ANNUAL REPORT 2013-2014

ABR
THE AMERICAN BOARD OF RADIOLOGY
EXCELLENCE • PROFESSIONALISM • PUBLIC TRUST • EST. 1934

The Values

featured on the cover of this report combine to form a complete picture of the standards upheld by the ABR. We are proud to see these values displayed in the professional lives of ABR-certified diplomates.

Contents

ABR Mission

To certify that our diplomates demonstrate the requisite knowledge, skill, and understanding of their disciplines to the benefit of patients.

ABR Vision

The ABR will be the recognized leader in advancing patient care by continuously improving the professional standards of our disciplines through certification of our diplomates.

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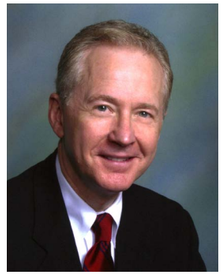
Professionalism in Our Time



Milton J. Guiberteau, MD

Currently, and as it should be, professionalism is a very conspicuous topic in medicine in this time of tumultuous change, particularly in our own specialty of radiology. I see the term everywhere. The word rolls easily off the tongue, and heads nod approvingly. However, in my experience, there is often an underlying frustration and uneasy understanding of what professionalism actually means to us, even though it is considered one of the ABR's core values. And we are not alone. A universal definition in our profession is not available. When I ask colleagues what it means to them, I often get responses ranging from a mute stare to a confident litany of traits and behaviors that every radiologist should possess. This need to reduce such a lofty concept as professionalism—with its underlying fundamental principles and professional responsibilities—to a group of loosely related but measurable behaviors of individual physicians is understandable. Fundamentally, professionalism must be grounded in what physicians actually do to employ core competencies, which when translated into behaviors, put the patient first and foremost. But is this behavioral view all there is to professionalism?

At the other end of the definition spectrum are those who take a larger view, focusing on our collective moral authority to hold one another accountable to a common set of values and behaviors expected of us. These societal service standards define us as patient-centered medical practitioners and earn us certain rights and privileges in return. Both aspects—individual competencies and collective responsibility—are valid and, in fact, are inseparable in the continuum that constitutes professionalism. Both are presently under the same unprecedented demands and challenges that are driving changes in our healthcare system. As viewed through the lens of unrelenting social and professional transformation, both must be recognized and accommodated through the initial and continuous certification requirements and processes of the ABR.

For individual radiology professionals, ABR certification is the most widely and highly valued practice and privileging credential required by medical institutions and healthcare systems. The ABR Board of Trustees, consisting of your colleagues from all walks of radiological practice, has worked hard to ensure that our programs meet the needs of practicing radiologists and medical physicists by maintaining and further enhancing the value of our certification and Maintenance of Certification (MOC) efforts in the professional, public, and regulatory arenas. For example, the Federation of State Medical Boards has agreed to accept ABR certification as meeting the requirements of its proposed Maintenance of Licensure (MOL) programs for state medical boards, and CMS recognizes the value of ABR MOC as a marker of quality care in its payment incentive programs. And the list is growing. As ABR certification and MOC become essential credentials of professionalism that satisfy many masters, ABR processes and requirements must change with the shifting views of professionalism. Today's definition of medical professionalism has evolved from physician autonomy to accountability, from expert opinion to evidence-based practice, and from self-interest to shared responsibility in integrated healthcare systems. While many underlying values have been omnipresent, new ones unique to our time have been added. These include managing resource allocation and conflicts of interest, measuring and improving quality of care, ensuring safe patient imaging, and facilitating interactions among the various players in the healthcare system. These too must be accommodated by the ABR's programs if we are to remain relevant and empowered to shape the future of medical practice in our specialty.

While meeting the demands of professionalism isn't easy or simple, the rewards are considerable.

Attendant with these necessary changes in the ABR's program requirements has been the concomitant responsibility of the ABR to make diplomate compliance as efficient as possible. Our Board of Trustees and I as your President are committed to programs and processes that interface as seamlessly as possible with practice patterns. We see no contradiction in the marriage of lofty goals with the hard work we put in every day. To this end, we have devised and encouraged the use of established society registries, CMS reporting measures, electronic peer review programs, and group efforts for fulfilling MOC practice quality improvement requirements. Thus, more opportunities than ever are available to help you comply with quality efforts that exemplify present-day professionalism in the workplace. What better time and place to demonstrate our commitment to professionalism than in the evaluation of processes we engage in every day.

Although demonstrating expected behaviors and commitment to the values of professionalism are important for accountability, regulatory, and enforcement purposes, our responsibilities to professionalism do not end with individual diplomate certification and MOC. As professionals and ABR diplomates, all of us have a duty to recognize our collective responsibility to professionalism as an expression of our group obligations to the public trust, as well as our promise to hold each other accountable for meeting those obligations. In doing so, we acknowledge not only that professionalism is how we ensure that radiologists are worthy of trust, but also how we manifest a belief system about how best to organize and deliver healthcare.

Such a belief system posits that optimum patient care is best delivered and controlled by those with the knowledge, skill, and trust of patients to provide it. This sort of grand enterprise cannot be accomplished by individuals but requires representation and negotiation by strong, cohesive professional organizations that cradle and proclaim the collective standards of our profession. The ABR is vital to this mission. Moreover, the authority of the ABR in servicing this aspect of professionalism is possible only through the support of a community of radiologists who collectively agree that our values and standards must be maintained and who support the legitimacy of professional organizations to promote and enforce such standards and values.

To dismiss this collective depiction of professionalism as simply a high-minded, lip-serviced abstraction would be unwise in our time. Neglect or complacency only invites further weakening or replacement of our professional belief system as a central doctrine of healthcare. And the current medical environment we inhabit is bursting with eager alternatives. One is a growing belief in consumerism, in which regulation of medical practice is governed by the expectations of consumers of medical care and implemented through competitive marketplace forces. In addition, managerialism, which is already front and center, promotes a system in which corporate managers and/or bureaucrats formulate and enforce practice standards for physicians.

In both systems, the inability of our radiology community to govern its own work would effectively present a fundamental challenge to societal confidence in professionalism and thus weaken trust in radiologist self-regulation. As a substitute for self-regulation, neither of these alternatives represents a palatable scenario, although both are sure to play roles in our future. We must remain in positions of strength today to negotiate with these alternatives tomorrow. It is our mutual responsibility as professionals to actively inform and support the efforts of the ABR and other radiology professional societies involved in preserving our heritage of professionalism.

While meeting the demands of professionalism isn't easy or simple, the rewards are considerable. For those who believe that physicians—radiologists in our case—know best how to care for our patients; that we must put them first in health and safety; that we as individuals and collectively as a specialty should hold ourselves and our colleagues to reasonable standards of knowledge and skill; and that our specialty must change to meet the dynamic challenges of the future and demonstrate that we are not lagging behind in the eyes of patients and the public, the American Board of Radiology stands ready to continue its 80-year mission of preserving traditional values, as well as developing contemporary visions of an evolving professionalism. Only then can we demonstrate that ABR diplomates, individually and collectively, fulfill what is now demanded of us. In doing so, we ensure that radiologists and our professional belief system remain pertinent and powerful in the modern healthcare system.

A MESSAGE FROM THE ABR EXECUTIVE DIRECTOR

This is my first report in my new position as executive director of the ABR. I am tremendously honored and grateful to have this opportunity to serve the Board and our profession. My heartfelt thanks go to the ABR Board of Trustees and our many volunteers. I also want to thank Drs. Gary Becker and Jennifer Bosma for their leadership and many contributions to the ABR.

Valerie P. Jackson, MD, FACR

These are times of great change. The ABR exam changes coincided with major economic and healthcare changes in the United States. The financial crash in 2008 and uncertainty about the economic future of radiology and medicine have led to a tight job market. Fewer radiologists have been retiring, and groups have been reluctant to hire new radiologists in the face of uncertain volumes and reimbursements in the future. The result has been an unprecedented degree of anxiety and anger.

After I accepted this position, I was repeatedly asked three questions:

1. Why would you want to be the person everyone loves to blame (the ABR executive director)?

I certainly don't want anyone to dislike me, but I don't expect to get any love letters in this job. I understand the anger and frustration that many have about the ABR—or any organization that has an impact on one's career and livelihood. My goal is to help our candidates and diplomates navigate our ever-changing professional world. Please keep in mind that we are here for you!

2. Why did the ABR change the diagnostic radiology (DR) examination structure?

There is folklore that the examination schedule was changed because department chairs and residency program directors complained that their senior residents were "missing in action" for their last year of residency training. While they did complain, this was not the major reason for the change. The field of diagnostic radiology has grown so much over the years, and the way we practice has changed so that it is no longer possible for a radiologist to be an expert in everything. Ninety-four percent of diagnostic radiologists practice in four or fewer domains or subspecialty areas. It no longer makes sense to repeatedly examine every radiologist on every aspect of DR if they are not going to use the information. The complaints of the past about useless minutiae on the written and oral DR exams should be gone. Now the tested information is meant to be pertinent to modern practice.

The Core Exam, which is given after the third year of radiology residency, covers everything at a level that should be expected for an individual with three years of DR training. Many or most residency programs have been proactive in developing a new curriculum to ensure exposure to all components of DR training necessary for the examination. Many have developed novel "board review" sessions to reflect the new examination format. The Association of Program Directors in Radiology (APDR) is to be applauded for its creative and thoughtful plans to help programs prepare their residents for the exam.

The Certifying Exam is taken 15 months after the completion of residency (three months after fellowship, if one is done). This is a modular exam where the candidate selects areas of current or projected practice in just the same way the modules are selected for the Maintenance of Certification (MOC)—now called Continuous Certification (ConCert)—Exam. A "general radiology" module is an option, but one that is not likely to be selected very often. I must emphasize the similarity of the Certifying Exam to the MOC Exam, as I describe below.

3. Why can't the ABR fix the job situation?

The reasons for fluctuations in the job market for any profession are complex. Whose job is it to control the job market and the number of available radiologists?

Not the ABR. Our job is to protect the public and ensure that our diplomates have the knowledge necessary to provide good patient care. We create exams and grade them according to the performance of each candidate, not the status of the job market.

Not the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee (RRC). The committee's job is to accredit residency and fellowship training programs. The number of residents allowed for each program is determined by the resources of the department, not by the job situation.

Not the American College of Radiology (ACR). While they are the major U.S. organization for our profession's political and economic issues, and they have extensive resources for government relations, they cannot control the economic environment or individual practices.

Therefore, the only groups that can potentially control the hiring of radiologists are the individual practices and healthcare systems that employ diagnostic radiologists, radiation oncologists, and medical physicists. However, they are subject to the same economic pressures and market forces as the rest of our world.

I have heard statements such as "our DR group won't hire anyone who is not board certified!" In the past, especially when the job market was wide open, it was common to accept residents into jobs without fellowships and well before they were certified. Under the new paradigm, residents will have plenty of time to complete their Core (comprehensive) Exam before they begin their job searches. The Certifying Exam will be much more focused, with candidates selecting their own clinical modules, usually in the area(s) of their fellowship and projected practice. Therefore, they shouldn't need an extended period of time to study, and thus, studying should not disrupt their new practices.

Why should you believe me? The Certifying Exam structure is basically the same as that of the MOC Exam. I took my MOC Exam in October 2013. My clinical focus for more than 20 years has been breast imaging, so I selected three clinical modules in breast imaging and took the required Noninterpretive Skills (NIS) module. (Hint: Use the NIS Syllabus, which is linked on the ABR website at www.theabr.org/ic-dr-certifying exam).

Despite the fact that my clinical practice of breast imaging was only one day per week or less during my 11 years as a department chair, I felt well prepared (without studying) for the parts of breast imaging that I practiced regularly—screening and diagnostic mammography, breast ultrasound, and interventional procedures. I had not been performing breast MRI, so I spent extra time reading books and articles on this topic. I did not take any time off work to study, nor did I devote months to cramming information. I had no trouble passing the exam and feel that learning new things such as breast MRI was not a waste of time, as I should be knowledgeable about all aspects of my subspecialty area, whether I actually perform and/or interpret the procedure or not.

The reasons for fluctuations in the job market for any profession are complex. Whose job is it to control the job market and the number of available radiologists?

It is important to remember that DR was the last ABMS specialty to complete certification during residency training. Thus, credentialing boards and hospital systems are accustomed to our new system of delayed certification until candidates are out in practice.

There are no easy solutions to the difficult situations we face today. However, disseminating information about changes in ABR processes is critically important. The ABR is working to get the word out to the radiology community, practices, hospitals, and healthcare systems.

We all need time . . . for practices to start hiring again, for older radiologists to retire if they wish, for everyone to get used to the new exam process, and for the U.S. healthcare economic situation to settle down. In the meantime, I welcome your feedback about how the ABR is doing. We are here to serve you!

CERTIFICATION STATISTICS

General Certificates Issued by Decade (1930-2013)										
Year Founded: 1934	1934-1939	1940-1949	1950-1959	1960-1969	1970-1979	1980-1989	1990-1999	2000-2009	2010-2013	**TOTAL**
	1,413	1,844	3,303	4,175	9,318	10,083	12,391	12,994	6,811	**62,332**

General Certificates Issued 2004-2013											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**
Diagnostic Radiology	1,047	1,094	1,133	1,162	1,207	1,233	1,239	1,257	1,328	1,329	12,029
Medical Physics	97	135	141	136	200	204	204	315	263	264	1,959
*(Therapeutic)**	(71)	(109)	(121)	(116)	(181)	(169)	(181)	(263)	(232)	(211)	(1,654)
*(Diagnostic)**	(22)	(20)	(16)	(16)	(14)	(28)	(22)	(41)	(29)	(45)	(253)
*(Nuclear)**	(4)	(6)	(4)	(4)	(5)	(7)	(1)	(11)	(2)	(8)	(52)
Radiation Oncology	48	107	136	135	123	166	139	148	155	170	1,327
Total	**1,192**	**1,336**	**1,410**	**1,433**	**1,530**	**1,603**	**1,582**	**1,720**	**1,746**	**1,763**	**15,315**

*Specific specialty of medical physics

Subspecialty Certificates Issued 2004-2013											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**
Neuroradiology	86	81	134	139	148	158	167	185	197	189	1,484
Nuclear Radiology	7	7	4	2	3	2	5	7	7	13	57
Pediatric Radiology	17	28	24	31	34	41	40	53	59	60	387
Vascular & Interventional Radiology	98	77	74	88	81	103	98	117	133	150	1,019
Hospice & Palliative Medicine*	NA	NA	NA	NA	9	0	11	0	42	0	62
Total	**208**	**193**	**236**	**260**	**275**	**304**	**321**	**362**	**438**	**412**	**3,009**

*Subspecialty approved in 2006; examinations offered every other year, beginning in 2008. Certificate administered by the American Board of Internal Medicine.

Number of Diplomates Participating in Maintenance of Certification				
	Diagnostic Radiology	Radiation Oncology	Medical Physics	**TOTAL**
Enrolled in MOC*	19,668 (1,872)	2,841 (253)	2,473 (71)	**24,982 (2,196)***

*As of September 18, 2014. Number of lifetime certificate holders in parentheses.

EXAMINATION STATISTICS

Diagnostic Radiology Physics Exam Pass Rates		
Year	Second-year residents	Third-year residents
2008	90%	88%
2009	90%	90%
2010	94%	88%
2011	N/A*	99%
2012	N/A*	N/A*

Diagnostic Radiology Clinical Exam Pass Rates		
Year	Third-year residents	Fourth-year residents
2008	96%	98%
2009	92%	97%
2010	94%	91%
2011	95%	98%
2012	N/A*	94%

*Second-year and third-year residents did not take exams in this category because they are transitioning to the Core and Certifying exams.

Diagnostic Radiology Oral Exam Pass Rates	
Year	Residents taking exam for first time
2008	88%
2009	90%
2010	92%
2011	89%
2012	89%

Diagnostic Radiology Core Exam Pass Rates	
Year	Residents taking exam for first time
2013	87%

Radiation Oncology Initial Exam Pass Rates (residents taking exam for first time)			
Year	Clinical	Physics	Biology
2009	98%	89%	96%
2010	96%	90%	91%
2011	94%	96%	97%
2012	95%	80%	88%
2013	93%	91%	96%

Medical Physics Part 1 Exam Pass Rates		
Year	General	Clinical
2009	77%	85%
2010	77%	85%
2011	72%	84%
2012	82%	83%
2013	71%	73%

Medical Physics Part 2 Exam Pass Rates			
Year	Diagnostic	Nuclear	Therapeutic
2009	70%	58%	70%
2010	69%	62%	72%
2011	74%	33%	72%
2012	69%	62%	74%
2013	68%	50%	59%

Medical Physics Oral Exam Pass Rates	
Year	Residents taking exam for first time
2009	55%
2010	53%
2011	56%
2012	56%
2013	50%

Medical Physics 2013 Oral Exam Results (CAMPEP)			
	All Takers	First-Time Takers	In CAMPEP Residency
Total	414	285	42
Pass	207 (50%)	167 (59%)	32 (76%)
Condition	66 (16%)	47 (16%)	6 (14%)
Fail	141 (34%)	71 (25%)	4 (10%)

Radiation Oncology Oral Exam Pass Rates	
Year	Residents taking exam for first time
2009	89%
2010	85%
2011	82%
2012	82%
2013	89%

MAINTENANCE OF CERTIFICATION UPDATE

The ABR recently launched two new beneficial programs related to Maintenance of Certification (MOC) and has joined an ABMS initiative that will help its diplomates complete Part 4 of MOC, Practice Quality Improvement (PQI). We are also in the process of establishing a direct feed of CME and Self-Assessment CME (SA-CME) data from societies to myABR. We hope these new initiatives will help save our diplomates both time and money.

MOC Team Tracker

MOC Team Tracker

Many ABR diplomates are busy in group practices and seldom find time to log in to their myABR accounts. Yet, staying current with myABR attestations and entering and checking data are integral to MOC participation. To assist our MOC participants in group practices with their MOC "bookkeeping," the ABR has developed a new online program called MOC Team Tracker.

This online tool is available to diplomates in all ABR disciplines—diagnostic radiology and the subspecialties, radiation oncology, and medical physics. Its use is optional for each diplomate, and not all members of a group are required to participate. Group practices (defined as two or more ABR diplomates) will designate a single Organization Manager who will be responsible for overseeing the program. To ensure that the system structure is scalable for groups of various sizes, the Organization Manager will be authorized to appoint one or more Group Practice Administrators (GPAs).

GPAs are authorized to sign on and manage the input of MOC participation data for the group's members. Each GPA will have a unique list of diplomates, as well as an individual user name and password that allows the GPA to log in to the MOC Team Tracker system. In addition to facilitating data entry, GPAs will be allowed to track each individual member's progress in meeting MOC requirements and issue reminders to participants who fall behind, thus averting potentially inconvenient situations at a later date.

More information can be found on the ABR website at www.theabr.org/moc-team-tracker. To get started, email MOCTeamTracker@theabr.org.

The Whole Practice MOC Discount Pilot Program

As an incentive for group practices to encourage MOC participation by all their members, the ABR will offer a group-wide discount of 10 percent on the current year's annual MOC fees. Discounted fees will be available to members of qualified practices beginning in 2014, and this three-year pilot program will take place through 2016.

Policies and requirements for receiving the Whole Practice MOC discount are outlined on the ABR website at www.theabr.org/moc-whole-practice-discount. Note that requirements are different for 2014 and will change in 2015 and beyond.

The Multi-Specialty MOC Portfolio Approval Program

Engaging groups of healthcare professionals in practice-relevant QI projects that meet specified criteria and simultaneously fulfill MOC Part 4 requirements is a potentially powerful way to advance healthcare quality and safety, while reducing the burdens on diplomates, administrative support staff, departments, and institutions. All these potential benefits can be realized through the ABR/ABMS Multispecialty MOC Portfolio Approval Program (Portfolio Program).

Because the ABR joined the Portfolio Program in July 2014, QI efforts involving ABR-certified physicians and QI efforts in the field of radiology now may be submitted by approved Portfolio Sponsors for MOC credit through the Portfolio Program. For practices and institutions prepared to sponsor MOC Part 4 projects that meet ABR/ABMS requirements, and to approve, monitor, and attest to meaningful participation of ABR diplomate-participants in these projects, the Portfolio Program may be an appropriate relationship to implement. If you believe that your healthcare organization or institution may qualify as a Portfolio Sponsor, you can find more information at http://mocportfolioprogram.org. You may also contact the ABMS or email abrmocp@theabr.org.

Coming Soon: ABR Direct Feed of Society Data to myABR

For more than seven years, the ABR has accepted automatic data transfer from the CME Gateway as a service to our diplomates participating in MOC. Individuals who opted in to the Gateway have been able to have CME and SAM credits earned from participating societies automatically recorded in their ABR Personal Databases (now known as myABR). For the most part, this system has worked well in helping society members track their CME credits toward meeting the requirements of MOC Part 2 (Lifelong Learning and Self-Assessment).

In some cases, however, ABR receipt of data through the Gateway has not been complete and current due to the multiple electronic "handoffs" from the societies through the Gateway to the ABR. The possibility for unreliable data has been exacerbated by the need to separately track the new type of CME credit known as SA-CME.

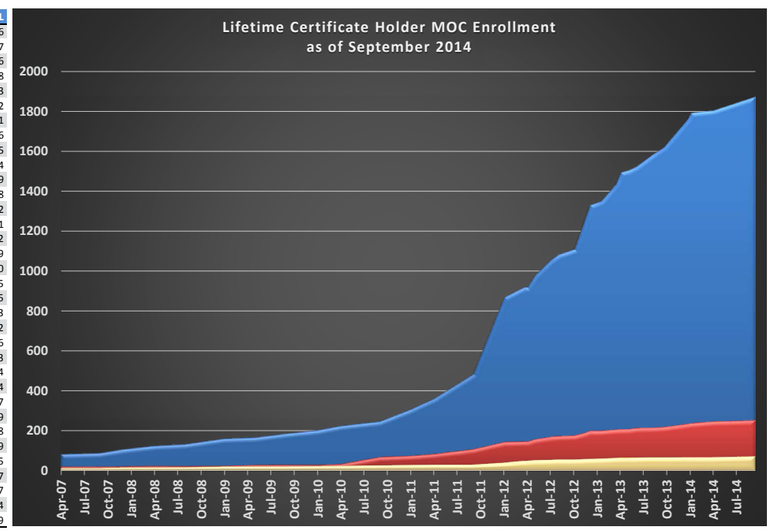
To ensure the reliability of data received on behalf of our diplomates, the ABR is in the process of creating a direct data feed of CME credits from societies to the ABR. We believe this will reduce the risk of delayed updates and inaccurate data in a diplomate's myABR account, possibly leading to inadvertently reporting a diplomate who has actually earned the correct number of CME and/or SA-CME credits as "not meeting the requirements of MOC."

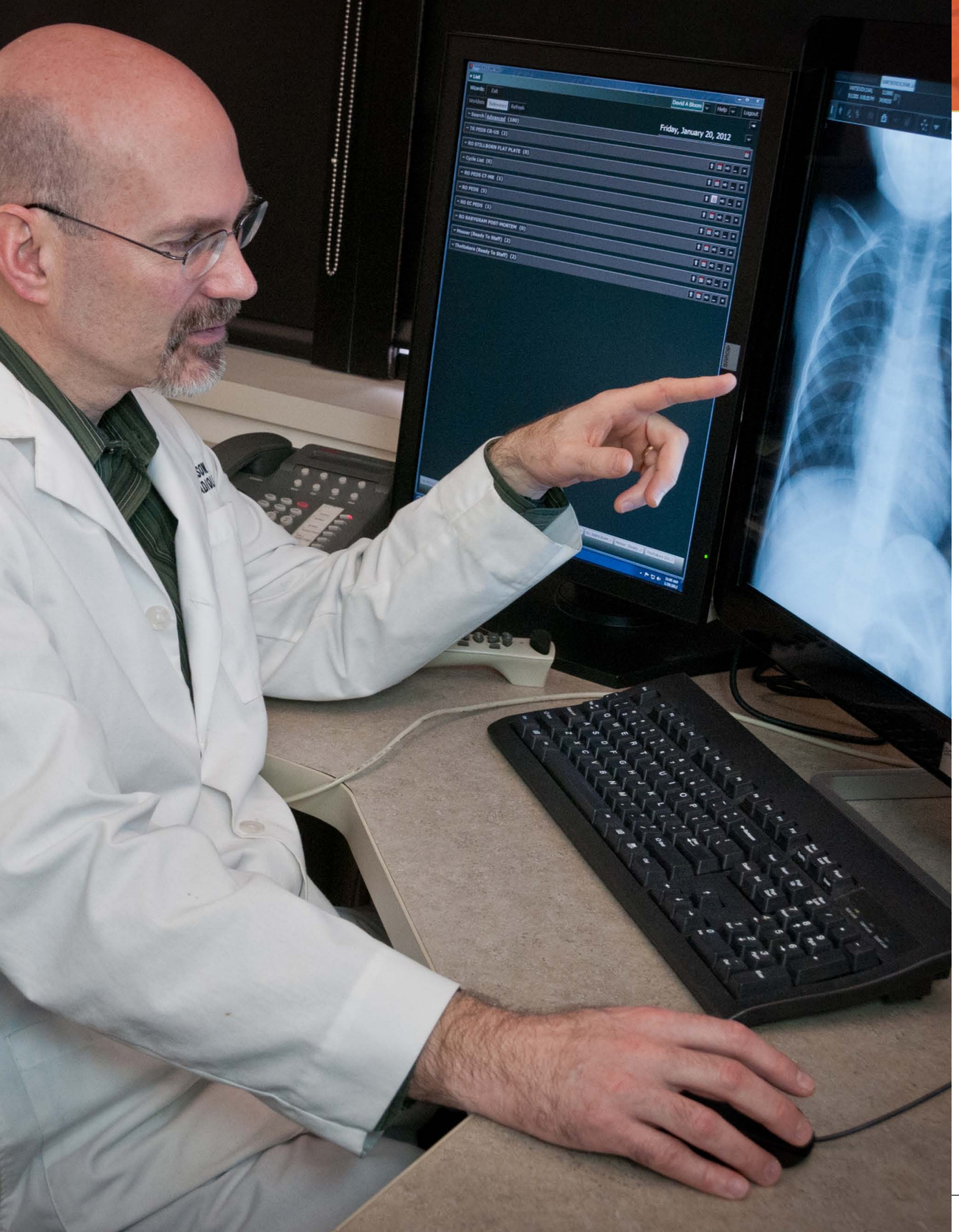
The CME Gateway will still exist as a service to radiologists for tracking CME from multiple societies and regenerating CME certificates. However, the ABR has made a decision not to consume data from the Gateway feed after a direct feed of society CME credits has been established with each respective society. You will be notified when direct data feed is operational; in the meantime, data queries from the CME Gateway will continue. Please remember to check myABR to ensure that your CME credits are properly entered (https://myabr.theabr.org/login).

Enrollment in MOC for Lifetime Certificate Holders

Diagnostic Radiology | Radiation Oncology | Medical Physics

DATE	DR	RO	MP	ALL
Sep-14	1872	253	71	2196
Apr-14	1803	247	67	2117
Jan-14	1791	238	67	2096
Dec-13	1756	235	67	2058
Sep-13	1618	219	66	1903
Aug-13	1580	216	66	1862
Jun-13	1522	214	65	1801
May-13	1503	209	64	1776
Apr-13	1493	208	64	1765
Mar-13	1434	207	63	1704
Jan-13	1349	200	60	1609
Dec-12	1329	200	59	1588
Nov-12	1218	187	57	1462
Oct-12	1108	177	56	1341
Aug-12	1082	174	56	1312
Jul-12	1054	171	54	1279
May-12	979	159	52	1190
Apr-12	919	147	49	1115
Mar-12	919	147	49	1115
Jan-12	868	145	40	1053
Sep-11	483	109	30	622
Apr-11	361	85	30	476
Jan-11	308	76	29	413
Sep-10	247	70	27	344
Apr-10	225	35	24	284
Jan-10	203	31	23	257
Sep-09	187	31	21	239
May-09	167	30	21	218
Jan-09	162	26	21	209
Aug-08	134	24	17	175
Apr-08	126	25	16	167
Dec-07	108	23	16	147
Sep-07	89	22	13	124
Apr-07	84	22	13	119





DIAGNOSTIC RADIOLOGY REPORT

by Kay H. Vydareny, MD
Associate Executive Director for Diagnostic Radiology and the Subspecialties

Kay H. Vydareny, MD

Once again, this has been a busy year for the discipline of diagnostic radiology. The initial certification examination shift from the old to the new exam paradigm will be completed this year. The final oral examination, a capstone for generations of diagnostic radiologists, will be given in Louisville this November; after that, all candidates for initial certification in diagnostic radiology will be tested using the computer-based Core and the Certifying examinations. The Maintenance of Certification/ Continuous Certification program also has undergone growth this year. Some changes in the program have been made since last year, which we hope will make it easier for diplomates to comply with the requirements. More details about each of these efforts can be found below.

We would like to thank the 306 diagnostic radiology volunteers, serving on 31 separate committees, for helping the ABR with these endeavors. Indeed, the ABR could not perform its mission without the assistance of these volunteers, who spend countless hours writing new questions, evaluating questions written by others, and putting together the examinations.

Initial Certification

Since the last "full" oral examination in June 2013, the ABR has administered two other oral exams, with the truly final oral exam on the horizon in November 2014. Each examination has been progressively smaller but has been conducted with the same efficiency and uniformity as prior sessions. After the November 2014 exam, candidates who have not yet passed the oral exam, and who are still board eligible, will transition to the computer-based Core Exam. (For more information on board eligibility, please see the article on page 22.) Candidates who condition the exam in November will take the Certifying Exam at its first administration in October 2015, including the required Essentials and Noninterpretive Skills modules and one module in each conditioned section.

A total of 1,426 candidates took the June examination. The time to complete scoring was shortened, and candidates received their results eight weeks after the exam.

The administration of the Core Exam in June 2014 was carried out at the Tucson and Chicago exam centers. As in the past, thanks to the efforts of ABR staff and volunteers, the administration was nearly flawless. A total of 1,426 candidates took the June examination. The time to complete the scoring of the exam was shortened from last year, and candidates received their results eight weeks after the exam. The statistics for first-time takers were as follows: 91 percent passed, 0.7 percent conditioned (all in physics), and 8.3% failed. These results were similar to those of the 2013 Core Exam.

The scoring methodology for the Core Exam is explained fully on the ABR website at www.theabr.org/ic-dr-score. In short, a candidate must meet the passing standard for the entire examination (the "Angoff passing standard"), which is set by a group of ABR volunteers. If that standard is attained, then a candidate must meet the passing standard on each of 18 categories; the passing standard for physics is higher than that of the other categories, reflecting the central role that physics plays in the discipline of diagnostic radiology. The Core Exam was administered for the third time in October 2014.

The Certifying Exam will be delivered for the first time in October 2015. Physicians who satisfactorily completed their diagnostic radiology residencies in June 2014, and who have passed the Core Exam, will

be eligible for this computer-based examination, also administered at the ABR exam centers in Chicago and Tucson. The modules on the Certifying Exam will be identical to those on the Maintenance of Certification (MOC) Exam since the Certifying Exam is truly the first MOC Exam of a candidate's career.

Some candidates who finished their residencies in June 2014 have been concerned that their inability to become board certified during residency will hinder their job searches. The ABR understands this concern and is attempting to ensure that practices are aware of the change in the examination timing. We will continue to work with the American College of Radiology, the Radiology Business Management Association, and other organizations to make certain that all practices that are hiring radiologists are aware of the change in timing of the Certifying Exam. For more information on these efforts, please see the message from Dr. Valerie Jackson, executive director of the ABR, on page 4.

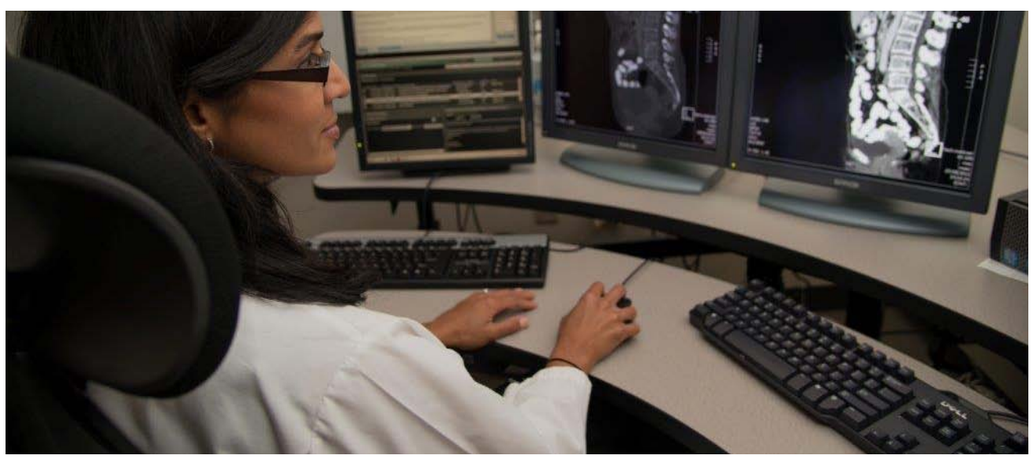
Maintenance of Certification/Continuous Certification

The transition to Continuous Certification remains confusing to some diplomates. The change was undertaken to make compliance with the requirements easier and to emphasize that such compliance is best when it is a continuous, rather than episodic, process. If you have questions about the process that can't be answered by searching the ABR website (www.theabr.org) or myABR (https://myabr.theabr.org), please call the ABR office.

The ABR has joined the other ABMS boards in the public reporting of each diplomate's MOC status. This transparency enables the public, including credentialers, to quickly check the certification status of physicians. Each diplomate must ensure that his or her personal myABR portal accurately reflects MOC participation so public reporting will be correct.

The MOC examination remains a computer-based exam that is administered twice a year and that must be passed at least once every 10 years. Diplomates may choose their clinical practice modules based on their practice patterns, and for the first time this year, a "general" module was included. As in the past, a diplomate may choose one, two, or three modules in a given practice area; the first module will be at a fundamental level, while subsequent modules in the same practice area will be at an advanced level. A Noninterpretive Skills module must be taken by all candidates. A syllabus that incorporates the information included on this module is available on the ABR website.

More information about new programs to benefit ABR diplomates participating in MOC is available in the MOC Update article on page 8 of this report.



by Paul E. Wallner, DO; Dennis C. Shrieve, MD, PhD; and Anthony L. Zietman, MD

Initial Certification

For several years, the radiation oncology community has been undergoing an introspective analysis to consider future directions for radiation and cancer biology research and the relevance of currently taught and tested topics. Some of this review was prompted by clear evidence of reduction in federal research support, but there was also a concern that current avenues of research were not likely to ensure the future growth and relevance of the clinical radiation oncology enterprise as cancer management moves more in the direction of therapies targeted at the molecular level.

Paul E. Wallner, DO, Associate Executive Director for Radiation Oncology

Dennis C. Shrieve, MD, PhD, Trustee and Assistant Executive Director, Initial Certification, Radiation Oncology

Anthony L. Zietman, MD, Trustee and Assistant Executive Director, Maintenance of Certification, Radiation Oncology

In a similar effort, the ABR radiation oncology trustees regularly evaluate material included in the initial certification examinations. Changes in examination content are designed to mirror current clinical practices and evolving trends in the basic sciences of radiation oncology. All radiation oncology clinical category committees continue to add significant image content to the computer-based examinations, as well as nonclinical skills items such as quality assurance, patient safety, biostatistics, and bioethics. These items will be increasingly evident in future examinations.

Based on previously completed American Society for Radiation Oncology (ASTRO) surveys, there is a perception that radiation oncologists may not be sufficiently experienced in diagnosis and management of radiation-related morbidity. To meet this concern, all clinical category committees will add additional morbidity-related content to written and oral examinations. The radiation oncology-related biology research community is reviewing the essential elements of the emerging science of genomics and proteomics. The cancer and radiation biology section of the qualifying examination will be altered accordingly. Concurrent with clinical, physics, and biology enhancements to the initial certification examinations, the web-based radiation oncology examination study guides are also being updated to enhance guidance to candidates preparing for the various examinations.

The radiation oncology trustees are committed to carrying out a triannual clinical practice analysis (CPA) designed to better inform this decision-making process for the clinical examinations. In 2010, the CPA was designed to evaluate how radiation oncologists practice, e.g., modalities employed, dosimetric considerations, utilization of brachytherapy and image-guided techniques, etc. The 2013 CPA was tailored to provide a snapshot of what radiation oncologists actually do, e.g., are ABR diplomates treating pediatric cancers, thyroid cancers, etc.? Future examinations will more closely mirror actual clinical practices.

The radiation oncology-related biology research community is reviewing the essential elements of the emerging science of genomics and proteomics.

Review of current clinical practice has also prompted revisions of the physics elements of the initial qualifying (computer-based) examinations. Items related to the rules for calculation and placement, handling, and clinical applications of sealed-source radium have been removed. With an increasing penetration of proton therapy facilities, a decision

has been made to add some proton and other particle therapy-related physics questions to the examination inventory. The Accreditation Council on Graduate Medical Education (ACGME) does not yet include clinical considerations of proton therapy in its essential requirements for training in radiation oncology, so clinical questions related to this modality will not be added to the examinations at this time.

Maintenance of Certification

The primary focus of trustee and category committee work on the radiation oncology Maintenance of Certification (MOC) program has been related to Parts 3 and 4. In 2013, the radiation oncology trustees committed to the development of a modular Part 3 examination, in which diplomates could select portions of the examination that most appropriately mirror their own practice patterns. Senior academic physicians who often limit their clinical responsibilities to one or two sites of disease or organ systems have frequently raised this issue as an examination concern. The modular MOC Part 3 exam is currently under construction and will be available for its first administration in October 2015.

As currently planned, the Part 3 examination will consist of 200 scorable units. Two modules will be required of all diplomates: a 120-unit general radiation oncology module and a 20-unit nonclinical skills (NCS) module that will include items related to bioethics, biostatistics, quality assurance, and patient safety. Thus, all examinations will include a required 140 units.

The remaining 60 units will consist of two optional modules of 30 units each, which diplomates may select from the radiation oncology list of eight clinical categories. Each MOC-enrolled diplomate will select these optional modules, which may be in one or two sites or organ systems, at the time of examination registration. During examination administration, the pre-selected modules will be accessible to each diplomate, with a latent downtime of only 30 to 60 seconds between modules.

Diplomates enrolled in the Focused Practice Recognition in Brachytherapy initiative are required to undergo testing in brachytherapy as a critical element of the program. Their requirement may be fulfilled by selection of either one or two optional brachytherapy modules. Development of a sufficient item inventory to fulfill the needs for brachytherapy modules will necessitate a delay in introduction of these optional modules until the spring 2016 examination administration.

Radiation oncology diplomates have frequently indicated difficulty in developing MOC Part 4 Practice Quality Improvement (PQI) projects, partially because of the typical team approach of radiation oncology practice and the associated uncertainties regarding attribution of responsibility for various activities and outcomes.

The modular MOC Part 3 exam is currently under construction and will be available for its first administration in October 2015.

The ABR has been working with the American Board of Medical Specialties (ABMS) and its Member Boards to develop projects that will better serve the needs of institutions, departments, and individual diplomates. In July 2014, the ABR joined the new ABMS Multispecialty Portfolio Approval program, which allows practices and institutions to sponsor MOC Part 4 projects and to approve, monitor, and attest to meaningful participation of ABR diplomates who participate in these projects. Further details can be found in the MOC Update on page 8.

We have also been working with various stakeholder organizations such as the American Society for Radiation Oncology (ASTRO), the American College of Radiation Oncology (ACRO), the American Brachytherapy Society (ABS), and others, to develop template projects that can be used by individual diplomates. Links to these projects are available on the ABR website and the sites of the various organizations.

MEDICAL PHYSICS REPORT

by G. Donald Frey, PhD, Associate Executive Director for Medical Physics

Over the past year, the three medical physics trustees have remained unchanged. J. Anthony Seibert, PhD, is the trustee for diagnostic medical physics. Jerry D. Allison, PhD, continued his term as trustee for nuclear medial physics, and Geoffrey S. Ibbott, PhD, continued as trustee for therapeutic medical physics and secretary-treasurer of the Board.

G. Donald Frey, PhD

Initial Certification

2014 is the first year in which new applicants for board certification in medical physics have been required to complete a CAMPEP-accredited residency to be eligible for certification. This is the last step in a series of changes that began in 2012. The purpose of these changes has been to standardize the training necessary to become a board-certified physicist. The plan for the changes was first announced in 2002, so the changes have been more than a decade in the making. Medical physics training is now very similar to that of our physician colleagues.

Exam statistics have shown the value of these changes. Graduates of CAMPEP education programs and residencies show much better performance on ABR examinations than candidates who did not have a CAMPEP education (see page 7).

This was also the last year that the ABR planned to administer the medical physics oral exam in Louisville. Those of us who had been going to the Crowne Plaza (Executive West) for decades were sad to be saying goodbye to the place. However, an in-depth analysis showed that Louisville really was the best place to hold the oral exam, so we will continue in Louisville for at least a few more years.

A big change for next year is the revision of the oral exam categories. The current categories have been used for decades, and the therapeutic medical physics categories continue to perform well. However, with changes in the fields of diagnostic medical physics and nuclear medical physics, the current categories did not discriminate as well as they should have.

A list of the new examination categories can be found on the ABR website at http://www.theabr.org/ic-mp-study-guide#oral. These categories will be used in all oral exams, for both first-time candidates and candidates who have previously taken the oral exam. Note that the category descriptions give a general idea of the content. In any particular examination, the material from the categories is sampled, and additional material related to the categories may be included as the field evolves.

Another major change in medical physics requirements is an adjustment in the documentation of requirements for a second certificate. Medical physics is unusual among the ABR disciplines in that many diplomates seek a second primary certificate. In applying to the ABR for certification in an additional medical physics specialty, the diplomate now must demonstrate that he or she has the equivalent of at least one year of clinical experience in that specialty. Another ABR diplomate, who is certified in the specialty for which the individual is seeking additional certification, must attest to this. The clinical experience need not be obtained in a full-time position but should be consistent with the requirements of the specialty, with the total time committed to clinical experience in the specialty being one year or more. One year is defined as at least 80 percent FTE effort. The clinical experience must address the competencies listed in *AAPM Report 249: Essentials and Guidelines for Clinical Medical Physics Residency Training Programs,* Section 2.5, 3.5, or 4.5.

Upon ABR acceptance of the application, the diplomate will be admitted into the Part 2 and Part 3 (oral) examination process. The standard ABR exam fee schedule will apply. After the diplomate has been approved for Part 2 in an additional specialty, he or she will be considered a board-eligible candidate in the additional specialty and will be allowed six years to complete the certification process. If certification is not completed within six years, the candidate's board-

eligible status will expire, and the candidate will need to complete at least one year of additional training at an institution that has a CAMPEP-accredited residency program before a new application can be filed. Diplomates who apply for a second or third certification must receive approval to take Part 2 within four years, or the ABR will remove the application from the certification process. In this case, the diplomate would then need to complete a year of clinical experience at an institution that has a CAMPEP-accredited residency program before a new application could be filed.

2014 is the first year in which new applicants for board certification in medical physics have been required to complete a CAMPEP-accredited residency to become board eligible.

Applications to take the Part 2 exam in a second or third specialty of medical physics are accepted between July 1 and January 31 of the year before the examination, which is usually held in August.

Maintenance of Certification

The recent changes in Maintenance of Certification (MOC), due to the transition from a 10-year cycle to Continuous Certification, were addressed by the MP trustees and volunteers at the American Association of Physicists in Medicine (AAPM) Spring Clinical Meeting and Annual Meeting. To answer individual questions, the ABR also had a booth at the AAPM Annual Meeting. These changes are described in detail on the ABR website at www.theabr.org/moc-rp-landing.

Continuous Certification requirements are the same across all three ABR disciplines, but medical physicists have more options for fulfilling the requirements of MOC Part 2, Lifelong Learning and Self Assessment. The annual look-back period for Part 2 is three years, and a diplomate must have completed 75 hours of continuing education in the previous three years. (An important exception for the first full look-back in March 2016 only is that credits obtained in 2012 will also be counted.) Of these 75 hours, 25 must be self-assessment CME (or CE for physicists). SA-CE is a new concept, and medical physicists have three options for earning credits, rather than two.

The first option, Self-Assessment Module (SAM) credit, is not new, and SAMs will continue to be counted as one of the forms of SA-CE. There are many sources of SAM credit, and the ABR maintains a list of available SAMs at www.theabr.org/moc-rp-sam.

The second option, which is new, is SA-CE credits for completion of all AMA Category 1 CE activities in "enduring materials" (including web-based and print) and "journal-based CE" formats. The key factor is that the materials include a post-test with a required score for successful completion.

The third option for SA-CME credits, unique to medical physics, is the self-directed educational project (SDEP). In an SDEP, the diplomate designs a learning project that meets his or her practical clinical needs. A physicist may claim up to 15 CE credits per year for successfully completing an SDEP. The SDEP does not need to be submitted to the ABR for approval, but like all self-attested material, it can be audited. Examples of SDEPs are available on the ABR website at www.theabr.org/moc-rp-sdep.

Another unique medical physics issue is the requirement for attestation for some medical physicists. Those who have a state license from Florida, Hawaii, New York, or Texas are exempt from attestation even if they do not live in one of those states. Other medical physicists must attest every five years.

If you have any questions about fulfilling the requirements of MOC under Continuous Certification, please call the ABR Connections Center at (520) 519-2152 or email moc@theabr.org.

INTERVENTIONAL/DIAGNOSTIC RADIOLOGY REPORT

The new interventional radiology/diagnostic radiology (IR/DR) primary certificate, approved by the American Board of Medical Specialties (ABMS) in 2012, is now one step closer to implementation, and the ABR could issue the first initial certificates as soon as 2017. The IR/DR certificate was designed to recognize interventional radiology as a unique medical specialty, addressing the diagnosis and treatment of diseases through expertise in diagnostic imaging, image-guided minimally invasive procedures, and the evaluation and clinical management of patients with conditions amenable to these methods. Those certified in IR/DR will have demonstrated competency to practice in diagnostic radiology, as well as the full scope of interventional radiology.

The program requirements for the Interventional Radiology Residency Program have been approved by the Committee on Requirements of the Accreditation Council for Graduate Medical Education (ACGME); at the time of this report's publication, they were in the final editing stage. Once finalized, the program requirements will allow the ABR to continue the planning and subsequent implementation of operational details for the new certificate. The application for the new residency will be created, and requests for application for the new IR Residency are anticipated to begin in mid to late 2015. All applying sites will require an on-site visit. Programs may be able to become accredited and start to enter trainees as early as the 2016-2017 academic year.

Expected Components and Rules

Individuals interested in IR/DR certification will need to apply specifically for this new residency. Candidates may NOT be actively enrolled for certification in both DR and IR/DR—only one training program leading to certification may be pursued at any given time. However, during the initial years of implementation, some transfers from DR to the IR/DR certification pathway are expected and will be accommodated.

Candidates for the IR/DR certificate will be required to successfully complete a residency at an ACGME-accredited IR program to meet the training requirement for certification. The program requirements provide three potential ways to achieve this training: either a five-year integrated program of diagnostic and interventional radiology, or a combination of DR residency followed by an independent one- or two-year IR program. The number of years spent in the independent IR program depends on how much interventional radiology experience the resident obtained in his or her DR program. More details on certification requirements will follow after program requirements are finalized.

The examination structure will consist of the DR Core Examination in the 36th month of residency training, and an IR Certifying Examination with both oral and computer-based components three months after completion of training. Details of the examination structure and specific requirements for each exam are still being determined.

Impact on VIR Subspecialty

To increase quality and safety for the public, the IR/DR certificate is designed to eventually replace the VIR subspecialty certificate. The transition is expected to be a seven-year process. The ACGME anticipates that the last year of accreditation for one-year VIR fellowships is 2021-2022. When the ACGME ceases to accredit VIR fellowships and instead accredits only the new IR residencies, the VIR subspecialty certificate will sunset. Those who hold a VIR subspecialty certificate will be issued a replacement IR/DR certificate at no additional cost if they are meeting all MOC requirements. This process will likely begin in 2018.

Suggestions for Candidates Currently in Training

The ABR recommends that these candidates continue their training and seek certification according to the current processes. Those interested in practicing in IR can seek certification in DR with a subspecialty in VIR, or pursue these two certificates via the Diagnostic and Interventional Radiology Enhanced Clinical Training (DIRECT) pathway. Those who have begun DR training also may have the opportunity to transfer into an IR residency at their own institution to seek initial certification in IR/DR.

The ABR will continue to provide information regarding the new IR/DR specialty certificate as it becomes available. Please check our website at www.theabr.org for the latest information.

William G. Spies, MD, FACR, is a diagnostic radiologist and nuclear medicine physician at Chicago's Northwestern Memorial Hospital, the main teaching hospital of Northwestern University's Feinberg School of Medicine. As an ABR diplomate who is certified in diagnostic radiology and also holds a subspecialty certification in nuclear radiology, he has served as an ABR volunteer since 1986 in various capacities: oral examiner for both the Diagnostic Radiology and Nuclear Radiology Oral Exams, panel chair, member of the Written Examination Committee and chair of the Nuclear Radiology Section, member and co-chair of the Core Examination Nuclear Radiology Committee, and member and chair of the Nuclear Radiology Subspecialty Examination Committee.

William G. Spies, MD, FACR

Dr. Spies has volunteered for the ABR over the years for several reasons. His primary academic interest is in the area of undergraduate and resident and fellow education, including examination development and administration. In addition, he thinks that service to the Board is a vitally important element in maintaining high-quality resident training and evaluation.

"I fully subscribe to the ABR mission to serve patients, the public, and the medical profession, and I strive to ensure that ABR diplomates continue to maintain the high standards of knowledge, performance, safety, and professionalism set forth by the Board," he told us. "My involvement with the Board has also allowed me to improve the focus of my own resident teaching and to provide me with insight into the general state of radiology residency training across the country and beyond. In addition, my service to the ABR has been one of the most rewarding aspects of all my professional experiences throughout my career.

"The best part of volunteering for the ABR has been the opportunity to meet and interact with so many highly intelligent, talented, motivated, and dedicated professionals in the numerous fields of radiology, as well as the highly professional, capable, hardworking, and personable ABR staff. None of what we do for the ABR could be accomplished without the help of all these wonderful people. This experience has afforded me the opportunity to meet and spend time with many of the leaders and emerging leaders of radiology in an environment in which everyone doesn't have to run off to fulfill other professional or personal obligations and can take the time to unwind and interact with colleagues in a relatively relaxed setting.

"In many cases, this environment has facilitated developing more meaningful relationships with those who were previously my mentors, as well as those whom I have mentored. Throughout these experiences, I have been able to learn a great deal and to develop extremely rewarding professional relationships and friendships that I highly value. The spirit and morale of all those who contribute to this organization at all levels has never ceased to impress me, more than any other professional organization that I have worked with. For all the time and hard work we volunteers contribute to the ABR, we are constantly and sincerely reminded in many ways of how much our efforts are appreciated, and we also never fail to have a good time and a laugh or two along the way as we accomplish the sometimes formidable tasks set before us by the Board."

Dr. Spies thinks that service to the Board is a vitally important element in maintaining high-quality resident training and evaluation.

For Dr. Spies, the practice of academic nuclear medicine and other areas in radiology with which he has been involved, such as body imaging, has been very rewarding and stimulating. He feels that due to the ever-changing nature of clinical practice in these areas, his work never becomes stagnant and continues to challenge and stimulate. The interaction with residents and involvement in resident training and evaluation has been a major source of career satisfaction, as has his involvement in clinical research with partners in imaging, clinical practice, and industry.

"As for many of my peers, this overall satisfaction and enthusiasm has been somewhat dampened by growing frustrations created by increasing government intrusion, politics, red tape, and administrative regulation over the years, which often places barriers between physicians and their practice of medicine," Dr. Spies explained. "These factors have sometimes led to more challenging work environments and economic conditions, and a degree of deterioration in the relationships among radiologists and colleagues in other specialties and hospital administrative staff. Nevertheless, the practice of medicine remains a vibrant, enjoyable, and meaningful career. These challenges will in large part need to be met and addressed by the rising younger generation of physicians who will ultimately replace us, including the residents we currently train and evaluate via the ABR examination process."

Board certification is, to Dr. Spies, an important symbol and verification of the achievement of a level of excellence in training and professionalism commensurate with the expectations of patients, colleagues, and the public.

"All of us who have achieved this certification have a right to be genuinely proud of our accomplishment," he said. "Coupled with the related concepts of Maintenance of Certification and continuing medical education, board certification is an important element in preserving the level of quality in radiology practice and ongoing education that we have come to enjoy and expect from all our diplomates—past, present and future."

Front Sign

Room Décor

Viewbox Exam Set-up

Hallway

Photographs of the Executive West Hotel, Louisville, Kentucky, taken by Dr. William Spies in the mid-1980s

Dr. Spies has gathered a comprehensive collection of famous anecdotes from his many years of serving as an ABR oral examiner. He also produced one of the very few existing sets of photographs depicting the horrendous original décor of the Executive West Hotel before the first of several remodeling projects that began in the late 1980s! One of his favorite memories was being afforded the distinct honor, by the ABR workroom staff in Louisville, of ringing the chimes for the final oral examination of the week some years ago, an honor he shared with co-examiner and friend Mike Hartshorne, which has since also been bestowed on other examiners.

The ABR currently has about 500 volunteers, not including oral examiners in medical physics and radiation oncology.

"And I would be remiss in not mentioning my great appreciation for the many colleagues who helped me develop into an effective member of the ABR volunteer team and made this experience so much more enjoyable and fulfilling, including Mickey Guiberteau, Fred Mettler, Barry Siegel, Doug Maynard, Kay Vydareny, and Bob Hattery, to name just a few, as well as the many dedicated ABR staff members who help develop and administer the exams."

Despite fully understanding the reasons for abandoning the diagnostic radiology oral examination process, Dr. Spies said that he will nevertheless greatly miss his biannual trips to Louisville to meet and work with his many valued ABR friends and associates, not to mention the thousands of residents they have helped to train and evaluate over the years.

The ABR currently has about 500 volunteers, not including oral examiners in medical physics and radiation oncology. For more information on contributing to the profession of radiology by serving as an ABR volunteer, please visit www.theabr.org/volunteers.

The ABR Board Eligibility Policy

According to the ABR Board Eligibility Policy, adopted in 2011, candidates have specific time limits for remaining eligible to be initially certified by the ABR and to maintain their status as "board eligible." Those who have not achieved certification by the end of their time limit can no longer describe themselves as board eligible.

For diagnostic radiology (DR) and radiation oncology (RO) candidates who have already completed training, the board eligibility period ends according this schedule:

End of Training	Termination of Board Eligibility
2004 or prior	December 31, 2014
2005	December 31, 2015
2006-2010	December 31, 2016
2011 and later	Six full calendar years from end of training

Board eligibility begins at the completion of DR or RO residency training in a department with a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC). For international medical graduates, "end of training" is defined as the end of the four-year period outlined in the Sponsoring Department Agreement. After they become board eligible, candidates have six calendar years to attain certification. DR candidates must pass the Core and Certifying exams, and RO candidates must pass the qualifying (computer-based) and oral exams.

To become board eligible in medical physics (MP), candidates must complete a CAMPEP-accredited residency program or be approved for Part 2 of the initial certification examination, whichever comes first. The candidate then will have six calendar years to attain certification by passing Part 2 and the oral exam (Part 3). Candidates who completed their training or received approval for Part 2 before January 1, 2011, will have until December 31, 2016, before their board eligibility expires.

For more information on board eligibility and reinstatement of board eligibility status, see www.theabr.org/ic-gen-board-eligibility.

The ABR welcomes the following new trustees, whose terms of service began on July 1, 2014. ABR trustees participate in leadership and decision making to carry out the ABR's mission and set standards for board certification in initial certification and Maintenance of Certification.

Donald J. Flemming, MD, a diplomate of the ABR in diagnostic radiology, is the G. Victor Rohrer professor of radiology education at Penn State Hershey Medical Center. He is a renowned musculoskeletal (MSK) radiologist, regarded as one of the foremost authorities in the field.

Dr. Flemming earned his medical degree from the State University of New York at Buffalo in 1985 and served his internship and residency at the National Naval Medical Center in Bethesda, Maryland. He completed a one-year fellowship at the Armed Forces Institute of Pathology in Washington in 1996. An active medical researcher, Dr. Flemming has written extensively on MSK imaging and is coauthor of *Arthritis in Black and White, 3rd Edition*. He has also received numerous honors and awards for excellence in teaching and meritorious service.

John A. Kaufman, MD, is a 1982 graduate of Boston University School of Medicine who was a surgery intern at the Hospital of the University of Pennsylvania, and then a general medical officer in the U.S. Indian Health Service. He trained in diagnostic and vascular/interventional radiology at Boston Medical Center and then joined the Section of Vascular Radiology at Massachusetts General Hospital, until becoming a member of the Dotter Interventional Institute as a professor and Frederick S. Keller Chair of Interventional Radiology.

Dr. Kaufman is also professor of radiology, surgery, and medicine at Oregon Health and Science University in Portland and is chief of vascular and interventional radiology and director of the Dotter Institute. He has published peer-reviewed articles, edited several books, and lectured at local, national, and international meetings.

The ABR thanks the following trustees, whose terms ended June 30, 2014. We greatly appreciate their many years of faithful and dedicated volunteer service.

James P. Borgstede, MD, a board-certified diagnostic radiologist, is currently professor and vice chair of radiology at the University of Colorado Denver. Dr. Borgstede was a member of a private radiology practice for 27 years in Colorado Springs. He left this practice in 2007 for a fellowship in magnetic resonance imaging at the University of California at San Diego. He served the ABR as a trustee for nine years beginning in 2005 and was ABR president from 2012 to 2014.

Dr. Borgstede also oversaw the Noninterpretive Skills (NIS) Certifying/MOC Exams Committee and chaired the MOC Coordinating Committee from 2008 to 2011. He has been active in the politics and leadership of radiology and has delivered more than 100 lectures nationally and internationally regarding socioeconomic issues, government relations, quality, safety, and other medical topics.

Thomas A. Berquist, MD, who is board certified in diagnostic radiology, has been affiliated with the Mayo Clinic since 1977, first in Rochester, Minnesota, and then in Jacksonville, Florida. In Jacksonville, he became chair of the Department of Radiology before serving as director of the Radiology Residency and Musculoskeletal Fellowship programs. He has been either a member or chair of more than 50 Mayo committees.

Dr. Berquist served as an ABR trustee from 2006 to 2014, overseeing various musculoskeletal committees as well as being an item writer. He is recognized as an accomplished author of 36 widely used radiology textbooks and over 100 publications, and he has given more than 170 lectures and presentations, both nationally and internationally.

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