The goal of the ABOS is to ensure both the public and the broad medical community of the high quality of orthopaedic professionals providing musculoskeletal care for society. Traditionally, we have done this through setting standards for orthopaedic education at the residency and fellowship level, as well as the certification and recertification process. More recently, incorporation of lifelong learning and evidence of practice performance have come to the fore, as the Maintenance of Certification (MOC) process.

As one begins training in orthopaedic surgery after medical school, involvement with the ABOS begins before the orthopaedic trainee is aware of this certifying body. We set standards for orthopaedic education and curriculum development. There was a time when simply specifying duration of training was sufficient requirement for orthopaedic education. Today, we are faced with an environment where “time in the saddle” is not sufficient measure of adequacy of training.

As external forces alter the training environment, we must adapt to ensure competence and quality in our graduating orthopaedic surgeons. Specifically, the work hour limitation and practice supervision have altered the educational experience. This alteration may be for the better, but it has certainly changed residency training. In order to be certain that trainees have acquired the skills and experience necessary to practice independently, requirements for education must be altered. The ABOS is monitoring orthopaedic education and reviewing orthopaedic curriculum and requirements at all levels in postgraduate education.

Once the orthopaedic surgeon has completed training, the Part I written examination tests his or her knowledge base. The written examination has exceedingly high validity and reproducibility. It does not test the skills necessary to practice; it only ensures that the orthopaedic surgeon possesses a basic fund of knowledge which we believe is a necessary requisite to orthopaedic practice. As one might guess, there is a strong correlation between performance on Part I and success in practice, as measured by our oral examination 2 years into practice. As one begins their orthopaedic career, aspects of professionalism, communication, surgical skills and performance review are major determinants of success in the safety, quality, and productivity in practice. The present evaluation of one’s practice by an oral examination, as well as peer evaluation, is our way to measure surgeon competence.

By passing the Part II exam, orthopaedic surgeons demonstrate to the public, payers and regulatory agencies that they are capable of practicing orthopaedic surgery consistent with the standards of our specialty. This is not enough! Continued growth in knowledge and competence, as well as adherence to ethical standards, in an evolving medical environment is mandatory.

Over time, the incremental changes in on-going evaluation of performance have involved the adoption of the recertification process in the mid 1980’s through the maintenance of certification process developed in the last decade. At the present time, our MOC process incorporates peer evaluation and evaluation of performance in practice. The broad environment seeking assurance of our competence of professionals, however, will continue to look for more. In the future, orthopaedic surgeons will be subjected to increased scrutiny from the public and payers in terms of quality, safety and cost. State licensure will be dependent on on-going performance and testing in some manner. Payers, both private and government, will require certification of quality and cost measures as part of one’s reimbursement program.

It is our goal to attempt to synchronize the effort at evaluation of performance in practice quality and efficiency in a way that is most efficient for the practicing orthopaedic surgeon and most valuable for the external constituencies looking for assurance of performance excellence.

While it may seem that the American Board of Orthopaedic Surgery is invading the individual practice environment in which surgeons live and work, creating hurdles to overcome, I assure you that we are working to provide an optimal environment for the development of our profession. As you read this issue of the Diplomate, you will become aware of what we are doing in each of the major areas in which the ABOS is involved. I look forward to further discussion with all of you and assure you that we have the best interests of the public and the profession in mind as we carry out our duties.
The pathway to Board Certification in Orthopaedic Surgery involves the Part I Written Examination, taken after the completion of an accredited Orthopaedic Surgery Residency program and the Part II Oral Examination, taken after two years in the practice of Orthopaedic Surgery. Orthopaedic Surgeons who successfully navigate the application and credentialing processes that allow them to sit for and pass those two examinations become Diplomates of the American Board of Orthopaedic Surgery (“Board Certified”). Certificates awarded prior to 1986 conferred lifetime certification; certificates awarded since that time have been good for 10 years. The ‘recertification’ process began in 1993 and was replaced by the Maintenance of Certification (MOC) process in 2010. Your American Board of Orthopaedic Surgery (ABOS) has been and remains committed to making the MOC process meaningful and value-added for our diplomates and our field. My predecessors and current colleagues on the ABOS have worked tirelessly to find a meaningful process for the continuing board certification of orthopaedic surgeons, while adhering to the directives of the American Board of Medical Specialties (ABMS). The methods of regulation that we develop for our Profession have made and will continue to make a major difference in how we are perceived by other healthcare professionals, by society, and, most importantly, by our patients.

The ABOS is an independent organization with the responsibility to oversee the requirements for both education and certification of orthopaedic surgeons in the United States and Canada. The ABOS is an autonomous body with voting membership in the American Board of Medical Specialties (ABMS). The ABMS is the umbrella organization of the twenty-four legitimate American Specialty Certification Boards. The mission of the ABMS, as stated in its bylaws, is to assist the member Boards in their role in Certification of Physicians. The methods of regulation that we develop for our Profession have made and will continue to make a major difference in how we are perceived by other healthcare professionals, by society, and, most importantly, by our patients.

The ABOS MOC program was developed with input from an AAOS/ABOS Task Force with the goal of compliance with ABMS requirements, representing the interests of the public, and offering a quality improvement model for ABOS Diplomates. The ABOS satisfies each piece of the MOC puzzle in the following ways:

I. Evidence of Professional Standing
   - Licensure Status
   - Admitting Privileges

II. Evidence of Life-long Learning and Self-Assessment
   - Continuing Medical Education
   - Self-Assessment Exams

III. Evidence of Cognitive Expertise
   - A Secure Examination (Computer or Oral)

IV. Evaluation of Performance in Practice
   - Case List Submission
   - Peer Review

This is a process that has been developed by orthopaedic surgeons for orthopaedic surgeons – the ABOS is committed to continuing to review and refine the process to look for ways to make it meaningful, user friendly, and value-added to practicing orthopaedic surgeons. The ABOS will continue to look for new resources that assist orthopaedic surgeons in navigating the MOC process and improving quality of care. This must be done while staying true to the ABOS mission of serving the public and serving our profession.

Several important developments will be of interest to participants in the MOC process. The ABOS welcomes your input in providing insight into ways in which the MOC pathways can be streamlined. Please pay close attention to the topics covered below and help the ABOS in our efforts to make MOC valuable to orthopaedic surgeons and our patients. We are committed to continuing to improve the process so that it is not disruptive to the practice of orthopaedic surgery for our Diplomates, yet allows a reasonable evaluation of continuing competency that will stand the test of scrutiny from outside our profession.

Those Diplomates whose certificates expire in 2017 or later will be required to complete two three year cycles of Continuing Medical Education (CME) and Self Assessment Examination (SAE) credits. Those cycles of CME credits will be due at the 3 year mark and 6 year mark of the 10 year cycle. Plans are underway to require that diplomates complete Patient Communication and Patient Safety CME modules from the American Academy of Orthopaedic Surgeons (AAOS) website – these modules are available at no charge to AAOS members on the Orthopaedic Knowledge Online (OKO) website. Major upgrades have been made in the ABOS information systems and the CME entry process should be a smooth one for Diplomates at this time. The ABOS website has been updated and includes excellent information to allow an orthopaedic surgeon to easily find where they stand in the MOC process. The navigation through the website has been streamlined – please visit www.abos.org regularly to determine where you stand in the MOC process and please call the staff at the ABOS office with any questions.

An important development has been made regarding the Self Assessment Examination (SAE) credits required as a facet of the Part II of the MOC process. The ABOS feels strongly that a portion of the CME requirement involve examinations that are “scored and recorded.” These should not be ‘score as you go’ examinations, but
have a formal scoring process by the CME provider. The ABOS has guidelines that must be met to be approved as qualifying SAE credit. Outside organizations will now be able to submit information to the ABOS concerning their SAE products and receive approval – diplomats should look for that approval when evaluating SAE products and inquire about that approval if it is not readily apparent. This process should allow diplomats a wider array of choices to satisfy the SAE requirement.

Part 4 of the MOC process continues to be a challenge for the ABOS – ideally, this portion of the certification involves some type of quality improvement for the Diplomate, allowing a comparison of an orthopaedic surgeon’s own practice with other like practices regionally and nationally, preferably involving the use of some type of practice standard. This is currently done with the ABOS Peer Review process and also the submission of case lists by the Diplomates. The ABOS is currently working on Practice Improvement Modules (PIMs) that would allow a surgeon to collect data on 10 cases of a particular category, submit that data and evaluate the data compared to other surgeons’ practices. At that point, the surgeon could participate in educational programs and make appropriate practice changes, and then collect another 10 cases to look for improvement. It is this type of self-reflection that captures the spirit of the ‘Performance in Practice’ portion of the MOC process. In addition, the ABOS is looking into other ways for orthopaedic surgeons to satisfy the ‘reflective’ nature of MOC Part IV. Many organizations, both professional and medical, are requiring use of clinical databases in which performance and practice can be analyzed in an effort to improve care and outcome. It is the mission of the ABOS to improve care through such self-reflective instruments as databases, PIMs, or case lists, and we will continue this process. These instruments would allow a diplomat to satisfy Part IV and may become an acceptable alternative to the current submission of a case list. The current goal of the ABOS in this area is to develop guidelines that will allow outside organizations to assist in the development of such instruments.

An area which will be receiving a great deal of attention by both the ABOS and outside organizations is that of ‘participation.’ The question of whether an orthopaedic surgeon is a ‘participant’

(Maintenance of Certification Continued on page 13)
The Recertification Examination is the high stake exam component (part 3) of the four part Maintenance of Certification (MOC) program aimed at lifelong learning and practice improvement. The recertification examination options include 1) a computerized written exam or 2) an oral recertification pathway.

The computerized written pathway has a number of tests available. The general orthopaedic examination consists of approximately 200 questions and covers general clinical material that orthopaedists should know regardless of their area of expertise. Alternatively, there are three specialty practice profile examinations in the area of adult reconstruction, sports medicine and surgery of the spine. These examinations consist of approximately 40% general clinical questions and 60% subspecialty questions. In the area of hand, there is a combined hand examination available only to candidates who hold a CAQ in surgery of the hand. For this exam, there are 80 general orthopaedic questions and approximately 160 CAQ hand surgery questions. Lastly, there is a combined sports medicine examination pathway for candidates who hold a subspecialty certification in orthopaedic sports medicine. This pathway consists of 120 sports medicine questions and 80 general orthopaedic surgery questions.

The sports practice profile examination will end after the 2011 cycle and the combined recertification sports examination will only be available to those with a subspecialty certificate in sports medicine.

In 2010, there were 941 orthopaedic surgeons who took the computer recertification examination. The general orthopaedic exam pass rate was 97%. The subspecialty examination pass rate for adult reconstruction was 98%, 98% for sports medicine and 98% for spine.

The alternative recertification option is the oral pathway. For the orals, the process is similar to Part II of the Boards. The examination is focused on the submitted case list and the Diplomate choses the subspecialty of the exam panel. One hundred and thirty-four orthopaedic surgeons chose this pathway for recertification with a pass rate of 87%.

At www.abos.org, the content of the core orthopaedic knowledge for the recertification examination is listed with general items ranging from 15 to 30%, upper extremity 15 to 30%, lower extremity 35 to 54%, spine 2% and tumor and tumorlike conditions 3-5%. More specific details can be gleaned from this web page under the Maintenance of Certification tab for Diplomates. Diplomates are eligible to take a recertification examination up to two years prior to their expiration date on their certificate provided they have completed the MOC requirements.

The reporting date for MOC case lists and CME/SAE are 15-23 months prior to the computerized test. The application for the computerized test is due MAY 1st, the year PRIOR TO the exam.

PLEASE, visit www.abos.org to familiarize yourself with the deadlines.

### 2011 SCHEDULE
MOC RECERTIFICATION EXAMINATIONS
Applications Closed

General and Practice Profiled Examinations in Adult Reconstruction, Sports Medicine, & Surgery of the Spine: March 1 thru April 30, 2011 at Prometric Testing Centers, Nationwide
Oral Recertification Examinations July 18, 2011 at the Palmer House Hilton, Chicago
Combined Hand Examination September 12-24, 2011 at Prometric Testing Centers, Nationwide
Combined Sports Examination November 3-16, 2011 at Prometric Testing Centers, Nationwide

### 2012 SCHEDULE
MOC RECERTIFICATION EXAMINATIONS
Applications Available: February 1, 2011 Applications Deadline: May 1, 2011*

* Diplomates must have completed the MOC requirements prior to 2011 in order to apply.

### All Recertification Examinations Statistics

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
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<tr>
<td><strong>Examinees</strong></td>
<td>1115</td>
<td>1071</td>
<td>957</td>
<td>1340</td>
<td>1242</td>
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<tr>
<td><strong>Passes</strong></td>
<td>1074 96%</td>
<td>1036 97%</td>
<td>922 96%</td>
<td>1297 97%</td>
<td>1194 96%</td>
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<tr>
<td><strong>Fails</strong></td>
<td>41 4%</td>
<td>35 3%</td>
<td>35 4%</td>
<td>43 3%</td>
<td>30 3%</td>
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### Recertification Examinations Pass Rates

<table>
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<tr>
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<th>2006</th>
<th>2007</th>
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<th>2009</th>
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<tbody>
<tr>
<td><strong>General Clinical</strong></td>
<td>96%</td>
<td>97%</td>
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<td>97%</td>
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<tr>
<td><strong>Adult Reconstruction</strong></td>
<td>95%</td>
<td>99%</td>
<td>99%</td>
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<td>98%</td>
</tr>
<tr>
<td><strong>Sports Medicine</strong></td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>Spine Surgery</strong></td>
<td>96%</td>
<td>93%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>Combined Hand</strong></td>
<td>99%</td>
<td>98%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td><strong>Combined Sports</strong></td>
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<td>98%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td><strong>Oral Recertification</strong></td>
<td>93%</td>
<td>95%</td>
<td>91%</td>
<td>87%</td>
<td>87%</td>
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</tbody>
</table>
The Credentials Committee of the American Board of Orthopaedic Surgery is charged with assessing applicants’ and diplomates’ professional competence and adherence to acceptable ethical and professional standards. In this role, the Credentials Committee routinely receives information about applicants prior to the Part II Oral Certification examination and the Recertification examinations. The Credentials Committee also reviews information pertaining to the committee’s purview received at any time from state licensing boards, the public, or medical professionals.

All diplomates of the ABOS and candidates for ABOS certification must demonstrate evidence of professional standing. A full, unrestricted license to practice medicine (in all state jurisdictions in which applicant/diplomate holds a license) is required.

Practice Performance Assessment also occurs at the time of the Part II Oral examination and Recertification examination. The main tool used for Practice Performance assessment has been the Peer Review form. The Peer Review form is sent out to a number of individuals including orthopedic colleagues, current and former practice partners, residency and fellowship program directors, hospital chiefs of staff in orthopedics, surgery, emergency medicine, radiology, and anesthesiology, operating room nursing supervisors, and heads of orthopedic nursing, each of whom is named by the applicant or diplomate. The Peer Review Form is designed to gain information about how the applicant or diplomate performs in the areas of six main competencies: professionalism (5 questions), communication and interpersonal skills (1 question), patient care and surgical skills (3 questions), practice-based learning and improvement (1 question), systems-based practice (1 question), and medical knowledge (1 question). Candidates waive the right to take action on information provided in good faith on the Peer Review form. The ABOS is indebted to the thousands of ABOS diplomates who complete these Peer Review forms each year. The success of the credentialing process is dependent upon each diplomate’s sincere efforts in this area.

For candidates with certification expiring in 2010 and thereafter, a three-month case list will be required. The case list will be used in several ways in the Maintenance of Certification process, but for the Credentials Committee, the case list will be evaluated as part of the Practice Performance Assessment.

The Credentials Committee routinely meets twice each year to review applicants for the Part II Oral examination and for Recertification. For the 2010 Recertification examination, 1254 applicants were admitted to the examination, 11 were deferred and 1 was denied the opportunity to sit. For the 2010 Part II Oral examination, 705 applicants were admitted, 15 were deferred, 4 were denied the opportunity to sit, and 4 were deferred for a practice site visit. The Credentials Committee also reviewed 7 active certificate holders whose state medical license had been revoked or encumbered with licensure restrictions; the ABOS revoked all 7 certificates. The names of individuals whose license was revoked in 2010 are published below.

The Credentials Committee is indebted to each ABOS diplomate who participates in the peer-review process, which is so important to the public mission of the ABOS.

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**REVOKED CERTIFICATES**

To date, the American Board of Orthopaedic Surgery has revoked the certificates of 59 Diplomates. Listed below are the most recent certificate revocations.

<table>
<thead>
<tr>
<th>Former Diplomate</th>
<th>Last Known City/State</th>
<th>Year Revoked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bernard Z. Albina, MD</td>
<td>Houston, Texas</td>
<td>2011</td>
</tr>
<tr>
<td>Richard Coveney Anderson, II, MD</td>
<td>Newport, Rhode Island</td>
<td>2011</td>
</tr>
<tr>
<td>Gonzalo Antonio Covarrubias, MD</td>
<td>Mission Viejo, California</td>
<td>2011</td>
</tr>
<tr>
<td>Donald Baker Miller, Jr., MD</td>
<td>Scottsdale, Arizona</td>
<td>2011</td>
</tr>
<tr>
<td>Michael Warren Reed, MD</td>
<td>Panama City, Florida</td>
<td>2011</td>
</tr>
</tbody>
</table>
The first thing to notice this year is that the name has been changed from Certificate of Added Qualification in Surgery of the Hand (CAQSH) to Subspecialty Certificate in Surgery of the Hand (SSC-Hand).

The Joint Committee on Surgery of the Hand is composed of appointed representatives from the three parent Boards of Surgery (ABS), Plastic Surgery (ABPS), and Orthopaedic Surgery (ABOS). This committee is charged with developing, administering and setting passing standards for the examination for the Subspecialty Certificate in Surgery of the Hand (SSC-Hand). Each individual Board sets the passing standards for the SSC-Hand when it is used as the Part III secure examination portion of the Recertification process.

In 2010, the SSC-Hand examination was administered during the September testing window as a secure computer based examination in numerous local testing centers, as it has been done since 2003. The computer based test has proven to be both more convenient and economical for those candidates who do not have to lose additional practice days to travel.

Hand Certification Examination:
A total of 88 Hand Surgeons took the Subspecialty Certificate in Surgery of the Hand on examination. Of these, 81 were first-time takers and 7 were Reexaminees. Of those taking the certifying examination, 57 were ABOS Diplomates, 22 ABPS, and 9 ABS Diplomates. For Orthopaedics, this compares with 66 who took the exam in 2009 and 80 in 2008. One hundred sixty-two items were used in the test. Thirty percent of the questions were new to this year’s examination, while the remainder had been used on prior tests. Reliability coefficient and Standard error of measurement demonstrated acceptable results to ensure comparability with previous examinations.

The Joint Committee on Surgery of the Hand reviewed the scores and psychometric data and set the passing score for the 2010 SSC-Hand Certification examination. The Tucker Linear Equating model was used to determine comparable passing scores and to determine changes in examination difficulty and examinee group performance from year to year on the SSC-Hand examinations. A passing score of 66% correct was identified by the Committee representing the three parent Boards. This compares with 68% correct in 2009, and 64% correct in 2008. The overall failure rate for all three Boards’ hand surgeons was 11.4%.

SSC-Hand Recertification Examination:
A total of 179 Diplomates took the SSC-Hand for Recertification via a computer-based test. This included 128 ABOS Diplomates, 37 ABPS and 14 ABS Diplomates respectively. The same examination was administered for both the Certifying and Recertification Examination. Of the ABOS Diplomates, 105 took the Combined Hand Recertification Exam with the Core Orthopaedic Questions for the dual Recertification of both their Orthopaedic Boards and Subspecialty in Hand. Twenty-three Orthopaedic Diplomates recertified the Subspecialty Certificate in Hand only. Performance, equating and scoring were comparable to previous years.
The purpose of this report is to review and update you on Subspecialty Certification in Orthopaedic Sports Medicine. This report will include: 1) A brief history of the process, 2) The current status of Sports Subspecialty Certification, and 3) Future directions including folding the Sports Subspecialty Certificate into the MOC process and the creation of an oral sports recertification pathway.

It is critical for you to know that the grandfather period ends in 2012, so the upcoming 2011 exam will be the last chance for those individuals who did not graduate from an ACGME accredited fellowship to sit for the Sports Medicine Subspecialty Certification examination.

1) Brief History
In 1998, the leadership in Orthopaedic Sports Medicine decided to pursue Subspecialty Sports Certification Status (Hand surgery was approved in the 80’s). After careful deliberations and analysis of scientific surveys, it was determined that Orthopaedic Sports Medicine had “a unique body of knowledge and area of practice” worthy of subspecialty certification. The original application was submitted to the ABOS in 1998 and it was approved in 2000. Then, it was sent to the ABMS (the “mother” board) for approval in 2003. Over the next 4 years, the ABOS and NBME worked on developing an examination that was fair, psychometrically sound, valid, and reflected our “body of knowledge.”

2) Current Status of Sports Medicine Subspecialty Certification
The first examination was given in 2007. Since then, we have completed 4 years of examinations. Each year, the exam consists of approximately 200 questions and is given over a 4 hour time period. Starting in 2010, the exam contains video questions. The content breakdown that was determined to reflect the “body of knowledge” (ie curriculum) of a graduating sports medicine fellow or practitioner is as follows:

- General principles (5%) (Research, study design, statistics, ethics, professionalism)
- Medical aspects of Sports Medicine (20%)
- Musculoskeletal (75%) - Upper extremity (30%), Lower extremity (40%), Spine (5%)

In addition to the usual rigorous psychometric evaluation done with the NBME, the past 4 tests have also undergone a standard setting exercise. This involves having 10 experienced (ACGME accredited fellowship and in practice a minimum of 10 years) sports orthopaedists siting the exam and acting as judges to rate all items and determine passing rates. This exercise was done to further adjust and establish a final passing score. The results of the past 4 exams are listed on this page. Over the past 2 years, the Board has made several changes in the application process to make it more user friendly. A drop-down menu of acceptable Sports Medicine cases was created. Also, a “counter” was created to show the number and type of cases entered. These changes make it easier for the applicant to record acceptable Sports Medicine surgical and non-surgical cases. The minimum number of Sports Medicine cases required to sit the exam is 125. One hundred and fifteen of the 125 are surgical (75 arthroscopies) and 10/125 are non-surgical cases.

3) Future Directions
A critical goal of the subspecialty certification process is to make it consistent with the Subspecialty Certification in Surgery of the Hand (formally Certificate of Added Qualification or CAQ) and the MOC process. With this in mind, in 2009, the Board approved the following proposal:

“Those individuals who pass the Sports Medicine Subspecialty Certification Exam will be eligible to sit a combined pathway examination to satisfy Part III MOC requirements when the Diplomate is eligible to apply for recertification of the primary certificate.”

The primary orthopaedic and subspecialty certificates will then have the same expiration dates. The Combined Sports Examination satisfies Part III of the MOC requirements. It is 200 questions in length and will consist of 120 questions from the Sports Medicine Subspecialty Examination pool and 80 questions from the General Orthopaedic Exam pool. The first Combined Sports Examination was given this past year from November 4-17. Sixty-three candidates took the examination.

(Subspecialty Certificate in Orthopaedic Sports Medicine Continued on page 13)

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### Subspecialty in Orthopaedic Sports Medicine Statistics

<table>
<thead>
<tr>
<th>Year</th>
<th>Examinees</th>
<th>Passes</th>
<th>Fails</th>
</tr>
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<tbody>
<tr>
<td>2007</td>
<td>587</td>
<td>529</td>
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<td>2009</td>
<td>322</td>
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</tr>
<tr>
<td>2010</td>
<td>419</td>
<td>365</td>
<td>54</td>
</tr>
</tbody>
</table>

For the Combined Sports Exam schedule, see page 4.
A key mission of the ABOS is to certify the expertise, knowledge, judgment, and skills of orthopaedic surgeons through the Part I Certification Examination. The examination is designed as the first part of a two-stage process to provide a fair and accurate assessment of the ability of surgeons trained in orthopaedics to provide the highest quality, state-of-the-art care to members of the public. The examination was developed through the active oversight of the 2009-2010 Written Examination Committee. Dr. Regis O’Keefe served as chair, and the committee members included Drs. Albanese, Anglen, Baumhauer, Emery, Ezaki, Harner, Haynes, Herkowitz, Kasser, Luck, Marcus, Marsh, Martin, Thompson, Weinstein, and Vail. A special thanks goes to Dr. Richard Haynes and Dr. James Luck who are retiring from the WEC.

The 2010 Written Certification Examination was created through the work of over 70 orthopaedic surgeons practicing throughout the United States. These surgeons represent all disciplines and subspecialties within orthopaedic surgery. The process of creating the 2010 examination began two years earlier during the summer of 2008, when the members of the Question Writing Task Force were provided with their question writing assignments. Eight more steps followed: 1) Examination questions were submitted to the National Board of Medical Examiners (NBME) in December 2008; 2) NBME staff edited and categorized examination questions into one or more of 18 subcategories. 3) Questions were returned to the question writers for additional review prior to the meeting; 4) The Question Writing Task Force convened in Philadelphia for a review of all of the questions. Approved questions received final edits and were entered into an item library at the NBME. 5) In November 2009 the Field Test Task Force met in Chicago to review and approve questions tentatively selected for the 2010 examination. 6) The NBME assembled the proposed examination, with attention to broad representation of all areas of orthopaedic practice. 7) In February 2010 the ABOS Written Examination Committee met and discussed and approved each examination question selected for the examination. 8) In March 2010 the Chairman of the Written Examination Committee and the Executive Director reviewed the proofs and gave final approval to the examination.

Eligibility for the Part I Certifying Exam requires that candidates complete an ACGME accredited orthopaedic residency that includes 51 of 60 months of clinical training. Canadian residents that have passed the Royal College of Physicians and Surgeons Examination are eligible for ABOS Part I examination. A third pathway is the scholar track whereby a foreign trained orthopaedic surgeon may seek approval to take the Part I examination following a total of five years of clinical orthopaedic experience at a US academic center.

Prospective candidates are encouraged to register for the examination soon after receiving their scheduling permits so as to maximize the chance that they will be assigned to the test site of their choice. The registration process requires candidates to complete an ABOS-sponsored tutorial that familiarizes candidates with the examination format. The 2010 examination was designed with 7 separate test blocks. Blocks 1-6 each had 52 questions with 75 minutes for completion. Block 7 had 15 questions and a total of 30 minutes for completion. There is 40 minutes of break time during the examination.

2010 ABOS Part I Certification Examination was held on July 8, 2010. This was the second year that the examination was presented in a computerized format. The computerized examination allows the inclusion of multimedia questions that include explorable CT/MRI scans, arthroscopy videos and physical exam videos. More than 170 Prometric Test Sites were used across the United States and Canada. A total of 779 examinees initiated the examination and all candidates completed the examination. 684 candidates took the examination for the first time while 95 candidates were repeating the examination due to prior failure.

The 2010 examination consisted of 312 questions. The members of the Written Examination Committee performed a key validation process and 8 items were invalidated. Thus a total of 304 questions were used to score the examination. In August 2010 the ABOS Written Examination Committee convened to review in detail candidate performance on the examination and to set a passing standard based upon the distribution of scores and a detailed psychometric evaluation of the test. The candidates were notified of their results in September 2010.

The passing standard for the 2010 examination was set at 1.12 logits. The examination is designed to provide candidates with the same opportunity to pass the examination each year. In order to judge the difficulty of the test and to assess the performance of candidates relative to other years, the examination contains a set of previously used examination questions. Each of these questions has detailed statistics from previous examinations, and the performance of current candidates on these questions relative to candidates in other years permits standardization of the examination between candidate pools in different years. Thus these previously used questions serve as equators that permit the same passing standard from year to year. The passing standard used in 2010 year was identical to the passing standard used in 2009 (Scale Score = 170 and Proficiency/Logits Score = 1.12). On the 2010 examination, this corresponded to a raw score of 215 correct answers (70.7%).

(Part I Certification Continued on page 13)
The purpose of the Part II oral examination process is to evaluate candidates’ clinical competence through credentialing and an examination. Unlike the Part I written examination, which primarily assesses knowledge, the goal of the Part II examination is to assess the application of knowledge. Upon successful completion of the Part II examination, candidates become Diplomates of the American Board of Orthopaedic Surgery and Board certified in orthopaedic surgery for a period of 10 years. This also marks the beginning of the first Maintenance of Certification cycle.

The 2010 ABOS Part II oral examination was administered July 21-23 in Chicago, IL. In order to be admitted to the oral examination, a candidate must have successfully completed the Part I written examination, possess a full and unrestricted medical license in the United States or Canada or be engaged in full-time practice in the United States federal government for which licensure is not required. Candidates also must have been in practice for at least 22 months, of which at least 12 were in a single location. Candidates are evaluated through a peer review process that includes input from their residency program director, orthopaedic colleagues, hospital chief of staff, and chiefs of orthopaedics, surgery, anesthesia, and operating room nursing staff. After reviewing the application and associated information, the ABOS Credentials committee determines which applicants are approved to sit for the Part II examination.

The oral examination allows peer review of the candidate’s practice and decision making. The board examiners are volunteer, board certified orthopaedic surgeons. All examiners are required to participate in the recertification process. The examination is based on the 6 month case list submitted by the examinee. The case list is reviewed in advance and 12 cases are selected for inclusion in the examination. The candidate is allowed to delete two cases, leaving 10 cases to serve as the basis for the examination. The candidate brings supporting documentation and selected images to Chicago.

The examination is divided into three 35 minute periods with two examinees in each period. During each examination period, examiners ask the candidate questions related to selected cases presented. The examiners also have access to the candidate’s practice profile. Specific skills evaluated for each case are data gathering, diagnosis and interpretive skills, treatment plan, technical skill, outcomes, and applied knowledge. There are global evaluations of surgical indications, surgical complications, and ethics and professionalism. Each of the two examiners grades the candidate independently. The scores are adjusted to account for examiner difficulty. The scores from all of the candidate’s examiners are combined to form a composite score for the candidate. The examination is structured so that it is possible for all examinees to pass the examination. There is no pre-determined failure percentage.

In 2010, there were 680 candidates and 164 volunteer examiners. Eighty-seven percent of the candidates completed a fellowship. Six hundred two received passing scores for a pass rate of 88.5%. The pass rate for first time takers was 89.8% and for those repeating the exam 78.4%.

In an effort to improve the examination process, the Board actively seeks feedback from examinees during debriefing sessions immediately following the examination. Candidates are asked to complete a questionnaire. During the sessions, verbal feedback is requested from the group. ABOS directors are present to answer questions and listen to comments from the candidates.

Over the past several years there has been a definite trend toward digital imaging in hospital and office settings. This trend is expected to continue. Candidates have historically brought hard copy images to the examination. The limited access to hard copy images has made this more burdensome for the candidates. Many candidates have to pay for printed copies of images. Furthermore, the variability in printing methods has recently led to inconsistency in the quality of images available for the examination. There is the additional burden of carrying the material to the examination in Chicago. The questionnaires from the debriefing sessions indicated that 88% of candidates have digital imaging in either their hospital or office. Fifty-six percent have digital imaging in both settings. The verbal feedback overwhelmingly supported the use of digital imaging for the examination.

The Board has been actively exploring a transition to digital imaging. Board Directors have evaluated digital imaging systems to determine their appropriateness for the examination. The goal is to identify a reliable system that allows candidates to easily upload images and consistently produces high quality images that can be easily managed during the examination. As a trial, Directors uploaded images to two different systems, and then reviewed the image presentation in small groups to select a format for the examination. A mock oral examination utilizing this JPEG based format was held during November of 2010 at the Palmer House in Chicago. This included volunteer candidates from the 2010 oral examination, Board examiners and Board Directors. The plan is to utilize the digital imaging system for the 2011 oral examination.

The ABOS Board of Directors is grateful to all of the participants in this voluntary activity. We believe that the oral examination is an essential component of our certification process.
ATTENTION DIPLOMATES ... We need your help!!!

The following pages list candidates that have applied for Part II of the certifying examination for 2009. In an attempt to enlarge our peer review of candidates, we ask that you review this list and submit comments on persons that you know, in regard to their competence to sit for the exam. Good faith attention of the Credentials Committee at ABOS, 400 Silver Cedar Court, Chapel Hill, NC 27514, or by email to dfrazier@abos.org.
<table>
<thead>
<tr>
<th>State</th>
<th>Candidates</th>
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<tr>
<td>INDIANA</td>
<td>Anderson, Rebecca Bennett, Coats, David Alan, Harris, Damian Michael</td>
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<td>Matthew Ryan, Merrell, Greg Alan, Ritter, Kyle Patrick, Sieradzki, James Paul,</td>
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<td>Jeffrey Alan, Pate, Ryan Cyril, Patel, Amar, Stueve, Jacob Saunders,</td>
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<td>Samuel Christopher Britton, Crawford, Charles Hopkins, Kern, Brian Scott,</td>
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NORTH DAKOTA
Ackerman, Duncan Blaine

OHIO
Abbott, James Douglas
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McKinney, Bart Issac
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Shaver, Jonathan Christopher
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Bauer, Brent J.
Beaty, Stacy Gerald
Benavides, Jerome Michael
Bergeson, Ryan Kirkhus
Breznita, James Louis
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Campbell, Winifield M.
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Cho, Alexander
Clark, Russell Jay
Duffy, Michael Fahey
Fehsenfeld, Drew Mathew
Gloystein, David Michael
Graves, Richard Marshall
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Heinrich, John Bradford
James, Kevin Bernard
Kibule, Leonard Kayemba
Launikitis, Robert Anthony
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Martyak, Gregg G.
McGarry, John Eamon
Murray, Travis Norman
Orr, Justin Dennis
Osborn, Patrick Marshall
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Reddy, Veerabhadra
Rey, Jesus
Rhim, Richard Dongil
Robertson, William Joseph
Rose, Harris Samuel
Rouhipour, Varqar
Sathy, Ashoke Kasyp
Schoenberg, Andrew Jason
Scoberceca, Razvan George
Seroyer, Shane Thomas
Shellock, Jessica Leigh
Siddiqui, Saqib Armughan
Stehly, Eric Matthew
Stein, Joshua Daniel
Tinley, Jason Christopher
Vara, Christopher Sean
Wang, David William
Ward, Russell Alan
Williams, Nathan Edward
Wilson, Benjamin Scott
Younas, Shiraz Ahmad

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Hallows, Rhett Kendall
Hooley, Eric Wayne
Klatt, Joshua William Bendz
Winter, Bret Ryan

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Cervieri, Christina Leigh
Cheatham, Seth Adam
Cooper, Minton Truitt
Cunningham, Mary Rose Anne
Deal, Dylan Nicole
Ebersberger, Marc Lee
Esway, Jan-Eric
Kalluri, Prakasham
Kavanagh, Mark Lawrence
Lutton, David Matthew
Mierisch, Cassandra
Miyamoto, Ryan Glenn
Patterson, Phillip Justin
Pilkinson, Trinity O’Neil
Sabet, Hajeer
Schmitz, Matthew Robert
Sharma, Vivek
Shimer, Adam Lynn
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Boyer, Jason
Branstetter, Joanna Garnas
Clabeaux, Jonathan James
Freeborn, Mark Allen
Gibbons, David John
Howe, Christopher Ray
Howlett, John Patrick Charles
Iyengar, Jaideep Jairapkash
Koo, Samuel
Kung, Peter Ling-Hung
Leavitt, Shane Colby
Lee, Michael Bor-Hwa
Lu, Dawei
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Marion, Chad Jonathan
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Will, Ryan Edward
Zhuge, Wu

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Felder, David Arthur
Hahn, Joseph Mitchell

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Enright, William Joseph
Fairchild, Todd Alan
Haemmerle, Marcus James
Klein, Steven Mark
Neubauer, Joshua McCarty
Tracy, Sean Carroll

WYOMING
Laman, Brian David
Zebroski, Jeremy Paul
in the MOC process is one that is being asked of the ABOS more and more frequently. MOC is being viewed more and more as an ongoing educational journey as opposed to a trip taken once every ten years. While we might like to satisfy a set of requirements once every ten years and be done with it, the public and our patients prefer a process that calls for more continuous education. The ABOS is currently working through how to define that aspect of Board Certification – the definitions could have far reaching implications on diplomates and their ability to practice. These decisions will be carefully thought out and the goal will be to arrive at a meaningful, yet clear way to determine ‘MOC participation.’

MOC continues to receive broad support from both inside and outside of our profession. It is a good thing for the practice of medicine; it is a better thing for our patients. The ABOS will continue to look for assessment instruments that can be validated and as those are developed, more options for satisfying the requirements of MOC will be available to allow you to demonstrate your competency and improve your practice. Orthopaedic surgeons from all fields and all geographic areas volunteer countless hours to assist the ABOS in the development, deployment, and evaluation of our Board Certification processes – this volunteerism is unprecedented in other fields of medicine and is greatly appreciated. Our certification is more valuable because of that volunteer participation.

As I stated last in last year’s report, the ABOS MOC process has been and will continue to be among the finest of those offered by all of the ABMS Boards – it has value in assessing our competency and value in improving the care of our patients. In 2009, the ABOS marked the 75th Anniversary of its founding – a history commemorating that event was written and published by former ABOS Executive Director, G. Paul DeRosa, M.D. and that history was titled “Doing the Right Thing.” We must continue to ‘do the right thing’ with the MOC process. Board Certification in Orthopaedic Surgery has great meaning and worth – we are committed to keeping it that way.

The current practice profile sports recertification examination will be phased out after 2011. Starting in 2012, those individuals who do not possess a Subspecialty Certificate in Sports Medicine and want to recertify their Primary Orthopaedic Certificate, the following options are available:

- General Orthopaedic Computer-Based Examination
- An oral examination based upon a 6 month case list of the Diplomate

(This will be given by a Sports Medicine exam panel)

Over the next year, the ABOS will work with the ABMS to get approved an Oral Pathway that will satisfy subspecialty recertification in Sports Medicine in the MOC process. This will give the Diplomate who has a subspecialty certificate in Sports the option of either a written or oral pathway to satisfy both the primary and subspecialty certificate for the remainder of their professional careers.

The passing rate for United States and Canadian medical school graduates that were taking the examination for the first time was 88.4%. The passing rate for international medical school graduates was 31.4%; for international medical student graduates the passing rate was 11.1%. The passing rate for the entire candidate pool was 80.6%.

The validity of the test can be determined by the test psychometrics. The mean item discrimination, which determines how well each individual question discriminates between those who obtained high scores and those who achieved low scores was 0.27. The KR20 internal consistency reliability coefficient, the measure of how much an examinee’s score would vary across repeated testing with different questions on the same content, was 0.90. The psychometric results are consistent with a highly valid examination and similar to the examination performance in prior years.

The passing rate for the 2010 SSC-Hand Recertification examination a passing score of 64% correct was selected by the Committee, resulting in a failure rate of 7.8%. ABOS determined a minimum passing score of 63.5% for the 2010 Combined Orthopaedic and SSC-Hand Recertification Examination. This results in a failure rate of 3.8% for the total group, 3.0% for first-takers, and 20.0% for repeat candidates.

The dates for the 2011 SSC-Hand examination have been set. The Certification examination will be administered as a computer based test on September 12, 2011. The window for the SSC-Hand recertification examination will be September 12 - 24, 2011. The deadline to apply for the SSC-Hand for Certification or Recertification is February 1, 2011. For the Combined Hand examination, refer to the MOC Exam schedule. Please see the complete Rules and Procedures for the SSC-Hand on the ABOS Website www.abos.org.

The Joint Committee has supported an Oral pathway as an option for combined recertification of the SSC-Hand and the Orthopaedic Boards as part of Maintenance of Certification (MOC). Details are being worked out, but it is anticipated that this pathway will be an option for those who hold the SSC-Hand to recertify both the Orthopaedic Boards and the Hand certificate during the 2013 testing cycle.
IMPORTANT INFORMATION FOR DIPLOMATES WITH CERTIFICATES EXPIRING IN 2013
MOC REQUIREMENTS ARE DUE DECEMBER 15, 2011

If you have not yet completed your MOC requirements and your certificate expires in 2013, you must complete your MOC requirements by December 15th of this year to avoid having a lapse in your certification. Please refer to the grid on page 3 for the complete timeline for the 2013 examination.

CONTACT US:
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Fax: 919-942-8988
Or Visit Our Website: www.abos.org