

**A HISTORY OF THE AMERICAN BOARD OF ANESTHESIOLOGY**  
**1938 - 2003**

Myer H. Rosenthal M.D.  
Stanford, California  
Director of the ABA, 1986 – 1998

Francis P. Hughes, Ph.D.  
Raleigh, North Carolina  
ABA Executive Vice-President, 1982-

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## **Forward**

The American Board of Anesthesiology (ABA) approved a plan in 1995 to modify the format and content of the Board's oral examination in 1997 and subsequently to change the grading and decision-making. In 1998, the ABA approved a project to record the changes that have occurred in the administration of the ABA oral examination since the Board's inception. The scope of the project expanded soon after work began to include a history of the Board's first sixty years. This monograph provides an overview of the efforts that culminated in the establishment of the American Board of Anesthesiology. It traces changes in the size and organization of the ABA Board of Directors and the Board's requirements for examination and for certification. A section notes changes over time to the ABA examination system and to the different examinations that comprised it. Primary sources for the monograph were minutes of ABA meetings and the annual ABA Booklets of Information. The recollections of Former ABA Directors, Drs. Al Betcher, William Hamilton, Arthur Keats, Emanuel Papper, Rick Siker and Steve Slogoff and Miss Charlotte Hickcox, former executive secretary of the ABA, provided information when the documentary record was silent. The reader will note that few references are cited throughout the monograph including a number of quotations. This approach was chosen given that the vast majority of information with the exception of the publications cited in the references was provided through thorough review of the minutes of the meetings of the ABA since its inception and the annually published Booklets of Information provided by the ABA.

## **Establishment of the Board**

Certification in anesthesiology had its inception in the United States with the establishment of the Committee on Fellowships by the New York Society of Anesthetists (NYSA) in 1931. The NYSA was formed in 1912 by combining the Long Island Society of Anesthetists, which had been established in 1905, with a Manhattan group of anesthesiologists. Thus the beginnings of organized anesthesiology took its routes with the establishment of the Long Island Society in 1905.

The founding of the NYSA was largely dependant on the efforts of Francis Hoeffler McMechan.<sup>1</sup> As opposed to the relative isolationism of many others involved in attempts at early certification, McMechan was an internationalist and spent much of his career in fostering cooperation between anesthesia organizations across the globe. His efforts led to the founding of the International Anesthesia Research Society (IARS) in 1922. With McMechan's efforts at international certification beginning in 1931, he was seen as a rival to the efforts of the NYSA and thus was opposed by that body as well as the American Medical Association (AMA) and its component body for certification established in 1933, the Advisory Board of Medical Specialties (ABMS). McMechan was successful in establishing the International College of Anesthetists (ICA), which awarded its first certificates in 1935, approximately 1 year prior to those of the Committee on Fellowships. The requirements established by the ICA for certification included

1. Knowledge of the candidate's medical school and type of anesthesia practice.
2. Knowledge of the candidates practice for the past 3 years as well as meetings attended and papers published.
3. Submission of 10 complete records including preoperative evaluation with a discourse on that which was learned from each case.

The NYSA's Committee on Fellowships was incorporated in 1935 in New York. The charter stated that the corporation formed "under and by virtue of the laws of the State of New York - - - the name of which shall be Examining Board, Committee on Fellowship, American Society of Anesthetists or American Board of Anesthesiology." The Committee members were:

William Branhower, MD  
T. Drysdale Buchanan, MD  
E. Leslie Burwell, MD  
Archer C. Bush, MD  
Simon D. Ehrlich, MD  
Bernard H. Eliasberg, MD  
Robert B. Hammond, MD  
George W. Tong, MD  
Paul M. Wood, MD

Its first formal meeting was on July 23, 1935 with Dr. Buchanan as chair and Dr. Wood as secretary. The Committee acted quickly to grant Fellowship to 88 members of the NYSA in 1936, "certifying on record only", a process that was to extend only until January 1, 1937. This organizing committee stated that it was necessary to establish an examining board in anesthesiology because "the basic science for anesthesiology must, of course, stress pharmacology and physiology which, apparently, are less important to the operating surgeon."

The NYSA's Committee met with many obstacles as it attempted to proceed with the Fellowship, including the AMA's reluctance to recognize its objectives based on its perceived representation at the local level rather than its national status. Anesthetists outside New York had already been invited to join the NYSA, and by 1935 members represented 17 states. Recognizing the impediment of the New York identification, the NYSA decided to change its name to the American Society of Anesthetists (ASA). Thus, the NYSA was incorporated in New York as the ASA on December 10, 1936. In its by-laws the ASA stated that the purpose of the Committee on Fellowships was "to protect the public against irresponsible and unqualified practitioners who profess to be specialists in anesthesiology."

The ASA was unsuccessful in these early days in gaining approval from the ABMS to develop a primary Board, as the AMA and most of its component societies referred to anesthetists as "surgeons specializing in anesthesia." Recognizing that the current climate did not favor separate Board status, the Committee on Fellowships decided to open discussion with the American Board of Surgery (ABS) in an attempt to gain recognition within that structure. Representing the Committee, Drs. Ralph Waters and Paul Wood made a presentation to the ABS on January 10, 1937. Following these early discussions, the ABS instructed the ASA to form an "examining board in anesthesiology" and a formal affiliation agreement with the ABS took place on June 2, 1937. In anticipation of this agreement the articles of incorporation of the examining board were filed in New York in 1936. The initial Board was to be composed of nine voting members and a tenth representative from the ABS. An anesthetist from the Board would also attend ABS meetings. These members would be nominated as follows and their nominations approved by the existing Board.

3 by the ASA  
3 by the ABS  
3 by the section of surgery of the AMA

The purpose of the examining board, as defined by the articles and nearly taken verbatim from establishing guidelines of the Committee on Fellowships, was to

1. Establish criteria of fitness to practice anesthesia.
2. Increase educational facilities in medical schools and hospitals, and furnish lists of these together with list of individual instructors who give adequate instruction and training in Anesthesiology.

3. Arrange, control and conduct examinations to determine the qualifications, and grant certificates to those who voluntarily apply and meet these required standards.

The proposed initial Board of Trustees was to be comprised of the following physicians:

T. Drysdale Buchanan - New York City  
Arthur Guedel - Los Angeles  
John S. Lundy - Rochester, Minnesota  
Emory A. Rovenstine - New York City  
Henry S. Ruth - Philadelphia  
Ralph M. Tovell - Hartford, Connecticut  
Ralph M. Waters - Madison, Wisconsin  
Paul M. Wood - New York City  
Philip D. Woodbridge - Boston

Dr. Arthur Elting from Albany, New York was to be the ABS representative. Dr. Buchanan was designated Chairman, Dr. Ruth Vice Chair and Dr. Wood Secretary-Treasurer. The initial Articles of the Board left it to the discretion of the Directors whether there should be 1 secretary-treasurer or 2 separate officers.

Initially the guidelines for implementation designated the following criteria for certification:

1. Medical school graduate
2. Completed internship
3. 2 years training of which 18 months was practical training in anesthesia
4. 2 years of practice solely in anesthesia
5. Member of the AMA or comparative approved national medical society.

This final requirement was a revision of the initial plan of the Committee on Fellowship of the NYSA, which had stipulated that a candidate must be a member of the NYSA.

In the beginning the Board had delineated 4 categories of individuals for certification with ultimate successful application requiring a vote of two-thirds of the ABA and approval by the ABS.

- I. Founders: Professors and Associate Professors previously elected to Fellowship in the ASA - to be certified without examination.
- II. Group A: Those having practiced anesthesia for 15 or more years - must appear before the Board but could be certified without examination.
- III. Group B: Those practicing for 7.5 years or greater with 1500 major procedures - certified following an oral examination.

- IV. Group C: Those satisfying the initial guidelines above and having prepared 150 of their cases for evaluation.

The examination process was to include a

1. Written exam
2. Oral exam
3. Practical exam at the individual's site of practice

In establishing the makeup of the new Board it became clear that Dr. Arthur Guedel could not be certified using any of the 4 categories. Dr. H. Boyd Stewart of Tulsa, Oklahoma replaced him and thus was the composition of the new Board formalized on August 3, 1937. It was not until April 1943, that Dr. Guedel was certified by a mail vote of the existing Board, and he indicated his appreciation for such consideration given that he did not satisfy any of the criteria for inclusion.

In February 1938, The ABMS approved the ABA as a sub-board of the ABS and on March 23, 1938, the State of New York awarded a Certificate of Incorporation to the new Board. The final Articles of Incorporation replaced the 3 appointed members from the ABS with 3 appointed by the American Society of Regional Anesthesia and changed the designation of Trustees to Directors. An initial proposal for appointment of Directors to terms ending December 31<sup>st</sup> of either 1940, 1941, or 1942 for 5-year renewable terms was modified to end on December 31<sup>st</sup> of 1940, 1942, and 1944 for 6-year renewable terms.

The initial Founders group was composed of 40 anesthetists and included all of the Directors. This occurred despite a move to eliminate the category of Founders and to place those individuals in the category within Group A, which would require that they had at least 15 years of 100% practice of anesthesia. Recognizing that this would eliminate consideration of 95% of those proposed as Founders along with a majority of the Directors, including Rovenstine, Wood and Tovell, the ABS rejected the proposal and retained the Founders group as initially designated. The Founders and an additional 6 candidates from Group A were certified on January 1, 1939.

Existing documents are unclear as to whether the first ABA written examination was administered in 1938, or on March 28 or September 9, 1939. Douglas Bacon's exhaustive research indicates that March 28, 1939 was the date of the first ABA written exam and he has included the actual examination in his summary of the establishment of the ABA.<sup>2</sup> ABA records however, indicate that an earlier exam was administered on October 21, 1938, that was similar to the one in 1939 but required more effort by the candidate.<sup>3</sup> The first ABA oral exam was administered by the Directors and 5 guest examiners on October 12, 1939.

In March 1940, the ABMS recommended to the AMA that the ABA become an independent primary specialty board and this was accomplished on February 16, 1941. Also in June of 1940, the AMA created the Section on Anesthesiology, which some historians felt was not merely coincidental with the passing of one of

the AMA's perceived antagonists, Dr. McMechan who died on June 26, 1939. Tragically Dr. Buchanan, whose influence had been paramount in establishing both the Committee on Fellowships and the ABA, died suddenly on March 22, 1940. He was succeeded by Dr. Charles McCuskey as an appointee by the AMA for the period June 9, 1940, through December 31, 1941. With the death of Dr. Buchanan in 1940, Dr. Rovenstine became President of the ABA.

With the establishment of the ABA as a primary board of the ABMS, the initial By-Laws stated the following objectives:

1. To elevate the standard of anesthesiology
2. To familiarize the public with its aims and ideals
3. To protect the public from irresponsible and unqualified practitioner
4. To examine and certify

### **Organization of the Board**

Following its formation and establishment as an independent primary specialty Board in 1941, the ABA continued to be concerned about geographic representation on the Board of Directors. The Board identified one of the positions nominated by the AMA Section on Anesthesia as coming from the western United States and assigned Dr. McCuskey to this seat. The desire for geographic representation and the inability of ASRA to provide nominees led the ABA in 1942 to modify the nomination process and to increase the size of the Board to ten Directors. The ASA and the AMA Section on Anesthesia each would nominate individuals for election to four seats on the Board of Directors, and The New England Society of Anesthesia and the Anesthesia Section of the Southern Medical Society each would nominate individuals for one seat. Of the nine ABA Directors in 1942, Drs. Lundy, McCuskey, Ruth and Tovell were AMA nominees; Drs. Rovenstine, Waters, Wood and Woodbridge were ASA nominees; and Dr. Stewart was the Southern Medical Society nominee. The New England Society of Anesthesia nominated Dr. Meyer Saklad and when he took his seat in 1944, the number of ABA Directors became ten. At that time ASRA became inactive and formally dropped its role as a nominating body.

Dr. Rovenstine's role as President and Director of the ABA was placed in jeopardy in the late forties. He came under investigation by the New York State Society of Anesthesiologists (NYSSA) for alleged advertising practices after a series of articles in the New Yorker Magazine in the fall of 1947 were published dealing with his contributions to the new specialty of anesthesiology.<sup>4-6</sup> The medical establishment at that time felt that these articles were self-serving and self-promoting therefore not consistent with the standards of a medical professional. The NYSSA eventually censured and suspended him, leading to his resignation as an ABA Director on July 19, 1948. Dr. Wood also resigned at that time. Drs. Donald L. Burdick and Frederick P. Haugen replaced them on the Board. Of the original Directors, Drs. Stewart and Waters resigned in 1946, Dr. Woodbridge in 1947 and Dr. Tovell in 1949. They were replaced by Drs. Rolland J. Whitacre and John W. Winter (1947), Curtiss B. Hickcox (1948) and Stuart C. Cullen (1950).

Individuals who resigned their position as an ABA Director were considered Advisory members of the Board. They were invited to all Board business meetings without voting rights until 1949, when the designation was changed to that of Past Director. Past Directors participated voluntarily as examiners even though they were not invited to the Board's business meetings. Years later the designation was changed to Former Director and Former Directors continue to assist the Board at the oral examinations.

At a special meeting in June of 1950, the ABA decided to expand the number of Directors to 11 to provide an odd number for voting purposes. The distribution of nominations was then fixed at 5 for the AMA and 6 for the ASA. Dr. Scott M. Smith was elected to fill the 11th position in 1950. This number of Directors remained unchanged until 1973 when a 12th Director was added because of increased work demands. This number persists to the present.

In the late 1940's and early 1950's conflicts over control of the ABA developed between the ABA and its nominating components, the AMA and the ASA. In 1949, the role of the component societies in the nomination process for ABA directorships was eliminated and all nominations were assigned to the AMA and the ASA. The Southern Medical Society had nominated Dr. Winter to fill Dr. Stewart's term when he resigned in 1946. By the time that term expired in 1949, nominations for the position as well as that of the New England Society had been transferred to the ASA. The ASA refused to nominate Dr. Winter to succeed himself and instead Dr. Harvey C. Slocum was chosen. The ASA also had refused to nominate Dr. Ruth and Dr. Lundy for reelection in 1950 because members had complained over the "heavy-handedness" of some of the Directors and out of concern for the perpetuity of some director positions. The ABA, "in defiance of their wishes", reelected Drs. Ruth and Lundy and insisted that if the ABA so desired, a specific individual should be on the nominating list from either the AMA or ASA. In 1951, a Committee for Liaison with the ABA was set up by the ASA at the request of the ABA in an attempt to resolve differences between the two organizations regarding the appointment of directors and their tenure. Edward B. Touhy was appointed in 1951 to fill the unexpired term of Dr. Ruth, but the AMA did not nominate him for reelection when the term expired in 1955. Of the nine Founding Directors, Dr. Lundy served the longest and his service ended in 1955.

Nomination privileges for the Board had never been given to the ABA itself. On August 12, 1960, the ABA, ASA and AMA approved the creation of a joint nominating committee of the ABA-ASA-AMA. In 1961, this Joint (Triple) Committee was established and provided the ABA with the ability to have more influence over the composition of the Board while maintaining the right of the ASA and the Anesthesia Section of the AMA to nominate for Director positions. Each body was to send 2 representatives with the addition of the President of the ABA as non-voting chair of the committee. Each AMA and ASA representative was allotted 1 vote and the ABA representatives were allotted 2 votes each. The Triple Committee selected 3 nominees per available position, and the ABA elected Directors from the slate of nominees. This mechanism,

which exists unchanged to the present, provides the ABA with more influence over the composition of the Board while maintaining the right of the ASA and the Anesthesia Section of the AMA to nominate individuals for ABA directorship.

Until 1950, the number of 6-year terms to be held by an individual Director was unlimited if nominated and elected. Beginning in 1950, Directors were limited to no more than two 6-year terms and subsequently in 1957 to three 4-year terms.

### **ABA Officers**

The initial by-laws of the Board established the offices of President, Vice-President and Secretary-Treasurer and left to the discretion of the Board the option to separate the latter office. The Board created the office of Assistant Secretary in 1950 and later expanded the position to Assistant Secretary-Treasurer. Dr. Hickcox was first to hold this new office. The Board decided in 1999 to replace the offices of Secretary-Treasurer and Assistant Secretary-Treasurer with the offices of Secretary and Treasurer beginning in 2000.

Expanded activity of the Board led to the creation of an executive secretary position to manage the office and deal with administrative functions. This position has had only two full-time occupants since its inception in 1950 - Ms. Charlotte Hickcox from 1950 through 1979 and Francis P. Hughes, Ph.D. from 1982 to the present. Consideration in the past was given to the appointment of a physician to function in this administrative leadership position. It was decided both in 1974 and again in 1981 that the Board would be better served without long-term individual physician leadership, but rather to persist with rotation of physician direction. The position of Executive Secretary was renamed Executive Vice-President in 1994.

### **The College and the In-Training Council**

The ASA Committee on Fellowships continued to exist throughout the period the ABA was established and approved by the ABMS as a primary specialty board. The Committee provided Fellowship certification as an alternative to Board certification and for those unsuccessful in satisfying the requirements of the ABA either for examination or certification. The ASA changed its name to the American Society of Anesthesiologists in 1945, and two years later replaced the Committee on Fellowship with the American College of Anesthesiologists (ACA). During the ensuing years, the ACA and the ABA conducted their own written and oral examinations, which both organizations developed and administered separately.

Motivated by a desire to explore recertification in anesthesiology, the ABA and ASA established a liaison committee in 1971. The recertification issue was soon abandoned and the liaison committee formed an examination committee with Dr. William Eggers as Chair, which began to consider the feasibility of using the same written examination for the ABA and ACA certification processes. ABA and ACA representatives worked together to develop one examination to serve as the written component for both certifying organizations and to assess the

knowledge of residents during training. To obtain general acceptance and credibility from as many quarters as possible the committee used question writers and consultants representing both the ABA and ACA to develop this exam.

In 1974, the liaison committee recommended the establishment of a permanent examinations committee, and the ABA-ASA Joint Council on In-Training Examinations was established the following year with Arthur S. Keats, MD as Chair. By then, the specialty had come to accept that ABA certification should be the only certification process for anesthesiology. The Joint Council would develop a single written examination to be used in the ABA certification process and to follow the progress of residents in training. The ABA examination would be a subset of the in-training examination. In 1975 and 1976, the examination was administered only to residents in training, with 1,772 participants in 1975 and 2,118 in 1976. After this period of observation, the examination was administered to residents and certification candidates for the first time in 1977. Of the 3,351 participants, 1,542 were ABA candidates.

In 1976, the ASA formally voted to eliminate dual certification as it was "redundant, unnecessary and confusing to the medical and lay public" and instructed the ACA to cease administering a written examination. The last ACA written exam was administered in 1977, and it was that year's in-training examination. The last ACA oral examination was in 1980. The ACA did, however, continue the practice of giving reciprocal certification to Diplomates of the ABA until 1986, at which time the ACA was disbanded.

### **Accreditation of Residencies**

With its establishment in 1937, the ABA had responsibility for approval of residency training and other anesthesiology educational objectives. It approved preceptors as the initial step in the process of program approval until an ABA Diplomate could inspect the program. If the inspection was successful, the ABA approved the residency training program. The growth in the number of ABA-approved programs was dramatic, with 45 by 1943 and 213 in 1950. However, there were only 107 anesthesiology trainees in 1950.

The Board expressed its desire to separate itself from non-resident educational activities in 1948 and in 1949 wrote to encourage the ASA to establish a special course for candidates just prior to the ASA Annual Meeting. This led to the initiation of the Refresher Course Lecture Series in 1950.

The Residency Review Committee (RRC) was created in 1957 to ease the work of the ABA and to share the Board's responsibility for approving anesthesiology training programs with the AMA Council on Medical Education. The RRC was composed of 3 ABA directors and 3 AMA appointees recommended by the ABA. The complete separation of the ABA from the accreditation process occurred in 1981 when the AMA, ABMS and the American Hospital Association (AHA) established the Accreditation Council for Graduate Medical Education (ACGME) and gave it full responsibility for accreditation of internship and residency training

programs. The ABA provided Directors to serve as members of the Residency Review Committee (RRC) and to advise on training requirements. The ABA also retained the right to stipulate the training necessary for admission to its examination and certification system and, thus, continues to exert considerable influence on training programs and their accreditation.

### **ABA Office**

The original office of the ABA was on 5th Avenue in New York City. Upon the election of Dr. Hickcox as Secretary in 1950, the Board office was moved to Hartford Hospital in Connecticut. Subsequently, the Board relocated its office in Hartford to Farmington Avenue (1958) and then to Constitution Plaza (1963). In 1965, the ABA was incorporated in Connecticut. The Board office was moved to Raleigh, North Carolina in 1995.

### **Meetings**

ABA business meetings have always coincided with the Board's spring and fall oral examinations. As the number of candidates increased, so did the Board's examination responsibilities and the need for improving quality control by having Directors audit more examinations. An annual winter business meeting, first proposed in April 1965, was initiated in January 1975. The ABA held its first summer meeting in 1995 as a retreat to reevaluate the oral examination. The Board continues to meet each summer to decompress the business agenda of its spring and fall meetings. Whereas Directors had been elected at the fall business meeting, the advent of the summer meeting allowed this important function to occur without the constraint of the oral examination week.

### **Credentialing and Qualifications**

The major responsibilities of the ABA are setting the requirements for acceptance into the examination system, determining which applicants meet the entrance requirements, and preparing and conducting examinations. At its inception the Board identified the criteria required for admittance to its examination process and for certification as an ABA Diplomate. Appearing in the first ABA Booklet of Information in 1937, these included:

1. Satisfactory moral and ethical standing
2. Membership in the AMA or other medical societies acceptable to the Council on Medical Education and Hospitals of the AMA
3. Practice limited to anesthesia (as stipulated by the ABS)
4. Graduate of a Grade A medical school in the United States or Canada recognized by the Council of Medical Education and Hospitals of the AMA or a graduate of an approved foreign school
5. Satisfactory completion of a minimum of 1 year in an approved internship
6. Duly licensed by law to practice medicine.

In its first *Booklet of Information* the ABA gave notice that after January 1, 1944, three years of post-internship training and an additional three years of practice would be required. However, the 2-year training option was still in effect in 1945; and three years of post-internship training was not fully implemented until May 1986.

At its meeting on June 9, 1940, the ABA began what was to be a continuing refinement of its criteria for training and practice when it identified two pathways for entrance into the examination following medical school and internship.

1. 2 years of approved post-internship training plus 3 years of 100% anesthesia practice
2. 5 years of 100% anesthesia practice.<sup>7</sup>

Candidates who used the first pathway could take the written examination immediately following training, which could be in an approved program or under the supervision of a preceptor approved by the Board. In 1950, the Board allowed candidates to take the written examination upon completion of the internship and two years of clinical anesthesia training.

Training no longer was optional beginning in 1945. Candidates who used the second pathway had to complete five years of full-time anesthesia practice following internship to take the examinations. Full credit was given for military anesthesia practice and training during World War II. Although training no longer was optional, The Board retained the right until 1950 to electively allow individuals into the examination process:

"In exceptional instances the Board may, in its discretion, accept for examination, candidates who have met all the preliminary requirements, and have clearly demonstrated their identity as an anesthetist over a period of years, but whose formal training does not comply with the full requirements to be exacted in the future."<sup>8</sup>

The 100% practice ruling had been instituted in 1938 at the insistence of the ABS. This caused quite a bit of disagreement by the ASA leadership and had resulted in the 1940's and 50's in the removal of several certificates from anesthesiologists whose practice was no longer limited to the specialty. In response to external pressures the Board, in 1957, removed the requirement for 100% anesthesia practice following certification, but retained it as a credentialing requirement to gain admission to the examinations. In April 1960, the Board voted to eliminate the practice requirement but continued to insist on 100% anesthesia participation during residency training.

In 1944, the ABA eliminated the Groups A, B, and C identified at the time of its inception. Consistent with its initial provisions the Board continued to require membership in the AMA or its equivalent, graduation from a grade A medical school and an approved internship.

It is noteworthy that the Board at its meeting in 1948 voted 7 to 2 to insist that anesthesia trainees be taught "the entire scope of perioperative care." As recently as 1997, the Board enunciated clearly and unequivocally that anesthesiology encompasses all aspects of perioperative management.

In 1950, the Board added ASA membership "in good standing" to the requirement of AMA membership. This qualification gained added significance in the Board's deliberations over its attitudes towards involvement of candidates with nurse anesthesia as discussed below. The requirement for membership in local and national societies, existing since the establishment of the Committee on Fellowships in 1931, was eliminated in 1953. 1950 saw the addition of a certification requirement that applicants shall "personally prepare such case history abstracts of personally conducted procedures pertaining to Anesthesiology as the Board may specify." This option was eliminated in 1965.

### **Clinical Competence**

The Board has endeavored to identify competence by means not available in either a written or oral examination since the inception of ABA certification. Early attempts included requiring a practical examination at the candidate's practice location and a survey of the candidate's practice by those familiar with the candidate. It was evident early on that those involved in the training of an anesthesiologist were likely most able to assess competence in the clinical environment and the individual's ability to perform tasks in a safe and satisfactory manner. Therefore, in 1946 the Board began requiring six-month reports by applicants and yearly reports by residency directors or preceptors. This practice continued essentially unchanged until 1975, when the Board introduced the formal Clinical Competence Committee (CCC) evaluation report. Candidates completing 24 months of training after December 31, 1974, had to have on file with the ABA a satisfactory CCC report following 24 months of clinical anesthesia training as a condition of admission to the ABA examination system. In 1977, the Board mandated that program directors file a CCC report in July and January for each resident who began training on or after July 1, 1977, and spent any portion of the preceding six months in clinical anesthesia training. In 1983, the ABA announced that it would grant credit for clinical anesthesia training only to the date of the resident's most recent satisfactory CCC report from the program. The ABA now requires additional training for any resident who receives consecutive unsatisfactory CCC reports for training on or after July 1, 2000.

### **The Three Year Anesthesia Residency**

From its inception, and for almost forty years thereafter, the Board debated the advisability of increasing the anesthesia residency to three years. In its first *Booklet of Information* the ABA announced that, effective January 1, 1944, it would require candidates to have three years of post-internship training in anesthesiology and an additional 3 years of practice; however, the two-year training option was still in effect in 1945. The Board voted in 1957 to increase the training requirement from two years to three years on July 1, 1963, but this

decision was met with great debate and later that same year the Board rescinded the date and indicated that the decision would undergo further consideration.

A survey of teaching hospitals was conducted in 1958. Of the 42 responders, 27 supported the idea of a three -year residency and 15 did not. In September 1958, the Board voted again to increase the anesthesiology training requirement to three years on July 1, 1963 and after July 1, 1965, to admit to the written examination only candidates who had completed three years of post-internship anesthesiology training. The Board further stipulated that after July 1, 1964, those programs offering only two years of anesthesiology training would have their accreditation withdrawn. The Board received considerable written and vocal criticism from program directors and the ASA over this new policy. Led by Drs. John Dillon and Robert Virtue, these individuals raised such alarm that the ABA held a special meeting with program directors in New York City on December 8, 1959, and heard presentations from both sides of the issue. A second similar meeting took place on October 5, 1960. As a result of these meetings the Board rescinded plans for requiring three years of clinical anesthesia training and decided instead to create the third year as an option.

The training pathway for admission to examination remained essentially unchanged, requiring two years of post-internship training and three years of practice until 1962. In that year the ABA informed its constituency that for those taking the written examination for the first time after June 1966, there would be two training paths to certification.

1. Three years of training of which two must be in clinical anesthesia followed by one year of practice
2. Two years of clinical anesthesia training with four years of practice.

The third year of training could be in basic science, pathology, internal medicine, general surgery or one of the anesthesia subspecialties. The Board expanded the third year in 1966 to include research, advanced anesthesia training, basic science or other clinical discipline. With the introduction of these pathways, the Board changed the timing of the written examination, so that candidates completing the first pathway could take the written examination immediately after the three years of training and those completing the second pathway could take the examination after completing the first year of anesthesia practice.

The Board modified the practice requirement in 1966. It granted credit towards two of the four years of anesthesia practice for one year of scientific work performed following the undergraduate degree, or one year of residency training in another medical specialty recognized by ABMS, or a Ph.D. degree in a scientific field. The ABA made further modifications to the practice requirement in 1970, when it granted credit for up to three years of the four years of practice using similar criteria.

During this same period the ABA modified policies concerning acceptable anesthesia and internship training experiences. In 1966, it decided to grant up to six months of credit toward the third year of training for anesthesia experience during the internship. Commensurate with the Viet Nam conflict, military personnel who had completed at least six months of formal anesthesia training could receive credit for military anesthesia experience on an individual basis. The internship year requirement had not changed significantly since the inception of ABA certification even though it underwent some modification to allow anesthesia experience; however, in 1973 the ABA defined the internship to include twelve months of "non-clinical anesthesia" training and renamed it the Clinical Base Year (CBY). Also in 1973, the Board began to refer to the third year or anesthesia training as the "optional year", once again modified the training requirements for certification, and defined the continuum of education in anesthesiology to include:

1. CBY plus 3 years of training; or
2. CBY plus 2 years of training and 2 years of practice.

ABA candidates could receive credit towards the two-year practice requirement for military experience, 5 years of continuous training or practice outside the United States prior to beginning training in the United States or Canada, or similar options as already in place. A candidate with a Ph.D. in a related field could apply to the Board for full credit for the optional year beginning in 1977, as could a candidate with training in another ABMS medical specialty.

In 1984, 47 years after the ABA had first indicated its desire to require three years of anesthesia training following internship, the Board announced that it would require three years of Clinical Anesthesia training in addition to the Clinical Base Year. The Board mandated the optional year as a third clinical anesthesia (CA-3) year for candidates who begin the first Clinical Anesthesia year (CA-1) of training after May 1, 1986. The training expected during the CA-3 year fell into three tracks - advanced clinical anesthesia (ACT), subspecialty anesthesia training (SCT), or clinical science - research (CST), the latter to last for 6 months with the remainder as ACT. Consistent with previous ABA policies, a program director could recommend that the ABA grant a resident up to six months of credit towards the CA-3 year requirement for certification by an ABMS Member Board or a PhD degree in a discipline related to anesthesiology. All candidates for ABA certification had to complete a minimum of 30 months of clinical anesthesia training, including subspecialty training. The ABA fully implemented a three-year anesthesia residency training requirement, post-internship, in 1986.

In 1991, the Board expanded its Clinical Scientist track to include 2 options. In addition to the Clinical Base Year and 30 months of clinical anesthesia training that included 6 months of advanced or subspecialty anesthesia, clinical scientists could do 6 months of research and residents interested in a career as an academic investigator could do 18 months of research.

After studying the impact of CA-3 year credit for non-anesthesia training on examination performance, the Board discontinued the option of credit for ABMS

Board certification or a Ph.D. for residents beginning their CA-1 year after September 1, 1992. However, the Board continues to grant at most 6 months of credit toward the research component of the Academic Investigator option of the CST for a PhD degree in a discipline related to anesthesiology.

### **The ABA and Nurse Anesthesia**

The attempt by Dr. McMechan to establish an international anesthesia certification program derailed, in part, because the qualifications for certification of anesthesiologists did not clearly indicate opposition to the certification of nurse anesthetists (NA) and the physicians who worked with them. The founding Directors of the ABA were quite familiar with organized nurse anesthesia. The ABA stated unequivocally that it credential only physicians, which contributed to its acceptance among those physicians practicing anesthesia. However, organized nurse anesthesia brought pressure, and the American Board of Surgery requested a meeting between the ABA Directors and representatives of nurse anesthesia. The groups met on November 27, 1938, with the goal set by the ABS to have the ABA sanction nurse anesthesia certification. The nursing and ABA representatives were not able to reach agreement and the proposals were quashed, due in part to mutual mistrust and the physician concerns about independent nurse practice. The minutes of several ABA business meetings provide further evidence of the ABA's concern over nurse anesthesia. Beginning in 1941 and for several years thereafter, the Board would invite all Diplomates to a dinner prior to the oral examinations to discuss policies and concerns related to anesthesiology. At such a meeting in June of 1942, the attendees discussed withdrawing certification from those teaching nurse anesthetists; however, the Board decided at that time to not become further involved in issues pertaining to nurse anesthesia. Again in October 1949, several directors indicated their unwillingness to certify physicians involved with nurse anesthesia. When the ABA added the requirement for ASA membership in "good standing" in 1950, it was stated that "if a man signs a nurse's training certificate he is not in good standing in the ASA." After much discussion at a 1953 Board meeting, the directors voted to certify an anesthesiologist from Massachusetts who was training nurse anesthetists. In April 1974, the ABA and other physician anesthesia organizations were becoming increasingly concerned over the progress being made by the American Association of Nurse Anesthetists (AANA) to permit training and certification of nurse anesthetists without physician involvement. In an attempt to minimize the impact of the AANA, the ABA sent a proposal to the ASA President, which expressed the Board's "... willingness to explore the possibility of acting as a certifying and program accrediting body as an alternative track for anesthetists." The AANA was well on its way to gaining official status as the agency to accredit nurse anesthesia schools when, in April 1976, the Board reiterated its offer to "accept responsibility ... for examination and certification of non-physician anesthesia personnel." The Board has remained aloof from involvement with nurse anesthesia since then, leaving the debate to the specialty's political organization, the ASA.

## **Foreign Trained Physicians**

International medical graduates (IMGs) have posed a more difficult dilemma for the ABA over the years. There are at least two facets to the issue: the medical education and background of foreign-trained physicians, and the training and qualifications of foreign-trained anesthesiologists.

International medical graduates have extremely disparate medical backgrounds and qualifications. From its inception, the Board has attempted to assure that only IMGs with a medical education background comparable to that of U.S. educated physicians could gain admission to its certification process. The ABA allowed graduates of AMA-approved foreign medical schools to enter into its examination system from 1937 to 1947. The Board deleted any reference to international medical graduates in its 1947 Booklet of Information and added the option for candidates to be a Diplomate of the National Board of Medical Examiners (NBME).

"An applicant must be a graduate of a Grade A medical school in the United States or Canada recognized by the Council on Medical Education and Hospitals of the AMA, or a Diplomate of the NBME."

The Board revised the requirement in 1951 so that IMGs could be eligible to enter ABA examinations system only if they passed or were eligible to take the NBME examinations. In 1954, the Board stopped accepting graduates of Grade B medical schools for examination and required IMG applicants to be licensed in the state in which they were practicing. The 1956 Booklet of Information stated: "Each applicant . . . must have been graduated from a medical school approved by the Council on Medical Education and Hospitals of the AMA, *or have been screened by organizations acceptable to the Board.* ..." This was the first time Canadian medical graduates were not specifically considered. In 1961, the Board announced that the only screening organizations acceptable to the ABA were the NBME and the Educational Commission for Foreign Medical Graduates (ECFMG), which had given its first examination in 1958. The Board added the Federal Licensing Examination (FLEX) "or any recognized medical licensing body" to the list of acceptable screening organizations for IMGs in 1972.

The ABA said little and made no specific reference to consideration of foreign anesthesia training until April 1969, when the Board adopted and promulgated its first policy directly applicable to foreign anesthesia training. The policy statement acknowledged that the ABA had, in fact, been granting credit towards its training requirement to holders of the English and Canadian Fellowships. It described a two-year investigation by the Board of the certification requirements and processes of the English, Irish, South African, Australian and Canadian Colleges and reported the Board's finding that the certification processes of the Colleges and the ABA were comparable. In light of that finding, the ABA decided to allow entrance directly into the written examination to holders of these fellowships, provided they satisfy all of the other entrance requirements with the exception of training. At the same time the Board stated its feeling that such "dual

certification was neither necessary nor desirable" and discouraged the need for ABA certification by these Fellows. The Board published these findings and policies in the 1970 ABA Booklet of Information.

On October 29, 1969, the ABA received a communication from the Faculty of Anesthetists of the Royal College of Surgeons of England (FARCS) expressing appreciation for the equivalency statement and indicated the same respect for the ABA certification. This, however, did not lead to U.S.-trained anesthesiologists being admitted to Fellowship examinations on the basis of their ABA certification. In 1977, the ABA added the requirement that Fellows of the Faculty of Anesthetists of the Royal Colleges (FFA) must practice anesthesiology or train in anesthesiology in the United States for one year prior to certification. Then, in 1982, the ABA required FFAs, except Canadian Fellows, to complete one year of Clinical Anesthesia training in an ACGME-accredited training program prior to being accepted into the ABA examination system. In 1986, the ABA eliminated a long existing policy of accepting anesthesia training in Canadian programs approved by the Royal College of Physicians and Surgeons and required Canadian FFAs to have one year of training in an ACGME-accredited anesthesiology program in order to be admitted to the ABA examination system. The gradual change in the ABA policy concerning FFAs of the Royal Colleges was due, in no small part, to the failure of those Colleges to grant reciprocal recognition to ABA certification and to admit ABA Diplomates to their certification processes without additional training.

At its January 1993 meeting, the ABA rescinded its Royal College certification policy effective December 31, 1993. The principal reason for the Board's action was the realization that the ABA could not objectively verify the comparability of any other organization's certification requirements with that of the ABA. However, the ABA had assured many FFAs practicing in the United States of the comparability of their FFA certification and had openly discouraged them from seeking dual certification. The Board would acknowledge statements it had made in the past about the comparability of their certification, but in the future it would no longer make any statement about the comparability of their certification and the ABA certificate. In consideration of its past position and the impact of its decision on these individuals and on FFAs who had made plans to train in the United States, the ABA formulated a plan for progressive implementation of the decision to rescind the Royal College Certification policy. The implementation plan had three basic parts:

1. Any FFA candidate desiring certification under the preexisting one-year training option must complete one year of prospectively approved training as a resident in an ACGME-accredited anesthesiology program by August 31, 1995.
2. Alternatively, an FFA candidate may qualify with two years of full-time anesthesiology practice in the United States, the second year of which occurred between January 1, 1992 and December 31, 1995.
3. FFA candidates must apply to take their first ABA written examination no later than January 10, 1997.

The ABA required all foreign-trained anesthesiologists to complete the same continuum of education as U.S. medical graduates (i.e., one year of Clinical Base and three years of Clinical Anesthesia training in ACGME-accredited programs in the United States) beginning with applications for examination in 1998. The ABA continues to accept the Clinical Base Year of training in a Canadian institution that is affiliated with a medical school that is approved by the Liaison Committee on Medical Education (LCME).

### **Doctors of Osteopathy**

The decision of the California state legislature to recognize osteopathic physicians similar to medical doctors influenced the ABA position regarding osteopathic physicians and osteopathic training. The ABA decided in 1971 to give the same status to Doctors of Osteopathy as to Doctors of Medicine and in 1980 to accept Clinical Base training in programs approved by the American Osteopathic Association (AOA). The Board continues to require that all candidates for ABA certification complete the clinical anesthesia training requirements while enrolled as residents in an ACGME-accredited anesthesiology program.

### **Recertification**

In March 1958, the Board began to consider the value of recertification and the potential need to assess the continued competency of its Diplomates. However, no further action was taken. Recertification became a major issue beginning in March 1971, when ABMS began to pressure Member Boards to consider recertification. The ABA was reluctant to join a majority of ABMS Boards and initiate a recertification program, because there was a lack of objective evidence that certification improved outcome and the quality of care or that there was a predictable decrement in knowledge and skill requiring reexamination at a defined period of time. Acquiescing to external pressure, in 1979 the ABA announced its intention to implement recertification beginning in 1984.

The Board continued to deliberate recertification and remained unconvinced about its necessity and value.<sup>9</sup> In 1982, the ABA rescinded its proposal and indicated that it was continuing to study the value of recertification. After concluding that there was a value to recertification, and following meetings with the ASA, the ABA announced in 1990 its intention to develop a voluntary process for Continued Demonstration of Qualifications (CDQ).<sup>10</sup> The CDQ program would "allow ABA diplomates to demonstrate current knowledge and quality of practice for recredentialing where state, local and federal legislation mandates." The ABA offered the first CDQ examination on May 15, 1993. The Board changed the terminology and the name of the certification from CDQ to recertification after the ABMS, in March 1996, approved the ABA application to recertify its diplomates.

The ABA approved a policy of time-limited certification at meetings in 1994 and 1995, and announced its intention to issue only time-limited certificates effective January 1, 2000.<sup>11</sup> The ABMS approved the ABA application to issue time-

limited certificates at its March 21, 1998 meeting. All certificates issued by the ABA on or after January 1, 2000, are time-limited and expire at the end of the tenth year following the successful completion of the certification examination.

The prolonged deliberation of the ABA regarding recertification was a consequence of the consensus of the ABA that insufficient data existed that demonstrated the relationship of board certification and therefore recertification on the quality and superiority of clinical practice of certified compared to non-certified practitioners. Although the validity of structured certification processes as an indication of the quality of practice in the specialty of anesthesiology may still not be scientifically established, literature began to appear that demonstrated enough relevance to the value of recertification such that the ABA felt it proper and appropriate to acquiesce to the encouragement of the ABMS and comply with the insistence that all ABMS Boards adopt formal recertification procedures.<sup>12,13</sup>

### **Subspecialty Certification**

The ABA has also deliberated at length over the value of subspecialty certification. Although consistently unenthusiastic about creating an environment that fostered competition, and unwilling to participate in actions that could lead to unhealthy economic credentialing, the ABA did eventually seek ABMS approval for subspecialty certification in Critical Care Medicine (CCM) and Pain Management (PM).

The Board recognized the primary role of anesthesiologists in establishing the discipline of critical care medicine (CCM) and wanted to assist those with an interest to maintain a viable presence in its practice. The ABA determined that specific designated training in critical care should be a requirement of the continuum of education in anesthesiology and, in 1983, adopted the policy that all candidates must complete 2 months of CCM training during the clinical anesthesia portion of their residency. Effective January 1, 2001, the Residency Review Committee requires all residents to have two contiguous weeks of postanesthesia care experience in addition to 2 months of CCM training. CCM was and remains at present the only time-designated clinical rotation in the continuum of education in anesthesiology.

The ABA also recognized the importance of critical care medicine to the specialty and in 1972 began considering certification in the subspecialty. The Board invited the Society of Critical Care Medicine (SCCM), the ABMS, and other ABMS Member Boards with an interest in the subspecialty to open a dialogue, but ABMS and the other Member Boards were not enthusiastic. In 1977, the SCCM approached ABMS to discuss the possibility of obtaining certification in the subspecialty. In response, the ABA and three other ABMS Member Boards initiated exploratory investigations into both joint and individual mechanisms for subspecialty certification. When discussions about a combined approach to multidisciplinary CCM certification with anesthesiology, internal medicine, pediatrics and surgery foundered, the ABA and the other specialty Boards applied to the ABMS individually for authorization to certify in the subspecialty.

ABMS approved the applications at its March 21, 1985 meeting. The ABA offered its first CCM written examination on September 27, 1986.

The Board's determination to pursue CCM certification for its Diplomates arose from concern that in a multidisciplinary subspecialty anesthesiologists would be placed at a disadvantage and risk exclusion if other specialists could obtain CCM certification and they could not. Similar reasoning motivated the Board to seek certification in pain management. In 1989, the Board notified ABMS of its intent to certify in pain management and had discussions with other ABMS member boards with an interest in the subspecialty. ABMS stipulated that the subspecialty certificate would have to be time-limited and on September 26, 1991, authorized the ABA to issue pain management certificates that expired in ten years. The ABA offered its first pain management examination on September 11, 1993. On March 21, 2002, the ABMS approved the ABA request to change the name of the Pain Management certificate to Pain Medicine.

### **Disabilities**

ABA policy governing examination and certification of physicians with a history of substance abuse and test accommodations for candidates with a documented disability has evolved over the past 30 years. Passage of the Americans with Disabilities Act by the federal government exerted considerable influence on ABA policy.

The Board always has required candidates for certification to hold a license to practice medicine. Because of the growing awareness of the incidence of substance abuse among anesthesiologists and the Board's unwillingness to function as a policing body, the ABA modified the licensure requirement. Since 1973, candidates for ABA certification have to hold a medical license that is unrestricted.

The ABA first published a formal policy on substance abuse in the 1986 Booklet of Information. The policy stated that the ABA would examine a candidate with a history of substance abuse that currently is under control and would defer certification of a candidate with a history of substance abuse until five years after the date of its last evidenced occurrence. When the Americans with Disabilities Act of 1990 (ADA) was signed by President George H. W. Bush<sup>14</sup>, legal counsel advised the ABA to stop deferring the certification of all candidates with a history of substance abuse for the same length of time; instead, the ABA should consider the particular circumstances of the candidate's history of substance abuse and determine whether and for how long to defer an individual's certification. Thus, in 1993 the Board deleted all reference in its policy to the specific length of time certification would be deferred for candidates with a history of substance abuse.

The ABA instituted its policy regarding nonstandard administration of an ABA examination for candidates with a documented disability in 1991. That policy continues to the present time and states that the ABA will make reasonable modifications to the standard testing conditions to accommodate a candidate

with a disability when it determines from the evidence that the nature and severity of the disability significantly impacts the candidate's ability to perform functions required for taking the examination. The ABA does not make modifications to standard testing conditions that impose an undue burden on the Board's assessment programs or fundamentally alter the measurement of skills or knowledge that the program is intended to test.

### **The Examination System**

A number of the Founding Directors of the ABA had been involved in establishing the NYSA Committee on Fellowships, and it is not surprising that the ABA examination system took its direction from plans the Committee on Fellowships had formulated. The Board's examination system began in 1939 and initially had three parts – a written, oral and practical examination. The Board exercised considerable discretion in determining which candidates would be eligible to sit the various examinations and which might be excused from any or all of them.

### **Written Examination**

The first several ABA written examinations were made up of five essay type sections. Each section of the exam had 5 questions that were to take 15 minutes each to answer. The sections for the first several examinations were pharmacology, anatomy, physics and chemistry, pathology, and physiology. To maintain the unbiased nature of the scoring, candidates were given an identification number and instructed not to place their names on the examination book.

There is uncertainty as to the date of the first ABA written examination and the number of questions candidates had to answer. In his paper, Dr. Douglas Bacon reprints the March 1939 examination, which indicates that candidates were required to answer only three of the five questions in each section, and leaves it to the reader to infer that it is the first ABA written examination.<sup>2</sup> There is some evidence from a review of the minutes of the ABA Examinations Committee that the ABA actually gave its first written examination in 1938, and that candidates were to answer each of the questions in every section for a total testing time of 7.5 hours, including breaks.<sup>3</sup> Further, the minutes of the ABA's meeting on April 10, 1940, indicate that the ABA Examinations Committee decided to decrease the testing time and to require candidates to answer only three of the five questions in each section of the written examination. The ABA records are not clear on either issue.

At least three members of the ABA Examination Committee graded a candidate's written examination, and the candidate's test score was the average of the examiners' grades. It is of interest that at this early time the Directors decided on a passing standard (criterion-based standard) rather than one that assured a predetermined pass rate as was to become the practice in future years. The passing criterion for each examination section was a grade of 60% per subject, and the passing grade for the entire examination was set at 75%.

The ABA required candidates with a passing final grade to repeat any sections of the examination that were graded below 60% and candidates with a final grade below 75% to retake the entire exam. If the passing candidate's final grade was less than 80%, the ABA gave a list of the candidate's deficient areas to the candidate's oral examiners to further explore these areas of perceived weakness. The Directors acknowledged that the passing criterion for the ABA written examination likely was far more difficult than those of other specialty boards and felt justified in their attempts to "maintain a high standard."

In 1941, the Examination Committee determined that it needed to obtain more data points to give an accurate assessment of performance. It increased each section to 6 questions and required the candidates to answer 4 in each section. Additionally, to ease the workload of the Examination Committee only one Director graded an examination if his resultant grade was at least 85%. In 1942, the Board reaffirmed 75% as the lowest passing score for the written examination and stopped requiring candidates who were deficient on the oral examination to repeat the written examination.

The number of candidates increased dramatically following World War II, and in 1946 the Board began to ask other ABA Diplomates to assist in grading the written examination. The Examinations Committee determined to replace the essay questions on the written examination with multiple-choice questions, and did so abruptly and with little notification. In January 1948, the ABA offered its first multiple-choice examination with 125 questions. The number of questions increased over the next twelve months to 250 in July 1948 and 300 in January 1949. The multiple choice questions on these written examinations were evenly divided among five categories similar to the essay examination categories.

By 1949, the ABA was administering the examination in 13 locations nationally and had begun to use a normative standard. The Board set the passing or cut score to yield a failure rate of 25%; however, some candidates were "conditioned" and required to repeat the category in which they performed the poorest. For example the results for 1951 showed a failure rate of 25%, a "conditioned" rate of 15.7%, and a pass rate of 59.3%. The ABA discontinued the twice-yearly administration of the written examination in 1950 and to the present administers the examination annually in July. It was Board policy until 1952 to have an ABA Diplomate and a proctor present for all written examinations when the proctor was given sole responsibility for conducting the examination.

The ABA continued to discuss the quality of the written examination and, more importantly, the use of a normative standard with a 25% failure rate. In July 1957 a new format was introduced with 200 multiple choice questions without categorization. Then, with the assistance of the Educational Testing Service (ETS) in Princeton, New Jersey, the ABA began to use a 180-question exam and only a total test score. In 1959, the ABA conducted an equating exercise using items from 1956 and 1957 examinations in an attempt to shift from a norm-referenced to a content-based standard. The ABA changed to a content-based standard for the 1960 and 1961 written examinations and selected 75 of the 180

questions in each examination from earlier examinations for equating purposes. The Board considered the low failure rate on the examinations, 16% and 18% respectively, unacceptable and was uncomfortable allotting so much of the examination for previously used questions. In 1964, the ABA increased the number of questions to 210 and returned to the earlier normative standard with a 25% failure rate in 1965. The Board ended its relationship with the ETS in 1965 and began to get support and consultation for its examinations from the NBME, which persists to the present time.

In order to gain sufficient material the Board began inviting all oral examiners to participate in the writing of questions for the written examination. The ABA Examinations Committee served as the editorial body and prepared the examination. In September 1966, the ABA directors had their first discussion concerning the establishment of an in-training examination to assist programs in monitoring the progress of their residents and evaluating the quality of their training program. The following year the Board voted to proceed with plans for such an examination and to set up a liaison committee with representatives of the AMA, ASA and ABA "to explore the possible methods and techniques" for such an examination. The first meeting for this purpose was on March 2, 1968 with representatives of the Association of University Anesthesiologists (AUA), AMA Section on Anesthesiology, ASA and the Board. After this meeting only the ASA, through the American College of Anesthesiologists (ACA), and the ABA retained any meaningful interest in the project.

At its March 1972 meeting the ABA developed the concept of working with the ACA to produce an "in-service training exam" for all residents that also would be used as the ABA written examination. The Board approved the concept in October 1972, contingent on the ACA discontinuing its certifying examination. With the beginning of the elimination of the ACA in 1974, the ABA and the ASA/ACA formed a committee to prepare an in-training examination for residents. The 1977 in-training examination consisted of 350 items, and for the first time the ABA selected between 220 and 240 of the in-training examination questions as the ABA written examination. The Board set the cut score at 60% of the items correctly answered, and the fail rate among the ABA candidates who were American Medical Graduates (AMG) was 32%.

The ABA and the ASA formed the Joint Council on In-Training Examinations to maintain the input of a diverse cadre of anesthesiologists into the test development process. Each organization appointed four members to the In-Training Council (ITC) and added three adjunct members. All ITC members would be ABA Diplomates, but the ABA representatives did not have to be an ABA Director. The adjunct members became regular members in 1979, and the ITC initiated a formal structure of question writers who were ABA Diplomates. Soon thereafter, the question authors came from the group of ABA Diplomates who had been nominated to be an ABA oral examiner. The ITC eventually established an editorial board to perform the initial screening and editing of submitted questions, and the editors continue to perform that function to the present.

The Board made significant improvements during the 1980's and 1990's to the way in which it set the passing standard for the written examination, analyzed the examination and reported test scores to candidates. The ABA set the examination cut score using a normative standard until the 1980's. In the 1980's, the Board began to equate examinations given in different years so it could use the same passing standard and compare examinee performance from one year to the next. The ABA reported a percent correct score to candidates until 2001 when a standardized score, equated to a benchmark scale, replaced it. The Board used a norm-referenced cut score until 1988. The normative standard produced a fairly constant success rate within the reference group of American medical school graduates taking the written examination for the first time. In the late-1970's and the early-1980's, the cut score was approximately 60% of the test items answered correctly, and the annual success rate in the group was about 70%. Around 1978, the Board began to consider replacing the normative standard with a criterion-referenced standard that was content-based. The Board would set the examination's cut score before the examination was administered, based on expectations the Directors had about candidates answering the test items correctly. The ability of the candidates to meet the content-based expectations, and not the Board's preconceived notions about the percentage of knowledgeable candidates, would determine the success rate for the examination. In 1979, the Directors prospectively increased the cut score to 65% in an attempt to raise the passing standard until a criterion-referenced standard for the examination could be developed, but when informed after the examination was given that the success rate would be unacceptably low, the Board lowered the cut score to its previous level and used equating analyses to apply that cut score to subsequent examinations until it set a content-based standard.

The Board began efforts to develop a content- or knowledge-based standard for the written examination in 1979. The rationale for change was public statements indicating that it would be "mandatory that specialty boards set reproducible standards that are fair to the examinee and still assure the public that a successful candidate is prepared for independent practice." The Board conducted a series of studies in the mid-1980's, in which individual Directors expressed their expectations about the likelihood of success "minimally competent" candidates would have with individual examination items. The Board used the content-based standard for the first time in 1989, and the success rate was higher than it would have been with the normative standard.<sup>15</sup> Using equating analyses, the ABA applied the 1989 knowledge-based standard to written examinations it administered through 1994. The Directors repeated the same standard setting exercise in 1994, and based on the findings of the study the Board raised the knowledge-based standard slightly for the 1995 written examination and subsequent examinations. It plans to repeat the standard setting exercise at intervals in the future and reassess the knowledge-based standard for the ABA written examination.

Since the late 1970's, the In-Training Council has included approximately 100 test items with a good performance history in each year's examination. It does this to make better use of its item pool and for test equating purposes. The

NBME uses the Rasch psychometric model to equate test scores from different administrations of the examination.<sup>16</sup> The equating analyses do not permit the comparison of scores on the in-training examination and the ABA written examination. They do permit the ITC to compare the performance of individual residents and resident cohorts on successive administrations of the in-training examination and the ABA to apply the same passing standard in different years despite fluctuations in test difficulty. The ABA used the Rasch model to apply the 1979 normative standard to written examinations it administered through 1988. The Board and ITC continue to use the model to equate scores on their examinations to a benchmark scale.

The ITC had been reporting an equated scale score for the in-training examination, in addition to the percent correct score, since the early 1990's. In 2001, the ITC stopped reporting a percent correct score for the in-training examination, and the ABA replaced the percent correct score for its written examination with an equated score on a scale that is different from the in-training examination scale. These changes eliminate facile inappropriate comparisons of in-training and ABA test scores and preclude misconceptions about the constancy of the ABA minimum passing standard due to fluctuations in test difficulty.

### **Oral Examination**

Like the written examination, the ABA oral examination has also been a process in evolution. The Board conducted its first oral examination on October 12, 1939, in New York City. Initially, the Directors and a few invited examiners from the Founders group participated in the examination. The Board administered the oral examination biannually the first several years and made numerous changes to the organization of the oral exam as it experimented with a variety of options to best accomplish the task of certification.

At first, candidates were examined in 3 rooms for 10 minutes each, with a two-minute break between each room. There were 2 examiners in each room, 1 of which was a director. The Board gave the examiners, including Directors, certain guidelines and assigned topics to cover. After the topic was covered to the satisfaction of the examiner, the examiner could question the candidates about any subject. A partial list of topics assigned to examiners in 1942 follows:

|      |            |                        |                    |
|------|------------|------------------------|--------------------|
| Drs. | Rovenstine | Chemistry              | Therapeutic Blocks |
|      | Apgar      | Shock                  |                    |
|      | Adriani    | Laboratory Research    |                    |
|      | Beecher    | Respiration            |                    |
|      | Bishop     | Teaching Organizations |                    |
|      | Brace      | Animal Experimentation |                    |
|      | Saklad     | Rectal Anesthesia      |                    |

After a group of 9 candidates were examined, the Directors and "courtesy examiners" met to discuss the examinees' performance. Courtesy examiners

could express their views, but only the ABA Directors graded the candidates. The discussions lasted for twenty-four minutes; then, the examiners proceeded to examine the next group of nine candidates. Candidates received one of three grades: pass, fail or conditioned. A conditioned grade meant the candidate had to repeat the oral examination in 6 months or both the written and oral examinations for a particularly weak candidate. When the ABA Directors could not determine a grade for an examinee, the Board deemed the candidate to be questionable and held a repeat examination at the end of the day, in two rooms for twenty minutes each with two ABA Directors per room. The Board had the right to refuse reexamination to any candidate if it determined that certification was not appropriate. The minutes of Board meetings during this period include evidence that the examiners might discuss factors other than a candidate's examination performance.

Changes in the format of the exam continued through this early era as follows:

- 1939 – 3 rooms, 10 minutes per room, 2 examiners per room
- 1941 – 1 room, 10 minutes, 3 examiners
- 1942 – 9 rooms, 20 minutes per room, 1 examiner per room
- 1943 – 4 rooms, 20 minutes per room, 2 examiners per room

Candidates serving in the armed forces during World War II were not able to return to the United States to take their oral examination, so the Board arranged for them to be examined where they were stationed. Two ABA Directors, Dr. Tovell in Europe and Dr. McCuskey in the Pacific, conducted individual oral examinations for military candidates in their respective theaters of operation. They graded the candidates and reported the outcome to the Board. Stateside, the Board conducted oral examinations in several cities simultaneously with three Directors and "auxiliary examiners" as needed.

Changes continued after the war ended. In October 1946, the Board continued with the format of 4 rooms per examinee with 2 examiners per room and each room lasting 20 minutes. Questionable candidates were reexamined at the end of the day in four other rooms. The Board stopped the practice of reexamining questionable candidates in October 1947.

The Board changed to a percentage score for the oral examination in 1947, and examiners could assign a grade between 0% and 100%. Examiners continued to meet after examining a group of candidates, and "associate examiners" grades were counted for the first time. An average grade less than 60% was an absolute failure. Results for the October 1947 examination were 29 pass, 15 fail and 2 conditioned.

The Director and auxiliary examiner had the same amount of time to question a candidate until 1948, when the Board allotted Directors fifteen minutes and the auxiliary examiner five minutes. The Board reorganized the oral examination schedule and format in 1949. The Directors and 12 associate examiners could examine a maximum of 72 candidates in three days. Candidates were examined in three rooms, the time per room varied from 20 to 30 minutes, there was an

ABA Director and associate examiner in each room, and examiners disqualified themselves if they had personal knowledge of the candidate. The grades were weighted so that the three Directors' grades each counted as one grade and the average of the three associate examiners' grades counted as one grade. The candidate's grade was the average of the four grades, and the Board required a grade of at least 75% to pass the oral examination.

The increasing number of candidates made other changes necessary. In 1950, a Director and a regular associate examiner were present in two of a candidate's three examination rooms and a special associate plus a regular associate examiner were present in the third room. The ABA Examinations Committee invited the associate examiners with little formal discussion until 1951, when a list of potential associate examiners was created and a negative vote by one Examinations Committee member would eliminate a prospective examiner.

Throughout the 1950's the Board attempted to reconcile the need to examine an increasing number of candidates and their desire to have Directors remain directly involved in the examination of every candidate. Although the Board made few changes during this period, it considered a number of suggestions including decreasing the number of examination rooms per candidate to two, increasing the number of examinations per year to three, and increasing the number of days per oral examination to five. The Board would adopt the first and third options in the future when the need to do so became unavoidable.

Examiners continued to assign candidates a grade between 0% and 100% until 1955, when the Board required that grades be recorded in multiples of 5%. In 1956, the Board discontinued the practice of examiners discussing the performance of candidates in the room prior to assigning a grade, and to this day ABA policy requires independent grading by individual examiners. The Board changed its grading policy in 1957 to allow only percent grades of 65, 70, 75, 80, and 85 and to require an average percent grade of 75 for passing. However, there still was discussion at the end of each day to analyze the results for candidates in a "gray zone" with a score of 74% - 76%. In September 1958, the Directors began to audit examiners, and in particular the senior examiner as the Directors did not have the opportunity to examine with them.

In September 1958, the Board experimented with providing a case history, which would be used as a springboard for the initial part of each oral examination session, but decided not to take away the freedom of examiners to examine on topics and issues of their choosing. The Board continued to give examiners instructions and preferred topics through the 1960's. Examiners prepared lists of the topics they covered, and the candidates brought the lists to the examiners in the following rooms for inspection to prevent redundancy in the candidate's oral examination.

The logistics of organizing one week of oral examinations biannually was becoming progressively more difficult as the number of candidates increased. Rather than examining for more than one week or more often than twice a year, the Board elected to investigate the validity of the oral examination results and

whether it was necessary to examine candidates in three rooms, with a pair of examiners per room. At the time of its study the ABA conducted a three-room examination and used the five-point scale that included a grade of 75. In his 1962 publication Carter reported that his analyses of the ABA data demonstrated the validity of the two-room examination was satisfactory.<sup>17</sup>

The Board changed the oral examination format in October 1961. A candidate's examination consisted of two, thirty-minute examinations with two examiners per room. The Board established a formal hierarchy of examiners and placed a director, former director or senior examiner in each examination room with a junior, less-experienced examiner. It introduced a four-point grading scale (70 - 73 - 77 - 80), assigned the same weight to every examiner's grade in the computation of the candidate's average score, and retained 75 as the minimum passing grade. In November 1962, the Board changed the passing standard to average grades greater than 75.0 and eliminated the gray zone, thus making a meeting at the end of the day to discuss candidate results unnecessary. In an effort to determine whether the two-room examination was a reasonable alternative to the three-room examination the ABA had discontinued, in 1969 the Board commissioned the NBME to study the measurement characteristics of the ABA oral examination. Kelley's published report of the findings of the NBME study reassured the ABA that continuing the two-room format was acceptable.<sup>18</sup>

Perhaps due to the influence of the political and social climate of the mid-1960's the ABA initiated an appeals process in September 1966 for candidates who thought that they had performed poorly and that their oral examination was unfair. Without knowing the examination results, a candidate could request a second examination later the same day. The Board reported only the results of the second examination to the candidate and did not consider the results of the first examination in its certification decision. Few candidates used the appeals opportunity, and there is no record of an original decision being reversed. The Board stopped the practice following the April, 1967 examination.

Acting on the belief that some relationship should exist between performance on the written and oral examinations, in October 1968 the Board elected to increase the oral examination score of candidates who had a written examination score above a certain value. Beginning with the October 1969 oral examination, the "value added" system added 0.25 to the oral examination grade of candidates with a written examination grade between 80% and 84% and 1.05 to the oral examination grade of candidates with a written examination grade greater than 84%. The Board eliminated the "value added" system in 1975 after finding that it had little effect on the oral examination results.

The ABA experienced several unusual logistical problems with the conduct of its oral examinations during the 1960's. It became increasingly concerned about frequent instances of prejudicial behavior towards candidates and, on occasion, directors at meeting venues. At its April 1963 meeting the ABA unanimously passed the following resolution:

“Although the Board does not assume any responsibility for travel arrangements nor housing for its candidates, it does request assurance that no candidate will be denied lodging in a hotel and use of its restaurants and other public facilities solely because of his race or religion.”

Because of a strike at the Sheraton Hotel in Philadelphia, the Board had to cancel the examination midway through the October 1963 oral examination week and hold a two-day oral examination for 99 candidates on December 7 and 8, 1963 in New York City.

The Board began a major revision in the oral examination in 1969 to address concern that lack of sufficient structure and uniformity of content, due to the degree of freedom examiners had to choose the topics for the examinations they conducted, threatened the examination's validity and fairness to the candidate. Although some guidance had been provided in assigning topics, the degree of freedom given to examiners had exacted a price in a lack of control by the Directors and a serious dissimilarity to the examinations between rooms. Therefore, the Board began to consider the use of the guided question. For the next 3 years the Directors developed and refined a 20-minute guided question and introduced the format in 1972. The Board gave examiners the case to be discussed and sufficient questions to be asked involving the pre-, intra, and post-operative management of the patient indicated. The Board gave the examinees a brief case history and a brief period of time to consider the anesthetic management of the case prior to entering the room. The same format was used in both of the candidate's rooms. This plan provided for a similar discussion of the same case simultaneously in each examination room.

The senior examiner continued to have freedom to choose topics for questioning during the final ten minutes of the examination session until 1978. Then, the Board introduced identical suggested topics to be used by the senior examiner in each room for the examination session. Although the Board encouraged senior examiners to follow the outline of suggested topics, the very use of the term "suggested" implied that freedom of choice might still exist. To more closely regulate this portion of the exam and avoid examiner preference based on expertise, the Board changed "suggested" to "additional" in 1990 and instructed senior examiners to follow the subject matter provided. The oral examination had become quite structured by this time. Senior examiners had five minutes for preoperative assessment, junior examiners fifteen minutes for intra- and post-operative assessment, and senior examiners ten minutes for additional topics to provide breadth to the examination with questions on most if not all subspecialty areas of anesthesiology. The Board allowed candidates ten minutes between examination sessions to prepare for the next case.

There was little change in the oral examination process for the next several years. Then, in 1995, the board determined to reexamine the format related to the increasing emphasis on a complete role in perioperative management for the anesthesiologist. The Board was concerned that five minutes was insufficient time to cover preoperative evaluation in any depth. The ABA also realized that

the junior examiner rarely, if ever, asked questions on postoperative care during the middle 15 minutes of the session allotted to both intra- and postoperative care. Following a retreat in August 1995, the board reaffirmed that the oral examination is essential to its assessment of those qualities of an anesthesiologist not readily evaluated by a written examination. Moreover, the Board reexamined the then current format as described above and considered a number of options to improve the assessment process. The Board retained the two-room examination with two examiners per room but increased each examination session to 35 minutes and reconfigured the content of each session. The redesigned oral examination format the Board introduced in April 1997 included the following features:

- Session 1: Module A - Intraoperative Management (senior examiner -10 minutes)  
Module B - Postoperative Care (junior examiner - 15 minutes)  
Module C - Additional Topics (senior examiner - 10 minutes)
- Session 2: Module A - Preoperative Evaluation (senior examiner -10 minutes)  
Module B - Intraoperative Management (junior examiner - 15 minutes)  
Module C - Additional Topics (senior examiner - 10 minutes)

The assignments gave senior examiners the first and third modules for a total time of 20 minutes and junior examiners the second module for 15 minutes. The Board felt this new unequal distribution of time was appropriate given the relative experience of the 2 examiners.

As a consequence of its 1995 retreat and careful study during the intervening years, in April 2003 the Board introduced changes to the examiner grading, oral examination score computation and the passing standard. The changes are a significant departure from the past. Every examiner was expected to record three ratings for a candidate – 1 per each module. Examiners were instructed to use a linear four-point rating scale (1, 2, 3, and 4). Candidate scores were computed and equated for differences in content difficulty and examiner grading severity, using a sophisticated, multi-facet measurement model. The Board set a criterion-based passing standard on a benchmark scale developed for the examination. The ABA postulated that these changes would dramatically increase the objectivity of oral examination grading and decision-making.

### **Practical and Survey**

The final components of the examination process also were an outgrowth of the plans put forth by the Fellowship Committee of the NYSA. They were a practical examination and a survey examination. Both were methods to obtain an on-site assessment of the candidate's practice of anesthesiology.

The practical examination was to be an on-site evaluation of the anesthetist's practice including record keeping, conduct, ethical behavior, technical skill and

knowledge. From its inception in 1939, the practical examination was conducted in a subjective and non-uniform manner, with the Board arriving at individual decisions regarding its application to candidates based on familiarity and personal knowledge. This evaluation occurred at the candidate's practice location and included "observation in the operating room, cadaver demonstration of regional blocks and sights for alcohol injection, and procedures for resuscitation, treatment of pneumothorax and clinical experimentation." Additionally, the Board instructed examiners to evaluate the means for the candidate's remuneration and there is reference in documents to a candidate in 1940 whose certification should be withheld because he was "working for a salary." Similarly, the Board instructed examiners to evaluate the candidate's involvement with nurse anesthesia; however, there is no indication as to whether this alone impacted the outcome of the practical examination. Initially, only ABA Directors performed the evaluation, but by 1947 the Board commonly assigned 1 or 2 Diplomates from the candidate's geographic area to conduct the practical examination. The Board was quick to assign the cost to the candidate, particularly when requests came in for overseas evaluation. In 1950, the Board formally declared the practical examination to be at "the Board's discretion" and discontinued it altogether in 1958.

The survey was another method to gain on-site evaluation of the candidate, but it was not meant to replace, or assess the same qualities as, the practical examination. The Board first introduced the survey in 1949-1950 as a means for determining whether the candidate has "high ethical and professional standing." One or more ABA Diplomates conducted the survey when the candidate was at the 4th year of the examination continuum, had practiced the specialty for two years, and would be eligible for the oral examination in one year. A "favorable" report to the Board was a requirement for admission to the oral examination. The Board made the survey optional and at its discretion when it discontinued the practical examination in 1958, and it eliminated the survey altogether in 1977.

### **Reexamination and Reapplication**

It had been ABA policy from the Board's inception to allow every candidate three written examination opportunities and three oral examination opportunities per application, without limit to the number of applications. The Booklet of Information (BOI) has always included the statement: "The Board may, however, at its discretion deny a candidate the privilege of reexamination." In 1953, the Board elected to add the requirement for an additional year of training prior to any reapplication, but still retained the 3-exam rule per application. A major change in the reapplication policy came in 1958, at which time the Board determined that 3 failures in either the written or oral examination would void the application and that no further applications would be acceptable. Thus, the candidate had 3 attempts at the written and/or the oral and that was the extent of their ability to become certified. In 1968, the policy allowing reapplication was reinstated; however, acceptance of reapplication required written certification from the director of an approved program that the applicant received "counsel relative to a course or program of study". In 1973, the ABA allowed reapplication without stipulation, but in 1984 it adopted the policy that remains in effect to the

present . Applicants have to satisfactorily complete one year of training in an ACGME-accredited anesthesiology program or qualify on an entry examination acceptable to the ABA, if they completed the anesthesia residency more than twelve years ago or the ABA previously declared their second or subsequent application void for any reason. The ABA designated the annual in-training examination for anesthesiology residents as the entry examination and determined the minimum passing score on the examination for the purpose of reapplication.

### **Examination Fee Schedule**

The Board sets the fees for application and for reexamination to meet the cost of operating the ABA office and providing examination and other services to residents and program directors, candidates and diplomates. The following chart displays the ABA fees from the Board's inception to 2003.

| YEAR | PRIMARY | REEXAMINATION<br>WRITTEN | REEXAMINATION<br>ORAL | CCM     | PAIN    | RECERT |
|------|---------|--------------------------|-----------------------|---------|---------|--------|
| 1937 | \$50    |                          |                       |         |         |        |
| 1941 | \$75    |                          |                       |         |         |        |
| 1948 | \$100   |                          |                       |         |         |        |
| 1950 | \$125   | \$15                     | \$15                  |         |         |        |
| 1953 | \$125   | \$25                     | \$25                  |         |         |        |
| 1958 | \$150   | \$50                     | \$50                  |         |         |        |
| 1967 | \$175   | \$50                     | \$50                  |         |         |        |
| 1968 | \$175   | \$50                     | \$85                  |         |         |        |
| 1970 | \$225   | \$85                     | \$85                  |         |         |        |
| 1976 | \$325   | \$100                    | \$100                 |         |         |        |
| 1981 | \$450   | \$100                    | \$100                 |         |         |        |
| 1982 | \$450   | \$200                    | \$200                 |         |         |        |
| 1984 | \$650   | \$150                    | \$300                 |         |         |        |
| 1986 | \$650   | \$150                    | \$400                 | \$1,000 |         |        |
| 1989 | \$850   | \$200                    | \$500                 |         |         |        |
| 1992 | \$1,100 | \$200                    | \$700                 | \$1,000 | \$1,000 | \$475  |
| 1997 | \$1,700 | \$400                    | \$1,100               | \$1,000 | \$1,000 | \$700  |
| 2003 | \$2,300 | \$400                    | \$1,500               | \$1,000 | 1,000   | 700    |

### **The Consultant**

The Board's concern over perception of its objectives and the outcome of its decisions has been evident throughout its existence. Careful attention to terminology and wording of all documents and correspondence has been a major objective. In 1976, the Board initiated the use of the term "consultant" to define more clearly its objectives in certifying candidates. The 1976 ABA Booklet of Information included the statement: "The Board intends that its certification reflect evidence of qualification as a physician, and as a specialist and *consultant* in anesthesiology." The Board added to the statement in 1982: "A

*consultant* anesthesiologist possesses adequate measures of knowledge, judgment, clinical and character skills, and personality suitable for patient care and for serving as the leader of the anesthesia care team." In 1988, the ABA expanded the statement to include Webster's definition of a consultant as an "expert with the ability to deliberate with others providing advice and opinions in areas related to the practice of anesthesia including all specialties." By 1995, the Board was interested in advancing the philosophy of the anesthesiologist as perioperative physician and had become concerned that the term "consultant" implied a lack of direct patient care responsibility; therefore, the ABA ceased using the term "consultant" and substituted "a Diplomate of the Board" in its place.

### **Diplomate Attributes**

The ABA began in 1980 to define the attributes it expected of a Board certified anesthesiologist. Initially, the Board identified the following criteria: cognitive knowledge, technical skills, judgment, adaptability, and personal characteristics. It continued to refine the criteria during the next 8 – 10 years to better define for the examiners the attributes the Board designed the oral examination to assess. The Board determined that technical skills and personal characteristics were best assessed by the residency program director and faculty and that knowledge was best measured by the written examination. The ABA designed the oral examination to assess the candidate's ability to: (1) use sound judgment in decision making and management of surgical and anesthetic complications, (2) apply scientific principles appropriately to clinical problems, (3) adapt to unexpected changes in the clinical situation, and (4) logically organize and effectively present information. It instructs oral examiners to use these diplomate attributes as the basis for their assessment of a candidate's oral examination performance.

### **Final Comment**

The American Board of Anesthesiology has since its founding over 60 years ago attempted through continuous and rigorous deliberations to provide the opportunity for its candidates to demonstrate to the public, the medical establishment and regulatory agencies impartial and objective evidence of having successfully achieved recognition as physicians whose training and practice qualifies them as experts in their field as perioperative anesthesia practitioners. This historical review of the course of the Board's development provides evidence for its continuing efforts at refining its policies and procedures in an effort to produce the fairest means of certification while also recognizing its responsibility to insure that its processes reflect a commitment that its Diplomates represent excellence in the medical specialty of Anesthesiology. The purpose of this undertaking was to draw to the attention of both anesthesia specialists and future Directors of the ABA the considerable thought and effort put forth by those who came before and to identify the history of those specific areas that continue to cause reflection and changes in the certifying processes. It is through such an understanding of the past that future deliberations often became more insightful and fruitful as one attempts to achieve positive growth through knowledge of the past and an understanding of the implications for current and future change.

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