

Vascular Surgery Action Committee: Report to SVS Board – October 2007

Committee Members:

Jack Cronenwett, MD, Chair
O. William Brown, MD
Elliot Chaikof, MD
G. Patrick Clagett, MD
Clement Darling, MD
Julie Freischlag, MD
Peter Lawrence, MD
Michel Makaroun, MD
Linda Reilly, MD
John Ricotta, MD
Greg Sicard, MD

Activity

The VSAC was charged by the SVS to recommend optimal methods to promote independence for the specialty of vascular surgery. Three working groups were formed to investigate certification, training and scope of practice. Each group met by conference call, and their recommendations were shared with the entire committee. The VSAC then met in person on October 7 to develop this summary and recommendations.

Conclusions

A. “Independence” of a specialty is primarily determined by:

1. Control of certification and training
2. Ownership of identity

Control of certification and training is a function of Board and RRC status, and is currently reduced by the lack of clear acknowledgement by the ABS that current trainees in general surgery who wish to practice vascular surgery should complete a vascular fellowship. Control is also reduced by the fact that VSB decisions about certification are theoretically reversible by the ABS and that there is no RRC component with independent purview over vascular surgery program accreditation, but rather this function is served by a small number of vascular surgeons on the Surgery RRC with a predominate membership of general surgeons.

Identity is a function of specialty size and society advocacy, rather than Board or RRC status. This is demonstrated by many influential specialties, such as cardiology, which do not have separate Board status, but have substantial identity. Ownership of the specialty by vascular surgery is reduced by competition with cardiology, cardiothoracic surgery and interventional radiology for interventional procedures, and to a decreasing extent with general surgery, due to their decreasing performance of complex vascular surgery operations.

B. Functional evaluation of an independent Board and RRC:

Potential advantages:

1. Explicit control of certification and accreditation
2. More apparent ownership of identity

Potential disadvantages:

1. Loss of influence of a larger Board (ABS) at ABMS
2. Significant cost per certificate/re-certificate, plus new MOC costs
3. Reduced influence regarding general surgery training/certification without representation on ABS
4. Potential for reduced efficacy of interaction with general surgery program director in 0-5 rotation negotiations without the support of the ABS and (GS) RRC

Application for an independent Board would be strengthened by a predominance of 0-5 residency programs instead of post-general surgery fellowships, as well as active support by the ABS. Current discussions at the ABS regarding subspecialties in general surgery, such as oncologic surgery and acute care surgery, suggest that the ABS may be considering a move toward a federation model, in which there would be multiple autonomous Boards, such as the VSB, and an overarching Board (ABS) to coordinate agendas and make decisions about joint or overlapping initiatives, analogous to the American Board of Medicine.

C. How to create independence in the current Board-RRC system:

1. Codify in writing the relationship between VSB and ABS such that VSB has control over all vascular certification issues. This relationship should not be changeable by either party without joint approval, but should be re-reviewed for appropriateness in 5 years.
 - a. Encourage the federation concept described above for the ABS
2. Establish an independent group to control vascular training and accreditation.
 - a. A separate RRC, or
 - b. A Vascular Review Group within the current RRC with a codified responsibility to review vascular programs, and define the vascular curriculum, and an appropriate administrative structure to accomplish these responsibilities.
3. Elimination of vascular surgery as an essential component of general surgery training
 - a. ABS should declare that new general surgery diplomates are not certified in vascular surgery and that those who wish to practice vascular surgery should obtain vascular surgery certification.

D. How to overcome potential disadvantages of an independent Board:

1. Maintain excellent relationship with ABS and GS program directors
 - a. Periodic meetings, joint representatives
2. Cannot avoid increase in cost, so increased cost of a separate Board would need to be covered by SVS and/or by member contributions, as is done by other small Boards.

E. Keys to increased ownership of identity:

1. Advocacy by SVS on issues such as branding, interaction with primary care, etc.
2. Statement by ABS that new general surgery diplomates should complete a vascular fellowship if they intend to practice vascular surgery

Recommendations:

The VSAC unanimously recommends that the SVS pursue a strategy to achieve the functional goals of independence in the most direct manner.

1. Obtain control and ownership by working with ABS and ACGME/RRC to accomplish the above requirements specified in paragraph C.
 - a. SVS should work expeditiously to initiate discussions with the ABS in collaboration with the VSB.
 - i. Control of vascular surgery certification issues by VSB.
 - ii. Statement that future GS diplomates should complete a vascular fellowship if they intend to practice vascular surgery.
 - iii. Elimination of VS as an essential component of GS.
 - iv. Review initial agreement after 5 years.
 - b. SVS should work to initiate discussions with RRC/ACGME in collaboration with the APDVS.
 - i. Vascular surgery review group with codified responsibility for oversight and review of VS programs and sufficient administrative support.
 - ii. Revisit discussion with ACGME about separate RRC because of separate primary certificate, even though same Board as general surgery.
 - c. These goals should be accomplished within the next year.
2. Encourage the development of 0-5 VS residency programs
 - a. Provide direct support to all program directors who need assistance.
 - b. Communicate with vascular surgeons at centers without current fellowships to encourage them to develop vascular training programs.
 - c. Sponsor a competitive research scholarship for 0-5 residents to allow dedicated research years, analogous to such scholarships by SUS, ASA, etc.
3. Communicate with SVS membership that functional goals are being addressed via a pathway judged to be most feasible, preserving options for future change if this proves advantageous.

- a. This is judged to be the best option by the VSAC because of the early stage of 0-5 program accreditation and the many changes being considered at the ABS, such that future membership in the ABS might have considerable functional as well as financial advantages.
4. The VSAC will continue to investigate key issues that could influence alternate strategies:
 - a. Investigate cost of independent Board.
 - b. Investigate precedent for separate RRC given primary certificate.
 - c. Obtain ABS data to define current scope of practice in both VS and GS by case-logs submitted by surgeons re-certifying in both VS and GS.

The above summary and recommendations have been reviewed and approved by all committee members.

Respectfully submitted,

Jack L. Cronenwett, M.D., Chair