ABU Report

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MESSAGE FROM THE PRESIDENT

Do we effectively police ourselves?

"*Medical professionals are the most qualified to provide oversight and direction to their own*." Neumayer, *Bulletin of the American College of Surgeons* Vol.84, No.4, 1999.

'*Every doctor will allow a colleague to decimate a whole countryside sooner than violate the bond of professional etiquette by giving him away*." George Bernard Shaw

The medical landscape has evolved profoundly since the early 20th century when George Bernard Shaw claimed doctors will not police their own. Indeed the founding of the various specialty boards, including the American Board of Urology (ABU) in 1935, arose in response to diploma mills and egregious practices by self-proclaimed medical specialists. Pope Brock portrays this era of greed and malpractice in the book *Charlatan*. This book chronicles the escapades of Dr John Brinkley, who with dubious credentials, claimed to restore virility by implanting goat testicles into patients. A genius at marketing, he became one of America's wealthiest men during the Depression. Of course we believe that type of behavior no longer exists. Yet, seventy years later, outcries across the Atlantic in England triggered by the murders of patients at the hands of Dr. Harold Shipman and the "Bristol case" have forced the British government to question whether their medical profession (their General Medical Council) can self regulate physicians.

In our country state licensing boards and American Board of Medical Specialties (ABMS) through boards such as the ABU essentially "self regulate". The public and its trust in physicians have granted us this enormous responsibility, but we are more than ever, at risk of losing this trust. Our board works tirelessly to establish credentials and set fair and reasonable standards for the training of urologists. As a result of constantly improving training standards, we have some of the most talented surgeons of any specialty at completion of residency or fellowship. As we begin the early part of the 21st century the scope and challenges facing specialty boards may be shifting in response to the public's expectations. Society takes for granted competence in training. Today's health care debate focuses on such issues as choice, cost effectiveness, reduction of medical errors and access. As individual physicians our primary accountability is to our patients. As a specialty what is our accountability to society?

William D. Steers, MD
President

Within government health care policy circles a subtle but tectonic shift has occurred. Professional societies and boards are often only asked to provide input on major health care issues after decisions have been made. It appears that the Institute of Medicine (IOM), composed of brilliant academic physicians, Nobel laureates, health care policy gurus, ethicists, and other experts, but few if any community practicing physicians, is leading the charge on resident work hours, quality initiatives, topics for comparative efficacy trials, and attention to medical errors. Why aren't professional societies such as the American Medical Association and American College of Surgeons, or specialty societies such as the American Urologic Association (AUA), or medical boards such as the ABU being asked to propose solutions to these issues? Perhaps those in power have concluded that we cannot police ourselves because we have our own colleagues' economic interests as our top priority.

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Message from the President

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How effectively do we police ourselves? We have been proactive in stipulating curricula and requirements for specialty certification. As a profession some use a recent report of US nationals trained abroad having higher death rates than US schooled doctors as proof that our entry processes are robust[1]. But it's the *exit* processes that worry me. Specialty boards are reactive and lack adequate data or mechanisms to proactively ensure that surgeons maintain ethical and professional behavior and practice high quality, cost effective urology. Methods of rehabilitation of those engaging in unprofessional or unethical behavior are often limited to temporary suspension and courses. Because of limited resources the ABU relies on state licensing boards to provide information that may lead to revocation of certificates. How good are they at this? Similarly we delegate responsibility to our professional society, the AUA, to investigate potential ethical violations. But how many urologists have been sanctioned by the AUA?

What does the public think? What percent of urologists would need to be sanctioned in order to provide the public with face validity that our procedures are in fact appropriate? If we fear criticizing colleagues for personal or legal reprisals don't we risk reinforcing the public perception that we are mostly focused on preserving a financial monopoly and maintaining a code of silence? Such perceptions could trigger, as in England, discussions of dismantling all self-regulation of medicine because we have not lived up to our claims of a higher standard and calling than other professions.

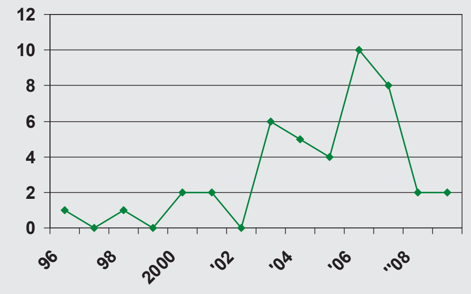
The uproar from some practicing physicians concerning Maintenance of Certification (MOC) in part reflects the understandable cumulative frustrations of increased work, unfunded mandates, lack of data demonstrating the process results in improved quality, and more intrusion into their practices. Though understandable, most of us would argue that MOC is necessary in order for us to police ourselves. Though an imperfect system, at least the billing log and peer review components provide some insight into our professionalism and ethics. Other components, such as Continuing Medical Education (CME) credits, practice assessment protocols (PAPs) and ten year testing, help assure appropriate cognitive knowledge, a precursor to quality care..

The ABMS and AUA have made the strategic decision to be leaders in quality initiatives. The ABMS will focus primarily on process, while specialty societies promote education and research including guideline development. It will be some time, if ever, before new educational initiatives, outcome measures and processes are validated by improved patient outcomes and fewer medical errors. The American Council on Graduate Medical Education (ACGME) initiated the clinical competencies for trainees and now the "Milestones" project. These are ambitious programs that once validated and agreed upon may some day be applied to physician practices. Such measures, although an added burden, pale in comparison to the alternative of total government regulation.

Methods the ABU employs to ascertain whether urologists are practicing professional, ethical, and quality care include the ten year examination, peer review, analysis of billing records, malpractice summaries and modules on safety and ethics. If issues arise, diplomates are first asked to explain in writing any concerns raised by the board. The majority of responses are adequate and prompt no further action. However, when responses to queries are inadequate the diplomate may be asked for an interview. Of note, the number of certificates revoked has slowly risen over the past decade (Fig 1). Does this indicate that we are doing a better job of policing our own? Possibly not, because most adverse actions taken are the result of state licensing boards revoking medical licenses primarily due to criminal convictions that have also risen over the same period. Interviews can have the therapeutic effect of remediating practice patterns suspicious for overutilization. However, the lack of quality outcome data and too little peer review limits our ability to live up to the public's expectations. Furthermore, the few quality outcome measures that exist may only be meaningful when applied to institutions, groups or countries. The data is not convincing that current quality metrics capture good practice when applied to individual practitioners in part due to problems in patient variability or conflicting objectives[2-3]. Rarely do doctors "rat" on colleagues. Peer review is overwhelmingly positive and when negative comments are made there is frequently the suspicion of retribution by competing practices. When state medical boards were asked from where do complaints

Figure 1

ABU Diplomates Whose Certificates Were Revoked



that initiate an investigation originate, the answer is almost never (<1%) from other physicians[4]. A recent article in JAMA noting that two-thirds of physicians who know of an impaired physician fail to report that colleague reinforces the notion that we are not policing ourselves[4].

Can we be more effective? In the spirit of openness, the Trustees will have their potential Conflicts of Interest reviewed and posted for the public on the Web. Certainly, robust quality metrics are needed. Our peer review should probably include nurses or other health care professionals consistent with a "360 degree evaluation". Requesting incident reports including "near misses" from hospitals or surgery centers would be insightful but probably protected as confidential quality data. Admittedly such measures are unlikely to be greeted with enthusiasm by our peers. But ask yourself what is today's equivalent of goat testicle implants and can we proactively identify the Dr Brinkleys? ■

[1]Norcini JJ, Boulet JR Dauphinee WD, Opalek A , Krantz ID, and Andersson ST: Evaluating the quality of care provided by graduates of international medical schools. Health Aff 29:1461-1468,2010.
[2]Werner RM. Asch DA. The unintended consequences of publicly reporting quality information. JAMA 293:1239-1244, 2005.
[3]Ofri D: Quality measures and the individual physician. NEJM 36:605-607,2010.
[4]Bovberg RR, Gittler J. State of Discipline of Physicians: Assessing state medical boards through case studies. US Dept Health and Human Services, Feb 2006.
[5]Catherine M. DesRoches, Sowmya R. Rao, John A. Fromson, Robert J. Birnbaum, Lisa Iezzoni, Christine Vogeli, and Eric G. Campbell Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues. *JAMA* 304:187-193,2010.

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, 600 Peter Jefferson Parkway, Suite 150, Charlottesville, VA 22911, or fax your comments to 434/979-0266.

Trustees and Executive Staff of the American Board of Urology

Winter Meeting 2010

Back row (from left): Gerald H. Jordan, MD; J. Brantley Thrasher, MD; Margaret S. Pearle, MD, PhD; Barry A. Kogan, MD; Peter N. Schlegel, MD; Ian M. Thompson, Jr. MD; Robert R. Bahnson, MD; Michael L. Ritchey, MD

Front row (from left): John B. Forrest, MD; Timothy B. Boone, MD, PhD; Stuart S. Howards, MD; Michael O. Koch, MD; Paul H. Lange, MD; William D. Steers, MD; Ralph W. Clayman, MD

The Board Welcomes...

New Trustees: Ian M. Thompson, Jr, MD and J. Brantley Thrasher, MD

Dr. Ian Thompson is Chair of Urology and Director of the Cancer Therapy and Research Center at the University of Texas Health Science Center at San Antonio. A native of Missouri, he received his B.S. from the United States Military Academy at West Point, M.D. from Tulane University, residency at Brooke Army Medical Center and fellowship in oncology at Memorial Sloan Kettering Cancer Center. He has previously served as Chair of the Society of Urologic Oncology, Chair of the Residency Review Committee, and is currently serving as Chair of the GU Committee of the Southwest Oncology Group, and Chair of the Steering Committee of the Early Detection Research Network of the National Cancer Institute. He was nominated to be a Trustee of the ABU by the American Association of Genitourinary Surgeons.

Dr. J. Brantley Thrasher is the William L. Valk Chair, Dept of Urology and Co-Director of Operative Services at the University of Kansas Medical Center. A native of South Carolina, he received his B.S. from Clemson University and M.D. from the Medical University of South Carolina. He completed an internship at Walter Reed Army Medical Center, residency at Fitzsimons Army Medical Center and Urologic Oncology Fellowship at Duke University. Dr. Thrasher has served as Chair of the AUA Public Media Committee, Society of Urologic Oncology Fellowship Committee and as a member of the AJCC, AUA Practice Guidelines Committee, AV Committee and Vice-Chair of the AUA Prostate Cancer Guideline Committee. He is the immediate Past-President of the South Central Section of the AUA and is presently the SCS representative to the AUA Board of Directors, Secretary of the SUO and member of the RRC for Urology. He was nominated to be a Trustee of the ABU by the American Urological Association. ■

The Board Thanks . . .

Michael O. Koch, MD and Paul H. Lange, MD

Dr. Michael Koch served as a Trustee of the American Board of Urology from 2004-2010, and as President from 2009-2010. He also served as Secretary-Treasurer, and Chair of the AUA/ABU Joint Examination Committee and Finance Committee. Trustees serve our specialty out of true altruism with no compensation often at the consternation of many practicing urologists that resent the increasing regulations and requirements to which they are subjected.

During his time on the American Board of Urology, the trustees were confronted with enormous challenges including mandates from the ABMS on maintenance of certification, the pediatric subspecialty certification and now the female pelvic medicine and reconstructive urology subspecialty certification amongst others. In addition, the Board established a code of ethics that each diplomate should adhere to, and embarked on an initiative with the ACGME to establish, for the first time, specific milestones as residents train to become ABU certified urologists. In every case, the trustees acted with due consideration and in what they felt was the best interest of our specialty and the public.

He would like to thank the trustees and staff of the American Board of Urology for their support and friendship over the past 6 years. He expressed that "it was an honor to be a part of a group whose overwhelming concern is maintaining and improving the quality and integrity of our specialty. The Board of Urology is extremely fortunate to be supported by a highly skilled, dedicated, and professional staff lead by Dr. Stuart Howards. I would like to thank them all for their support and dedication during my term on the ABU. The trustees and all diplomates of the ABU owe them our sincere gratitude."

Dr. Paul Lange served as a Trustee of the American Board of Urology from 2004-2010, and as Vice-President from 2009-2010. He also served on the Qualifying (Part 1) Examination Committee, Policy Committee, Credentials Committee, Committee on Female Urology, and as Chairman of the Bylaws and Publications and Research Committees. He has been a very valuable member of the Board, who because he is an independent thinker and thoughtful person, made many unique and important contributions to the discussion of various issues.

Dr. Lange stated, "it was an honor to serve as a Trustee of the ABU and a revelation to learn all that the Board does for American urology. I rest easy about the future quality of urology, despite all the challenges, knowing first hand the dedication and commitment of the ABU staff and current Trustees." ■

Female Pelvic Medicine and Surgery Subspecialty

On July 29, 2010, the American Board of Medical Specialties (ABMS) Committee on Certification, Recertification and Subcertification (COCERT), which is the committee that reviews applications for new subspecialty certifications, had a first reading of the joint application from the American Board of Urology and the American Board of Obstetrics and Gynecology (ABOG) for subspecialty certification in female pelvic medicine and surgery. Dr. Larry Gilstrap III, Executive Director of ABOG, and Dr. Stuart S. Howards, Executive Secretary of the ABU, and two urogynecologsts who are on the Joint Fellowship Accreditation Committee for fellowships in female pelvic medicine and surgery attended. The first reading was approved. There will be a second reading the in Fall. It is likely, but not certain, that the subspecialty will be considered for approval by the ABMS in 2011. If approved, it is likely that accreditation of the fellowships will be done by the ACGME. ■

American Board of Urology Adopts Expert Witness Policy

The Trustees of the American Board of Urology have adopted an expert witness policy for sitting Trustees. The policy states that Trustee shall not be allowed to serve as Expert Witness (for either plaintiff or defendant) in medical liability cases while a Trustee of the Board. The policy applies to new cases (after term of service on board commences), and will not apply to providing medical testimony for a Trustee's own patients. ■

American Board of Urology Policy for Expired or Revoked Certificates

Diplomates who are candidates for recertification can take the recertification examination in year 7, 8, or 9. Candidates who fail to pass the examination by the end of year 9 will lose their certificate upon its February expiration. The candidate then has two grace years during which time he/she can apply to take the recertification exam another two times (year 10 and 11); if the candidate passes the recertification examination in the 10th year, the certificate is returned. In the 11th year, but not in the 10th year, the candidate must submit a new log. If the candidate fails in year 11, he/she will have to repeat the entire certification process again in order to obtain a certificate.

Diplomates who let their certificate lapse (due to not taking the recertification examination) and individuals who have had their certificate revoked: Individuals, who are within 5 years of active practice, are allowed two attempts to pass the recertification examination during a consecutive two year period. They also must have: an active medical license, peer review, pay a $1500 fee, submit a log, and have a total of 150 Urology focused CME credits since the time of lapse or revocation. At least 90 of the Urology focused CME credits must have been obtained in the year prior to taking the recertification examination.

If applicant has not been in practice for over 5 years, then the applicant is no longer eligible to take the recertification examination and will need to repeat the entire certification process in order to obtain a certificate. ■

In Memoriam

The office of the American Board of Urology regretfully reports receiving notification in 2009 – 2010 that the following Diplomates have passed away.

Alfred M Alden MD
Robert J Bacon MD
Courtland A Blake MD
Harold J Bradly Jr MD
Frank H Carter MD
Morris M Crisler Jr MD
Robert F Dykhuizen MD
J L Eshleman MD
Malachi J Flanagan MD
Keith E Gawith MD
Ernest R Gentile MD
Joseph Gilbert III MD
Milton H Gitter MD
Hossein Golji MD
Andrew Steven Griffin MD
B Holly Grimm MD
Joe S Gunter MD
Mark W Harrold MD
Vital E Haynes MD
Paul J Hettle MD
William W Hoffman MD
John H Hoskins MD
Erik Houttuin MD
John J Ippolito MD
Parvis Javaheri MD
Robert C Kettunen MD
Babiano M S Kim MD
William S Klutz MD
LaGrande C Larsen MD
Stephen M Lazarus MD
William T Lucas MD
Andrei N Lupu MD
John F Machen MD
Gulamhusain H Moonda MD
Edward H Murphy MD
Leon I Nowakowski MD
Stanley R Oppenheim MD
Richard R Paterson MD
Carlton E Patrick MD
Isaac M Prlina MD
Robert A W Pullman MD
Charles S Putnam Jr MD
Hugh C Rogers MD
Charles D Scruggs MD
Robert F Seymour MD
John A Sibley MD
John H Small MD
Anthony L Spirito MD
Beverly G Stewart MD
Roy F Stinson MD
Edward Tarabulcy MD
John D Tharp MD
Vincent Verderame MD
Richard D Williams MD

Changes to ABU Recertification Examination Format

The format of the American Board of Urology Recertification Examination will change beginning in 2011. The examination will continue to be a four-hour, proctored, computerized examination administered annually at nearly 200 Pearson VUE testing centers located throughout the United States, Canada, and Puerto Rico in October each year. The examination will no longer consist of five modules covering the domains of urology, three of which are selected by the candidate. It will be replaced by a 100 question examination covering the domains of urology, with very few pediatric questions. Pediatric questions remaining on the examination will relate to very common pediatric conditions. Statistics from past examinations show that with the exception of the Pediatric module, which very few examinees except pediatric urologists select, candidates select nearly equally from the other four modules.

The rationale for the change in format is to provide consistency with other ABU examinations, increase the statistical psychometric validity of the examination, address the numerous complaints from Diplomates regarding the verification of which modules they selected on the examination, and eliminate concerns expressed by many Diplomates regarding whether the modules they selected were the ones that were scored. ■

Urology Training Update

The American Board of Urology mandates a minimum of 5 clinical years of postgraduate medical training. Training must include:

- 48 months in an ACGME-approved urology program
- 3 months of general surgery in an ACGME-approved surgical program
- 3 months of core surgical training (e.g. intensive care unit, trauma, vascular surgery, cardiac surgery, etc.) in an ACGME-approved surgical program
- 6 months of other rotations, not including dedicated research time, in an ACGME- or RCPS(C)- approved core surgery program

If your program includes a research rotation during the 48 months of urology training, the Board recommends that you switch from a 2+4 to a 1+4 with the Urology Residency Review Committee (RRC). A research rotation can still be incorporated; however, it cannot interfere with the one year ACGME-approved general surgery requirement or the 48 months ACGME-approved urology requirement. ■

2010 Qualifying (Part 1) Examination

283 candidates took the 2010 Qualifying (Part 1) Examination at Pearson VUE Test Centers across the country. 256 (90%) passed and 27 (10%) failed. 251 first time US urology residents passed the examination.

2010 Certifying (Part 2) Examination

The 2010 Oral Examination was challenged by 250 candidates. In 2010, the candidates were rated on each of the individual questions associated with each protocol. The questions were then classified under the appropriate clinical skills within each protocol. The clinical skills under which each of the questions was classified were: 1) History/Examination, 2) Imaging/Laboratory, 3) Diagnosis/Differential, 4) Management, and 5) Complications/Follow up. This allowed the examiner to assess candidates from five perspectives using questions associated with each of those clinical skills. All candidates challenged the same six protocols. 234 (94%) of candidates passed the examination and 16 (6%) failed. As always, examiners were evaluated on their severity and consistency.

2010 Pediatric Subspecialty Certification

51 urologists took the 2010 PSCE. 47 (92%) passed and 4 (8%) failed. Since the implementation of subspecialty certification in pediatric urology in 2008, a total of 274 pediatric urologists have challenged the examination. 268 passed and are subspecialty certified in pediatric urology. Their subspecialty certificates are subject to Maintenance of Certification (MOC), with the class of 2008 currently completing their Level 1 MOC requirements of an online application, license verification, and completion of an online self assessment tool called a Practice Assessment Protocol (PAP).

2009 Recertification Examination

469 candidates sat for the 2009 Recertification Examination at Pearson VUE Test Centers across the country in October 2009. 459 (98%) passed and 10 (2% failed). ■

Update on Milestones Project for Urology Residency Training

In issue 17, October 2009, of the American Board of Urology report, Dr. Michael Ritchey described the next step in the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project. The progression to competency based education and assessment will require the identification of specialty specific "milestones" of competency. An example of such milestones would be the assessments of childhood development that a pediatrician documents during routine office appointments. It will also require evaluation tools to document their achievement. An example of this would be the skill tests that must be successfully performed to advance to the next level in martial arts.

The residency review committee for urology, chaired by Dr. Michael Koch, and the American Board of Urology elected to be involved early in this process. A milestones committee chaired by Dr. Michael Coburn has begun its work of defining the milestones within each of the six core competencies for residency training in urologic surgery. Once the measurement tools have been agreed upon by the committee, the ACGME will then seek a mechanism for the storage and retrieval of this information. At this time, the ACGME is in the design phase of a learning portfolio to be provided to all ACGME accredited programs.

The interested reader can learn more by visiting the ACGME website (www.acgme.org) and clicking on Outcome Project on the left-hand menu.

Members of the urology milestone project working group from the American Board of Urology include Drs. Robert R. Bahnson, Michael L. Ritchey, and Ian M.Thompson, Jr. ■

Oral Certification Examination Scoring

The American Board of Urology considers the oral examination to be an integral component of board certification in urology. The purpose of the oral examination is to test the candidate's ability to evaluate and manage clinical situations seen in everyday practice. Emphasis is placed on the candidate's ability to organize information, order appropriate laboratory and imaging studies, interpret the results, manage urologic disease or dysfunction, handle complications and provide a strategy for follow up care. The 2011 oral examination will focus on the management of six selected cases presented to the candidate, with less emphasis on simple data gathering and fact recollection then in previous examinations. ■

Pediatric Urology Subspecialty Examination

Beginning with the 2010 cycle, the Pediatric Urology Subspecialty Certification examination will be offered every two years; i.e. 2010, 2012, 2014, etc.

In June of 2011, postcards will go out to each diplomate coded "pediatrics" practice type in the ABU database that will state the following:

Applications for the 2012 American Board of Urology Pediatric Subspecialty Certification Examination will be mailed to interested pediatric urologists on August 1, 2011. The application deadline for the June 2012 examination is September 15, 2011 along with an application fee of $2500. A twelve-month log reflecting all office visits, hospital, ambulatory care, and office procedures for each facility where one practices must be submitted by October 1, 2011. Thirty hours of pediatric urology focused CME credits must be documented by December 1, 2011.

To receive an application, individuals must contact the ABU office prior to September 1, 2011 or download application documents from the ABU website and mail to the Board office by the required deadlines. Contact information for the American Board of Urology is 434/979-0059 or via email to certificationcoordinator@abu.org. **Even if you have contacted the ABU in the past regarding the PSCE process, you must communicate your request for a 2012 application packet in order to insure receipt of the necessary application materials.**

The Society for Pediatric Urology (SPU) and the American Academy (AAP) Section on Urology will have this information available to post on their websites.

The 2012 PSCE is scheduled for Friday, June 1 and Thursday, June 7. ■

American Board of Urology to Post Trustee COI Statements

Beginning in 2011, the American Board of Urology will post its Trustees' conflict of interest statements on the ABU website. The policy requiring Trustees to submit annual, updated COI statements was approved at the recent summer meeting of the Board. The ABU Executive Committee will oversee and manage potential conflicts of sitting Trustees. ■

American Board of Urology Change of Address Policy

The processes of Certification, Recertification, and 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 for influence on fees.

It is critical 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, 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 transfer important information to the Diplomate and currency in MOC, recertification, or certification could be impacted. 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 result in the revocation of your certificate. ■

American Board of Urology Annual Certificate Fee Policy

The American Board of Urology initiated a $200 annual certificate fee in January 2009. The fee replaces all periodic Recertification Examination or Maintenance of Certification fees and is invoiced to all practicing Diplomates of the ABU regardless of the status of their certificate; that is, time limited or unlimited. Time unlimited diplomates are not required to pay the fee, but are encouraged to participate on a voluntary basis.

Diplomates should mark their calendars and inform their staffs that this fee is invoiced annually in January and payment is due by April 1 each year. It is the responsibility of the Diplomate to ensure that the Board office has an accurate mailing address and email address, as there will be no waiver of late fees due to outdated information.

For diplomates with time limited certificates, non-payment of the fee by the April 1 deadline will result in a doubling of the fee to $400. Non-payment of the fees by July 1 will result in a doubling of the fee to $800. Non-payment of the total fees by November 1 will result in revocation of certification. Non-compliant Diplomates will be reminded by email after the first quarter of the year and by mail after the second quarter of the year. Final notice will be sent by certified mail giving the Diplomate the opportunity to pay all fees prior to revocation. ■

Not sure if the ABU office has your current address?

Complete and fax this form to 434/979-0266 or mail to:
American Board of Urology, 600 Peter Jefferson Parkway, Suite 150, Charlottesville, VA 22911.

ABU ID ____________________ Effective Date: ____________________

First Name | Middle Name | Last Name | Suffix | Title

Street Address or PO Box

City | State | Zip

Daytime Phone | Email address

ABU Maintenance of Certification (MOC)

In 2009, all of the 255 diplomates who were required to complete Level 1 of MOC did. In 2010, there are 496 diplomates in Level 1 of MOC. As of this printing, over half of these have completed all requirements for Level 1. There will be 541 entering Level 1 in 2011. The requirements for Level 1 are to complete an online application, summit a copy of their active medical license, and complete an online Practice Assessment Protocol (PAP).

In 2011, the first group of 255 Diplomates will enter Level 2 of MOC. They will be required to submit a copy of their active medical license and complete and online Practice Assessment Protocol (PAP). The Level 2 candidates will also need to complete 90 hours of CME credits and have satisfactory peer review.

All doctors who are required to enter the MOC process in 2011 will receive a postcard in late December listing their MOC requirements. In April 2011, eligible doctors will receive a letter with their user name and password to log in to the ABU website to complete their application. They will also be provided a list of the applicable requirements in that mailing.

The current requirements for each level of MOC are shown in the adjoining chart. These are subject to change as ABMS requirements for MOC change. The MOC Entry Timeline chart shows when Diplomates who certify or recertify beginning in 2007 are expected to enter each level of MOC. Any questions about the process can be emailed to MOCCoordinator@abu.org. ■

MOC Entry Timeline

CERTIFICATION PROCESS

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

RECERTIFICATION PROCESS

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

MOC Requirements

Requirements	Level 1 (year 2)	Level 2 (year 4)	Level 3 (year 6)	Level 4 (years 8-9)
Complete application online	yes	supplemental application	supplemental application	supplemental application
ABU office verify licensure	yes	yes	yes	yes
ABU office complete peer review		yes		yes
Candidate: Complete online Practice Assessment Protocol	yes	yes	yes	yes
Candidate: Submit documentation of 90 hours of CME		yes		yes
Candidate: Submit 6 month electronic practice log				yes
Candidate: Computer-based closed-book exam				yes

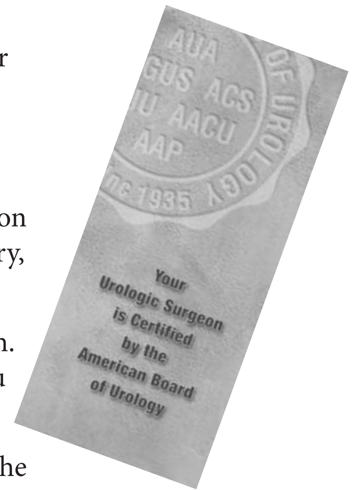
9/2008

ABMS Mandates Reporting of MOC Status by 2011

The American Board of Medical Specialties has mandated that all ABMS member boards report the status of their Diplomates to the ABMS by 2011. The ABU will be required to transmit its Diplomate's certification status, clinical status (active, inactive or unknown) and participation in MOC to ABMS for publication in its online directory. ■

Brochure Describes Certification

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



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

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