits and potential consequences. Paramount is the maintenance of the highest standards for both training and care of our patients.

The core curriculum committee realizes the enormity of this project with both its potential and its possible pitfalls. It is felt that the core curriculum will be a “living document” with continual growth and has great potential in an electronic informational age. ■

In Memoriam

The office of the American Board of Urology regretfully reports receiving word in 2006-2007 that the following Diplomates have passed away.

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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.

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 - 100 - \$33.00
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 - VA residents add 4.5% sales tax

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.

Voluntary Dues Contributors

The Trustees wish to thank the following Diplomates for their support of the Board's activities with their voluntary contributions from September 2006 through August 2007.

This list may also be found on the Board's Web site, www.abu.org.

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business meetings of the Board each year, and may serve as representatives of the ABU to the RRC, American Board of Medical Specialties (ABMS) or other organizations and attend those meetings as well. During their final year on the Board one of the trustees serves as president and the other as vice-president. It is safe to say that all of the trustees feel it is an honor to serve on the Board, and that the time spent is extremely worthwhile and rewarding in spite of the lack of reimbursement and consequent loss of practice income.

If an individual would like to serve on the board he/she should contact the society which will be one of the two nominating societies during the next year. The American

Board of Urology office is pleased to supply any interested person with the two nominating societies in any given year.

The current ABU trustees are: Peter R. Carroll, MD, President of the Board (AUA); Howard M. Snyder, III, MD, Vice President (AAGUS); David A. Bloom, MD (AAP); W. Bedford Waters, MD, President-Elect (ACS); Michael O. Koch, MD (AUA); Paul H. Lange, MD (AAGUS); Ralph V. Clayman, MD (SUU); William D. Steers, MD (AUA); Timothy B. Boone, MD (AAGUS); Gerald H. Jordan, MD (ACS); Barry A. Kogan, MD (AUA); and John B. Forrest, MD (AACU). ■

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Website Update

The American Board of Urology will launch its new, improved web site in October. The site has been redesigned to provide comprehensive information for our Candidates, Diplomates, Medical Organizations, and the Public in a more efficient and comprehensive way.

The information on the site is also available from the ABU office, but the new website will provide round-the-clock accessibility to the most frequently sought information. The new contact information will allow you to communicate with the Board staff via email at your convenience.

Please visit our site soon at www.abu.org. We look forward to receiving your comments or suggestions.



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