The Remedial Year in the General Surgery Board Certification Process: How Effective Is It?

Christina G. Rehm, MD, and Pamela A. Rowland, PhD†*

*Department of Surgery, Oregon Health and Sciences University, Portland, Oregon; †Dartmouth-Hitchcock Medical Center and Dartmouth Medical School, Hanover, New Hampshire

BACKGROUND: The American Board of Surgery (ABS) intends to assure high standards for knowledge and experience in every graduate from an approved general surgery program. They have gone to great lengths to devise an optimal remediation process for every candidate failing to reach these standards. But what is the effectiveness of the remediation process?

METHODS: ABS data outlined the history and development of the remediation process up to its current form. A core component of this process is a specifically structured additional year of training at selected institutions.

Ten institutions, which were classified as outstanding by the ABS, received a standardized confidential questionnaire to collect data that included the institution's impetus to administer a remedial year (RY), organization of their RY, specific emphasis points, role of advisors, funding, and choice of RY candidates. Each institution was asked to mail a letter to their RY graduates, asking for their participation in a follow-up study aimed at characterizing the failing candidate.

RESULTS: ABS data have been available since 1980. Pass rates for the qualifying written examination (QE) improved steadily from about 63% in 1985 to 78% in 2003. Pass rates for the certifying oral examination (CE) have been consistently around 75% since 1985 with improvement to just above 80% within the last 4 years.

In 1995, a new ABS policy was announced requiring an additional year of structured training with specific elements. For the QE, the general pool pass rates continued their steady improvement. Although the results for RY candidates did reveal a 20% improved pass rate, they were still 30 percentage points lower when compared with the general pass rates. No improvement was noted in the CE results.

In 2003, ABS enacted the latest policy change, which consists of an alternative pathway for QE. The initial experience for 2003 is disappointing. Less than 10 candidates have taken advantage of this alternative, and pass rates have not improved. The policy for CE was changed to allow 5 attempts (up from 3 attempts) in 5 years, and currently it is too early to determine the impact of this change.

Nine of 10 institutions agreed to participate in our study. They identified the essential elements of a successful RY. They also emphasized that CE remediation has to go beyond correction of simple knowledge deficits. And they characterized the ideal candidate for remediation.

No RY graduates agreed to participate in the planned follow-up study to characterize the failing candidate.

CONCLUSION: The RY process seems to have a valid potential if specific conditions are met. We do believe that differentiation is needed between the QE and the CE remedial year programs. Because the CE incorporates rhetorical skills, an emphasis should be placed on public speaking and presentation skills in a remedial year for the CE.

We recommend several possible avenues for consideration: identifying the resident at risk and intervening during residency, incorporating the RY process into the ongoing practice routine of the individual candidate, and actively recruiting participation of candidates in a needs assessment study. (Curr Surg 62:644-649. © 2005 by the Association of Program Directors in Surgery.)

KEY WORDS: remediation, American Board of Surgery, general surgery board certification, the failing general surgery resident, interpersonal and communication skills

INTRODUCTION

The American Board of Surgery (ABS) was founded with the principal objective to certify the education, experience, and knowledge of broadly qualified and responsible surgeons, in the public interest and for the good of the specialty.[1] Although it is explicitly not the intention of the ABS to qualify surgeons for staff privileges in hospitals, the reality is that without board certification, practicing surgery is virtually impossible in most hospitals, except for underserved areas.

The board certification process requires a qualifying written examination (QE) followed by a certifying oral examination

Correspondence: Inquiries to Christina Rehm, MD, VAMC Department of Surgery, PO Box 1034, P3SURG, Portland, OR 97207; fax: (503) 220-3415; e-mail: rehmc@ohsu.edu

0149-7944/05/$30.00
doi:10.1016/j.cursur.2005.02.001

(CE). Board eligibility is achieved only after successful completion of an approved residency. The candidate is awarded 5 attempts within 5 years to pass the QE, followed by 3 attempts within 5 years for the CE to achieve board certification.

Each year, approximately 3% of the initial cohort of applicants exhaust their admissibility without passing either the QE or the CE. This failure constitutes a devastating tragedy not only for the young surgeons, but also for their families, practice, finances, and communities.

Therefore, ABS has developed a remediation process to help these candidates regain their board eligibility.

The purpose of this study is to examine the effectiveness of the remediation process.

METHODS

Data provided by ABS outlined the history and development of the remediation process and described its current form. The most recent process (up to 2003) required a specifically structured additional year of remedial training at selected institutions approved by ABS. The 10 most successful institutions in this remedial year (RY) process, as defined by ABS, were investigated with a standardized confidential questionnaire as to their RY structure and experience (Table 1). Available statistics of the impact of this RY on pass rates were compiled and outlined the developments of the remediation process.

This project was reviewed and approved by the Institutional Research Integrity Office of the Oregon Health and Sciences University.

RESULTS

Data on pass rates for both the QE and the CE are available for 1980 to 2003 (Table 2). For the QE, pass rates improved steadily from about 63% in 1985 to 78% in 2003. For the CE, pass rates have been around 75% since 1985, with improvement to just above 80% in the last years.

Table 3 shows pass/fail rates for the established remediation process during the same time period. Before 1985, this process consisted of regaining board admissibility after obtaining 100 hours of continued medical education (CME) and did not improve pass rates for either the QE or the CE. From 1985 to 1995, an additional year of residency was required, which significantly improved pass rates for the CE (72%), but it did not achieve much for the QE (20% pass rate). These findings resulted in a policy change at the ABS 1995 directors meeting: From now on, an additional year of structured training with specific elements (Table 4) was required at selected ABS-approved institutions. The required structure for this additional year does not differentiate between QE and CE.

Table 3 also shows the impact of this new policy on pass/fail rates. For the QE, the general pool pass rates continued their steady improvement. The pass rates for RY candidates did show 20% improved pass rates, but compared with the general pass rates, they were still 30 percentage points lower. The numbers for the CE are even more disappointing; no improvement occurred.

ABS also estimates that approximately 33 candidates (or 3%) of the initial cohort lose admissibility each year for both the QE and the CE. Out of this pool for the QE, only about 4 to 5 candidates per year (or 14%) complete RY to return for a sixth attempt, and of those, less than 50% pass. A larger percentage of the CE failure pool, 7 candidates (or 23%), return for a fourth RY attempt, but without improved odds at passing.

In 2003, ABS enacted the latest policy change, which con-

TABLE 1. Questionnaire: Essential Data Points

- Characteristics of the program as a general surgery program
- Impetus for offering a remedial year
- Structural components of the remedial year
- Teaching emphasis, if any, on core active and passive required learning elements
- Work load during the remedial year, call obligation, protected study time
- Characteristics of the dedicated remedial year mentor/advisor
- Track record
- Individual recommendations for emphasis points
- Individual assessment and interpretation of the individual success formula

TABLE 2. ABS Examination Results 1980 to 2003

	QE		CE	
Year	**Total #**	**% pass**	**Total #**	**% pass**
1980	1821	54.3%	1351	71.6%
1981	1748	57.6%	1363	77.1%
1982	1633	57.1%	1248	77.2%
1983	1597	59.1%	1182	72.5%
1984	1541	59.7%	1258	73.2%
1985	1612	63.2%	1259	73.6%
1986	1583	63.0%	1241	69.1%
1987	1495	77.2%	1328	73.1%
1988	1562	64.0%	1360	74.0%
1989	1569	66.3%	1284	75.5%
1990	1496	67.4%	1313	74.7%
1991	1434	70.4%	1303	76.1%
1992	1389	73.4%	1330	75.0%
1993	1364	74.3%	1283	78.4%
1994	1347	76.3%	1276	75.7%
1995	1298	79.9%	1239	78.4%
1996	1274	76.6%	1304	78.1%
1997	1300	76.9%	1262	78.2%
1998	1300	78.3%	1241	77.1%
1999	1323	78.3%	1241	80.9%
2000	1296	77.9%	1287	79.6%
2001	1287	78.9%	1267	81.1%
2002	1285	75.0%	1168	83.2%
2003	1268	78.0%	1184	83.0%

Courtesy of the American Board of Surgery.