The American Board of Colon and Rectal Surgery: Past, Present, and Future

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Abstract

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Since the incorporation of the American Board of Proctology, development and refinement of the process of board certification has been a critical part of the establishment and growth of the specialty of colon and rectal surgery. Continued commitment to the process begun by the early pioneers of this field provides quality practitioners not only when initially trained, but increasingly throughout the continuum of each diplomate's professional career. Board certification and maintenance of certification are the most tangible examples of our commitment to our patients and the public.

Objectives: On completion of this article, the reader should be able to understand the evolution of the primary certification process and should be able to define the current process of maintenance of certification.

Certification by the American Board of Colon and Rectal Surgery has long been considered the ultimate achievement after the conclusion of clinical training in colon and rectal surgery. The history of the origin and growth of the board is illustrative of the importance of an independent specialty, with equal stature within many organizations to other boards with much larger membership. We owe a debt of gratitude to our founders that can never be repaid.

Formal establishment of the field of proctology was the result of a meeting in Columbus, Ohio in 1899, during which 13 physicians who had been meeting informally on at least an annual basis declared themselves experts in a field that had not been formally included in the curriculum of medical schools. Dr. Joseph Matthews of Louisville, Kentucky had recently been elected president of the American Medical Association and was named the first president of the American Proctologic Society; he is widely regarded as the "father" of modern colon and rectal surgery in the United States, having studied at St. Mark's Hospital in London and then returning to Kentucky, limiting his practice to diseases of the

colon and rectum. He established a Department of Proctology at the Kentucky School of Medicine in 1883 and was a prolific writer and revered teacher of his chosen specialty.

Interest in the field grew, as reflected in the steady growth of the American Proctologic Society. By 1930 there were 100 members. In 1933, Dr. Curtice Rosser, in his presidential address to the American Proctologic Society, indicated that three specialties had already established independent boards—ophthalmology in 1916, otolaryngology in 1924, and obstetrics and gynecology in 1930—and strongly advised that proctology do the same. His vision for the need for an independent board was predicated on his belief that there needed to be a clear curriculum of the specialty and a method of identifying individuals qualified to practice. A committee was formed to explore establishment of this board.

The American Board of Proctology was incorporated in 1935. It should be noted that even as early as 1899 proctology was defined as "that branch of medical practice which deals with diseases of the colon, rectum and anus." This assumed definition would be a source for considerable debate in years to come. Shortly after its incorporation, the board petitioned the new Advisory Board for Medical Specialties (ABMS; the precursor of today's American Board of Medical Specialties) to begin to function independently.

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Prior to the establishment of ABMS, any practitioner could claim whichever expertise that they wished because there was not a system of validation of expertise. The first concept for a specialty board was espoused by Dr. Derrick Vail, president of the American Academy of Ophthalmology and Otolaryngology. Standardized curriculum and training would be followed by an examination by independent experts in the field; passing of the examination would result in approval to practice the specialty. In 1932 the National Board of Medical Examiners (NBME) created the Committee on Specialists, who subsequently presented their findings and observations. The primary focus of this report was to devise one nationwide specialty board for each specialty that would be charged with determining competence for practice. Subsequently, the Advisory Board for Medical Specialties was established in 1933 to provide a platform for sharing information and examination techniques while assuring independence of each individual board. There is no question that the growth of the board movement served to standardize the residency curriculum for each specialty and improve the overall quality of graduate medical education while improving the quality of medical care.

Although the American Board of Proctology was incorporated prior to the incorporation of the American Board of Surgery, the application by the proctologists for independent status was deferred by the Council on Medical Education of the American Medical Association (AMA); this particular committee of the AMA was charged with accrediting specialty boards. The suggestion was made that the American Board of Surgery should be established before the American Board of Proctology. In 1938 the ABMS decided that the American Board of Surgery should be in charge of development of certification in proctology. After considerable discussion, not all of which was without acrimony, the American Board of Surgery approved the formation of the American Board of Proctology as a subsidiary board, with the understanding that individuals interested in proctology must complete all of the components of the American Board of Surgery and pass the examinations in surgery before completing separate proctology training and passing an additional examination. Presuming successful completion of that exam, the individual would receive a separate certificate of competence in proctology but would not be awarded a certificate in general surgery.

Furthermore, the American Board of Proctology was to be organized as a subsidiary committee of the American Board of Surgery. Eight members of the Central Certifying Committee in Proctology of the American Board of Surgery were appointed:

Curtice Rosser, Louis Hirschman, Louis Buie, Collier Martin, Descum McKenney, Walter Fansler, Edward G. Martin, and Frank Runyeon.

These eight individuals, all recognized pioneers in proctology, were charged with developing a list of proctologists who would be eligible for certification without examination ("grandfathers") as exemptions to the total training requirements; they submitted 77 names in the "Founders list." The American Board of Surgery would not relinquish the requirements for complete training in general surgery for others

subsequently training in proctology. Consequently, from 1942–1949 only eight candidates were actually certified, at least in part due to the duration and complexity of achieving certification. Proctologists believed that certification at this dismal rate would result in the demise of the specialty. Moreover, certification in proctology was not generally accepted in the academic surgical community, which further deemphasized the value of certification in proctology. The American Board of Surgery continued to strongly urge the proctologists to be a true subsidiary board (i.e., give up their aspiration for independence).

Displeasure with the arrangement with the Board of Surgery prompted a meeting in 1945, the result of which was an appeal to the ABMS and the AMA Council. Armed with the support of these two powerful certifying bodies, the Central Certifying Committee met with the American Board of Surgery, who advised them to appeal directly to the ABMS (no doubt assuming their support). To their surprise, the ABMS recommended that the Board of Surgery make the requested changes in requirements. The Board of Surgery denied this request, asserting the need for at least 3 years of general surgery followed by 2 years of proctology, or 4 years of general surgery and one year of proctology to qualify for examination. The American Board of Surgery felt (without supporting data) that the duration of anorectal surgery training was insufficient to qualify for certification for independent practice.

Some time passed while the Central Certifying Committee (the Board) and the American Proctologic Society discussed their own internal differences of opinion regarding training and exercised some posturing regarding their relative importance in the process. These differences were settled, essentially without rancor, and a unified petition was submitted from the American Board of Proctology, with supporting documentation from the American Proctologic Society, to the ABMS. Once again, it was suggested by ABMS that the American Board of Surgery reconsider its stance; when this request was yet again denied, the ABMS agreed in 1949 to support the formation of the American Board of Proctology as the "18th primary specialty board." This was 14 years after the incorporation of the Board, which had preceded establishment of the American Board of Surgery by two years.

The original board was 10 members, with four each from the American Proctologic Society and the AMA Section of Gastroenterology and Proctology, and the remaining two from the Section of Proctology of the Southern Medical Association. Curtice Rosser was the first president, Walter Fansler the first vice-president, and Louis Buie the first secretary-treasurer. Their first charge was to create a constitution and bylaws; at that time each of the members of the board could serve up to two consecutive 4-year terms (8 years of continuous service). The only member without term limits was the secretary-treasurer (now the executive director), who served indefinitely at the "pleasure of the Board." It was their belief that one individual needed to provide some continuity and historical memory. Consequently, there have been only six executive directors in the history of the board. Only recently (2009) has this bylaw been changed, such that the executive director is now limited to a maximum 8-year

term as well. The sponsors of board members have also changed by eliminating sponsorship by the AMA and the Southern Medical Association, while adding the American College of Surgeons (ACS) and the Association of Program Directors in Colon and Rectal Surgery (APDCRS). Currently, there are 16 elected members: four from the ASCRS, two from the ACS, two from the APDCRS, and seven from the ABCRS (including the Executive Director). In addition, there is one representative from the American Board of Surgery.

From 1949 to 1955, there were two different certificates offered. One was in anorectal surgery, in which abdominal and radical rectal cancer resections were not included. Training consisted of internship and 3 years of graduate training, followed by not less than 2 years of training or practice limited to proctology. Additionally, individuals more than 10 years out of medical school who wished certification in anorectal surgery could document satisfactory training and experience along with evidence of "superior achievement" and ethical practice. These individuals were those who had been in practice and had sufficient experience to be considered for the required examination (again, the precursors of grandfathers). This particular window (without specific residency training requirements) was closed in 1951.

The other certificate was for applicants desiring certification in anorectal and colonic surgery. Following a year of internship, 3 years of general surgery, and two years of residency specifically in proctology, the applicant would be required to succeed in passing an examination. After 1959 the ABCRS required a minimum of 3 years in an approved general surgery residency and 2 years of colon and rectal surgery, either in an approved formal training program or a recognized preceptorship. Apparently, the sense that colorectal training would require more than one year substantially preceded the Blue Ribbon Panel of 2006, which proposed a 4-year general surgery/2-year colon and rectal surgery training paradigm recently that has not been embraced by the Board of Surgery.

Primary certification continues to require passing of an examination, the specifics of which are determined by the board. The original examination was given in two parts, with the first being both written and oral; the second was a clinical exam that included patients as well as pathology and radiology. The process continued to evolve through an optional practical examination within the candidates' office, including reviews of surgical procedures, office practice and records, with a Part I written qualifying examination and a Part III combined written and oral exam that comprehensively covered the theory and practice of proctology. Clearly this examination process is very labor intensive and is psychometrically difficult to validate. In 1972 the ABCRS adopted a multiple choice written examination as the qualifying exam.

Once the multiple choice format was adopted, the Board was challenged with the need to develop a pool of valid high quality and continuously changing questions; this effort has been led by a series of board members who have functioned as the written exam committee chair. Most recently, under the leadership of Thomas Read, a cadre of question writers has been developed to keep providing rotating questions for use in a computer-based examination as well as in recertifi-

cation and self-assessment exams. The qualifying exam is given once a year at computerized testing centers throughout the world. Psychometric testing services are currently purchased from the American Board of Surgery. All of these developments have substantially improved the quality of the written examination.

Certification requires that the candidate take and pass the written examination to qualify for the oral (certification) exam. The oral exam has also become more standardized over the years; currently, there are three sets of two examiners and five standardized questions from each of the three sets of examiners. The former sections of radiology and pathology have been interspersed within both written and oral exams. Unsuccessful candidates are offered the opportunity to discuss their performance with either the executive director or the examination chairs. Each candidate has three opportunities to qualify and three to certify, with an opportunity to requalify in the unusual instance of three failures.

Convinced of the importance of general surgery training for all colon and rectal surgeons, in 1980 the ABCRS required passage of the qualifying exam (written) of the ABS to qualify for the exam of the ABCRS and in 1989 required full certification by the ABS to be certified by the ABCRS. Since then, every board certified colon and rectal surgeon is also boarded by the ABS. Practicing colon and rectal surgeons often practice some amount of general surgery.¹ Members of the ASCRS perform general surgery in 74% of respondents, whereas 48% of Fellows perform general surgical procedures. This has potential practical national importance because there is a projected shortage of general surgeons in the United States that would be intensified by doing away with general surgery training for colon and rectal surgeons.²

Debate regarding the name of the specialty and the board, whether to be proctology or colon and rectal surgery, was quite heated. Senior members favored "proctology," arguing that diagnosis and treatment of the anus and rectum was the essence of the field. Others, particularly those who had substantial training in general surgery before training in proctology, invoked the original definition of 1900 to include the colon as well as the rectum and anus. The name change for the board was made official in 1959; the membership of the American Board of Proctology felt the field had not changed, but rather the definition of the field as it had existed had been clarified. In 1962 the American Board of Surgery (ABS) recognized that the name would not be rescinded despite their objections and asked that sufficient training be provided in general surgery to qualify for certification by the ABS. This request was taken to heart, as outlined above with double board certification. On the other hand, the American Proctologic Society was not officially renamed the American Society of Colon and Rectal Surgeons until 1973 (14 years later), indicating the depth of sentiment among the members.

The early history of the Board movement was embodied first by the Advisory Board for Medical Specialties, founded in 1933, with the express purpose of providing a venue for discussion of common problems among specialty boards and to act in an advisory capacity, coordinating efforts as much as possible. With the progressive definition of each of the discreet

specialties came greater acceptance of the need for more standardized training and primary certification methods within each specialty. The impact of the board movement cannot be underestimated with regard to the definition and evolution of residency training, as compared with ad hoc preceptorships.

Interestingly, one of the early pioneers on the American Board of Proctology was instrumental in leadership of the ABMS. Louis Buie was the first secretary-treasurer of the Board of Proctology and he subsequently became the first secretary-treasurer of the Advisory Board in 1957. Buie stayed in that position through the official organizational change to the American Board of Medical Specialties in 1970.

Early discussions at the ABMS focused on the definition of a certified specialist. Despite the fact that specific requirements for each individual specialty have changed over time, the initial emphasis on the primary certification process as defined by the specialty itself within the framework of the board movement has been and continues to be a major focus of each Board's activities. Early in this evolution the concept of time-unlimited certificates was challenged as potentially misleading to the public, who were demanding some reassurance that specialists were keeping abreast of developments within their field. Continuing medical education was the initial proposed solution to this public demand for staying current; unfortunately, cynicism regarding the validity of self-education alone controlled by individuals with a rather blatant conflict of interest resulted in the initiation of "recertification" examinations at regular intervals to demonstrate continued currency. This was quite contentious, with each board having its own debate and making its own decisions regarding whether to adopt time-limited certificates at all, and if so, identifying the acceptable interval between exams.

Dr. Herand Abcarian, the executive director of the board, supported the move to implement recertification, and in 1990 the ABCRS issued its first series of time-limited certificates, which initially were 8 years in duration. However, at the urging of the members of the ASCRS, time-limited certificates were temporarily suspended; in 1999, the duration of certificates was increased to every 10 years. The first examination was administered in 1991, with seven examinees (obviously all with time-unlimited certificates) and a pass rate of 100%. Through 2011, 924 participants have participated in the examination process with a 97% passage rate. The curriculum that forms the basis of the exam is publicized to the membership, and is based predominantly on the CARSEP (Colon and Rectal Surgery Educational Program), which is available through the ASCRS. The CARSEP is a self-assessment vehicle with multiple-choice questions designed and executed by the ASCRS with assistance from the ABCRS.

In 1999 the Accreditation Council for Graduate Medical Education (ACGME) introduced the Outcome Project. Six general competencies were described that were to form the framework for graduate medical education; these included patient care, medical knowledge, professionalism, system-based practice, practice-based learning and improvement, and interpersonal and communication skills.

It was the vision of the ACGME that modification of residency curriculum to incorporate the six competencies

and subsequent development of validated tools to measure outcomes would improve the overall quality of medical care. With the mandated adoption of the Outcome Project, the entire curricular requirements for graduate medical education were inexorably altered.

The ABMS was also wrestling with the concept of measurements of competence. Primary certification had been very carefully separated from assurance of competence by the boards. Dr. David Nahrwold, the president of ABMS at the time, suggested that a system be developed that could more reliably assure competence to the public throughout each individual specialist's professional lifetime. It was only logical to embrace the six general competencies that were the basis for the ACGME Outcomes project, reflecting and emphasizing the continuum of competency-based learning and measurement that would begin in residency and continue throughout one's professional career. A Task Force on Competence chaired by Dr. Nahrwold began the process of evolution from an intermittent static recertification exam to one of continuous competency assessment. After considerable discussion, four principles were endorsed by the ABMS that are the foundation of the Maintenance of Certification (MOC) programs: professional standing (license and credentials), commitment to lifelong learning (continuing medical education), periodic cognitive assessment (examination), and evaluation of practice-based performance.

By 2006, each of the 24 ABMS member boards had received approval for their plans to implement MOC and the amount of effort to develop validated systems that satisfy these requirements for both the diplomates and the public has been astronomical. It should always be remembered that the true motivation for MOC is to improve the quality of care for the patients that we serve.

Beginning in January 2011, all diplomates of ABCRS shall be enrolled in MOC when they are initially certified or recertified in the old "every 10-year" system. The essential components of the MOC system are as follows:³

1. Professional standing every 5 years—Full licensure in the state in which one practices, documentation of privileges in colon and rectal surgery and a letter of recommendation by the chief of surgery at one's hospital
2. Lifelong learning and self-assessment
3. Cognitive expertise every 10 years
4. Evaluation of performance in practice—Ongoing participation in outcomes databases or quality assessment programs (e.g., SCIP [Surgical Care Improvement Project], NSQIP [National Surgical Quality Improvement Program], UHC [an alliance of 116 academic medical centers and their affiliates, representing 90% of nonprofit academic medical centers], etc.)

Part 4 has represented the greatest challenge to develop surgeon-specific tools for measurement of performance and then to demonstrate practice based improvement. These vehicles will continue to change as more accessible and acceptable tools are developed.

Recently the ABCRS has adopted the Part 2 MOC requirements of the ABS.⁴ Rather than 30 credit hours per year of

category 1 CME over 5 years (150 hours), the cycle will be shortened to every 3 years, with 30 hours per year still being the requirement (90 hours). Two-thirds of these (60 hours) must be self-assessment CME. At present and increasingly in the future scientific meetings will mandate that portions of their educational activities incorporate self-assessment portions to facilitate measurement of learning. These changes will be evident, for example, at the upcoming annual meeting of the ASCRS. Category 2 CME has never been accepted by ABCRS for MOC and will not be accepted for MOC-CME. It should also be remembered that CARSEP and SESAP are accepted self-assessment tools and will be an essential portion of the MOC process, albeit with a greater frequency (every 3 years rather than every 5). Other self-assessment programs are listed on the ABS website.⁴

Because all colon and rectal surgeons are initially boarded by the ABS and the ABCRS, there is a reciprocal agreement that will facilitate the maintenance of both certificates when the diplomate believes it is in their best interest. Parts 1, 2, and 4 will be shared activities acceptable to both boards. By necessity, the cognitive examination in colon and rectal surgery should not be accepted by the ABS; additionally, to take the exam in colon and rectal surgery will require initial certification by ABCRS.

An unresolved and increasingly controversial issue is the group of diplomates with time-unlimited certificates (grandfathers). Time-unlimited certificates are under intense scrutiny by the public; there seems to be a preconceived notion that physicians who are not required to participate in MOC may be among those that are most in need of this educational process. As of May 2011, the total number of active ABCRS Diplomates was 1623; of these, 454 (28%) have time-unlimited certificates. Of the 454, 185 (41%) are age 62 or younger. Although the board does not currently intend to change its policy regarding time-unlimited certificate holders, voluntarily entering the MOC process would demonstrate a commitment to quality without placing their certificate at risk. As the MOC process unfolds, this may not be an option in the future.

Despite the fact that the board must keep its focus on the dynamic MOC process, the total primary certification examination must be continuously challenged for its relevance. Most of the ABMS member boards have abandoned the oral exams. Some (e.g., Plastic Surgery, Orthopedic Surgery) have based the second part of the exam more on individual candidate practice experience after passage of the initial qualifying (written) exam. Those that have continued with the traditional oral exam have generally maintained that the rationale for this portion of the evaluation is to test surgical judgment and integrated thinking during patient management. Notably absent from this evaluation is an assessment of technical skills and communication skills.

The ASCRS, in conjunction with the ABCRS and the Program Directors' Association, has initiated a project to create a Colorectal Objective Structured Assessment of Technical Skills (COSATS) examination. The initial pilot, designed by Sandra de Montbrun and Helen MacRae of the University of Toronto, has been completed and has demonstrated the ability to discriminate between general surgery chief residents and colon and

rectal residents with a high degree of reliability (unpublished data). Based on these observations, the next step is to attempt the exam in a larger setting on more individuals with the expectation that in the future at least a portion of the certifying examination for colon and rectal surgeons will be procedural competency based. The implications for MOC and possibly credentialing are self-evident.

In a similar vein, standardized patients are accepted as a valid mechanism for evaluating communication skills. A high stakes communication examination could be constructed to be added to the COSATS exam; this would give a true competency-based assessment of clinical skills.

In summary, the ABCRS remains viscerally committed to providing an examination and evaluation process that satisfies our responsibility to protect the public trust that constitutes the essence of the board movement. Understanding the importance of the independent board status provided by our predecessors is critical to maintaining our integrity as respected independent surgical specialists.

Acknowledgments

The history of the Board Movement and of the ABCRS has been extensively documented in references;⁵⁻⁷ these works form the essential basis of much of the historical narrative above. Although not directly plagiarizing text from any of these references, the observations and time sequences were liberally "borrowed" from them. In addition, this article has been reviewed for accuracy by Irene Babcock, who has worked with the ASCRS and the ABCRS for over 30 years and is currently the Executive Assistant for the Board. Finally, Dr. Herand Abcarian, who was the Executive Director of ABCRS for 20 years, has been kind enough to review this historical account. Without all of these contributions this work would not have been possible.

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