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EDITORIAL – HEALTHCARE POLICY AND OUTCOMES

Update on the American Board of Surgery Subspecialty Certificate in Complex General Surgical Oncology

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At the conclusion of my presidential address describing the events that led to a subspecialty certificate in Advanced Surgical Oncology at the 63rd Annual Cancer Symposium of the Society of Surgical Oncology (SSO) in March 2010, I stated: "It is fair to say that the goal is in sight, yet it is prudent to remind ourselves that we have not crossed the finish line yet".[1] 3 years later, I have realized how prophetic that statement was.

The events that followed the submission of a formal request by the American Board of Surgery (ABS) to the American Board of Medical Specialties (ABMS) to establish a certificate for Advanced Surgical Oncology and the subsequent steps that led to its approval by the ABMS have been detailed in a previous editorial.[2] This was an historical event for the discipline of surgical oncology, which was recognized as deserving of a formal training and a unique certificate. This was also a significant moment for the ABS in that this certificate is the first new certificate offered by the ABS in more than 20 years.

The process then continued with the Accreditation Council on Graduate Medical Education (ACGME). The ACGME asked the Residency Review Committee in Surgery (RRC-S) to specify the training requirements for surgical oncology programs. A subcommittee of the RRC-S was established with Drs. Peter Fabri, Mark Wallack, and Thomas Whalen (chair). The SSO was asked to name a representative, and Dr. Russell Berman joined the subcommittee. Once defined, the proposed program requirements were then sent to the GME constituency on February 6, 2012, for the statutory 45-day comment period. After the RRC-S collated and answered all comments received, it submitted the final document to the Requirement Development Committee of the ACGME Board of Directors for review. Finally, the full Board of Directors of the ACGME approved the program requirements at the June 10, 2012, meeting. By the first week in July, both the program requirements and the program information form (PIF) were available on the ACGME Web site.

In recognition of the high quality of program supervision that the Training Committee of the SSO had provided to SSO-accredited programs, the RRC-S, which has oversight responsibility for the fellowships, agreed that current SSO-approved programs would not require a site visit as a part of the initial accreditation review. Non-SSO-approved programs would require a site visit to verify and confirm the information provided in the PIF. In accordance with ACGME policy, programs accredited in the 2012–2013 academic year could request a retroactive effective date of accreditation to July 1, 2012, making graduates of these ACGME-accredited fellowships eligible to participate in the ABS certification process upon graduation on June 30, 2013.

In the meantime, changes also occurred at the ABS. The name of the Surgical Oncology Advisory Council (SOAC) was changed to Surgical Oncology Board. In addition, its composition was defined (Table 1). I was elected the first chair of the Surgical Oncology Board (2011–2012) and was then followed by Dr. Selwyn Vickers, who is currently serving a 2-year mandate. The newly established Surgical Oncology Board decided to award the certificate of Complex General Surgical Oncology to eligible candidates after successfully passing a qualifying examination (QE) and a certifying examination (CE), very much like the process leading to a certificate in surgery. The first order of business therefore became to establish a sizable multiple-choice question bank for the qualifying exam.

In order to expeditiously attend to this task, the Surgical Oncology Board created a group of 12 consultants, two for

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TABLE 1 Composition of the surgical oncology board of the American board of surgery

ABS director representing the SSO
ABS director representing the American board of colon and rectal surgery
Two additional ABS directors with a substantial interest and clinical practice in surgical oncology as evidenced by membership in one of the surgical oncology societies (SSO, AAES, ASBS, AHPBA)
Two SSO representatives, with one being the chair of the SSO training program directors committee
One representative each from the AAES, ABSB, and AHPBA
Executive director of ABS, ex officio

each surgical oncology subdiscipline (Breast: Kelly K. Hunt, MD, and Kimberly J. Van Zee, MD; Colon and Rectum: Alessandro Fichera, MD, and Martin R. Weiser, MD; Endocrine: Herbert Chen, MD, and James R. Howe, MD; Hepato-biliary-pancreatic: Michael Choti, MD, and Sharon Weber, MD; Melanoma, Sarcoma, and Cutaneous Malignancies: Brian J. Kaplan, MD, and Vernon K. Sondak, MD; Upper Gastro-intestine: Martin S. Karpeh Jr., MD, and Antony M. Lowy, MD). This group of consultants met twice in Philadelphia and did an enormous amount of work by phone and e-mail in between the two meetings. At the first meeting, on November 21, 2012, the composition of the QE was discussed, and it was decided to mirror the program requirements established by the ACGME (Table 2). At the second meeting, on April 16, 2012, many items were vetted and approved, sufficient for at least two separate and different QEs.

It is likely that the first QE will be offered in the fall of 2014. A CE would then follow in the spring of 2015. Case scenarios for the CE are now being prepared. As all certificates will be time limited, all diplomats holding such certificates will need to comply with an ABMS-approved MOC program to maintain such certification. The Surgical Oncology Board will define the components of the MOC program once the case scenarios for the CE have been finalized.

TABLE 2 Template composition of the qualifying exam for the certificate in complex general surgical oncology

Two hundred multiple-choice questions divided in:
(1) Surgical management (80 %)
Upper GI (15 %)
Hepato-pancreatic-biliary (15 %)
Colorectal (10 %)
Endocrine (10 %)
Breast (15 %)
Melanoma, cutaneous malignancies, sarcoma (10 %)
Miscellanea (regional therapies, palliation, pain therapy, end-of-life issues) (5 %)
(2) Medical and radiation oncology (10 %)
(3) Patient counseling (5 %)
(4) Clinical research and trial design (4 %)
(5) Community outreach (1 %)

One of the recurrent questions often asked regards the decision against grandfathering—that is, the ability to take a qualifying and a CE without having graduated from an ACGME-approved training program. The issue of grandfathering was debated extensively over a period of years by the SOAC of the ABS as well as by the leadership of the SSO. The position of not allowing grandfathering was reaffirmed on multiple occasions by both groups. This position resulted from two considerations. First, it was thought that surgeons previously trained in surgical oncology fellowships accredited by the SSO might be the logical group to consider for grandfathering, but that it would be difficult to establish a rational basis for restricting the eligibility period to a fixed number of years. Arbitrarily selecting those who trained during the last 5 years versus the last 10 years versus some other length of time could not be rationally defended. On the other hand, restricting eligibility to those who complete an accredited ACGME fellowship would pose no problem in defining the candidate group. Second, it would be difficult to exclude from grandfathering general surgeons who had not done an oncology fellowship but whose practice over a number of years had focused almost exclusively in this area. Defining this group accurately, however, and drawing distinctions among general surgeons who perform little surgical oncology would be arbitrary and divisive, when in fact nearly all general surgeons perform some degree of oncologic surgery. Again, it was thought that it was much more defensible and valid to only provide certification to those who complete an ACGME fellowship of known quality. Although this decision will limit the number of eligible candidates for the certificate and result in slow growth in numbers within our subspecialty, the group will be of uniform quality and training, and their distinction from general surgeons who have not obtained additional training will be clear. It was thought that this decision would significantly enhance the credibility of the new certificate in the long run.

"It is fair to say that the goal is in sight, yet it is prudent to remind ourselves that we have not crossed the finish line yet." Welcoming the first board certified surgical oncologists will be our finish line, probably in a couple of years. Or maybe that will be the "end of the beginning" as our immediate past president, Monica Morrow, entitled her 2013 presidential address.[3] In any event, we are living a historical moment for surgical oncology and the house of surgery.

DISCLOSURE The author declares no conflict of interest.

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