

ABA NEWS



THE AMERICAN BOARD OF ANESTHESIOLOGY®, INC.

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Report From the President

The ABA requests and receives outstanding assistance from some of its diplomates, many of whom are listed on pages 8-9. They serve as oral examiners, question writers and consultants for the in-training exam, as well as for exams in pain medicine and critical care medicine.

It seems to me that even a greater untapped pool for new ideas and initiatives rests with the thousands of practicing ABA diplomates who receive this newsletter. Now assuming you read this column (personal experience suggests that may be a bit of a leap), have access to email (not such a leap), and have suggestions or comments about what the ABA might do differently, better or, if you can imagine, not do at all (not much doubt about this one), I ask that you email your proposals to me at president@abanes.org. Although no topic is out of bounds, I would ask that you concentrate your efforts on a few issues the ABA is discussing at the moment, one of which is mentioned in this newsletter.

Maintenance of Certification (MOC) has been embraced by many of the leading groups in organized medicine – the American Medical Association, the American Board of Medical Specialties, of which the ABA is a member, and the Accreditation Council for Graduate Medical Education, which oversees all training programs through its Residency Review Committees (RRC). Therefore, the critical issues are when and how the four components of an MOC program will be implemented, rather than whether. Two of these - credentialing (licensure) and a secure exam - are already in place. The other two components - practice evaluation and life long learning - require new and innovative approaches. The former relates to assessment of an individual's practice performance – no mean feat we would agree. Are there procedures or methodologies



Stephen J. Thomas, MD

that would prove beneficial to both anesthesiologist and patient? If you were designing a program for life-long learning, what would you include? Should there be more than continuing education courses – whether they are in person, on-line, or journal format?

The next issue is a bit more complicated. Both the ABA and the RRC have emphasized the role of anesthesiologist as perioperative physician. In order to achieve this goal, the question arises should we train our

residents differently. For example, should we increase mandated time in critical care, in pain medicine, in preoperative assessment? Should we, as other specialties do, control the Clinical Base Year (internship)? If so, what additional skills would be most beneficial so that our trainees can 'walk this walk'? What areas of expertise are needed for your practices in the 'real world'? Also, are the recent studies in the literature with the accompanying ballyhoo from the Leapfrog Group (www.leapfroggroup.org), showing that in an ICU setting patients treated by 'intensivists' do better than those not receiving such specialized treatment, enough to encourage a return of anesthesiology interest in critical care medicine? Would such people find work in your groups?

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Finally, should there be accreditation of recognized subspecialties, e.g. cardiac, obstetric, neuro, in a fashion similar to critical care medicine, pain medicine, and pediatric anesthesia. Those in favor say if accreditation, with its standardization and periodic revision of curriculum and institutional review is good for core programs, it would also benefit the subspecialties. It could put us on a par with other medical and surgical subspecialties. Others argue that the programs we have are doing a great job and setting up these fiefdoms would inevitably complicate the delivery of care and perhaps lead to untoward economic consequences.

I will read all you send, summarize your views, and present them to the entire Board. The ABA will acknowledge receipt of your email. Given the deluge of emails I know will follow, you will forgive me for not replying personally. Contrary to the opinion of some, I too have a day job.

I look forward to this experiment in group thinking and hope you will contribute. ■

New Director

The American Board of Anesthesiology is pleased to announce the election of Douglas B. Coursin, MD, to its Board of Directors. Dr. Coursin began his service in this role at the conclusion of the Board's meeting in the autumn of 2001.

Dr. Coursin attended Wake Forest University and received his MD from Albany Medical College in 1976. He trained in internal medicine at Albany Medical Center Hospital (1976-1978) and the University of Wisconsin Hospital and Clinics, Madison (1978-1979) and became a diplomate of the American Board of Internal Medicine in 1979. He trained in anesthesiology at the University of Wisconsin Hospital and Clinics, Madison (1978-1980), became a diplomate of the ABA in 1982, and recertified in 2001. He trained in critical care medicine at the University of Wisconsin, Madison, with elective rotations at Stanford, Harvard, and the University of Miami, earned subspecialty certification in critical care medicine from the ABA in 1986, and recertified in 2001. Dr. Coursin has been a member of the ABA Examination Committee for Subspecialty Certification in Critical Care since 1994. He has held an academic appointment at the University of Wisconsin School of Medicine since 1981 and presently is Professor of Anesthesiology and Internal Medicine, Associate Director of the Trauma and Life Support Center, and Director of



Douglas B. Coursin, MD

the Anesthesiology Critical Care Fellowship Training Program.

Dr. Coursin was a founding member and president (1996-1997) of the American Society of Critical Care Anesthesiologists. He was a member of the House of Delegates of the American Society of Anesthesiologists (ASA) (1998-1999) and continues to serve as a member of the ASA Committees on Transfusion and Critical Care and Trauma Medicine. He is an editorial

board member of *Critical Care Medicine* and *Mayo Clinic Proceedings*, and an editor of a major textbook, *Critical Care Medicine – Perioperative Management*. He has published more than fifty clinical and scientific, peer-reviewed articles. He advised the FDA-NIH Steering Committee for Consensus on the Pulmonary Artery Catheter. He is a member of the Association of University Anesthesiologists and Fellow of the American College of Chest Physicians. Dr. Coursin was a visiting professor and consultant in anesthesia and critical care at Gloucester Royal Hospital, Gloucester, United Kingdom (July 1992 – January 1993) and Catherina Ziekenhuis, Eindhoven, Netherlands (March-April, 1993).

He is the husband of Marti and the father of Drew, a college sophomore. They currently live in Madison, Wisconsin. ■

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The ABA Oral Examination: An Update

The American Board of Anesthesiology establishes and maintains criteria for the designation of a Board certified anesthesiologist and establishes and conducts processes by which the Board may judge whether a physician meets those criteria. The Board designs the oral examination to assess the ability of board certification candidates to manage patients presented in clinical scenarios, with particular emphasis on the scientific and clinical rationale that supports the management.

The quality of the oral examination process and assessment of candidate performance are critical components of the determination of whether a physician has met the standards for certification as an ABA diplomate. Efforts of the ABA to assure and improve the quality of candidate assessment have therefore been longstanding. They include the training of all new examiners in the process of conducting the exam and evaluating candidates, ongoing assessment of all associate examiners during exam sessions, and critically monitoring individual examiner performance as a criteria for re-appointment to subsequent terms as an associate examiner. These activities have contributed to the maintenance of reliable and appro-

priate assessment of candidate ability and performance during the oral examination. In addition, over the last several years, the ABA has expended significant efforts evaluating methods that will enhance the candidate assessment process and facilitate the provision of meaningful feedback to unsuccessful candidates. After careful deliberation and evaluation, the ABA made several changes that improve the processes of examinee assessment and feedback.

Effective at the April 2002 oral examination, the outcome for each candidate was determined using multi-facet analysis, a well founded psychometric process that accounts for test task difficulty and examiner grading severity. The test tasks are pre-operative assessment, intraoperative management, postoperative management and additional topics that follow the primary case evaluation in both exam sessions. The multi-facet analysis is based on ratings assigned by 4 different examiners who each independently assess candidate performance in terms of the frequency that the candidate demonstrates the attributes of an ABA diplomate during discussion of the tasks.

Continued on page 14.

Maintenance of Certification

The ABA and 23 other member boards of the American Board of Medical Specialties (ABMS) have committed to being held accountable to the public that diplomates maintain the medical knowledge and skills in their respective specialty. In support of this commitment the ABA, in the early “90’s”, offered a voluntary recertification program to its diplomates called the Continuous Demonstration of Qualifications. Very few anesthesiologists took advantage of this program because permanent certificates were in place.

Recent board certification is now time-limited in most disciplines including Anesthesiology. The ABA commitment is to assure the public that a program is in place for continual evaluation of practitioners’ qualifications. The ABA has joined with other ABMS member boards in endorsing the concept that the profession is able to assess itself and require maintenance of certification (MOC) over the life of the certificate, at 10-year intervals in the case of Anesthesiology. Included in the MOC process are:

- Assessment of professional standing
- Practice assessment and performance in practice
- Self-assessment and evidence of life-long learning
- Secure examination

Professional Standing will be assessed by verification of credentials (full and unrestricted license to practice medicine in all the states in which the diplomate is licensed) just as for the primary certificate.

Currently, **Practice Assessment and Performance in Practice** is assessed at the local level since more sophisticated methods are not developed or available to anesthesiology at this time. The intent of practice assessment is eventually to establish evidenced-based benchmarked practices that are known to improve and optimize patient care and outcomes. Many boards are attempting to create an interim method of assessing practice performance until more sophisticated data based methods are available.

Formal **Self-Assessment and Life-Long Learning (LLL)** programs facilitate specialty-specific quality educational opportunities available in many formats to meet the needs of the diplomates in their practice. The ABA has created an entity to formalize this educational challenge while avoiding conflict of interest with the board’s primary mission, which is to certify candidates. This entity, The Council for Continual Professional Development of Anesthesiologists (CCPDA) has 9 members:

- 2 Appointed by the ABA
- 2 Appointed by the President of the ASA
- 5 At-large members selected by the ABA from nominees solicited from anesthesiologists throughout the country (all CCPDA members must be members of the ASA and diplomates of the ABA and have sufficient experience and interest in educational matters)

The CCPDA will act as an advisory committee to the ABA. It will set the direction for the development of LLL efforts, curriculum content and specific LLL requirements. It will submit its recommendations to the ABA for approval. The Council will officially begin to work in the summer of 2002.

The MOC process is meant to conclude with the administration of a **Secure Proctored Examination**. The recertification examination is still voluntary for anesthesiologists with permanent certificates issued prior to 2000, which will remain intact.

The current expected date of initiation of the MOC program in Anesthesiology is January 2004. Ongoing information about the ABA MOC program will be presented in these pages and perhaps in other publications as developments occur. ■

Changes in ABA Policies and Procedures

The ABA publishes its Booklet of Information annually to inform residents, training directors, certification candidates and other interested individuals of the policies, procedures, regulations and requirements that govern its examination and certification programs. The subjects of this article are changes to ABA policies regarding examination deferments and application time limits, Clinical Anesthesia (CA) training credit and non-standard examinations.

Examination Deferments and Application Time Limits

The examination system for the ABA's primary certificate has two distinct parts, the written examination and the oral examination. It is necessary for candidates to pass the written examination to qualify for the oral examination. After passing the written examination, candidates must wait at least six months to be eligible to appear for the oral examination.

Candidates should be aware that the duration of candidate status is limited. Every candidate is given one opportunity a calendar year, for three years, to successfully complete each examination requirement. Therefore, candidates must satisfy the written examination requirement within three years of the date of the first examination that follows acceptance of their application and then satisfy the oral examination requirement within three years of the date of the first oral examination for which they become eligible. The ABA will declare the application void if a candidate does not complete either examination requirement within three opportunities or three years, whichever comes first.

Furthermore, ABA policy requires every candidate to accept each examination opportunity offered by the Board. However, the Board appreciates that situations can arise that make it extremely difficult or impossible for a candidate to appear for an examination. If requested, the ABA will excuse a candidate for at most one opportunity to satisfy an examination requirement without forfeiture of the opportunity. The ABA must receive the request in writing by the date the response to the examination notice is due or, when documentation of an unanticipated emergency that precluded examination accompanies the request, within three weeks of the examination date. The ABA will not charge the examination fee

if this is the first such request. Otherwise, canceling or not keeping an examination appointment will result in forfeiture of the examination opportunity and fee.

Similar policies apply to candidates for subspecialty examinations in pain medicine and critical care medicine and all recertification examinations. For further information, please consult the latest edition (January, 2002) of the ABA's Booklet of Information.

Clinical Anesthesia Training Credit

Certain conditions must be met before the ABA will grant credit toward its certification requirements for a resident's CA training. The resident must complete at least six months of CA training in an ACGME-accredited anesthesiology program and the program's Clinical Competence Committee must grade the resident's overall clinical competence satisfactory for the six-month period of training. When both conditions are met, the resident receives one month of credit for each month of training. The ABA grants credit for a period of unsatisfactory CA training only if the resident immediately completes an additional six months of CA training in the same program with a satisfactory grade for overall clinical competence. Residents who receive a grade of unsatisfactory for consecutive periods of CA training will have to complete more than 36 months of CA training to receive 36 months of Clinical Anesthesia credit needed to satisfy the three-year CA training requirement for admission to the ABA examination and certification system.

Nonstandard Examinations

The ABA grants a candidate's request for examination under nonstandard conditions when it determines that accommodations are warranted. The determination is based on evidence of the nature and severity of the individual's disability and functional limitations. Because the nature and severity of a disability and its associated functional limitations may change with time, the ABA requires that the documentary evidence include testing results and evaluations that are sufficiently recent to demonstrate the current nature and severity of the disability and its functional limitations. Generally, testing and evaluations performed within five years meet this requirement. ■

2003 Examination Dates, Application Cycles and Fees

Critical deadlines and test dates for ABA certification and recertification examinations in 2003 are:

2003 Examinations					
<u>Examination</u>	<u>Exam Dates</u>	<u>Application Cycle</u>			<u>Documents Deadline</u>
		<u>Begins</u>	<u>Standard Deadline</u>	<u>Late Deadline</u>	
Primary Certification Written Exam	7/12/2003	10/15/2002	12/15/2002	1/15/2003	3/15/2003
Primary Recertification Exam	7/12-26/2003	10/15/2002	12/15/2002	1/15/2003	3/15/2003
Spring Oral Exam	4/7-11/2003	N/A	10/15/2002	N/A	N/A
Fall Oral Exam	10/27-31/2003	N/A	2/1/2003	N/A	N/A
Critical Care Medicine Certification & Recertification Exam	9/13/2003	12/15/2002	2/15/2003	3/15/2003	5/15/2003
Pain Medicine Certification & Recertification Exam	9/20/2003	12/15/2002	2/15/2003	3/15/2003	5/15/2003

The ABA made a number of changes to its examination and application cycles. The changes highlighted below standardize and streamline the application process.

Examination dates. The primary recertification examination has been moved from May to July. Now both the primary certification and recertification examinations will take place in July. The spring oral examination will continue to be held in April and the fall oral examination in either September or October. Subspecialty examinations will continue to be held in September.

Application cycles. The application cycles for all examination systems begin approximately nine months before the examination date (October 15 for primary certification and recertification, December 15 for subspecialty certification and recertification). The standard deadline for all examination systems is two months after the beginning of the application cycle (December 15

for primary certification and recertification, February 15 for subspecialty certification and recertification).

Late deadline. The ABA established a late deadline for each application cycle and a substantial late fee as an inducement to file an application by the standard deadline. The late deadline is one month after the standard deadline. The standard application fee and the late fee must accompany a late application. The late deadline is an absolute deadline. The ABA will not consider an application that arrives in the Board office after the late deadline.

Documents deadline. The ABA must receive the documentation necessary to make a determination about an applicant's qualifications for admission to its examination systems within three months after the standard deadline or two months after the late deadline.

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Application fees, late fees and reexamination fees for the 2003 application cycle are as follows:

<u>Examination</u>	<u>Application Fee</u>	<u>Late Fee</u>	<u>Reexamination Fee</u>
Primary certification	\$2,300	\$350	Written, \$400 Oral, \$1,500
Primary recertification	\$700	\$200	\$500
Subspecialty certification	\$1,000	\$200	\$750
Subspecialty recertification	\$1,000	\$200	\$750

Applicants are encouraged to submit applications for initial certification and for recertification in anesthesiology, critical care medicine and pain medicine electronically via the ABA's Electronic Application System (EAS). The EAS may be accessed through the ABA website at www.abanes.org. Alternately, paper application forms may be downloaded from the website or obtained from the Board office and mailed to the ABA.

Candidates who pass the 2002 written examination will receive an oral examination registration form in early September 2002 on which they may indicate their preference for the Spring 2003 or Fall 2003 oral examination. The oral examination

registration deadline is October 15, 2002. While the number of available oral examination appointments annually is sufficient to examine all of the eligible candidates, the number of spaces at each oral examination is limited. If the number of requests for a particular examination exceeds the number of available spaces, the ABA will schedule for that examination on a random basis and schedule the remaining candidates for the other oral examination.

The ABA will notify candidates of their oral examination assignment in late October 2002. Candidates will receive notice of the date and time of their examination appointment at least two months in advance of the examination. ■

**The ABA Electronic Application System
may be accessed through the ABA's website:
www.abanes.org**

Recognition of Diplomates' Service and Contributions in 2001

The American Board of Anesthesiology acknowledges a debt of gratitude to the ABA Diplomates who assisted the Board in 2001. The Diplomates voluntarily contributed their time and energy. The Directors truly appreciate their service and are pleased to recognize and thank them for their contributions.

Written Examination:

ASA representatives to the ABA/ASA Joint Council on In-Training Examinations:

Arnold Berry, MD	Philip Lebowitz, MD	Mark Rosen, MD
John Cooper, MD	Charles Otto, MD	Carl Rosow, MD
Jeff Gross, MD		

Examination Question Editors:

Steven Allen, MD	Bruce Kleinman, MD	Julia Pollock, MD
Audree Bendo, MD	Laurence Krenis, MD	Linda Rice, MD
James DiNardo, MD	Cynthia Lien, MD	Robert Sladen, MD
Carter Dodge, MD	Vinod Malhotra, MD	Richard Stypula, MD
John Ebert, DO	Donald Martin, MD	Richard Teplick, MD
John Emhardt, MD	Roger Mecca, MD	Helen Westman, MD
Robert Gaiser, MD	John Moyers, MD	Thomas Wolfe, MD
Eric Kitain, MD		

Test Question Authors:

William Denman, MD	Gerald Maccioli, MD	Steven Rose, MD
Heidi Kummer, MD	Rafael Ortega, MD	Randolph Steadman, MD
Alex Macario, MD	Emily Ratner, MD	Lena Sun, MD

Oral Examination:

Candidate Registration and Orientation:

Harry Bird, MD	Francis James, MD	Philip Larson, MD
Robert Epstein, MD		

Oral Examiners:

Stephen Abram, MD	May Chin, MD	Robert Forbes, MD
Anil Aggarwal, MD	Cantwell Clark, MD	Kent Garman, MD
John Ammon, MD	Neil Connelly, MD	Thomas Gayeski, MD
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Jeffrey Apfelbaum, MD	John Cooper, MD	David Glass, MD
Valerie Arkoosh, MD	Sandra Curry, MD	Nancy Glass, MD
Donald Arnold, MD	Laurie Davies, MD	Joel Gunter, MD
Douglas Bacon, MD	James DiNardo, MD	Alexander Hannenber, MD
Melinda Bailey, MD	Karen Domino, MD	Kenneth Haspel, MD
Steven Barker, MD	Hugh Dorman, MD	Joy Hawkins, MD
Richard Bartkowski, MD	John Drummond, MD	Carl Hug, MD
Kirk Benson, MD	Burdett Dunbar, MD	Richard Jaffe, MD
Edwin Bowe, MD	Charles Durbin, MD	Leslie Jameson, MD
Morris Brown, MD	John Ebert, DO	Scott Jellish, MD
Raeford Brown, MD	Paul Eckenbrecht, MD	Jeffrey Katz, MD
Sorin Brull, MD	John Eichhorn, MD	Jeffrey A. Katz, MD
Charles Buffington, MD	Jay Ellis, MD	Barbara Keller, MD
John Byrne, MD	Lucinda Everett, MD	Sean Kennedy, MD
William Camann, MD	Jeffrey Feldman, MD	Bruce Kleinman, MD
Donn Chambers, MD	Eugene Fibuch, MD	Lawrence Kushins, MD
Michael Champeau, MD	Michael Flynn, MB, ChB	William Lanier, MD

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Todd Dorman, MD
Andrew Gabrielli, MD

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Junior and Senior Editors of the In-Training Council

The American Board of Anesthesiology (ABA)/American Society of Anesthesiologists (ASA) Joint Council on In-Training Examinations has the responsibility of preparing the yearly in-training examination. The ABA then selects a subset of these questions to constitute its written examination.

For the in-training examinations in 2002 and preceding years, questions from assigned portions of the Content Outline were submitted yearly to the Joint Council by diplomates of the ABA who were nominated to be oral board examiners and by active oral board examiners themselves. These draft questions were first edited by a group of 25 Question Editors and then re-edited by the 14 members of the Joint Council before entering the question pool for the in-training examination. For potent demographic reasons related to the markedly decreased number of anesthesia residents in the 1990's, the ABA had to trim the "waiting list" of those nominated to be oral board examiners and required fewer active oral board examiners per examination. These actions severely reduced the list of question writers and the inflow of questions.

The ABA through its experience in the development of the Critical Care and Pain Medicine examinations has become comfortable with the concept of a small group of dedicated question writers. The ABA/ASA Joint Council has decided to create a similar system. Over the next year the Joint Council will recruit 40 question writers charged with the responsibility of creating ques-

tions for the in-training examination. They will be trained by the ABA and the National Board of Medical Examiners (NBME) and will be called Junior Editors of the ABA/ASA Joint Council on In-Training Examinations. The 25 current question editors will receive a refresher course from the NBME and become Senior Editors of the ABA/ASA Joint Council on In-Training Examinations.

The career paths of in-training examination question writer and oral board examiner are no longer linked. The natural progression through the question writer system will be from junior editor to senior editor to Joint Council member. However, being a junior or senior editor does not preclude an individual from becoming an oral board examiner, i.e., one could be both. If you are an ABA diplomate interested in becoming a junior editor, please send a letter-of-application and *Curriculum Vitae* to the Chair of the ABA/ASA Joint Council on In-Training Examinations. The commitment is to accept training and feedback in question writing from the ABA and the NBME and to prepare 15 questions per year from assigned sections of the Content Outline. The term of appointment is four years and renewable. Certificates for time in service will be awarded. For those in academic practice, this service commitment may assist in promotion. The Chair of the Joint Council will become a source of outside letters-of-recommendation. A yearly get together, perhaps at the annual meeting of the ASA, is anticipated. ■

ANNOUNCEMENTS

Subspecialty Certification in Pain Medicine

At its March 21, 2001 meeting the American Board of Medical Specialties (ABMS) approved the request from the American Board of Anesthesiology to change the name of its subspecialty certification from Pain Management to Pain Medicine. The ABMS also approved requests from the American Board of Physical Medicine and Rehabilitation and the American Board of Psychiatry and Neurology to change the name of

their subspecialty certificate. ABA Diplomates who hold the subspecialty certificate recommended the change to remove any confusion the public might have regarding the certification of physicians and others who treat patients with pain. The name change is consistent with recent changes in the name of the ASA Pain Medicine Committee and the ASRA journal, *Regional Anesthesia and Pain Medicine*. ■

Irregular Examination Behavior

There has been an increase in the number of incidents of irregular behavior observed by proctors of all written examinations sponsored by the American Board of Anesthesiology (ABA)/American Society of Anesthesiologists (ASA) Joint Council on In-Training Examinations and the ABA. The irregular behavior can be divided into four different categories: 1) behavior disruptive to other examinees; 2) bringing inappropriate paraphernalia into the examination room; 3) lack of respect toward the proctors when they try to enforce the rules of the examination; and 4) suspected cheating. Examinees should not bring personal digital assistants, calculators, watches with alarms or memory capability, paging devices, cellular phones, recording or filming devices, radios, reference material, briefcases, luggage, coats, beverages, or food of any type into the seating area of the testing room. Proctors are instructed to hold these items in a secure place for the duration of the examination. Proctors are also required to complete an Irregularity Report Form for each incident of suspect behavior. The Joint Council and the ABA will tend to side with the proctors and not the examinees in disputes over irregular behavior.

Copying requires special comment. Whenever one examinee is suspected of copying answers from

another, an analysis is performed on the examinations of both the copier and the person being copied. If a statistically significant correspondence is found between the wrong answers on the two examinations, the observations of the proctors are confirmed and copying is determined to have occurred. The copier is then judged to have violated the rules of the examination. The person being copied is assumed innocent unless the observations of the proctors support collusion. If no statistically significant correspondence between wrong answers is found, then neither examinee is judged to have cheated.

Violation of the rules of the examination may lead the Joint Council or the ABA: 1) to render the examination invalid and not report the grade; and 2) to declare a forfeit of both the examination fee and the opportunity whereby the candidate loses one of his or her three examination opportunities. When an in-training examination score is withheld, a letter is sent to the program director and to the candidate stating the reason why the grade was not reported. When an ABA examination is not graded, a letter is sent notifying the candidate of irregular behavior. The ABA also may determine that additional penalties are warranted. There is no appeal for these decisions. ■

Majority of Applications Filed Via Internet

Just four years after its introduction, the ABA's Electronic Application System (EAS) now handles nearly two-thirds of all applications filed with the ABA. The number of EAS users increased approximately 50% from the 2001 to the 2002 application cycle.

Introduced in 1999, EAS allows applicants for all ABA examinations to submit an application online and pay the application fee with their credit card (Visa or MasterCard). During the 2002 application cycle, two-thirds of primary and subspecialty applicants, and more than one-half of primary recertification applicants, used EAS.

The following table shows EAS usage by examination for the 2002 application cycle:

Primary certification examination	66%	N = 983
Primary recertification examination	55%	N = 95
Subspecialty examinations	68%	N = 187
All examinations	65%	N = 1265

We continue to improve EAS with the dual aims of making it even more convenient to use and increasing the percentage of applicants who apply online.

The 2003 application cycle opens October 15, 2002, when the ABA begins to receive applications for initial certification and recertification in Anesthesiology. The 2003 application cycle for initial certification and recertification in Critical Care Medicine and Pain Medicine begins December 15, 2002. In light of the shorter application cycles, the ABA encourages applicants to use EAS to submit their application online to assure it arrives at the Board office and is processed expeditiously. ■

**The Toll-free ABMS
phone number
for certification verification is
(866) ASK-ABMS
(866-275-2267)**

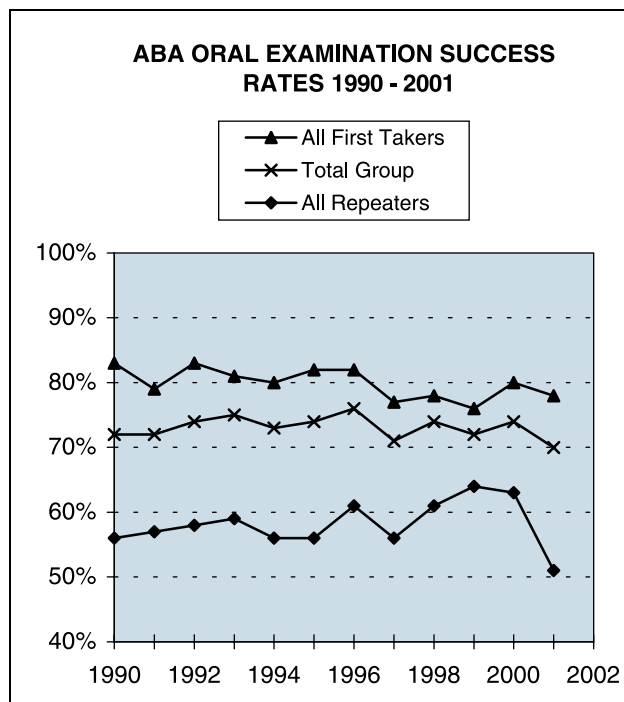
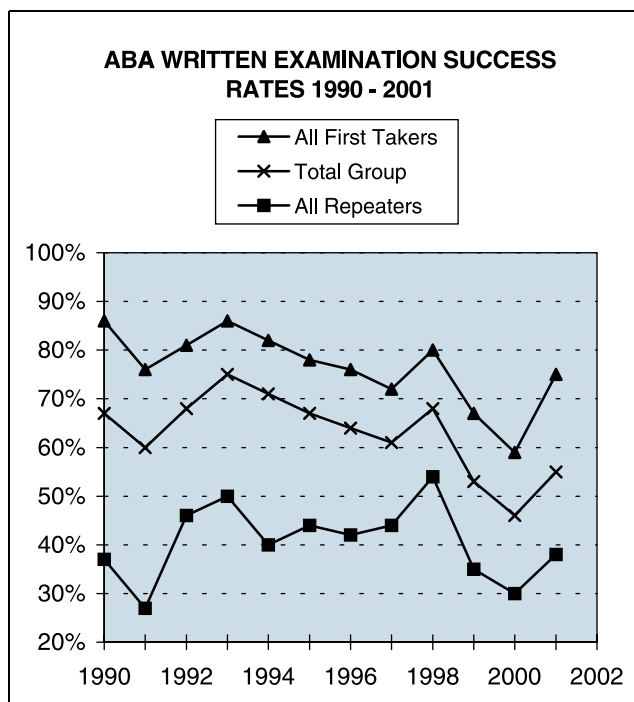
2001 Examination Results

Anesthesiology Certification

The ABA reports the success rate on its written and oral examinations for the subgroup of U.S. medical school graduates who took the examination for the first time.

	1997	1998	1999	2000	2001
Written	76%	84%	74%	71%	77%
Oral	80%	81%	78%	83%	81%

The ABA also notes the written and oral examination success rates for the entire candidate group and the subgroups of all first-takers and all repeaters. These are displayed in the following charts:



The ABA has certified 34,598 physicians as of December 31, 2001.

Anesthesiology Recertification

The success rate on examinations for voluntary recertification has varied between 98% and 100%. In recent examinations it is:

1996	1997	1998	1999	2000	2001
100%	99%	100%	100%	100%	100%

The ABA has recertified 1,448 diplomates in anesthesiology since the inception of the voluntary program in 1993.

Critical Care Medicine

The success rate on recent critical care medicine examinations is:

1991	1993	1995	1997	1999	2001
86%	83%	98%	87%	87%	82%

Analogous to the grading process used for the written examination, the ABA has established a benchmark scale for the oral examination (beginning in April 2002). The passing criterion reflects the performance of candidates who demonstrate the attributes of an ABA diplomate **often** during their oral examination and accounts for the standard error of measurement of the assessment. Based on research performed by the ABA over the course of several oral examinations, application of the multi-facet analytic methodology does not intrinsically alter the overall success rate for the oral examination. The passing rate for the oral examination has been, and will remain, fundamentally determined by the degree and frequency that candidates successfully demonstrate the attributes of an ABA diplomate, which are (1) appropriately justified medical judgment, (2) adaptability to changing clinical conditions, (3) application of knowledge to construct a rationale management plan and (4) ability to logically organize and effectively present information about issues of specific relevance to anesthesiology practice.

When notified of the results of the oral examination, unsuccessful candidates will now receive a performance report, identifying which of the 4 examination tasks were assessed to have marginal

or poor performance. Failing candidates will also be informed of the specific diplomate attributes (described above) that were rated as deficient by the examiners. This feedback is intended to improve understanding of candidates of the specific areas of unsuccessful performance and assist them in focusing their preparation for a subsequent examination opportunity. The additional efforts required for performance and validation of a multi-facet analysis to determine each candidate's oral exam outcome necessitates that examination results will be mailed by the 5th week following the examination. As in the past, exam results will not be provided by phone prior to the second Monday after the results have been mailed.

The modifications to the examination scoring procedures and the provision of more meaningful feedback to unsuccessful candidates represent enhancements to the assessment of candidate performance on the oral examination, a critical component of the process leading to board certification. In addition to these activities the ABA continues to evaluate and, when appropriate, will modify the oral examination content to assure quality, current relevance and breadth of assessment of the entire scope of anesthesiology practice. ■

2001 Examination Results (continued from page 13)

The ABA has certified 1,029 diplomates in critical care medicine since the program's inception in 1986.

Critical Care Medicine Recertification

The ABA initiated a voluntary CCM recertification program in 2001 and recertified 10 Diplomates in the subspecialty.

Pain Medicine Certification

The success rate on recent pain medicine examinations is:

<u>1993</u>	<u>1994</u>	<u>1997</u>	<u>1998</u>	<u>2000</u>	<u>2001</u>
94%	94%	89%	81%	71%	72%

Since the inception of the program in 1993, the ABA has issued 2,718 PM certificates.

Qualified diplomates of other ABMS Member Boards take the same PM examination and are held to the same passing standard as ABA diplomates. For these examinees the 2001 success rate was 68%.

Pain Medicine Recertification

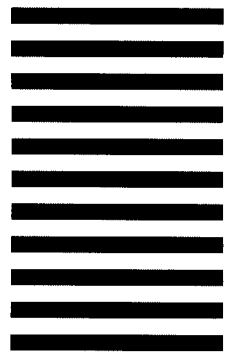
All ABA certificates in pain medicine are time-limited. The ABA has recertified 63 Diplomates in the subspecialty since beginning a PM recertification program in 2000. The PM recertification success rate was 63% in 2000 and 75% in 2001. ■



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