Demystifying the ABU (and interpreting the alphabet soup of acronyms associated with it)

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The American Board of Urology (ABU) has a very distinct mission that is often misunderstood by urologists in the community. In addition, there is an enormous number of acronyms associated with the ABU. In this paper, I will attempt to explain the workings of the ABU and to define and explain the acronyms.
The mission of the ABU is to act for the benefit of the public to insure a high quality, safe, efficient, and ethical practice of urology by establishing and maintaining standards of certification for urologists. The ABU views that it truly serves the public, and decisions made by the ABU are measured against the public's best interests.

Key Words: American Board of Urology, ABU

The ABU was organized in 1934. It is a not-for-profit organization and is one of 24 medical specialty boards under the umbrella of the American Board of Medical Specialties (ABMS). Currently, the ABU has 12 trustees. Two new trustees are appointed each year to staggered, 6-year terms. New trustees are chosen by the current trustees of the ABU based on the nominations of a number of major urological organizations including the American Urological Association (AUA), the American Association of Genito-Urinary Surgeons (AAGUS), the American Association of Clinical Urologists (AACU), the American College of Surgeons (ACS), the Society of University Urologists (SUU), and the urology section of the American Academy of Pediatrics (AAP). ABU trustees are volunteers and are not paid for their services. The current ABU trustees are shown in Figure 1.

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The primary work of the board is to certify urologists. Certification is based on meeting standards of education, knowledge, skills, ethics, and practice patterns. Candidates who demonstrate that they meet the standards are awarded certificates by the board. The specific wording of the certificates has changed over time, but all certificates indicate that the candidate has met all the requisites of the board and is therefore a diplomate of the American Board of Urology. The wording also notes that the certificate must be maintained up to date and that it is revocable at any time by the board if the candidate no longer meets the ABU's standards.

Because the function of the ABU is often misunderstood, it is important to realize that its role is very limited. Although it works alongside and sometimes in concert with other organizations, its mission is relatively narrow. It is not a part of the AUA, an organization that exists primarily to support its members. In contrast, the ABU exists primarily to ensure the public that ABU diplomates are qualified urologists. The ABU is not involved in the training of urologists or in the development of residency training programs. That is primarily a function of the American College of Graduate Medical Education (ACGME) through their Residency Review Committee for urology. Similarly, the ABU is not involved with licensing. That is a function of state medical boards. In essence, the ABU does not in any direct way control or

Figure 1. American Board of Urology trustees, February 2008.
Upper row, from left: Gerald Jordan, Timothy Boone, Ralph Clayman, William Steers, Barry Kogan, Margaret Pearle (in-coming trustee), Paul Lange and Michael Koch.
Lower row, from left: Robert Bahnson (in-coming trustee), David Bloom (in-coming Vice President), Bedford Waters (in-coming President), Peter Carroll (out-going President), Howard Snyder (out-going Vice President), Stuart Howards (Executive Secretary), John Forrest.

limit the practice of urology. Its role in these areas is only highly indirect in that if the board feels an individual practitioner is violating the public trust, it may act to revoke that practitioner's certificate.

The ABU certification process is complex. In simple terms, the applicant must first document satisfactory completion of an approved urology residency training program. This is the primary method the ABU uses to assess the applicant's education. The applicant must then pass a written Qualifying Examination (QE), generally (but not always) at the completion of residency training. After passing the QE, the applicant, who must also have been practicing as a urologist for at least 16 months in one location, must undergo a clinical practice assessment. This is done primarily by a formal, written, peer-review process including a review of the candidate's practice, based on a 6-month billing log of all patient interactions. Finally, the candidate must pass an oral Certification Examination (CE). The candidate must complete this primary certification process within 5 years of having completed an approved residency training program.

The QE is a carefully designed, thoroughly tested assessment of urological knowledge and practice. The examination consists of 300 multiple choice questions. It is given in a testing center that specializes in computerized tests and offers excellent security for the ABU. The testing centers are generally quiet, comfortable, and reasonably close to home for most urologists. The examination is constructed by a committee of subject matter experts with experience in subspecialty areas of urology. Individuals on this committee write proposed new questions, usually in their subspecialty area. These are edited by a urologist with considerable experience in the qualifying examination. These questions are then scrutinized by fellow experts in the subspecialty area and by other experts without expertise in this subspecialty. If the questions are deemed to be valid ones on important concepts by all these experts at different levels of scrutiny, the questions are then placed on the qualifying examination as field test items. Field test items are not identifiable by candidates. Candidate responses to the field test items are used only for statistical purposes, and not to determine whether the candidate meets the criteria for board certification. Only after successful field test performance can the question be used on the QE for assessment of the candidate. Questions that test poorly are either revised and field tested again or they are discarded. The subject matter of the questions covers the entire field of urology and includes uroradiology, uropathology, and the six major competencies as defined by the ACGME.

The QE is scored using a Rausch model. This method is criterion referenced, meaning that the ABU sets a minimum benchmark for what knowledge a urologist must have in order to be certified. This differs from a percentile or population based scoring system in which each year, candidates who fail to reach a given percentile fail; for example, in some systems, candidates with scores that are 2 standard deviations below the mean would automatically fail. The ABU believes that the methodology of criterion referencing is fairer, gives each candidate a uniform opportunity to pass, and keeps the standards equal from year to year. There is no mandatory failure rate, so that if the candidates were extremely capable in a given year, 100% could pass. Table 1 shows the pass rates for the QE over the past 15 years. In general, the pass rate has been higher recently than it was 10 to 15 years ago, suggesting that candidates who are finishing residencies now are more capable or better prepared than those in previous years.

After successful completion of the QE and 16 months of urology practice in one location, candidates are eligible for the second phase of the certification process. They must have an unrestricted medical license and hospital privileges. They must have favorable peer reviews from physicians in their local area and a favorable review of acting in a professional

TABLE 1. **Pass rate for the American Board of Urology Qualifying Examination, 1994 - 2008**

Year	# Candidates	Pass rate (%)
1994	330	84
1995	337	82
1996	319	82
1997	336	76
1998	338	80
1999	336	82
2000	345	72
2001	454	83
2002	329	82
2003	307	82
2004	317	83
2005	299	90
2006	278	88
2007	285	91
2008	278	88

manner (for example, handling complications in a timely manner, and the absence of/reasonably explainable malpractice complaints). If a candidate meets these criteria, the ABU reviews a 6 month log of that individual's practice and compares this log to the candidate's peer group. Again, a benchmark is set that the applicant must exceed, and, in addition, practice patterns that are out of the ordinary can be uncovered. The size of an individual's office practice, office procedures, and surgical practice are readily compared to those of his or her peer group. Discrepancies are sometimes seen, but are often logically explained. For example, a urologist might have an office practice that is no larger than 25% of all urologists in his or her peer group, but might be performing more retroperitoneal ultrasounds than 95% of his or her peers. Such discrepancies are not considered inappropriate unless there is no reasonable explanation. The candidate is given an opportunity to explain discrepancies, by either providing an overall explanation and/or by explaining individual cases. In the example given, the candidate may have been doing ultrasounds for inappropriate indications, but it is also possible that he or she is the practice's resource person for ultrasounds and all the urologists in the group refer all their ultrasound patients to the candidate, giving him or her a disproportionate number of cases.

After successful completion of all the above reviews, the candidate may take the CE exam. This is an oral examination designed to test the candidate's ability to gather information relevant to a clinical problem, manage the problem effectively, react in a timely fashion to complications, and act in a professional manner. Trustees of the ABU construct the questions, and the questions are rigorously reviewed on multiple levels. Each candidate receives identical questions and is scored identically based on their responses. Each candidate receives three different test case scenarios from two different examiners (for a total of six cases per candidate). Each examiner is carefully selected based not only on their knowledge and expertise but also on their ability to be fair and consistent. The scoring system is designed to be as objective as possible. The scoring tendencies of examiners are evaluated and statistically corrected, so that a candidate is not penalized for having a "hard" examiner, nor is he or she more likely to pass with an "easy" examiner. As in the QE, scoring is based on a criterion reference system. There is a benchmark set by the ABU, and there is no required number of candidates who fail. As in the QE, if the candidates were able, 100% could pass. Table 2 shows the pass rates in recent years.

Initially the certificates had no time limits. However, by 1980, it became apparent that to ensure the public's trust, it would be necessary to periodically verify that

TABLE 2. **Pass rate for the American Board of Urology Oral Certification Examination, 1994 - 2008**

Year	# Candidates	Pass rate (%)
1994	327	80
1995	324	79
1996	326	77
1997	313	78
1998	316	83
1999	305	81
2000	337	86
2001	331	87
2002	277	95
2003	281	87
2004	280	91
2005	262	95
2006	227	93
2007	283	91
2008	271	92

a urologist still met appropriate standards. Hence the process of recertification was begun. All new certificates awarded after 1985 are limited to 10 years, and as a diplomate approaches the 10 year point, he or she applies for recertification. It was felt that the board could not legally force urologists who held certificates with no time limits to obtain recertification. Many older urologists have not voluntarily done so. Although the ABU would strongly prefer that all urologists renew their certification periodically (again, primarily to ensure the public that urologists continue to meet the standards of the ABU), it is not legally possible to enforce that policy. Moreover, the ABMS has recently viewed that recertification every 10 years is itself insufficient to ensure the public of ongoing quality practice, and they have mandated a continuous process of Maintenance of Certification (MOC).

The recertification process that takes place 10 years after certification mirrors the certification process in many respects. As noted above, however, recertification is being phased out in favor of MOC, hence nearly all urologists will be participating in MOC. MOC is a process put in place based on the mandate of the ABMS. The purpose again is to assure the public that urologists who are certified maintain their qualifications over time. In addition, MOC most likely will suffice as documentation for most state boards for Maintenance of Licensure (MOL). It will likely be required for hospital privileges and may well be a part of Pay for Performance (P4P).

Although the exact details of the MOC process in urology are still being determined, the general plan is known. Every diplomate will be required, every 2 years, to provide documentation of licensure and to do a structured patient management review of 5 of their own patients who have a common urological problem. Examples of common problems that will be acceptable are shown in Table 3. The diplomates are then required to compare their treatment with established guidelines and/or practice patterns. Every 4 years, there will be a review of their credentials, a peer review, and documentation of their continuing medical education credits (CME). Every 10 years, they will be required to submit complete 6 month billing logs as documentation of their activities. These logs will be reviewed as described previously. Finally, every 10 years, the certificate holder will be required to pass a computerized examination similar to that described above.

TABLE 3. **Patient management review topics**

Management of stage Ta, T1, and Tis bladder cancer
PSA screening
E & M of ureteral calculi
E & M of vesicoureteral reflux
E & M clinically localized prostate cancer
E & M of erectile dysfunction
E & M of varicocele
Prophylaxis of deep venous thrombosis
Antibiotic prophylaxis for urological procedures

The ABU takes its mission seriously. We believe that the urological community, for the most part, provides a very high level of urological care for the public. Yet, it is important both to assure the public of that, as well as to find those few practitioners who may not provide care at that level. Providing this service to the public is our mission. More information about the ABU can be found at www.abu.org.

Disclosure

None declared. □