

Past Influences, Present Transitions, and Future Directions in 2009

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What has the American Board of Radiology (ABR) delivered for patients, the public, and the profession in its first 75 years? What must the ABR deliver in the next 75? The answer to the first question—public trust, professionalism, and the widely accepted gold standard of excellence in patient care—may be thought of as the three pillars of board certification. These are essentially the same for the ABR and the other American Board of Medical Specialties (ABMS) Member Boards. To explore the answers to the second question, it is helpful to review the environmental stressors and historical backdrop impelling the establishment and evolution of the specialty board movement.

At the January 2009 retreat of the ABMS, the Member Boards agreed unanimously that external environmental stressors are poised to shape health care reform and the practice of medicine in the United States more fundamentally, profoundly, and swiftly than ever before. They further agreed that for the specialty board movement to remain relevant amid the upheaval, major deliberate action steps must be taken by the ABMS and its Member Boards. The following brief historical highlights prepare us to better understand the steps the ABMS and its Member Boards, including the ABR, must take to meet the challenges of today and tomorrow.

Medical Education and the Beginnings of Public Accountability

Before 1875, there were no requirements to become a licensed medical practitioner. By the beginning of the 20th century, there were 155 “medical schools” in the United States, many of which were proprietary. However, there were no educational standards. Many school “curricula” touted holistic philosophies but were utterly lacking in science. After the Flexner Report was published in 1910 (see Chapter 1), it became clear to physician-educators, patients, and the public that the deplorable state of medical education in the United States and Canada demanded not just an overhaul, but a complete redesign. The report, commissioned by the Carnegie Foundation for the Advancement of Teaching at the behest of the Council on Medical Education of the American Medical Association (AMA), was such a sweeping indictment of US medical schools that nothing short of a complete transformation would suffice. As the report details, many schools had no admissions standards, but rather filled their classroom seats with young male recruits who had dropped out of high school. The schools had inadequate faculty and laboratories and lacked clinical instruction. In some schools, it was possible to complete one’s entire educational program without examining a single patient. With the exception of the subset of institutions tied financially and administratively to universities, schools lacked the resources to teach the latest in science and technology. Thus, neither students nor patients could derive the full

measure of benefit available from the modern technologies and discoveries of the day. In Abraham Flexner's own words, the "...self-registering thermometer, the stethoscope, the microscope, and chemical analysis [could] enormously extend the physician's range...provided...the physician is himself competent..." So there it was. The linkage between a quality educational experience, a competent physician, and the delivery of benefit to patients and the public had been identified.

After the Flexner Report, schools established standards and adopted many of the report's recommendations, as well as those of the Council on Medical Education of the AMA. But meeting the new standards was a costly endeavor, so many proprietary schools—unaffiliated with universities and unable to meet the financial demands—were forced to close. In contrast, the university-affiliated schools thrived. The industrial revolution had spawned many successful businessmen—philanthropists who were capitalists and did not overlook the opportunities in medical science and technology. New endowments to the most qualified and advanced medical schools—those already affiliated with universities—began to occur. At last, the public welfare seemed to be taking center stage, even if not for entirely altruistic reasons.

Science as the Foundation for Medical Practice

Throughout the 18th and 19th centuries, early American medicine was anecdotal and unscientific. Isolated observations about diseases and treatments were generalized arbitrarily. Theories of pathogenesis emerged without basis. But in the early 1900s, concomitant with the emergence of the specialty board movement, advances in science held the promise of improved medical care. Consequently, interest in the practice of medicine greatly increased. Newly available instrumentation also helped fuel interest in the practice of specific areas of medicine, and the era of specialization was born.

Unfortunately in this milieu, all was not well. Hospitals—which lacked even the most basic standards for cleanliness and nutrition—were dreadful

places that housed hopeless patients with chronic debilitating or fatal diseases. Many unscrupulous characters made false claims concerning their supposed expertise in any number of fields of practice. Consequently, the public fell victim to a system in dire need of a way to validate the credentials of individual practitioners.

With this background, the 1908 presidential address of Derek T. Vail, Sr., to the American Academy of Ophthalmology and Otolaryngology (see Chapter 1) marked the beginning of the specialty board concept. The actual specialty board movement began when the American Board of Ophthalmology incorporated in 1917. The American Board of Otolaryngology followed in 1924, the American Board of Obstetrics and Gynecology in 1930, and the American Board of Dermatology and Syphilology in 1932.

Graduate Medical Education

Specialization in medical practice required not just an examination and certification process, but a foundation in education and training. Although the Flexner Report had dealt squarely with the state of medical schools, it was left to the AMA, the National Board of Medical Examiners (NBME), and a number of medical specialty societies to set new standards for graduate medical education. In 1914, the AMA published a list of hospitals with approved internships. In 1920, the AMA's Council on Medical Education and Hospitals organized a series of committees to determine the required preparation to become a specialist in each field. Throughout the 1920s, the NBME studied and reported on examination and licensure processes for physicians in Europe. These reports informed the development of a pattern for testing and certification used by the Member Boards of the ABMS. In 1928, the AMA Council on Medical Education and Hospitals published "Essentials of Approved Residencies and Fellowships," and field staff members were first used to review training programs. This evolving system was the forerunner of today's Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review

Committees (RRCs). It was all beginning to come together: medical schools developing standardized curricula, accreditation of graduate medical educational training programs, and specialty boards certifying practitioners.

Standardized Testing

The industrial revolution, scientific advances, and the addition of training standards were not the only major changes in the early 20th century. The growth in specialized medical training and certification also coincided with, and was bolstered in part by, the emergence of standardized testing in America. By the mid-1930s, standardized testing in public schools, which began in 1909 with the introduction of the Thorndike Handwriting Scale, had become a major movement that included most schools. The College Entrance Examination Board, founded in 1900, had relied on essay examinations. But in 1926, the standardized, multiple-choice Scholastic Aptitude Test (SAT) was introduced. By the early 1940s, the SAT had become the preferred college entrance examination.

When the Russians launched Sputnik into space in 1957 and the American public was shocked at having fallen into second place, the American competitive spirit went into overdrive. All eyes turned toward public school education and standardized testing. The application of standardized testing to the assessment of professionals was natural. The addition of formal testing—by specialty boards rather than specialty societies—to the process of specialization and certification is an indicator that the leaders of the day understood the need for an arms-length relationship between authorities overseeing educational standards and those administering certifying examinations.

National Specialty Boards Form and Come Together

Training and certification were off and running, and the specialization movement began to flourish. In 1932, the NBME established a Committee on Specialists, which focused on specialization in medicine, the need for controls, and ways to assure

the public of the competence of a practitioner in a given field. This esteemed group determined early on that the prospect of a board for each specialty in each state was unfathomable. Consequently, all efforts were directed toward the formation of national specialty boards, which would set the standards for practice in each discipline. It was further determined that the boards could benefit from the assistance and counsel of a national advisory board composed of specialists from each of the fields.

In 1933 the Advisory Board for Medical Specialties was established by the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Obstetrics and Gynecology, and the American Board of Dermatology and Syphilology, together with the several associate member organizations, including the NBME, AMA, and American Hospital Association (AHA). In addition to those three, in 2009, associate members included the ACGME, the Accreditation Council for Continuing Medical Education, the Association of American Medical Colleges, the Council of Medical Specialty Societies, the Educational Commission for Foreign Medical Graduates, and the Federation of State Medical Boards. A constitution and bylaws adopted in 1934—the same year the ABR was incorporated—stated the purposes of the Advisory Board, which were appropriate for the times: discussion of problems common to the boards, advisory service, and coordination and economy.

Proliferation of Specialties and Subspecialties

Between 1933 and 1940, another eight medical specialty boards incorporated and joined the Advisory Board. These included the ABR, which incorporated in 1934 and joined the Advisory Board in 1935. The Advisory Board set the standards for approval of new specialty boards, and in 1948 the process was formalized by the creation of the Liaison Committee for Specialty Boards. Specialization and subspecialization have continued to the present. Since 1972, the ABMS Committee on Certification, Subcertification,

Recertification, and Maintenance of Certification (COCERT), has been the body responsible for reviewing and recommending or rejecting all proposals from Member Boards to issue new or modified certificates. The five most recently approved Member Boards of the ABMS are the American Board of Allergy and Immunology (1971), the American Board of Nuclear Medicine (1971), the American Board of Thoracic Surgery (1971), the American Board of Emergency Medicine (1979), and the American Board of Medical Genetics (1991). As of 2009, ABMS Member Boards examine, certify, and provide maintenance of certification (MOC) programs in 38 primary and 108 subspecialty disciplines.

Among the greatest pressures fueling the proliferation of subspecialty disciplines has been the explosion in medical scientific discovery and the application of advances in technology to medical practice. Physicians have resigned themselves to the fact that medical practice is vast. A natural response to this rapid pace of change is to narrow one's scope of practice. Such focus also enables one to increase and maintain proficiency. That is what specialization and subspecialization are all about. The other major response of the physician community to the pace of change has been the recertification (and subsequently, the MOC) movement.

War, Peace, Socioeconomic Factors, and Establishment of the ABMS

From 1933 to 1970, the Advisory Board functioned as a loose federation of certifying boards. As early as 1949, the idea of hiring a permanent staff to manage the activities was raised. However, it was not until the late 1950s that a central office began to function. When he died suddenly in 1957, Byrl R. Kirklin had been managing the activities of the Advisory Board for nearly a decade from his own office at the Mayo Clinic in Rochester (see Chapter 3). Luis A. Buie of Pittsburgh replaced him and was formally appointed secretary-treasurer, a part-time position. In 1961, the articles of incorporation were adopted, and a logo mark was approved by the US Patent Office. It was Dr. Buie's

idea that the logo could distinguish the approved boards from other boards of "questionable need or spurious origin." Throughout the 1960s, John C. Nunemaker, of the AMA staff, worked to establish a larger and more important role for the Advisory Board; he believed its major area of endeavor should be the relationships of the certifying boards with each other and with the profession. In 1970, the Advisory Board was reorganized as the American Board of Medical Specialties (ABMS), with goals including a more cohesive organization of certifying boards with uniform standards, policies, programs, and fees. Dr. Nunemaker, who became the first full-time executive director, implemented all of the following:

1. Two distinct types of membership: full (regular) and associate (nonspecialty-board organizations)
2. An office with full-time staff
3. Centralized diplomate certification data
4. Standing committees

The specialization movement did not remain steady and uninterrupted. Indeed, World War II and the postwar years had a damping effect. After 1941, no new boards were authorized until the American Board of Colon and Rectal Surgery and the American Board of Preventive Medicine were approved in 1949. What transpired during those years? During the war, many medical schools implemented abbreviated curricula in an effort to boost the output of physicians to serve in the military. The shortage of qualified specialists made it clear that the war years were ill suited to the elevation of standards in medical education as a priority.

In 1946, President Harry S Truman signed the Hill-Burton Act into law. It was designed to infuse federal dollars into the nation's hospital infrastructure. Although this legislation came with federal strings attached—notably, nondiscrimination rules and a requirement to provide a "reasonable volume" of free care to those who could not afford it—no systems were in place to enforce the law. This expansion in infrastructure through Hill-Burton

mirrored all that was transpiring in the business world. The focus was on growth and expansion.

Throughout the baby boom of the 1950s, Americans enjoyed postwar life. Business growth fueled a large workforce demand. The focus was not on raising standards in medicine. In fact, much of the effort of the specialty board movement during those years was channeled into simply trying to get 80% of physicians board-certified. In the health field in general, increasingly well-to-do Americans became interested in being protected against unacceptable or unbearable losses due to illness, and indemnity health insurance was born. The 1960s were also marked by the emergence of the civil rights movement, entanglement in Vietnam, campus antiwar activity, and social unrest. Throughout these two decades, no new boards were approved until the American Board of Family Practice became official in 1969—the same year Neil A. Armstrong walked on the moon.

Also new on the scene in the '60s were Medicare and Medicaid. Although conceived by Harry Truman 20 years earlier, these programs did not begin until Lyndon B. Johnson's administration, with the signing of the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act of 1965). Once public funding on this scale became a reality, the future of medicine was altered forever. Suddenly, the federal government needed to oversee a process whereby hospitals and health care institutions would qualify for funding. Although states had then and still have today the authority and responsibility to certify that hospitals meet the federal Conditions of Participation (COPs), they may cede that authority to another national credentialing organization that enforces standards that meet or exceed the COPs. Such organizations are said to have "deemed status." Almost all states recognize voluntary hospital accreditation by The Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations, or JCAHO) as evidence of an institution having met the COPs, and therefore qualifying for funding by the Centers for Medicare and Medicaid Services (CMS).

Although the number of specialties had grown only slightly by 1970, the number of specialists had grown substantially, and the nation had become concerned about a shortage of primary care physicians. Thus, public policy was directed at encouraging medical students to enter the primary care fields. Approval of the American Board of Family Practice in 1969 was a logical step. Still, public policy could only go so far. Owing to a palpable pressure from the pace of medical and scientific discovery and the application of new knowledge to clinical practice, the march toward further specialization and subspecialization continued. Physicians chose to limit their scope of practice and increase their expertise in a narrower field. Self interest certainly played a role, but it was also becoming more and more difficult to keep up with the many developments in medicine.

The Recertification Movement

Physician leaders also began to deal with the pace of discovery and the rapidly changing landscape of clinical medicine through recertification programs. The history of recertification is important since the movement served as the forerunner of the current competency movement, which aims to optimize the contribution of board certification and MOC to improved quality and safety in American health care. MOC also aims to achieve increased transparency and accountability to the public. Many of the drivers for this current movement are external to the house of medicine, but also are powerful and transforming.

From 1934 to 1936, the Advisory Board, in its infancy, concerned itself primarily with the following general qualifications of candidates for certification:

- Moral and ethical standing
- License to practice medicine
- Membership in the AMA
- Education: graduation from a medical school approved by the Council on Medical Education of the AMA (AMA/CME)
- One-year internship approved by AMA/CME
- Three years of clinical study in an institution

approved by AMA/CME, including specific content in anatomy, physiology, pathology, and specialty-specific basic science

- 18 months in an AMA/CME-recognized institution competent in the specialty
- Examination covering the basic science, clinical application, and public health related to the specialty
- Two years of practice in the specialty.

The topic of “reregistration at stipulated intervals” was first raised at a meeting of the Advisory Board in 1936. In 1940, a report by the Commission on Graduate Medicine concluded that the status of “board certification” gave the impression of competence, but that after a period of time in practice, there was no guarantee that an individual diplomate had continued to stay current with the latest science and clinical applications in his or her field. The report suggested that the certifying boards might want to consider issuing certificates in their fields that are valid for a stated period only. The idea emerged from both public demand for assurance about physician competence and, at this early time in the history, a sense of professional responsibility on the part of leaders in the board movement.

Still, physicians resisted change, and from the postwar expansion years to 1969, no measurable progress on the topic of recertification was made. Then in 1969, the American Board of Family Practice was launched with a policy of mandatory recertification, and the American Board of Internal Medicine adopted a policy of voluntary recertification. By 1973, all of the 22 then-existing boards had committed to the principle of recertification. Many states had implemented requirements for CME and had established the linkage between completion of CME requirements and license renewal. By 1982, nine boards had already administered recertification examinations and issued time-limited certificates. By 1995, 22 boards had time-limited certificates ranging from 7 to 10 years.

The Quality and Safety Movement and the Six Competencies

In 1999, the Institute of Medicine (IOM) issued its report, “To Err Is Human: Building a Safer Health System.” The report estimated that in American hospitals, 44,000–98,000 people were dying each year due to preventable errors. Reactions were many and varied. Some preferred to deny that this could be the case. Yet, this widely publicized report served to alert the public and the profession to problems within the health care system that could not be tweaked or simply repaired. The health care system would have to prepare for the most far-reaching and profound changes it had ever witnessed. A few of the major items to be addressed included the culture and environment of training, the adoption of principles of quality manufacturing and systems engineering in the practice environment, payment reform, and a complete retooling of health care. These changes were outlined in a second IOM report issued in 2001, titled “Crossing the Quality Chasm: A New Health System for the 21st Century.” This second report called for fundamental changes in the aims of health care that would render it safe, effective, patient-centered, timely, efficient, and equitable.

Concomitant with the release of the first IOM report, the ACGME and its RRCs were working to outline the principles of a new model for postgraduate training of residents. The central aim of the new paradigm was abandonment of the traditional time-in-service model of training, wherein the number of years of residency completed was the sole or major determinant of a trainee’s readiness for the certifying examination. The old model was to be replaced by a competency-based one, in which each resident would be required to master six core competencies essential to practice in the chosen discipline. These competencies have since become part of the fabric of every training program:

- Medical knowledge
- Patient care
- Interpersonal and communication skills
- Professionalism

- Practice-based learning and improvement
- Systems-based practice.

At the time the competencies were being adopted, David L. Nahrwold, chairman of surgery at Northwestern University, was serving on the ACGME. Dr. Nahrwold also was beginning his tenure on the executive committee of the ABMS. At the ABMS winter retreat in January 1998, he was charged by the group to present a white paper that would address the question, “What distinguishes ABMS Member Boards from all other boards?” Influenced by his involvement at ACGME, the only answer he could find to this important question was that ABMS Member Boards must assume responsibility for assuring the public of the competency of their physician diplomates. “Competence” is a word that previously struck fear in the hearts of the specialty board leaders because they reasoned that the boards could not assess competency with their examination processes. The notion of the Member Boards even trying to assure the public of physician competence seemed fraught with the peril of legal entanglements. Conventional wisdom was that the Member Boards and their examinations could assure the public that an individual diplomate had shown a certain standard of knowledge and understanding in the chosen field, but nothing more. Many still continue to believe this.

Dr. Nahrwold knew the public demand for competent physicians was justified. He was upset that the Member Boards seemed unwilling to address the need. His deep conviction was that the public should be assured of physician competence, as well as that the ABMS and the Member Boards had the obligation to ensure competence through their certification and recertification processes. Furthermore, if resident and fellow trainees were required to show the six competencies, should not the same competencies apply to diplomates of the Member Boards who were already in practice? Using this logic, Dr. Nahrwold succeeded in convincing the ABMS leadership to appoint a committee on MOC. Ultimately, about 100 ABMS volunteers and staff worked very hard on key issues to get the current

program off the ground. James A. Stockman of the American Board of Pediatrics was the first to speak of MOC, a term that was more widely and easily accepted in the context of medical specialty board certification. Sheldon D. Horowitz and Stephen H. Miller of the ABMS staff were also a great help to Dr. Nahrwold in morning brainstorming sessions that occurred when Dr. Nahrwold stopped by the office on his way to work at Northwestern University.

In September 1999, the six general competencies were adopted by ABMS. In March 2000, all 24 Member Boards formally committed to develop MOC programs in their disciplines. By March 2002, the ABMS had adopted the four components that every Member Board would be required to include in its MOC program:

- Professional standing
- Lifelong learning and participation in a program of periodic self-assessment
- Cognitive expertise
- Evaluation and improvement of performance in practice.

Subsequently, COCERT reviewed and approved each Member Board’s MOC program. By 2009, all Member Boards had MOC programs and had implemented all of the components. This means that no Member Board will issue a lifetime certificate of any kind, and all have requirements in professional standing, continuing education and self-assessment, and MOC cognitive examinations. In addition, all Member Boards have implemented practice performance evaluation and improvement programs, a cornerstone of physician responsibility in the quality movement.

In 2009, the ABMS MOC Task Force still grapples with many of the thorny questions that plague all the boards and attempts to develop policy and guidance in these areas. One example is the definition of a “clinically active” versus a “clinically inactive” physician. Another is reentry into clinical practice after a period of clinical inactivity. There are many others. The Committee on Oversight and Monitoring of Maintenance of

Certification, the body that actually develops new standards for MOC, has begun to work iteratively and interactively with the Member Boards. This is a new process, with which all are gaining experience.

Imminent Redesign of a Broken US Health Care System

The United States spends more money per capita on health care than does any other industrialized nation. In 2007, health care spending in the United States reached \$2.3 trillion. The nation spent nearly 17% of its gross domestic product (GDP) on health care in 2008, and the amount of spending is increasing by 7% per year. If unchecked, the growth would lead to a whopping 50% of the GDP spent on health care in 2030. Clearly, this is an unsustainable rate of growth in health spending. Now consider that one in seven Americans lacks health insurance, and that number is increasing with the unemployment rate because of the severe recession that began in December 2007 and continued to deepen into early 2009. An additional one in seven Americans is underinsured. In 2006, for the first time, less than 60% of gainfully employed Americans received any kind of health care benefits in the workplace. Soon, the proportion of national health expenditures made by the government will exceed that of private sources. These are indicators that the nation's employer-backed health system, to which all have become so accustomed, is failing.

Sadly, the United States is very far from achieving the quality of health care anyone would reasonably expect, given the expenditure. What is the evidence that American health care quality is poor? In 1960, the United States was 12th on the list of nations for infant mortality. In 2004, it had dropped to 29th. In 1984, the United States was 11th on the list for life expectancy, and by 2004, despite an average life expectancy of 77.9 years, it had dropped to 42nd place. Given the current national population and health problems such as obesity, which affects 30% of the population, the United States now faces the very real possibility that, for the first time in

history, it may witness offspring experiencing a life expectancy lower than that of their parents. In recent years, according to the National Center for Health Statistics, the number of health care disparities that have deepened or stayed the same exceeds the number of disparities that have improved. Finally, care is fragmented, and access to primary care remains limited. So Americans have learned to resort to urgent care centers and emergency departments and have forfeited continuity.

On his acceptance of the Derrick T. Vail award at the September 2007 meeting of the ABMS, David Nahrwold urged the ABMS to transform. He predicted that with the imminent arrival of national health care reform, the government would be faced with the daunting task of value-based health care spending at all levels, including that of individual practitioner reimbursement. At the practitioner level, the government will need standards-based rules for pay or no-pay decision making and perhaps for a graduated performance-based compensation scale. Yet the government will face the stark reality that it lacks the infrastructure and wherewithal to accomplish the task. The last time anything similar happened in the health system was when Medicare was created in 1965. The government was responsible for evaluating hospitals and health care institutions and providing funding only for those meeting the Medicare conditions of participation. However, no infrastructure was in place to provide for this critical function. Because the Joint Commission (then JCAHO) already had the standards in place for its voluntary hospital accreditation system, it easily achieved deemed status. Joint Commission-accredited institutions qualify for Medicare reimbursement.

Continuing with his reasoning, Dr. Nahrwold convincingly stated that no organizations were better suited to achieve deemed status in the area of physician performance assessment than the ABMS Member Boards. Therefore, the ABMS and its Member Boards should set their sights on achieving deemed status in the new health system. They may or may not want deemed status and the government regulation that may accompany it. Should the ABMS Member Boards venture into this territory?

If they simply step back and realize that the whole purpose of the board movement and its certification and MOC programs is to continuously improve health care quality and safety, then the obvious answer is “yes.” If the ABMS Member Boards fail to earn deemed status in physician performance measurement, there is no doubt that another organization will assume the responsibility. And at that point—the point of an authority external to the board enterprise having deemed status for physician performance assessment—the boards will have become irrelevant, and physicians will have ceded the last vestiges of public trust to another authority. In so doing, the ABMS Member Boards will have surrendered an immensely important component of what makes them uniquely professional: the public’s trust in their ability and willingness to self-regulate. This is an outcome that would not only be a sad day for the board enterprise but also would represent a collective failure to do just what needs to be done for the public, i.e., take responsibility for improving health care quality and safety.

Dr. Nahrwold’s Derrick T. Vail award coincided with the selection of Kevin B. Weiss as the new president and chief executive officer (CEO) of the ABMS. Dr. Weiss, who replaced Steve Miller in December 2007, had served as director of the Institute for Healthcare Studies at Northwestern University. With his extensive health services research background, he brought to the ABMS an expansive vision and an aggressive agenda of programs—all aimed at strengthening Member Board certification and MOC through physician performance assessment, transparency, and accountability. Dr. Weiss constantly implores the Member Boards to understand and abide by his sense of urgency about implementing the elements of his vision, ranging from public policy and government relations to a standardized Common Core Consumer Assessment of Health Plans Survey as part of MOC.

Because the 2009 growth rate in US health spending is the highest in the developed world and the economy is in its deepest decline since the Great Depression, it seems certain that health care reform is imminent. President Barack H.

Obama’s administration is pursuing an aggressive series of advances and reforms, which include completing the transformation to a totally electronic health record.

Health care quality organizations are anticipating a larger role in the era of sweeping reforms. The National Quality Forum (NQF) has become the de facto arbiter of physician performance measures that are passed on to CMS for approval. Physicians who meet the performance benchmarks qualify for a small increase (~ 1.5%) in reimbursement from Medicare for their professional services. This Physicians Quality Reporting Initiative (PQRI) is a major multidisciplinary effort organized under the AMA. The American College of Radiology is an active participant on behalf of radiology, and more than 100 organizations are included. The vast majority of the measures are brought forth by the Physicians Consortium for Performance Improvement, which is convened by the AMA. Once approved by the NQF, the measures go on to CMS for inclusion in the incentive reimbursement plan.

The ABMS has been attempting to get participation in MOC considered a “composite PQRI measure” warranting the above-mentioned incentive-level reimbursement. To accomplish this, ABMS has adopted a health policy agenda and has hired a Washington-based consultant. The consultant and ABMS leadership have held numerous meetings with staff and members of the Senate Finance Committee, which is chaired by Senator Max Baucus (D–Mont). Health reform legislation has been drafted, in which the wording for the MOC PQRI option can be found.

The many new activities and programs of the ABMS are costly. Not surprisingly, dues have already increased for the ABR. In 2007, ABR’s dues to ABMS were \$112,010, and in 2008 they were \$134,527. The dues are expected to increase sharply through 2011 to support the expansion of ABMS and its many activities. This very substantial change in resource consumption due to ABMS activities has not been limited to dollars, but rather includes the volunteer trustees and directors of the

TABLE 1: Organizations Included in the National Priorities Partnership

Quality Alliances
Ambulatory Care Alliance
Hospital Quality Alliance
Alliance for Pediatric Quality
Quality Alliance Steering Committee
Consumers
National Partnership for Women and Families
Consumers Union
AARP
AFL-CIO
Purchasers
National Business Group on Health
The Leapfrog Group
Pacific Business Group on Health
US Chamber of Commerce
Health Professionals and Providers
American Medical Association Physician Consortium for Performance Improvement
American Nurses Association
National Association of Community Health Centers
Accreditation and Certification
The Joint Commission
National Committee for Quality Assurance
American Board of Medical Specialties
Certification Commission for Health Information Technology
Insurers
America's Health Insurance Plans
Government
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Agency for Healthcare Research and Quality
National Institutes of Health
National Governors Association
Other Private Sector Organizations
Institute for Healthcare Improvement
Institute of Medicine

Member Boards and the board executives. This change has been necessary to meet the many demands resulting from meetings with health care purchasers, insurers, hospitals and health systems, the NQF, government, etc.

The NQF, which also serves a convening role for a diverse array of health care stakeholders, has recently expanded its mission to include the actual setting of a national quality agenda, and it has taken on a bold initiative: the National Priorities Partnership (NPP). This group of 28 major health care stakeholders has convened with the purpose of providing an organized approach and overarching strategy for the many well-meaning organizations and leaders attempting to improve health care quality and safety. If the priorities of all the stakeholders were aligned, and if steps could be taken—including the development of performance measures in accordance with the consensus priorities—then the country could be expected to move forward in achieving its priority-based health care goals. For a list of the organizations included in the NPP, see Table 1.

The NPP—led by Donald M. Berwick, CEO of the Institute for Healthcare Improvement, and Margaret E. (Peggy) O’Kane, CEO of the National Committee for Quality Assurance—has met frequently and developed consensus priorities and goals. It has drawn liberally from the IOM report, “Priority Areas for National Action,” and the US Department of Health and Human Services publication “Healthy People 2010.” In identifying the priorities, the NPP sought high-impact areas, which were defined as those that could remove waste, provide effective care, eliminate harm, and eradicate disparities. The six national priorities are:

- Engage patients and families in managing their health and making decisions about their care
- Improve the health of the population
- Improve the safety and reliability of America’s health care system
- Ensure that patients receive well-coordinated care within and across all health care organizations, settings, and levels of care
- Guarantee appropriate and compassionate care for patients with life-limiting illnesses
- Eliminate overuse while ensuring the delivery of appropriate care.

Importantly, the NPP has recognized not only that a transformation in the health care system is required but also that there are several key drivers of transformation. These include:

- Performance measurement
- Public reporting
- Payment systems
- Research and knowledge dissemination
- Professional development: education and certification
- System capacity.

All these drivers will require attention if health care reform is to become a reality. Insofar as physician performance is concerned, development of measures in each of these priority areas is planned, and there are targeted topics under each priority. For example, under the priority of eliminating overuse, many specific goals address a wide range of topics, from inappropriate medication use (overuse of antibiotics, chemotherapy in the last 14 days of life, etc.) to unnecessary laboratory tests, to inappropriate diagnostic imaging.

The August 2009 summit of the American Board of Radiology Foundation (ABRF) in Washington, DC, was planned as a program jointly sponsored by the ABRF and the National Institute for Biomedical Imaging and Bioengineering. The intent was to focus on inappropriate use of medical imaging. Organized by ABR past president and current member of the ABRF board of directors, William R. Hendee, the program featured a keynote address by Bernard M. Rosof, chairman of the AMA Physician Quality Reporting Initiative and head of the overuse priority work of the NPP. The purpose of the summit is to identify the root causes of overutilization of medical imaging and then to plan steps to deal with each one.

In more general terms, each NPP organization, including the ABMS, has committed to the consensus priorities, performance measurement, and public reporting. Each group also has stated its readiness to take action inside its own organization to

effect necessary changes. This means that individual Member Boards should begin making plans to work the national priorities into part 4 (Practice Quality Improvement [PQI]) of their MOC programs.

Final Remarks

It is plain to see that the ABR has become a larger, busier enterprise with an agenda that is necessarily much broader than testing. The self-imposed deadlines to transform the diagnostic radiology written and oral examinations to the new computer-based examinations (Core, June 2013; Certifying, September–October 2015) would have been enough of a challenge. In connection with this examination transformation, the ABR also is actively working to create the ABR Testing Operations and Management System, which will be a robust item-banking system and a software application for remote access for volunteers, item editors, examination assembly, and statistics. In addition, the ABR is due to deliver its first primary certificate diagnostic radiology MOC examinations in 2010–2012. These must be beta tested, beginning in late 2009. The ABR will impanel approximately 20 new committees to help with the new core and certifying examinations. Eighty-two committees of volunteers are meeting in 2009 to develop, refresh, edit, and refine various ABR examinations. Across diagnostic radiology and subspecialties, radiation oncology, and radiologic physics, volunteer content expertise is being combined with practice analysis surveys to fashion the ABR's examination blueprints. The blueprints will ensure the alignment of ABR examinations with contemporary practice.

Unfortunately, the ABR does not have the luxury to work only on new examinations for diagnostic radiology. It must actively administer current examinations as well as MOC programs in diagnostic radiology, radiation oncology, and radiologic physics. The latter has required building up the information technologies support for MOC, so that online interaction has become the routine way for diplomates to check their MOC status, pay fees, and update license and demographic information. It also has meant administration of subspecialty MOC examinations over the last several years, not

only in Tucson, but also at the annual meetings of the Radiological Society of North America, the American Society of Neuroradiology, and the Society of Interventional Radiology. Much additional work is required to render MOC part 4 (PQI) the robust component of MOC that it must be to eliminate waste, variation, and defect, and thereby advance quality and safety nationally. This work must be undertaken so that the value of MOC can be shown.

The rapid and extensive initial certification and MOC changes have required personnel for item editing, volunteer committee staffing, image processing, communication, and web design and development. Additional support is still needed in several areas, including psychometrics and database design. The ABR staff has grown to approximately 55 individuals, almost all based in the office in Tucson. Included are one full-time and three part-time associate executive directors: Jennifer L. Bosma in administration (full-time), Kay H. Vydareny in diagnostic radiology, Stephen R. Thomas in radiologic physics, and Lawrence W. Davis in radiation oncology, as well as Robert R. Hattery, former ABR president and executive director, now senior advisor to the executive director.

Space is a minor challenge in 2009 as the ABR attempts to accommodate many new committees with enough conference room space to do their work. A construction project aimed at reconfiguring the board room into three conference rooms with movable air walls will take place over the next several months.

Concomitant with all of this activity, the ABR has had to dramatically increase its involvement in the ABMS, simply to remain abreast of all that is happening. The ABR has done much more, though, than simply stay abreast. It has become a very active citizen of the ABMS Member Board community.

Not surprisingly, given the scope and volume of activity of today's ABR, the need to communicate as

TABLE 2: Sixteen Ways the American Board of Radiology (ABR) Communicates

ABR–society leadership meetings
Discussions at ABR booth at society meetings
Trustee presentations at society meetings
<i>The Beam</i> (electronic newsletter to diplomates and residents)
E-mail from ABR
Web content and frequently asked questions
One-on-one telephone conversations in office
Open microphone sessions
Pamphlet distribution
Stories, short articles, and announcements in newsletters of societies
Articles in major journals
Regular mail from ABR
Individual responses to specific e-mail questions
Surveys
Annual reports
Video

often as possible in as many ways as are feasible is truly compelling. ABR must communicate with its diplomates, sponsoring organizations, other specialty and subspecialty societies, and the public; and it must collaborate with other organizations to meet the challenges. For instance, without actively collaborating, the ABR would not be able to administer its “traveling” MOC examinations at the annual meetings of several societies (Table 2).

The many challenges the ABR is addressing could not be met without the incredible involvement and hard work of the trustees, who have organized themselves into more than 40 working committees and subcommittees to accomplish all that the Board and the foundation must accomplish. In addition, the ABR's extraordinary volunteers, including committee members, item writers, and oral examiners, make the entire enterprise possible. Finally, the talented and dedicated ABR staff members who faithfully implement the Board's vision are the reason the ABR is able to continue pursuing its mission to improve health care safety and quality.