Annual Report 2014 - 2015

ABR CERTIFICATION
Partners in Evolution

“Alone we can do so little; together we can do so much.”
- Helen Keller
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.
Evolution of ABR Certification: Process and Partnership

Annual reports can be prosaic reading, even for those who have a thirst for details. By tradition, they offer articles with tidbits of efforts expended and missions accomplished. This year is no exception as a number of significant ABR accomplishments of interest to our diplomates are described in this report. However, often missing are explanations of the motivations, practical assumptions, and processes that underlie these efforts. In this time of frequent change in our professional landscape, it seems reasonable that I provide you, our stakeholders, with more than a presidial summary of information already available on the pages that follow.

In a number of significant ways, the past year has been a pivotal one. As documented in this report, the year included (1) completion of transitioning the diagnostic radiology (DR) oral certification exam to a fully computer-based process; (2) the 2015 diagnostic radiology (DR) oral certification exam to a Continuous Certification (MOC) to a Continuous Certification exam to a fully computer-based process; (2) the 2015 diagnostic radiology (DR) oral certification exam to a Continuous Certification (MOC) to a fully computer-based process; (4) a major restructuring of ABR governance to better meet the challenges of the future. To say that these significant efforts expended and missteps in the MOC programs have allowed participants easy access to tools for meeting ABR requirements while fostering their satisfaction with the process itself.

Certification and Accreditation Organizations.

To align with the broader medical community beyond our own specialty, the ABR participates in an exchange of ideas with our partners in the ABMS board community, as well as accreditation organizations such as the Accreditation Council for Graduate Medical Education (ACGME). Certainly, in the past year, we have learned a lot from our fellow certification boards’ successes and missteps in their own programs, offering us processes to emulate as well as to avoid. Fortuitously, the ABR’s MOC program has proved to be a vital function of certification in the broader medical community, as well as relevant and appropriate for performance by busy practicing radiology professionals. This means avoiding the pitfalls of either overburdening our requirements or overreaching them by setting the bar too high.

Diplomates.

The introduction of MOC and Continuous Certification fundamentally changed the ABR-exam candidate interaction from a one-time encounter with the Board to a professional lifelong relationship. Thus, diplomate input into this partnership has become a valuable ongoing requirement for development and assessment of our programs. As the collective membership of our specialty, we place our trust in the ABR to perform the vital function of certification in a manner that is as robust, yet as nonintrusive, as also relevant and appropriate for performance by busy practicing radiology professionals. For the purposes of MOC and Continuous Certification, we have constructed a system that is built on a framework of feedback from our diplomates through focused online surveys, diplomate advisory committees, and direct interactions during ABR update sessions and at ABR kiosks at multiple national meetings throughout the year. These efforts have already borne fruit as evidenced by the recent improvements in ABR MOC Part 4 (Practice Quality Improvement), based on diplomate feedback. This change, which offers credit for quality activities already performed by diplomates in the course of their practices, has been very well received. And, as always, there is more to be done.

Already begun is a focused evaluation of MOC Part 3 through consideration of options for possible replacement of the current 10-year “recertification” examination. Because MOC is now a continuous process, it makes sense that a mechanism for ongoing assessment of knowledge and judgement be sought. This also has the potential to eliminate the time, travel, cost, and anxiety of the current exam-center testing model, as well as to link the discovery of any diplomate knowledge gaps with remediation through CME required for MOC Part 2.

The Bottom Line.

Board certification represents a radiologist’s personal commitment to provide a high standard of quality patient care and is an acknowledged benchmark of public trust. The ABR’s challenge in providing Continuous Certification is to achieve the delicate balance of creating rigorous and meaningful programs that are also relevant and appropriate for performance by busy practicing radiology professionals. This means avoiding the pitfalls of either overburdening our requirements or overreaching them by setting the bar too high.

While the Board must guard its privilege to operate without interference with its mission to protect the public, it also must be open to the perceptions and feedback from relevant communities and those who delegate to us the awesome responsibilities of self-regulation. These interactions ensure that our Board is operating within acceptable limits in reaching the program balance it hopes to achieve. Employing these methods, the past year has enabled us to successfully re-evaluate and improve problematic portions of our MOC program. I am convinced that through using the same methods, the coming year will provide additional opportunities for positive change.
Discovering ABR Teamwork

Since I began my position as ABR executive director in July 2014, I have been amazed and excited to discover something new almost every day. Usually, these discoveries are small yet very meaningful: the staff member who doesn’t drink coffee but comes in early and makes it for everyone else so several pots will be ready when they arrive; the support our employees offer others who are out sick by sending cards and flowers and donating paid time off from their own accounts to help those who don’t have enough to cover a major illness; the adoption of a stray cat, now known as the ABR mascot “Ollie,” by feeding her, giving her a kitty condo, and even providing veterinary care; the ABR team that recently participated on a Saturday morning in the local Community Food Bank walk and raised more than $1,200; and the genuine and touching sorrow expressed at the sudden death of a staff member, with the resulting effort to plant a tree accompanied by a stone placard in front of the building as a memorial.

These personal examples of teamwork and a caring attitude are evident every day in our staff’s dedication and hard work, bringing together each of their individual talents to accomplish our goals on behalf of ABR candidates and diplomates. This 28-member team is composed of practicing radiology professionals from around the country who, among many other tasks, donate countless hours working with exam committees, formulating and writing policies, developing strategic plans, assisting staff members with their projects, attending and presenting at society meetings, and sometimes making tough decisions on behalf of the ABR. Above all, they are dedicated to ensuring that ABR board certification is the most valuable credential possible, while at the same time listening and responding to the concerns of ABR candidates and diplomates.

Casting the net even wider, I cannot say enough to thank the many professional radiology societies, as well as our ABR volunteer committee members! As of October 2015, this group included 449 item-writing volunteers and 766 potential oral examiners. Without their help, the work of our governors, trustees, and staff would not be possible. They come from a variety of practice environments across the country and serve as committee chairs and members, oral examiners, self-assessment module (SAM) reviewers, and image asset contributors. Like our staff, they put in long hours and work hard but greatly enjoy the benefits of teamwork, including interaction with their colleagues; the exchange of ideas; the opportunity to create, assemble, and administer fair board examinations; and the satisfaction of giving back to their profession. And like our governors and trustees, they all participate in Maintenance of Certification, even if they are lifetime certificate holders, to exhibit the value they see and the trust they place in the ABR MOC program.

Perhaps the most important members of the ABR team, however, are you—our candidates and diplomates. As of December 31, 2014, the ABR had issued 64,840 certificates since its inception in 1934, with 17,899 of those issued in the past 10 years alone.

We consider you the most crucial members of our team, and we appreciate your feedback, whether it’s a congratulations for a job well done, a suggestion for improvement, or even a downright criticism. As mentioned in the MOC Update (see page 8), the feedback given by our ABR MOC Advisory Committees, as well as the many responses from diplomates to an April 2015 MOC survey, was very helpful to us in determining the important changes recently made to our MOC program. As the most essential part of our team, your opinions are truly appreciated.

During their breaks, some of our ABR staff members enjoy working on jigsaw puzzles, which we have set up on a table in our lunchroom. A recent puzzle was titled “Impossibles: The Borderless Puzzle with 5 Extra Pieces.” Usually, it takes a while for staff members to complete these puzzles since they only work on them for a few minutes at a time, and this one was particularly challenging. But finally, it was done, and I walked in one day to discover this handwritten note on top of the finished puzzle: “Impossible? I don’t think so!”

To me, this sums up the positive attitude I’ve seen displayed by all members of our ABR team—staff, trustees, governors, volunteers, candidates, and diplomates alike. With a team like ours, nothing is impossible, and I’m so proud and honored to be a part of it all!
### Certification Statistics

#### Subspecialty Certificates Issued 2005-2014

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<td>1,530</td>
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<td>1,763</td>
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</table>

*Due to the transition from the diagnostic radiology (DR) oral exam to the DR Certifying Exam, only those who took and passed a DR oral exam were certified in 2014. The first DR Certifying Exam was administered in October 2015.

**Specific specialty of medical physics

#### Specialty Certificates Issued 2005-2014

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**Specific specialty of medical physics

### Examination Statistics

#### Diagnostic Radiology Core Exam Pass Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Residents taking exam for first time</th>
<th>Pass Rate</th>
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<tr>
<td>2013</td>
<td>87%</td>
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<tr>
<td>2014</td>
<td>91%</td>
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<tr>
<td>2015</td>
<td>87%</td>
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#### Radiation Oncology Initial Exam Pass Rates

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<th>Year</th>
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<th>Physics</th>
<th>Biology</th>
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<tbody>
<tr>
<td>2010</td>
<td>96%</td>
<td>90%</td>
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<tr>
<td>2011</td>
<td>94%</td>
<td>96%</td>
<td>97%</td>
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<td>2012</td>
<td>95%</td>
<td>80%</td>
<td>88%</td>
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<tr>
<td>2013</td>
<td>93%</td>
<td>91%</td>
<td>96%</td>
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<tr>
<td>2014</td>
<td>92%</td>
<td>81%</td>
<td>87%</td>
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#### Radiation Oncology Oral Exam Pass Rates

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<tr>
<th>Year</th>
<th>residents taking exam for first time</th>
<th>Pass Rate</th>
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<td>2010</td>
<td>85%</td>
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<td>2011</td>
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<tr>
<td>2012</td>
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<tr>
<td>2013</td>
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<td>2014</td>
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#### Medical Physics 2014 Oral Exam Results

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<th>CAMPEP Residency</th>
<th>CAMPEP Graduate &amp; Residency</th>
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<tr>
<td>2010</td>
<td>39</td>
<td>31</td>
<td>29</td>
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<tr>
<td>2011</td>
<td>Pass 77%</td>
<td>83%</td>
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<td>2012</td>
<td>60%</td>
<td></td>
<td></td>
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<tr>
<td>2013</td>
<td>59%</td>
<td></td>
<td></td>
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<tr>
<td>2014</td>
<td>65%</td>
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*As of November 11, 2015. Number of lifetime certificate holders in parentheses.
Changes in MOC Part 4 Requirements
As a first step, the ABR announced the following appropriate improvements to Part 4, which took effect immediately:

Expanded Options for Satisfying Part 4 Requirements
The Board determined that in addition to the traditional PQI project methodology, radiology professionals may demonstrate commitment to quality and safety in patient care in numerous other ways. The new expanded options focus on giving Part 4 credit for activities that diplomates are already performing as part of their practices or voluntary professional efforts. The Board considers such engagement, especially in activities that increase visibility in and commitment to quality improvement both within and external to radiology departments, as fulfilling the intent of MOC Part 4 requirements.

These 16 activities are listed in detail on the ABR website at www.theabr.org/moc-part4-activities. This information also includes the required diplomate documentation of participation for each activity, which should be retained in case of an audit. The Board expects to expand these participatory quality improvement opportunities over time as new activities become staples of radiological practice.

As long as participation in such activities is meaningful and ongoing, it is permissible for a PQI project or activity to be used repeatedly to meet PQI requirements. This new policy regarding criteria for MOC Part 4 is in place for diplomates to use for fulfilling requirements for the March 2016 three-year look-back.

Expanded Options for PQI Project Methodology
The ABR continues to emphasize the importance of PQI projects as quality improvement tools. However, restrictions regarding methodology have been considerably relaxed. The new MOC Part 4 (PQI) policy greatly increases flexibility regarding choice of improvement methodology for PQI projects. Previously, PQI projects were required to use a prescribed Plan-Do-Study-Act (PDSA) process with inherently defined phases. In addition to the PDSA process, diplomates who choose to do a PQI project now may use any standard quality improvement methodology, such as Six Sigma, Lean, the Institute for Healthcare Improvement’s (IHI’s) Model for Improvement, and other methods. The ABR Part 4 policy has been expanded to accommodate these different approaches in recognition of the interval advancements in quality improvement science over the past decade.

Simplified Attestation on myABR
A second area of diplomate concern centered on time-consuming MOC data entry and detailed documentation on the myABR website portal. This has been addressed through “Simple Binary Attestation of Meeting MOC Requirements,” which will become available on myABR as of January 4, 2016.

In the current state, diplomates are required to log in to myABR each year and attest to the data necessary to meet participation requirements for each of the four parts of MOC. This sometimes involves uploading documents such as medical licenses or entering PQI project information. It also requires validating CME activity from the CME Gateway, as well as entering CME credits from organizations not contributing data to the CME Gateway. With simplified attestation, diplomates will need only to attest to the fact that each of the requirements for Parts 1 through 4 of MOC has been met. Entering detailed data will not be required each year; however, diplomates will need to retain this information in case of an audit, so they can document that they have indeed met the requirements of MOC.

If a diplomate is audited, he or she will be asked to provide the following documents:
• For Part 1, a valid state medical license
• For Part 2, records of completing 75 AMA Category 1 Continuing Medical Education credits, 25 of which are self-assessment CME, in the last three years
• For Part 3, no attestation will be required. The diplomate will be informed of his or her current MOC exam status for each certificate held and when the next exam will need to be passed.
• For Part 4, records of completing an appropriate PQI project or activity in the last three years

We hope this new process will reduce the burden of MOC documentation for ABR diplomates. This will also free up staff and development resources to permit the ABR to further improve not only MOC, but other areas of its diplomates’ experience with the ABR as well.

Future Focus for MOC Program Improvement: Part 3 (Knowledge Assessment)
The above improvements represent just the beginning of the Board’s ongoing commitment to continuously improve diplomate satisfaction with and sense of accomplishment through ABR MOC participation. In this respect, the ABR is exploring alternatives to the current Part 3 requirement of a secure, proctored MOC examination every 10 years. We will be working closely with ABMS and its member boards, radiology professional societies, and experts in the field to identify innovative knowledge-assessment tools that take advantage of new technological and communication norms. Our goal is to provide less intrusive, more relevant, and more cost-effective knowledge base sampling than past traditional methods. As progress is made in this area, the ABR will continue to reach out to its diplomates for input and feedback.

The new expanded options focus on giving Part 4 credit for activities that diplomates are already performing...
by Milton J. Guiberteau, MD, ABR President

After 80 years of a single governance structure at the ABR, the Board perceived a need for modification to meet growing demands and obligations and to better serve our candidates and diplomates. Consequently, the ABR trustees undertook a rigorous two-year evaluation of our governance system. The process included external expert assessment, internal analysis by the Board of Trustees of possible options proposed by a multidisciplinary task force, and the guidance of a governance facilitator. The Board undertook this process with the understanding that any changes would build upon the time-tested representation of clinical practice areas; would be compatible with our internal structure of multiple radiological disciplines (diagnostic radiology, radiation oncology, medical physics, and interventional radiology); and would improve the Board’s ability to respond to the needs of our stakeholders, as well as to those of the organization itself, in a thoughtful and timely manner.

After careful scrutiny of the options, a governance structure, which the Board believes will accomplish these goals and favorably impact our operations to achieve our mission in a more effective and responsive manner, was adopted in its final form at our October 2015 meeting. Consequently, the many duties relevant to the ABR’s mission of certification, previously divided between two smaller organizational components, the Board of Trustees, will retain its familiar structure of members with discipline and subspecialty expertise, reflecting major areas of current clinical practice. It will assume responsibility for the ABR’s largest core obligation of creating both initial certification and Maintenance of Certification (MOC) examinations and determining examination goals, content, scoring, and candidate feedback. A Board of Trustees with such a dedicated purpose will allow for a more coherent and concentrated examination effort necessitated by a significant increase in the number and frequency of examination administrations over the last decade.

A newly created, smaller Board of Governors (7 to 11 members), composed of the ABR officers and members with specific portfolios of responsibility, is charged with the nonexamination duties of the board. These responsibilities include ABR financial affairs, Continuous Certification (MOC) program processes, communications, strategic planning and priority setting, intersociety relations and outreach, and oversight of American Board of Medical Specialty matters. In addition to providing efficiency for the conduct of ABR business affairs, the establishment of a governing board requiring members with skills other than or in addition to academic expertise will allow for a composition reflective of the broader practicing radiology community.

While these changes will be transparent to our diplomates and others in the radiology and broader medical communities, the ABR is confident that this updated structure, reflective of the current operational norm in many professional organizations, will enhance our ability to serve our candidates and diplomates. Establishing an efficient, systematic approach to managing our mission of board certification is crucial during this time of changing and challenging practice environments.

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

Once again, this has been a very busy year for the discipline of diagnostic radiology. The transition to the new examination paradigm is now complete. For the first time, those who gain initial certification in diagnostic radiology in 2015 will have passed the computer-based Core and Certifying examinations. The Maintenance of Certification/Continuous Certification program also has continued to change to make it easier for diplomates to comply with the requirements. More details about these programs can be found below.

We would like to thank the 266 diagnostic radiology volunteers, serving on 31 committees, for helping the ABR with these endeavors. Indeed, the ABR could not perform its mission without the help of these volunteers, who spend countless hours writing new examination questions, evaluating questions written by others, and compiling the examinations. We can never thank you enough for what you do!

Initial Certification

The Core Examination was administered in Tucson and Chicago in June and November of 2015. The June examination continues to be the larger one since most of the candidates complete 36 months of training in diagnostic radiology in time for that administration. We continue to shorten the scoring timeline, and this year, candidates received their scores six weeks after the examination; this is approximately half the time needed for those who took the June 2014 examination to receive their scores. Statistics for first-time takers (1,188) were similar to those of the previous examinations: 87 percent passed, fewer than 1 percent conditioned (all in physics), and 12 percent failed.

The ABR continues to have an assortment of study aids available on the website for the Core Examination, including module blueprints and study guides, sample topic content, a Quality and Safety syllabus, and a practice examination. The Quality and Safety syllabus has been updated and incorporates all topics included on the examination. (Links to the study aids can be found at www.theabr.org/ic-dr-core-exam.)

For those who finished their training in June 2014 and passed the Core Examination, the long-awaited Certifying Examination was administered for the first time in Tucson and Chicago on October 1-2, 2015. A total of 1,099 candidates took the exam—846 in Chicago and 253 in Tucson. This total includes 8 candidates who previously conditioned the oral examination and were transitioned to the Certifying Exam. As expected, the pass rate on this examination was higher than that of the Core Exam; all candidates who finished their residency in June 2014 and passed the Core Exam also passed the Certifying Exam.

The Clinical and Noninterpretive Skills (NIS) modules administered on the Certifying Exam are identical to those found on the MOC exam. Study guides for the clinical modules, as well as a syllabus for the NIS module, are available on the ABR website. A study guide for the Essentials of Diagnostic Radiology module, which is unique to the Certifying Exam, is also available. (Links to all the study aids can be found at www.theabr.org/ic-dr-certifying-exam.)

Maintenance of Certification/Continuous Certification (MOC/CC)

As noted above, the ABR has attempted to make the MOC/CC process easier for its diplomates. This year has seen significant progress in this direction. Sixteen Participatory Quality Improvement Activities, as well as the traditional Practice Quality Improvement (PQI) Project, are now accepted as fulfillment of MOC Part 4 activities. Beginning Monday, January 4, 2016, diplomates will be able to simply attest on myABR to participation/completion of Parts 1, 2, and 4 of the MOC process, rather than having to delineate the specifics of each part. In addition, they will no longer be required to upload documentation of their MOC participation. The ABR will continue to audit a portion of diplomates each year, so primary documenta
tion should be retained in case an audit is requested.

Further details about these and other new initiatives can be found on our website (www.theabr.org/moc-part4-activities), as well as in the MOC Update article included in this report (see page 8).
A significant change in the new IC and MOC examinations is the introduction of a group of questions collectively referred to as non-clinical skills. This material includes items related to quality assurance and quality improvement, patient safety, bioethics, and biostatistics. Because this formalized material is new to the Board examinations, trustees and staff have developed a syllabus that will be embedded in the existing web-based IC and MOC study guides. A link to the new syllabus is now available on the ABR website (www.theabr.org/moc-ro-comp3) and contains essentially all material in these topics felt to be necessary for examination preparation. An effort has been made to assure that the material is relevant to the clinical practice of radiation oncology.

In 2010-2011, with the aid of a stakeholder’s advisory committee, radiation oncology staff and trustees developed a Focused Practice Recognition in Brachytherapy (FPRB) proposal, which was ultimately approved by the American Board of Medical Specialties. The project included elements of education, clinical care, clinical research, and data collection and received significant unrestricted financial support from Varian Medical Systems, Inc. Despite various organization announcements, publications, and presentations, participation was significantly lower than had been anticipated, and in February 2015, the ABR trustees decided to terminate the program. Participants will continue to actively use the FPRB designation through 2017, the originally planned demonstration project termination date. After that time, if queried, the Board will indicate that the diplomate had attained the recognition but that the program is no longer active.

All eight radiation oncology clinical category volunteer committees were re-organized effective January 1, 2012. At that time, it was anticipated that new appointees would serve terms of up to three years, with possible re-appointment, and that rotations on and off the committees would henceforth be staggered so that all appointments would not terminate concurrently. To maintain stability during the organizational transition, all certifying (oral) examination chairs retained their posts. Several of those chairs have now served for six or more years, and rotation of chairs has begun. The staff and trustees of the Board wish to acknowledge the extraordinary efforts and service of three oral examination chairs rotating from their posts:

• William Regine, MD, University of Maryland, gastrointestinal cancer chair, has been replaced by Michael Haddock, MD, Mayo Clinic/Rochester.
• Robert Amdur, MD, University of Florida, head/neck/skin cancer chair, has been replaced by Steven Frank, MD, MD Anderson Cancer Center.
• Julia White, MD, Ohio State University, breast cancer chair, has been replaced by Jennifer Bellon, MD, Dana-Farber Cancer Institute.

The RO trustees continue to recognize the importance of the Holman Research Pathway as a way to attract those with a strong research background into radiation oncology, and then to help them initiate careers as independent investigators. The last three years saw a decline in the number of applicants, but this year there was a spike, raising the possibility that these represent year-to-year variations rather than trends in any particular direction.

The radiation oncology trustees will be working with the Society of Chairs of Academic Radiation Oncology Programs (SCAROP) to encourage additional programs to recruit, support, and ultimately add Holman Pathway trainees to their departments.

As development of the modular examination proceeded, it became apparent that several combinations of clinical material that had served well for the qualifying and certifying examinations were not appropriate for the MOC examination. For future examinations, bone and soft tissue sarcoma questions will be removed from the thoracic (formerly called lung) category and included in the required general radiation oncology module. Skin cancers had been included in the head/neck category but will also be moved to general radiation oncology. Pediatric tumors will be removed from the adult central nervous system module beginning in 2017 and will be included in a new module(s) developed solely for that topic. A subcommittee under the aegis of the Central Nervous System Committee, to be chaired by Dr. Iris Gibbs of Stanford University School of Medicine, has been organized to develop the new pediatric modules.

A n important initiative during the past year was directed to improving volunteer clinical category activities and diversification of committee membership. Of eight clinical committees, six now have members in private practice. This level of diversity should provide candidates and diplomates with a greater level of assurance of fairness and relevance of both the initial certification (IC) and Maintenance of Certification (MOC) examinations. Committee esprit and function have also been significantly improved by implementation of periodic face-to-face meetings rather than reliance on conference calls and webinars. In-person meetings are being scheduled for each committee on a biannual basis, with the meetings devoted to development of both qualifying (written) and certifying (oral) examinations.

The new MOC Part 3 modular examination was administered for the first time in October 2015. The examination consisted of approximately 200 questions, of which 140 were in a required general radiation oncology module. Diplomates had the ability to select two additional modules, each containing 30 questions. These modules were taken from the current eight clinical categories, or diplomates could choose general radiation oncology questions.

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

The radiation oncology trustees will be working with the Society of Chairs of Academic Radiation Oncology Programs (SCAROP) to encourage additional programs to recruit, support, and ultimately add Holman Pathway trainees to their departments.
Finally, the ABR has instituted a rule stating that after passing the Part 1 exam, candidates will have no more than 10 years to become board eligible. Because some candidates pass Part 1 but never continue with the certification process, the new rule will allow dormant files to be closed. This rule has already been implemented, but candidates who now are reaching their 10-year limit will have until 2017 to become board eligible.

The Oral Examination

The Oral Examination in Medical Physics is designed to test the clinical skills of the candidate and assess his or her readiness to practice medical physics independently. A broad range of topics gives each candidate the following opportunities:

- To demonstrate an understanding of common medical physics equipment performance evaluations
- To analyze the results of these evaluations and make appropriate recommendations
- To explain how patient care may be affected by the performance of clinical equipment
- To analyze uncommon situations and explain how the candidate would approach them
- To communicate the results of medical physics evaluations.

The focus of the oral exam is on clinical competence. This distinguishes it from the Part 1 and Part 2 exams, which focus on the fundamental concepts of medical physics and include detailed calculations. The oral exam includes 25 questions in five categories. Each candidate is examined by five examiners, each of whom asks one question in each of the five categories. This ensures that the candidate’s score in each category is the average of the scores on five questions evaluated by five different examiners.

The oral examiners are selected from experienced medical physicists who have either MS or PhD degrees. If you were recently certified, you should be aware of the following:

- Continuing education (CE) and self-assessment continuing education (SA-CE) credit completed during the year of certification can be counted for your first MOC look-back.
- A Practice Quality Improvement (PQI) Project or Participatory Quality Improvement Activity completed during your residency can be counted for MOC.
- You may claim up to 25 CE credits for a year of fellowship in a clinical environment.

As these credits will not automatically appear in myABR, you should keep documentation in case you are ever audited. If you have any questions, please contact the ABR MOC Division by email (moc@theabr.org) or call the ABR Connections Center at (520) 519-2152.
The new interventional radiology/diagnostic radiology (IR/DR) primary certificate, approved by the American Board of Medical Specialties in 2012, continues to progress, 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 Accreditation Council for Graduate Medical Education (ACGME) has approved the program requirements for the Interventional Radiology Residency Program, and applications for program accreditation are now being received by the Radiology Residency Review Committee (RRRC). An onsite visit is required for all applying sites, and for the programs that have already applied to the RRRC, site visits are being scheduled. The first programs may be evaluated at the November 2015 meeting of the RRRC, and if accredited, they should be able 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 of DR residents into 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 will provide three potential ways to achieve this training: either a five-year integrated program of diagnostic and interventional radiology (this will be the first stage for most programs), or a combination of DR residency followed by an independent one- or two-year IR program (this will be implemented later by most programs who decide to offer it). 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.

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

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 will be 2019-2020. 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. (Please note, however, that DIRECT pathway candidates must finish their residencies and fellowships by 2020, and no new DIRECT pathway candidates may begin training after July 2016.) 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.
The ABR welcomes the following new trustees, whose terms of service began on November 1, 2015. 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.

**Michael G. Herman, PhD**
Michael G. Herman, PhD, is a board-certified medical physicist who is involved with practice, education, and research in the Department of Radiation Oncology at the Mayo Clinic in Rochester, Minnesota. He is professor of medical physics and chair of the Division of Medical Physics. He earned a bachelor’s degree in engineering physics at Lehigh University and a doctorate in experimental nuclear physics at the University of Rochester. Dr. Herman has held leadership positions in the American Association of Physicists in Medicine and the American College of Medical Physics. He mentors clinical medical physics fellows and graduate students with current interests in image guidance, particle therapy, and patient outcomes.

**Mary S. “Mimi” Newell, MD**
Mary S. “Mimi” Newell, MD, holds a lifetime certificate in diagnostic radiology and is an associate professor of radiology and associate director of Emory University’s Breast Imaging Division in Atlanta, Georgia. She graduated from the University of Michigan Medical School in 1984. She currently serves as chair of the Appropriateness Criteria and Parameters Committee for Breast of the American College of Radiology and treasurer of the Georgia Radiological Society, and her areas of clinical interest and special expertise include breast cancer imaging.

**M. Elizabeth “Liz” Oates, MD**
M. Elizabeth “Liz” Oates, MD, a diplomate in diagnostic radiology and nuclear radiology, received her education at Boston University School of Medicine and completed a radiology residency at LA County Harbor-UCLA Medical Center, as well as a nuclear radiology fellowship at Tufts-New England Medical Center. As Rosenbaum endowed chair of radiology and professor of radiology and medicine, Dr. Oates serves as the department chair at the University of Kentucky in Lexington. She chairs the American College of Radiology’s Commission on Nuclear Medicine and Molecular Imaging and serves on the Board of Chancellors. Dr. Oates also sits on the Diagnostic Radiology Residency Review Committee. Her interests include all aspects of nuclear radiology education and practice.

**James B. Spies, MD, MPH**
James B. Spies, MD, MPH, is chair and chief of service at MedStar Georgetown University Hospital’s Department of Radiology and professor at Georgetown University School of Medicine in Washington, DC. He was board certified in diagnostic radiology in 1984 and in vascular and interventional radiology in 1995. Dr. Spies earned a medical degree at Georgetown, served a residency at the UC School of Medicine in San Francisco, and completed a fellowship at the New York University School of Medicine. He is an interventional radiologist whose primary clinical and research interest is in uterine embolization for fibroids. His special interests include uterine artery embolization and gynecologic intervention.