

ABA NEWS

Vol. 18, No. 1

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.
A Member Board of the American Board of Medical Specialties



June 2005

Report From The President

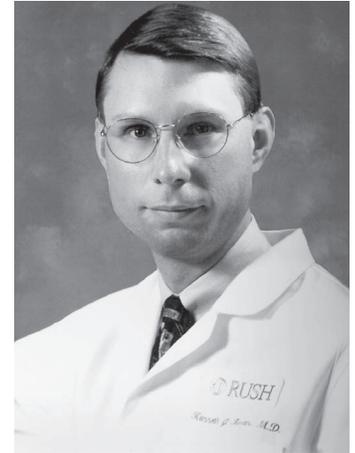
Over the past several years the ABA, along with 23 other medical specialty certifying boards recognized by the American Board of Medical Specialties (ABMS), has been actively engaged in efforts addressing the growing demands of patients and other stake holders for ongoing evaluation of quality of care provided by physicians. These demands have been triggered, in part, by

reports such as those published by the Institute of Medicine (IOM). Two major reports of the IOM, "To Err is Human" and "Crossing the Quality Chasm," identified deficiencies in patient safety and the quality of healthcare provided in the United States. The medical specialty of anesthesiology has been on the forefront of patient safety efforts, and a comprehensive process for assessment of ongoing competence makes sense for a specialty using rapidly evolving technology and approaches to patient management. Although no prospective, controlled study has been (nor ever likely will be) conducted to demonstrate a definite

link between board certification and quality, there is a common perception that the standards set by the ABA and other ABMS certifying boards are meaningful to the profession and to patients, and in some yet unquantified manner are related to quality.

The ABA has always upheld rigorous and credible standards for the certification of anesthesiologists and subspecialists in critical care medicine and pain medicine. The focus has more recently broadened from initial certification with periodic voluntary recertification to the concept of time-limited certification and maintenance

of certification. Completion of an approved educational and training program and a rigorous evaluative process designed to assess the knowledge, skills and judgment necessary to provide quality patient care are the underpinnings of the certification process. Maintenance of Certification in Anesthesiology® (MOCA™) consists of a four part framework that encompasses quality measures. Maintenance of Certification (MOC) requires evidence of lifelong learning and periodic self-assessment as well as evidence of practice performance and improvement (in addition to the traditional



Kenneth J. Tuman, MD

(continued on page 2)

Inside This Issue

New Director—Cynthia A. Lien, MD	4
Maintenance of Certification in Anesthesiology Update	4
ABA Information Sessions: 2005-2006	6
ABA Stops Using "Board Eligible"	7
Turn Electronic Devices Off at ABA Examinations	7
Misrepresentation of ABA Certification Status	7
Recognition of Diplomates' Service and Contributions 2004	8

Professional Standing Policies	10
Nonstandard Examinations	10
Only Electronic Applications	11
Changes in ABA Fee Collection Policies	11
2006 Application Cycles and Fees	11
ABA Website Features	12
ABA ID Number and ABA ID Card	13
2004 Examination Results	14
Upcoming Examinations	15

components of certification—cognitive expertise and professional standing). The directors of the ABA have carefully deliberated over the design of a MOCA program so that it not only fulfills the ABA's responsibility to the public requesting stricter self-regulation, but also maintains standards relevant to the specialty, and not just measurement for the sake of measurement. Importantly, the move from recertification (based largely on an update of knowledge demonstrated on a cognitive exam) to maintenance of certification (that effectively also requires demonstration of ongoing assessment in the physician's individual practice) represents a significant paradigm shift.

The article "The Role of Physician Specialty Board Certification in the Quality Movement," published in the September 1, 2004 issue of the Journal of the American Medical Association (JAMA 2004; 292:1038-1043), addresses and validates the importance of periodic re-evaluation of physician qualifications, including passing a cognitive test of medical knowledge as it relates to the perception linking ongoing certification and high quality. The authors asked the question "where are the physicians" in the quality of care movement that is sweeping the nation, and suggest that physicians have previously not been sufficiently involved in this activity. The authors of the article promote the medical specialty certification and MOC processes as our current best attempt at an evidence-based measure to address the national concern over quality of care and patient safety. The salience of these efforts is reinforced by the majority opinion of the public (patients) who view certification as an essential marker of physician quality. The JAMA article describes several findings from a Gallup public opinion poll concerning attitudes about physician qualifications.

The poll indicated that patients highly value certification as an indicator of quality and that they would change or select physicians based on whether that doctor is certified. As an example, 3 of 4 adults surveyed indicated that they place board certification status above the recommendation of trusted family

These survey results demonstrate that the American public has developed the expectation that physicians are committed to ongoing assessment and improvement of knowledge and skills.

and friends. More than 80 percent of those surveyed indicated they would more than likely seek another physician if their current physician's certification lapsed. Eighty three percent indicated that it was either very important or important for practicing physicians to be evaluated by an independent board of physicians and a similar fraction of those surveyed opined that physicians should be frequently evaluated. These survey results demonstrate that the American public has developed the expectation that physicians are committed to ongoing assessment and improvement of knowledge and skills. With this view, maintenance of certification can serve as a medium for physician specialists to publicly demonstrate their professional standing, cognitive expertise and record of practice based lifelong learning.

Setting aside the findings that the public highly values certification and MOC, the credibility of the board certification process as a precursor to quality of care

can be reasonably questioned in view of the absence of definitive scientific evidence. The absence of "proof" should not lead to the conclusion of proof of an absent relationship between these processes. There are many examples of the medical profession adopting sound practices despite the absence of direct proof of improved outcome. Pulse oximetry is a classic example where application is universal even though quality of care or practice outcome has not been "proven." Just as there is solid evidence that pulse oximetry provides a valid measurement and that it correlates with other physiologic parameters, there are analogous strengths of evidence for the value of several aspects of the assessments involved in the certification and MOC processes. A substantial body of evidence supports the validity of standardized cognitive testing based on relevant questions developed by experts in the specialty and using widely accepted, credible standard-setting methodology. Simply stated, such testing has value and validity to measure knowledge deemed important for delivery of quality care. The ABA has extended the principles of content standardization and psychometrically driven standard-setting methodology from the written examination(s) to the oral examination, with the goal of enhancing the validity and reliability of this component of the certification process. Parenthetically, the ABA Examinations Committee continually evaluates the examination process to assure that the evaluative approaches for certification and maintenance of certification are relevant and important to contemporary practice.

Additional inferential evidence supports the effectiveness of certification as a measure of quality. Certification examination results correlate with type and amount of training as well as with independent assessment (by training

program director) of clinical skills. There is mixed evidence that board certification reflects quality as measured by improved patient outcomes, largely because most studies of this subject have been designed only to show associations and the multifactorial determination of important clinical outcomes introduces many confounding variables that can interfere with definitive conclusions. For example, the Silber study of surgical patients in Pennsylvania (*Anesthesiology* 2002; 96:1044-1052) found that lack of board certification was related to higher mortality rates; however, type of hospital was not controlled in the study.

In addition to these lines of evidence in support of the certification process as a marker of quality, the behavior required to achieve and maintain board certification has been considered analogous to the principles of error prevention in medical care. Error prevention is improved when problem solving uses readily accessed habits of behavior as well as other more slowly processed, but complex knowledge, both of which are evaluated in various components of certification and MOC. Practice performance assessment (as part of MOC) and the oral examination process evaluate requisite habits of practice. These assessments are presumed (applying the rule of common sense) to be particularly important for patient safety in a medical specialty where rapidly changing clinical conditions frequently occur. Common sense also suggests that successful performance on a test of cognitive skills (both at initial certification and subsequently on an ongoing basis as part of MOC) is a

Currently, the link between physician certification and maintenance of certification programs and quality of care remains intuitive and inferred yet appears to rank highly in the public's assessment of physicians.

presumptive demonstration that the physician is more likely to possess the up-to-date knowledge base necessary to correctly answer questions that arise when problem solving is required in the clinical setting.

Currently, the link between physician certification and maintenance of certification programs and quality of care remains intuitive and inferred yet appears to rank highly in the public's assessment of physicians. While certification (and maintenance of certification) is not a warranty of competence, it represents a significant commitment to demonstrate that we, as physicians, are committed to "doing the right thing" for our patients. Some day, as the science of outcomes and performance assessment matures, robust national databases with a variety of outcome and practice information may allow more quantitative assessment of the association of certification and maintenance of certification with quality and outcome.

In the future, innovative approaches to quantitate the efficacy of the MOC process could perhaps include periodic assessments of physician compliance with established and up-to-date practice guidelines (e.g. guidelines for perioperative cardiac risk assessment and risk reduction with perioperative beta-adrenergic blockade). While certain non-technical aspects of physician competence, such as the ability to clearly communicate and discuss diagnostic and/or treatment plans are assessed in the initial certification process, effective evaluative tools are yet to be developed and applied for other essential attributes that define "behavioral competence" after initial certification. These aspects of competence, while exceedingly difficult to quantitatively assess, are obviously important for patients as well as the success of our profession. Also in the future, it is conceivable that aspects of the MOCA process could be incorporated or merged with requirements of payers, regulators or other entities that necessitate documentation of quality initiatives, reducing duplication of efforts. None of these potential concepts for the future will be easy to design or implement, but they could represent useful additional aspects of a broader periodic assessment of competencies of board certified physicians. Until then, I am confident that the weight of evidence indicates that the certification and maintenance of certification programs of the ABA represent a valuable and appropriately comprehensive approach that advances quality and provides the professional accountability expected by our patients.



New Director— Cynthia A. Lien, MD

The ABA is pleased to announce the election of Cynthia A. Lien, MD, to its Board of Directors. Her term as an ABA director began at the conclusion of the Board's autumn 2004 meeting.

Dr. Lien earned her Bachelor of Science degree in biochemistry from Brown University in 1980 and her Doctor of Medicine degree from Columbia University, College of Physicians and Surgeons in 1985. She was a medicine intern at Lenox Hill Hospital in New York, NY (1985-86) and an anesthesiology resident at Columbia Presbyterian Medical Center in New York (1986-89). Cindy holds ABA certification in anesthesiology (1990) and has recertified in the specialty.

Dr. Lien is a member of the anesthesiology faculty at Weill Medical College of Cornell University (1989-present) where she is Vice Chair for Academic Affairs and holds the rank of Professor of Clinical Anesthesiology. Dr. Lien has been Chair of The Section on Anesthesiology and Resuscitation of The New York Academy of Medicine since 2002. She is on the Academic Anesthesia Committee and the Subcommittee on Resident Research of the NYSSA. She has been on the ASA Committee on Geriatric Anesthesiology and presently serves on the Committee on Scientific Papers and the Refresher Course Committee. She has been Chair of the ASA Subcommittee on Neuromuscular Transmission since 1999.

Dr. Lien has been an ABA Associate Examiner since 1994 and is a Senior Editor for the Joint Council on In-Training Examinations.

Cindy lives in Manhattan with her husband, Dan, and her two daughters, Erika and Christina.

Maintenance of Certification in Anesthesiology Update

MOCA ENROLLMENT TOPS 4,000 DIPLOMATES

Less than 18 months after its launch in January 2004, the ABA's Maintenance of Certification in Anesthesiology Program® (MOCA™) now has more than 4,000 participants.

Prompted by newsletter articles, informational sessions and direct mailings throughout the year, 93 percent of 2000-2003 diplomates completed MOCA applications during 2004. Diplomates issued certificates between 2000 and 2003 needed to apply to MOCA by December 31, 2004 to be able to complete the MOCA requirements before their current certificate expires.

The ABA's communications currently are focused on the 1,278 diplomates certified during 2004. Diplomates issued certificates in 2004 need to complete their MOCA application by December 31, 2005 to be able to complete MOCA before their current certificate expires in 2014. As of February 28, nearly 40 percent (n=500) of the 2004 cohort had enrolled in MOCA.

MOCA also is an option for holders of non-time limited certificates issued in 1999 or earlier who need or wish to demonstrate their continuing qualifications. As of February 28, 261 non-time limited certificate holders are MOCA candidates.

During 2005, the ABA will issue its first MOCA certificates to those non-time limited certificate holders who have chosen to expedite the MOCA process. Diplomates who do not have a time-limited primary or recertification certificate may choose to expedite the MOCA process and receive their MOCA certificate in as little as 12 months after applying.

LL-SA AUDITS UNDERWAY

The ABA has started the process of auditing Lifelong Learning and Self-Assessment (LL-SA) submissions by MOCA candidates. The ABA conducted its first audits of LL-SA activities in November 2004. During 2005, the ABA will audit the LL-SA activities of more than 800 MOCA candidates.

MOCA candidates must complete at least 350 LL-SA credits during the 10-year MOCA program. A minimum of 250 credits must be Category 1 CME provided by ACCME-accredited sponsors. The ABA will audit each MOCA candidate at least once during the candidate's MOCA cycle.

During the audit process, the ABA requests a copy of documentation for specific LL-SA activities reported by a MOCA candidate. To obtain full credit for a Category 1 CME activity, the candidate must provide documentation that identifies the sponsor as accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the number of Category 1 credits/hours. For non-Category 1 LL-SA activities such as facility-based learning, the candidate is asked to submit documentation or an attestation of participation.

MOCA candidates are encouraged to retain documentation for all

LL-SA activities reported to the ABA. When auditing time-limited certificate holders, the ABA selects LL-SA activities reported to the ABA during the past three years. Non-time limited certificate holders who are expediting the MOCA process are instructed to provide documentation of LL-SA activities completed during the past three years.

LL-SA SUBMISSIONS

During the first 18 months of the MOCA program, ABA diplomates reported more than 14,000 LL-SA activities to the ABA. Each year, the ABA will ask MOCA candidates for documentation on thousands of LL-SA activities as part of the ABA's audit process. Reducing the need for ABA diplomates to report and document LL-SA activities to the ABA are the goals of a new system currently under development by the ABA.

Under the new system, CME providers would submit information on program participation by ABA diplomates directly to the ABA. The ABA would add the information to the diplomate's database record only if the CME provider includes the diplomate's unique ABA identification number. Activities reported by the CME provider on behalf of MOCA candidates would automatically be deemed as audited and verified by the ABA.

The ABA system initially will handle CME data from the American Society of Anesthesiologists. Future participants could include anesthesiology subspecialty societies and major healthcare systems.

DIPLOMATES CERTIFIED IN 2000 SCHEDULED FOR PPI ASSESSMENT

More than 850 MOCA candidates who received their primary certificates in 2000 are scheduled to undergo a 2005 assessment of their Practice Performance and Improvement (PPI).

MOCA candidates are scheduled for PPI assessment in the fifth and ninth year of the 10-year MOCA program. A satisfactory PPI assessment is a prerequisite to taking the Cognitive Examination. All MOCA candidates undergo a second PPI assessment prior to issuance of the MOCA certificate.

For their PPI assessment, MOCA candidates provide information about their practice of anesthesiology and its subspecialties during the past three years, including the institution(s) at which they practice and the number of days per week, on average, they spend in clinical practice. They inform the ABA about recent practice evaluations and involvement in practice improvement activities. The ABA then solicits attestations from physicians the candidates identify as being familiar with their practice.

In the case of an institution-based anesthesiologist, the ABA seeks attestations from the department chair, chief of staff, or credentials committee chair. If the candidate's practice is office-based, the ABA solicits references from three physicians who refer patients to the diplomate's practice.

The ABA asks that the referee attest that the MOCA candidate has met the ABA's clinical activity requirement. In addition, the ABA asks about evidence of periodic evaluations of the candidate's practice performance and of the candidate's involvement in practice improvement activities.

ABA Directors

Kenneth J. Tuman, MD: *President*

Raymond C. Roy, MD: *Vice President*

Steven C. Hall, MD: *Secretary*

David H. Chestnut, MD: *Treasurer*

David L. Brown, MD

Douglas B. Coursin, MD

Glenn P. Gravlee, MD

Orin F. Guidry, MD

Patricia A. Kapur, MD

Cynthia A. Lien, MD

Mark A. Rockoff, MD

Mark A. Warner, MD

ABA Committee Chairs

Mark A. Rockoff, MD: *Credentials*

Douglas B. Coursin, MD: *Examinations*

David H. Chestnut, MD: *Finance & Strategic Planning*

Steven C. Hall, MD: *Maintenance of Certification*

Raymond C. Roy, MD: *Oral Examination*

Douglas B. Coursin, MD: *Critical Care Medicine Examination*

Steven C. Hall, MD: *Pain Medicine Examination*

Glenn P. Gravlee, MD: *Nonstandard Examinations*

Mark A. Warner, MD: *Research*

Mark A. Rockoff, MD: *Bylaws*

Douglas B. Coursin, MD: *Technology*

ABA Management Team

Francis P. Hughes, PhD: *Executive Vice President*

John Markey, MBA, CPA: *Director, Finance & Administration*

Rhonda J. Oletti: *Manager, Credentialing Services*

Joseph C. McClintock, PhD: *Manager, Examination Services & Research*

Michael R. Rothwell: *Manager, Information Technology*

ABA Information Sessions: 2005-2006

The following special programs will be held to provide information and answer questions about the ABA programs for initial certification and Maintenance of Certification in Anesthesiology® (MOCA™). MOCA is the program that the ABA developed so diplomates with a time-limited anesthesiology certificate could maintain uninterrupted certification status. ABA directors will conduct information sessions in 2005 and 2006, in conjunction with annual meetings of the American Society of Anesthesiologists, the New York State Society of Anesthesiologists and the International Anesthesia Research Society. Following is the schedule for the special programs:

DATE AND LOCATION: Saturday, October 22, 2005, in conjunction with the Annual Meeting of the American Society of Anesthesiologists (ASA) in New Orleans, Louisiana at the Morial Convention Center, Room 243-245.

TIME: 5:30 PM- 6:30 PM

DATE AND LOCATION: Saturday, December 10, 2005, in conjunction with the 59th Post Graduate Assembly in Anesthesiology of the New York State Society of Anesthesiologists (NYSSA) in New York, New York.

TIME: 5:30 PM - 6:30 PM

DATE AND LOCATION: Sunday, March 26, 2006, in conjunction with the 80th Clinical and Scientific Congress of the International Anesthesia Research Society (IARS) in San Francisco, California.

TIME: TBD

At each session, prepared remarks by ABA directors will focus on topics such as:

INITIAL CERTIFICATION

- Comparison of the written and oral examinations, what each is designed to test.
- Specific areas evaluated in the oral examination.
- The mechanism of the oral examination.
- Common problems encountered by candidates in the examination system.
- Common reasons for failure in the oral examination process.

MAINTENANCE OF CERTIFICATION (MOCA)

- The components of the MOCA program.
- Lifelong Learning and Self-Assessment (LL-SA) requirements and CME activities that would be acceptable to the ABA.
- Assessments of Professional Standing and Practice Performance and Improvement.
- Cognitive Examination and the prerequisites for examination.
- Internet-based processes developed by the ABA to facilitate diplomate registration and participation.

The Board hopes you will be able to attend one of these sessions if you have questions or are seeking information about the examination process for initial certification, the oral examination format or content, or the MOCA program.



ABA Stops Using “Board Eligible”

In January 2005, the ABA decided to stop using the term “Board eligible” immediately.

The term has been given diverse meanings by various organizations over the years, and it has lost its usefulness as an indicator of a physician’s status with regard to specialty board certification. The ABA’s decision is consistent with the position of the American Board of Medical Specialties that its Member Boards should disavow the use of the term.

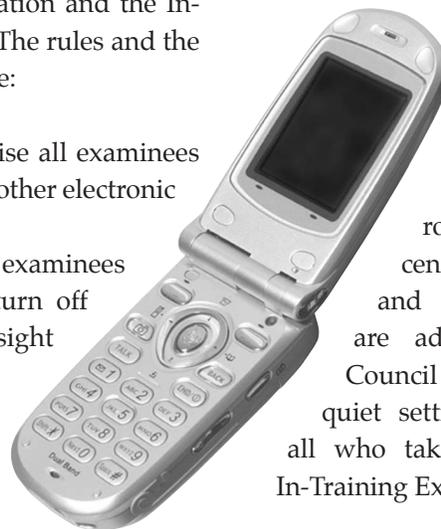
The ABA now reports the standing of an individual with regard to the ABA examination process based on her/his current status in the certification process. In response to an inquiry about a physician’s status, the ABA will only state that the individual is “Certified,” “Not Certified” or “In the Examination Process.”

The ABA reserves to itself exclusively the right to define an individual’s status relative to its examination and certification system.

Turn Electronic Devices Off at ABA Examinations

The ABA and the Joint Council on In-Training Examinations received a number of complaints in 2004 from examinees who were distracted and disturbed during their examination by sounds from cell phones and beepers. The Board and the Joint Council have clarified and strengthened their rules concerning the presence of cellular phones and other electronic devices at test centers where the ABA Written Examination and the In-Training Examination are administered. The rules and the consequences for not abiding by them are:

- The ABA and the Joint Council advise all examinees NOT to bring cell phones, pagers, or other electronic devices with them to the test center.
- The Chief Proctor will instruct examinees before the examination begins to turn off these devices and keep them out of sight during the examination.
- A proctor will collect the examination of any examinee in possession of an electronic device that emits a sound



during the examination and immediately escort the examinee from the test center.

- The examinee’s test will not be scored, there will be no score to report for the examinee, and the examination will constitute an opportunity to pass the ABA Written Examination if the examinee is a certification candidate.

Examinees taking computer-based ABA examinations are required to place all personal belongings in lockers or other secure storage spaces before they are permitted to enter the examination room. There are no such facilities at test centers where the ABA Written Examination and the ABA/ASA In-Training Examination are administered. The Board and the Joint Council expect that these rules will ensure a quiet setting, free of controllable distractions, for all who take the ABA Written Examination or the In-Training Examination.

Misrepresentation of ABA Certification Status

Diplomate status is achieved after considerable work, study, and dedication to achieving high standards of education and practice. Unfortunately a very few individuals have misrepresented their status with respect to certification by way of falsified documents with the ABA registered certification marks. The ABA has and will aggressively defend the integrity of its marks, which may include but

not be limited to available legal and financial remedies, and may place restrictions upon subsequent entrance into its examination system. When the Board has concluded that an individual misrepresented his/her ABA certification status or misappropriated its certification marks for whatever reason, it also shall notify state medical licensure boards known by it to have licensed the individual.

RECOGNITION OF DIPLOMATES' SERVICE AND CONTRIBUTIONS IN 2004

The ABA acknowledges a debt of gratitude to the ABA diplomates who assisted the Board in 2004. Although not ABA directors, they voluntarily contributed their time and energy. The ABA directors truly appreciate their service and are pleased to recognize and thank them for their contributions.

WRITTEN EXAMINATION:

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

Arnold Berry, MD	Jeff Gross, MD	Charles Otto, MD	Mark Rosen, MD
John Cooper, MD	Philip Lebowitz, MD	Patricia Petrozza, MD	John Rowlingson, MD
James DiNardo, MD			

Examination Question Senior Editors:

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

Examination Question Junior Editors:

Joseph Antognini, MD	William Gentry, MD	Barry Kussman, MB, BCH	Meg Rosenblatt, MD
Michael Ault, MD	Timothy Gilbert, MD	Catherine Lineberger, MD	Keith Ruskin, MD
Carolyn Bannister, MD	Stephanie Goodman, MD	Spencer Liu, MD	Randall Schell, MD
Edward Bertaccini, MD	Katherine Grichnik, MD	Thomas Mancuso, MD	Scott Segal, MD
Craig Bonnema, MD	Eric Hanson, MD	Michael Mazurek, MD	John Sullivan, MD
Carl Borromeo, MD	Stephen Heard, MD	James Munis, MD	Paul Ting, MD
Gregory Botz, MD	David Hepner, MD	Kenneth Nelson, MD	Michael Wall, MD
Russell Brockwell, MD	Rosemary Hickey, MD	Dolores Njoku, MD	Paul Ware, MD
John Chow, MD	Jeffrey Jacobs, MD	Mary Njoku, MD	Guy Weinberg, MD
Joseph Cravero, MD	Stacy Jones, MD	Lazarre Ogden, MD	David Wlody, MD
Denise Daley, MD	Judy Kersten, MD	Paul Pagel, MD	Cynthia Wong, MD
Steven Dunn, MD	Jerome Klafka, MD	Manuel Pardo, MD	
Richard Dutton, MD	Allan Kornfeld, MD	Anthony Passannante, MD	

ORAL EXAMINATION:

Candidate Registration and Orientation:

Harry Bird, MD	David Glass, MD	Francis James, MD	E.S. Siker, MD
Robert Epstein, MD	Carl Hug, MD	Lawrence Saidman, MD	

Oral Examiners:

John Algren, MD	Michael Cahalan, MD	John Ebert, DO	Frederick Hensley, MD
John Allyn, MD	William Camann, MD	James Eisenkraft, MD	William Hetrick, MD
Farid Amin, MD	Michael Champeau, MD	Sheila Ellis, MD	Roberta Hines, MD
John Ammon, MD	Gilles Chemtob, MD	John Emhardt, MD	Charles Hogue, MD
Jeffrey Andrews, MD	Grace Chien, MD	Jerry Epps, MD	Jack Isler, MD
Valerie Arkoosh, MD	May Chin, MD	Lucinda Everett, MD	Scott Jellish, MD
Donald Arnold, MD	Cantwell Clark, MD	Brenda Fahy, MD	Richard Kaplan, MD
Douglas Bacon, MD	Miguel Cobas, MD	Eugene Fibuch, MD	Jeffrey Katz, MD
Melinda Bailey, MD	Daniel Cole, MD	David Fish, MD	Jeffrey A. Katz, MD
John Barbaccia, MD	C. David Collard, MD	Joseph Fitzgerald, MD	Barbara Keller, MD
Steven Barker, MD	Neil Connelly, MD	Robert Forbes, MD	Robert Kelly, MD
Richard Bartkowski, MD	Joanne Conroy, MD	Arthur Foreman, MD	Sean Kennedy, MD
Karl Becker, MD	Ryan Cook, MD	Robert Gaiser, MD	James Kindscher, MD
Stephen Bell, MD	Gregory Crosby, MD	Thomas Gal, MD	Charles Kingsley, MD
James Berry, MD	Bruce Cullen, MD	James Gallagher, MD	Eric Kitain, MD
Arnold Berry, MD	Sandra Curry, MD	Thomas Gayeski, MD	Bruce Kleinman, MD
Casey Blitt, MD	Michael D'Ambra, MD	Mark Gerhardt, MD	Jonathan Kraidin, MD
Edwin Bowe, MD	Laurie Davies, MD	Martin Giesecke, MD	Jan Kramer, MD
James Boyce, MD	Fred Davis, MD	Nancy Glass, MD	Elliott Krane, MD
Ferne Braveman, MD	Steven Deem, MD	Michael Goldberg, MD	Rama Kulkarni, MD
Lois Bready, MD	James DiNardo, MD	Salvatore Goodwin, MD	Lawrence Kushins, MD
Morris Brown, MD	Carter Dodge, MD	Joel Gunter, MD	Carol Lake, MD
Sorin Brull, MD	Karen Domino, MD	Alexander Hannenberg, MD	John Lang, MD
Brenda Bucklin, MD	Kevin Donovan, MD	John Hasewinkel, MD	William Lanier, MD
Napoleon Burt, MD	Stevin Dubin, MD	Kenneth Haspel, MD	Charles Laurito, MD
John Byrne, MD	Bryan Dunlop, MD	Joy Hawkins, MD	Robert Leckie, MD

Jacqueline Leung, MD
Michael Licina, MD
Cynthia Lien, MD
Alan Lisbon, MD
Ronald Litman, MD
Keith Littlewood, MD
Spencer Liu, MD
Philip Lumb, MD
Thomas Mancuso, MD
Jonathan Mark, MD
Wayne Marshall, MD
Thomas Martin, MD
Douglas Martz, MD
Aubrey Maze, MD
Jocelyn McClain, MD
Brian McGrath, MD
William McIlvaine, MD
Thomas McLoughlin, MD
Patrick McQuillan, MD
Roger Mecca, MD
Robert Melashenko, MD
Ronald Miller, MD
Christina Mora Mangano, MD
Michele Moro, MD
Stanley Muravchick, MD
Michael Murray, MD

Mary Neal, MD
Joseph Neal, MD
Lars Newsome, MD
Chong Nicholls, MD
Kenneth Niejadlik, MD
Mary Njoku, MD
Mark Norris, MD
Christopher O'Connor, MD
John O'Donnell, MD
Michael Olympio, MD
Charles Otto, MD
William Owens, MD
Ronald Pearl, MD
William Perkins, MD
Gail Pirie, MD
Gerald Piserchia, MD
Susan Porter, MD
Donald Prough, MD
Kang Rah, MD
Thomas Rahlfs, MD
John Rask, MD
David Righi, MD
Peter Rock, MD
Mark Romanoff, MD
Mark Rosen, MD
Henry Rosenberg, MD

Meg Rosenblatt, MD
Carl Rosow, MD
David Rothenberg, MD
John Rowlingson, MD
Roger Royster, MD
Paul Samuelson, MD
Theodore Sanford, MD
Frank Sarnquist, MD
Scott Scharfel, MD
William Schechter, MD
Dawn Schell, MD
Steven Schwalbe, MD
Alan Schwartz, MD
Jeffrey Schwartz, MD
James Scott, MD
Phillip Scuderi, MD
Barry Segal, MD
Joseph Seltzer, MD
Nancy Setzer-Saade, MD
Leslie Shaff, MD
Sam Sharar, MD
James Shear, MD
Robert Sladen, MD
Richard Sommer, MD
Sulpicio Soriano, MD
M. Christine Stock, MD

Richard Stypula, MD
Santhanam Suresh, MD
Daniel Thys, MD
Michael Todd, MD
Kevin Tremper, MD
Christopher Troianos, MD
Donald Tyler, MD
Gregory Unruh, MD
Albert Varon, MD
Susan Vassallo, MD
Christopher Viscomi, MD
Russell Wall, MD
John Waller, MD
Terry Walman, MD
David Warner, MD
Matthew Weinger, MD
Chris Weinlander, MD
Charles Whitten, MD
Richard Wiklund, MD
Mark Williams, MD
Roger Wilson, MD
William Young, MD
James Zaidan, MD
Barry Zimmerman, MD
David Zvara, MD

Test-Writing Committee:

Douglas Bacon, MD
John Butterworth, MD
William Camann, MD
May Chin, MD
Neil Connelly, MD

John Cooper, MD
Karen Domino, MD
John Emhardt, MD
Eugene Fibuch, MD
Robert Gaiser, MD

Nancy Glass, MD
Jack Isler, MD
Cynthia Lien, MD
Philip Lumb, MD
William McIlvaine, MD

Joseph Neal, MD
Christopher Troianos, MD
Charles Whitten, MD
Mark Williams, MD
William Young, MD

CRITICAL CARE MEDICINE EXAMINATIONS:

Examination Committee:

Neal Cohen, MD
Heidi Kummer, MD

Michael Murray, MD

MD Richard Prielipp, MD

David Rothenberg, MD

Test Question Authors:

Timothy Angelotti, MD
Daniel Brown, MD
Jean Charchaflied, MD
Martin De Ruyter, MD

Todd Dorman, MD
Brenda Fahy, MD
Michael Gropper, MD
Jonathon Ketzler, MD

Michael O'Connor, MD
Marc Popovich, MD
J. David Roccaforte, MD
Elizabeth Sinz, MD

Stephen Surgenor, MD
Michael Wall, MD
Joel Zivot, MD

PAIN MEDICINE EXAMINATIONS:

Examination Committee:

Stephen Abram, MD
James Rathmell, MD
Richard Rosenquist, MD

John Rowlingson, MD
Anne Savarese, MD
William Spillane, MD

Santhanam Suresh, MD
Charles Argoff, MD (ABPN)
Misha-Miroslav Backonja, MD (ABPN)

Jon Streltzer, MD (ABPN)
Scott Ross, MD (ABPMR)

Test Question Authors:

Honorio Benzon, MD
Timothy Brennan, MD
Donald Denson, PhD
Gilbert Fanciullo, MD
Naeem Haider, MD
Joel Kent, MD
Jeffrey Koh, MD

Henry Kroll, MD
Stephen Long, MD
T. Phillip Malan, MD
David Martin, MD
Srdjan Nedeljkovic, MD
Karen Park, MD
Jaroslaw Przybyl, MD

Christine Sang, MD
David Sibell, MD
Richard Vaglianti, MD
Gilbert Wong, MD
Misha-Miroslav Backonja, MD (ABPN)
Martin Drooker, MD (ABPN)
Christina Herring, MD (ABPN)

Karin Westlund High, PhD (ABPN)
Bryan Kaplansky, MD (ABPNR)
Raphael Leo, MD (ABPN)
Marco Pappagallo, MD (ABPN)
Walter Strauser, MD (ABPNR)

REVIEW PANEL:

Lois Bready, MD
John Cooper, MD
D. David Glass, MD

Sean Kennedy, MD
Aubrey Maze, MD

Patricia Petrozza, MD
Susan Porter, MD

Myer Rosenthal, MD
Alan Jay Schwartz, MD

COUNCIL FOR THE CONTINUAL PROFESSIONAL DEVELOPMENT OF ANESTHESIOLOGISTS:

Arnold Berry, MD
Joanne Conroy, MD

Leslie Jameson, MD
William Owens, MD

Patricia Petrozza, MD
Meg Rosenblatt, MD

James Steven, MD

Professional Standing Policies

The ABA is one of 24 members of the American Board of Medical Specialties (ABMS). As such, it supports the principles of the ABMS and seeks to adopt policies that conform to ABMS policies and guidelines. The ABMS has indicated it expects all Member Boards to develop and enforce policies that assure individuals certified by Member Boards have professional standing acceptable to the public. In particular, all applicants, candidates and diplomates of ABMS Member Boards must hold an active, permanent and unrestricted license to practice medicine in one jurisdiction of the United States or Canada, and every US and Canadian medical license the physician holds must be free of restriction.

The ABA has adopted these principles and, effective July 1, 2005, will enforce the following policy on Professional Standing:

Individuals with a “severe restriction” on any medical license (considered currently by the ABA as a license that has been revoked, suspended, or surrendered in lieu of revocation or suspension) will not be awarded certification or recertification in anesthesiology or any of its subspecialties while the restriction is in effect. Applicants to the ABA will have their application rejected, candidates will be ineligible to take an ABA examination, and diplomates will be subject to certification revocation.

It should be noted that ABA policy requires all applicants, candidates and diplomates to inform the ABA in writing within 60 days of any restriction(s) placed upon their medical license(s), including “less severe” restrictions (e.g., probation, conditions). Individuals who fail to do this may be subject to additional sanctions. Currently the Federation of State Medical Boards (FSMB) is reporting to all ABMS Member Boards the names of individuals with state medical license restrictions.

For further information, individuals should refer to the ABA Professional Standing Policy in the ABA Booklet of Information which is available on the ABA website (www.theABA.org).

Nonstandard Examinations

The ABA supports the intent of the Americans with Disabilities Act by altering examination conditions as appropriate to accommodate a particular physical or cognitive disability. These accommodations are called nonstandard examinations and most often involve extended testing time for the ABA written or oral examination. ABA policies for Nonstandard Examinations are explained in detail in the ABA Booklet of Information in Section 7.

The ABA’s Nonstandard Examinations Committee reviews each request for a nonstandard examination. The request for accommodation must contain assessments performed by licensed professionals demonstrating that the individual has a disability and that the disability impacts the individual’s ability to take the specific examination (e.g., written or oral) under standard testing conditions. Because disabilities may change over time, the professional assessment must be current, which the ABA defines as within 5 years of the test date. In order to confirm the validity of a request for accommodation, the Nonstandard Examinations Committee frequently obtains one or more outside consultations from licensed professionals who have expertise in disability assessment. The committee then considers and acts upon the data supporting each individual request for accommodations. In order to provide sufficient time to properly evaluate each request for accommodations, the ABA office requires that the request for accommodation be received no later than six months prior to the examination date and that all documentation substantiating the disability be received no later than four months before the examination date.

The experience of the Nonstandard Examinations Committee indicates that candidates requesting accommodations may misunderstand the ABA’s process. One such misunderstanding is a candidate’s (or a candidate’s professional psychologist’s) assumption that a diagnosis of attention deficit disorder automatically qualifies for extended testing time. Many individuals who have this diagnosis do not qualify for extended testing time, because their psychological testing does not show that the disability significantly impacts specific skills needed to take the examination under standard conditions. Another frequent misunderstanding is a candidate’s assumption that previous examination accommodations (e.g., high school or college) automatically deserve accommodation for the ABA examination. The ABA considers each request on its current merits and bases each accommodation decision upon a current professional assessment that may or may not support a previous decision by another testing group to provide accommodation. The possibility also exists that the ABA will provide a greater or lesser degree of accommodation than a previous testing group provided. The ABA’s decisions about examination accommodations may be appealed through the formal review process described in section 6.05 of the ABA Booklet of Information.

Only Electronic Applications

The ABA Electronic Application System (EAS) has proven to be so popular and efficient that the ABA decided to stop accepting paper applications. Effective July 1, 2005, physicians applying for admission to any ABA certification program must use EAS, which is accessible via the ABA web site at www.theABA.org.

The ABA designed EAS to make filing an application quick and convenient. EAS enhancements continue to improve the system. The number of EAS users has steadily increased since the Board introduced EAS six years ago. More than 90 percent of the applicants for primary certification and recertification/MOCA in 2005 used EAS to file their application.

EAS filers enjoy several advantages by submitting an

application via the ABA web site:

- The Board receives the application instantly once it is completed and payment is submitted.
- There is an option to pay the application fee by credit card or by check.
- EAS offers helpful lists from which to select answers and signals you before filing the application if errors have been made.
- EAS provides a legible copy of the completed application, should you want one for your file.

Nevertheless, the ABA will consider written requests to file a paper application that are addressed to the ABA Secretary and include reasons for requesting an exception to this policy.

Changes in ABA Fee Collection Policies

The Board has approved a number of changes in its application procedures and fee collection policies. These changes, which become effective for the 2006 application cycle, are as follows:

- Application for admission to the ABA's examination system(s) must be made using the Electronic Application System, via the ABA website at www.theABA.org.
- The "administrative services fee," which covers the cost of processing examination applications, has been renamed the "application fee."
- The application fee is the only fee that will be collected with an application.
- Examination fees will be collected at the time the candidate accepts an examination opportunity.
- Every fee collected by the Board will be non-refundable.

The Board has reaffirmed its policy of collecting the oral examination fee only after the written examination requirement is satisfied.

These changes reflect the Board's commitment to reducing the financial burden on residents applying for certification and the increasing prevalence and efficiency of transaction-based, electronic commerce.

Complete details on the ABA's application procedures and fee collection policies are available in the February 2005 Booklet of Information, which is available on the ABA website at www.theABA.org.

2006 Application Cycles and Fees

	Begins	Standard Deadline	Late Deadline	Application Fee
Primary Certification	Oct 15, 2005	Dec 15, 2005	Jan 15, 2006	\$550.00
Primary Recertification	Oct 15, 2005	Dec 15, 2005	Jan 15, 2006	\$200.00
Critical Care Medicine and Pain Medicine Certification	Dec 15, 2005	Feb 15, 2006	Mar 15, 2006	\$250.00
Critical Care Medicine and Pain Medicine Recertification	Dec 15, 2005	Feb 15, 2006	Mar 15, 2006	\$250.00

ABA Website Features

The ABA website (www.theABA.org) provides timely information about the Board's specialty and subspecialty certification, recertification and maintenance of certification programs. It includes the latest editions of the ABA Booklet of Information and ABA News, the Board's annual newsletter, as well as announcements of current interest.

Popular website tools include the Online Diplomate Directory, which enables physicians, credentialing verification organizations and the public to verify the certification status of anesthesiologists, as well as the Online Portal, which permits diplomates, candidates and residents to log in and access a number of personalized services on a 24/7 basis. Portal users may:

- Submit address changes electronically.
- Apply for admission to the ABA's examination systems and the Maintenance of Certification in Anesthesiology Program® (MOCA™). Application fees may be paid online by credit card at the time of application or by printing an invoice and mailing it to the ABA along with a check.
- Obtain examination results online. This newest portal feature permits candidates to view their examination results generally one week prior to the date results are mailed.
- Take no-obligation "test drives" of online MOCA systems prior to applying for MOCA, to become familiar with system features and functionality. As an additional service, diplomates may enter Lifelong Learning and Self-Assessment (LL-SA) activities in their online portal accounts whether or not they have applied for MOCA, and print summaries of their continuing medical education activities.
- Print a customized fax cover sheet to use when sending correspondence to the ABA office.

The ABA has many exciting plans for the website in coming years, all aimed at making information and services more readily accessible.

ABA candidates may now obtain examination results online. This newest portal feature permits candidates to view their examination results generally one week prior to the date results are mailed.



ABA ID Number and ABA ID Card

The ABA has assigned a unique 8-digit ABA identification number (ABAIDN) to every record in its database. To introduce the ABAIDN, the Board soon will mail an ABA ID card to every resident and fellow, every applicant and candidate for primary certification, every applicant and candidate for subcertification, and every applicant and diplomate enrolled in the ABA Recertification Program or Maintenance of Certification in Anesthesiology Program®. Diplomates who do not receive an ABA ID card may request one by writing to the ABA office, and they may obtain their ABAIDN by accessing their personal portal account on the ABA website, www.theABA.org.

The card features the ABA address, phone number and fax number on one side, and the individual's name and ABAIDN on the other side. The ABA ID card is the size and shape of a credit card, made of thin Mylar plastic and fits easily in one's wallet.

Why is the Board sending individuals an ABA ID card? It is a handy reminder of your ABA identification number. Why is the ABA using an ABAIDN? To protect your privacy, help prevent identity theft and facilitate interactions between you and the ABA. The ABA has replaced the Social Security

Number (SSN) with the ABAIDN on letters and forms and is phasing out use of the SSN elsewhere in ABA operations. Please be sure to use your ABAIDN on letters, facsimiles and other types of correspondence you send to the ABA.

Your ABAIDN is one way to access your portal account on the ABA website at www.theABA.org and is the key to other functions the ABA plans to make available via its website. For example, the Board has plans for updating its database with information about your CME activities that it receives electronically from CME providers. We plan to deploy this functionality on a limited basis later in 2005, starting with the ASA. When the functionality is operational, diplomates in the MOCA™ program no longer will have to enter ASA-sponsored Lifelong Learning and Self-Assessment activities manually. Unlike self-reported CME, the ABA will accept LL-SA activities submitted electronically by the CME provider without requiring further verification and will automatically award the diplomate MOCA credit for those CME activities.

The Board encourages you to use your ABAIDN whenever you communicate with the ABA and to provide it to the ASA and other CME providers. To do so, you should keep your ABA ID card handy.



2004 Examination Results

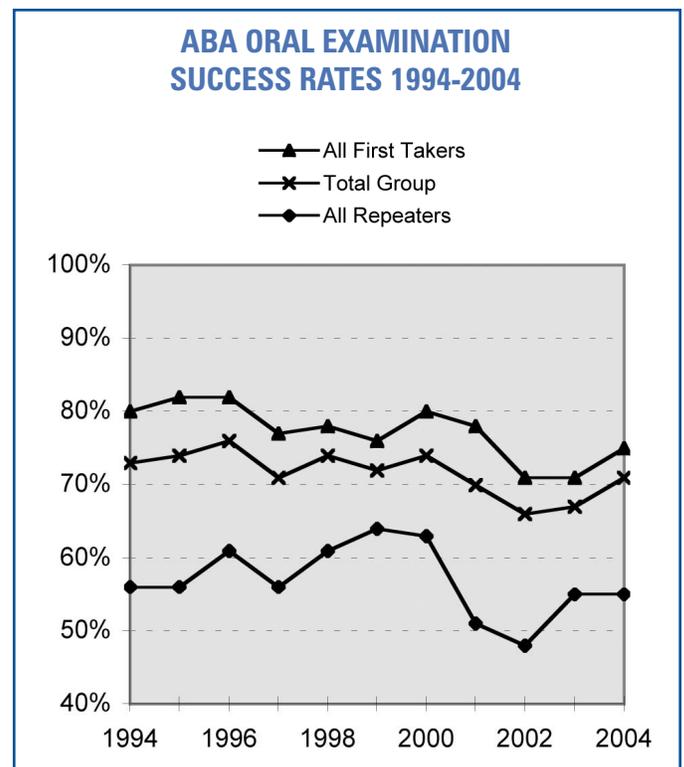
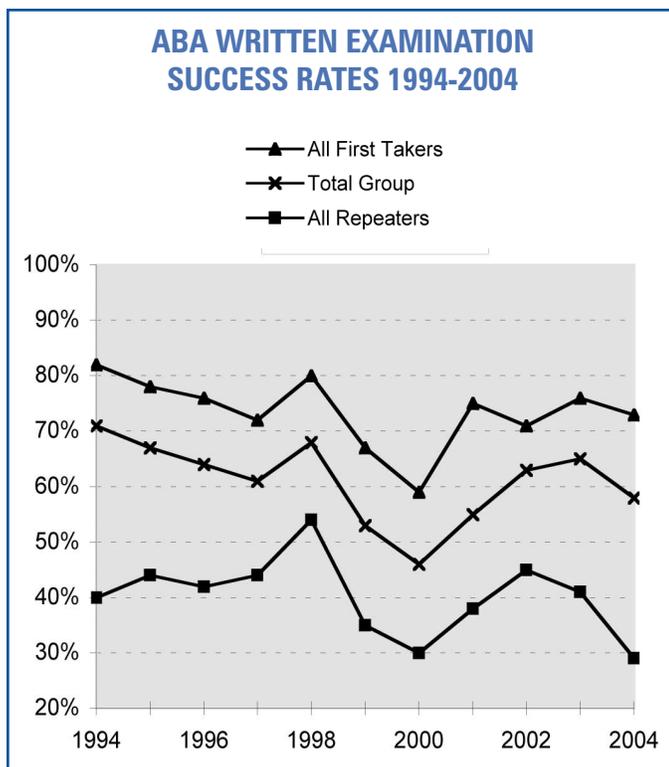
ANESTHESIOLOGY CERTIFICATION

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.

	2000	2001	2002	2003	2004
Written	71%	77%	84%	86%	83%
Oral	83%	81%	81%	79%	84%

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 charts below:

The ABA has certified 37,736 physicians in anesthesiology as of December 31, 2004. Approximately 35,400 diplomates are practicing anesthesiologists.



ANESTHESIOLOGY RECERTIFICATION

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

1999	2000	2001	2002	2003	2004
100%	100%	100%	99%	100%	100%

The ABA has recertified 1838 diplomates in anesthesiology since the inception of the voluntary program in 1993.

The ABA's voluntary recertification program ends in 2009. Thereafter, MOCA™ will be the only option for ABA diplomates who have a need to maintain their certification.

CRITICAL CARE MEDICINE CERTIFICATION

The success rate on recent critical care medicine examinations is as follows:

1997	1999	2001	2002	2003	2004
87%	87%	82%	65%	77%	84%

The ABA has certified 1135 diplomates in critical care medicine since the program's inception in 1986.

PAIN MEDICINE CERTIFICATION

The success rate on recent pain medicine examinations is as follows:

1998	2000	2001	2002	2003	2004
81%	71%	72%	71%	83%	79%

Since the inception of the program in 1993, the ABA has issued 3128 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 2004 success rate was 74 percent.

CRITICAL CARE MEDICINE RECERTIFICATION

The ABA initiated a voluntary CCM recertification program in 2001 for diplomates whose subspecialty certificate is not time-limited. To date, 30 have recertified in the subspecialty.

PAIN MEDICINE RECERTIFICATION

All ABA certificates in pain medicine are time-limited. The ABA has recertified 562 diplomates in the subspecialty since beginning a PM recertification program in 2000.

The success rate on recent pain medicine recertification examinations is as follows:

2000	2001	2002	2003	2004
63%	75%	89%	89%	88%

Upcoming Examinations

- July 9, 2005: Written Examination
- July 9-23, 2005: Computer-administered Examination for Primary Recertification and MOCA™
- Sept 10, 2005: Computer-administered Critical Care Medicine Certification Examination
Computer-administered Pain Medicine Certification Examination
- Sept 17-Oct 1, 2005: Computer-administered Critical Care Medicine Recertification Examination
Computer-administered Pain Medicine Recertification Examination
- Sept 26-30, 2005: Fall Oral Examination in San Francisco, CA
- Apr 24-28, 2006: Spring Oral Examination in Boston, MA

The American Board of Anesthesiology, Inc. Address Change Request

To notify the ABA of a change in your address, you may visit www.theABA.org, or complete the following detachable form and send it via facsimile to the ABA.

First Name	Middle Name	Last Name	Suffix
------------	-------------	-----------	--------

Organization Line 1

Organization Line 2

Address Line 1

Address Line 2

City	State	Postal Code/ZIP
------	-------	-----------------

Have you retired from the practice of anesthesiology? No Yes

Signature	Date
-----------	------

Please send via facsimile to (919) 881-2575. No cover sheet is required.



THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.
4101 Lake Boone Trail, Suite 510
Raleigh, North Carolina 27607-7506