OPINION

The case for an independent American Board of Vascular Surgery

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In a presidential address 4 years ago, I linked Darwinism and vascular surgery.[1] In that address medical specialties were equated with species. I was concerned then about the survival of our species, vascular surgeons. I am even more concerned now because our ability to survive and reproduce is controlled by an authority—the American Board of Surgery (ABS)—that has a conflict of interest: it simultaneously represents our needs and those of general surgery. Accordingly, I would like to advance the notion that to survive and flourish, to reproduce optimally, we must form an independent, American Board of Vascular Surgery (ABVS), which is approved by the American Board of Medical Specialties (ABMS).

The mission of the ABMS and its specialty Boards is to maintain and improve the quality of medical care.[2] The ABMS defines a medical specialty as a group of doctors who, from specialized effort and training, possess distinct medical knowledge and technical ability not possessed in full by other specialists.[3] The specialty must also reproduce itself by residency training programs accredited by the Accreditation Council for Graduate Medical Education.

Establishment of a new medical specialty Board must be based on major new concepts or substantial advances in medical science. It must represent a distinct, well-defined field of medical practice.[3]

Vascular surgery clearly fulfills the requirements to qualify as a separate specialty and should, by ABMS definitions, be entitled to its own board and residency review committee.[4] Why has this not happened? Simply stated, there is strong opposition from the ABS that wants to maintain vascular surgery as a subordinate subspecialty.[5] Its reasons for defending the status quo are complex. They involve concern for the traditional but outdated scope of general surgery, as well as issues of control and money. Improving the quality of care has not been a consideration.

In 1997, the leadership of vascular surgery, in a unanimous action, incorporated the ABVS.[6,7] These leaders were motivated by solid evidence that well-trained vascular surgeons, who perform large numbers of vascular operations, generally obtain better results than less well-trained surgeons performing sporadic vascular procedures.[8-16] The new Board was to improve patient care by making obsolete the existing two-class training system, in which every general surgeon is potentially a vascular surgeon. The formation of the ABVS was also prompted by the realization that in conflicts between vascular and general surgery over issues related to training and certification, vascular surgery, the subordinate specialty, had usually lost. Thus, in 1997, with the support of 80% of the Society for Vascular Surgery and the North American Chapter of the International Society for Cardiovascular Surgery membership responding decisively to a survey,[7,17] the intent of vascular surgery leaders was to obtain ABMS approval for the ABVS.[7] Ninety-one percent of responding vascular certificate holders were supportive of this effort.[7,17]

In reaction to our initiative, the ABS counterproposed a Vascular Surgery Sub-board that presumably would meet our needs, while keeping us in the ABS fold. It could have been a step in the right direction. Unfortunately however, the ABS defined the Subboard's duties as merely advisory.[18] Despite many requests, the ABS failed to grant the Subboard operational authority over matters normally handled by an independent Board. Final authority remained with the ABS directors. Moreover, in the document establishing the Vascular Sub-board, the ABS "reaffirmed its commitment to training the

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Competition of interest: nil

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broadly based versatile general surgeon . . . well-trained in all nine primary components of surgery."[18] Vascular surgery would remain one of these primary components. With these limitations, how could this Sub-board meet the legitimate vascular surgery needs that had originally led to the establishment of the ABVS?

In addition, a majority of members of the Sub-board were also ABS directors, which again raised the possibility of a conflict of interest. Would they serve the interests of general or vascular surgery when a conflict arose between these specialties?

However, the Sub-board proposal divided the vascular surgery leadership. Although some doubted the Sub-board could meet our needs, it was accepted for a trial in a spirit of cooperation. During its tenure, the vascular Sub-board has made important progress.[19] Unfortunately however, it has not been able to resolve fundamental issues, such as the two-class system of vascular surgeons that led to the ABVS in the first place.

At worst, the Sub-board system will not be responsive to vascular surgery's needs. At best, true conflict resolution between general and vascular surgery will be slow and cumbersome. Even if the Sub-board advances a proposal in vascular surgery's favor, the ABS directors or the Residency Review Committee for Surgery are likely to negate, modify, or delay it. This, in fact, has happened with one substantive issue to come before the Sub-board.[20,21]

At this crucial time, with other interventional specialists trying to take over the care of vascular patients,[22-26] we need governing bodies that are agile and quick. The Sub-board system is neither.

There are several clear reasons why an ABVS is critically important to those who practice mainly vascular surgery. The first is to facilitate the endovascular training and practice of active vascular surgeons who wish to participate in this rapidly developing field. Endovascular procedures will replace 50% to 80% of open operations.[27,28] Are vascular surgeons going to be doing them or not? A separate Board could enter into collaborative arrangements with interventional specialties. These arrangements could include a combined Board with interventionists. This would greatly facilitate unified group practices in which active vascular surgeons could be cross-trained in endovascular techniques without taking time from their practice. An ABVS and a Residency Review Committee for Vascular Surgery could also ensure a steady stream of new endo-competent trainees who can join vascular surgical practices and proctor mature vascular surgeons in situ. These and other innovative approaches will not happen under the current system.

Second, an ABVS will better define our specialty and unify our certification process to the outside world. Currently, there are good, well-trained, and committed vascular surgeons, including some cardiothoracic surgeons, who cannot take the examination to be certified because of technicalities. There are also other general and cardiothoracic surgeons who dabble in vascular surgery with poor results[8-15] and who claim vascular certification by virtue of their general surgery Boards. Is that good vascular surgical care? Vascular surgery should no longer be an ill-defined specialty, as the cardiologists claim we are.[22] An ABVS can help to overcome these problems and improve patient care.

Third, being a better defined specialty will help with reimbursement issues. Vascular surgeons have not done well when general and thoracic surgery represented their interests in the Hsaio Study. And in some of our Government Relations Committee dealings with Congress and HCFA, it would have helped greatly to say we are a separate specialty with our own recognized Board.

Finally, the most important reason to have an ABVS is that it will help to achieve the objectives of all specialization and specialty Boards, that is, to act in the public interest by contributing to the improvement of patient care . . . and to promote and enhance recognition of a single standard in preparation for practice in each specialty.[29]

Hopefully, these arguments will convince vascular surgeons that the ABVS is critically important to them, their patients, and their specialty. What is the next step? All vascular surgeons must impress on their leaders that this is a crucial survival issue and that continuation of the status quo will lead to our decline. The fact is that our dedication and unique expertise in managing vascular disease have long justified a separate specialty Board in vascular surgery. Now is the time. It is only evolution.

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Copies of the letters appearing in this list of references are available from the author on request.