***From the Editor***

# Reflecting on the Departure of Dr. Kay Vydareny and Improvements to the ABR MOC Process

*2017;10[3]:44-45*

**by Lane F. Donnelly, MD**

On June 30, 2017, Dr. Kay Vydareny retired from her role as the ABR's associate executive director for diagnostic radiology and the subspecialties, ending a long history of service to the ABR.

I first met Dr. Vydareny at the Association of University Radiologists (AUR) meeting, held in Cincinnati in 1993 when I was a radiology resident. I remember being struck by the way she treated me and the other residents. I felt that I had her unbridled attention and that she truly cared about what I had to say. She had a way of making everyone feel as if they were someone of importance. In contrast, I clearly remember another incident from that same meeting when a prominent radiologist told another resident and me, who were presenting before him, to be sure we finished on time because the audience was there to listen to him, not us. Dr. Vydareny definitely had an approach different from that individual. I had the pleasure of interacting with her on multiple other occasions over the years, related to the ABR and other societies, and I was always impressed.

Dr. Vydareny is an incredibly good listener, is genuinely concerned for the development and well-being of others, and is continually devoted to the right path. She always treated my family—whom she got to know via the ABR—and me with kindness and respect. She will be incredibly missed. I believe that the behavior of such people is infectious, and that the ABR is a better organization and group of people and has a better culture than it otherwise would have without the exposure to and guidance from people like Dr. Vydareny. Certainly, we at the ABR should aspire to continue to cultivate those attributes and that culture.

Dr. Vydareny's departure caused me to reflect on the ABR and, more specifically, the changes and improvements that have been made to the ABR Maintenance of Certification (MOC) process over the past five years. A great deal has been accomplished. Taking the lead from Dr. Vydareny and other like-minded ABR leaders, we have listened to the ABR community and have taken multiple actions to improve the ABR MOC process for all our diplomates. These changes include the following:

- In 2012, the ABR expanded the activities that qualify to meet self-assessment CME (SA-CME) requirements. We added SA-CME enduring activities from radiology journal

articles with self-assessment tests to the existing Self-Assessment Modules (SAMs) available from in-person, society-sponsored activities. This has made it much easier for diplomates to meet MOC Part 2 requirements without needing to travel.

- In 2013, the ABR launched the MOC Team Tracker program, which enabled group practices to appoint authorized administrators to help with bookkeeping and payments.
- In 2015, the ABR reviewed MOC Part 4 (Practice Quality Improvement, or PQI) and expanded the means by which diplomates could fulfill Part 4 requirements. In addition to performing PQI projects, diplomates have been able to meet Part 4 requirements by active participation in any one of many PQI activities, such as peer review, quality or safety review committees, and root cause analysis teams. This change has given diplomates the ability to receive Part 4 credit for quality work in which they were already participating.
- Also in 2015, the ABR launched its Connections Customer Service Center to expedite the ability for candidates and diplomates to receive answers to their questions in an efficient, friendly manner.
- In 2016, the ABR introduced simplified MOC annual attestation. This new process has eliminated the need for diplomates to upload or enter detailed information in myABR. Now diplomates need only to attest that they have met the requirements and produce supporting documentation only if they happen to be audited.
- On August 1, 2017, the ABR launched a new and greatly improved website (see announcement in this issue of *The BEAM).*
- As announced in 2016, the ABR will go live in 2019 with ABR Online Longitudinal Assessment (ABR OLA), which will replace the traditional 10-year examination as the way diplomates meet MOC requirements for Part 3. Benefits of the new ABR-OLA approach include elimination of the need for travel to exam centers, little impact on the workday, educational opportunities (immediate feedback will be provided after each question), flexible timing for answering questions, and reassessment in areas of potential weakness.

The ABR will continue to work to improve its processes in order to optimize value and reduce inefficiencies for candidates and diplomates. And we wish Dr. Vydareny all the best during this next chapter of her life. Please see the “Focus on Diagnostic Radiology” article for more tributes to her.

***From the President***

# The Value of MOC

*2017;10[3]:46-47*

**by Lisa A. Kachnic, MD**

Fun fact: I may be your first president who does not have a lifelong ABR certificate. I completed my radiation oncology training and initial certification in 1996, the year after time-limited certificates were first implemented in my discipline. Yet, despite having this new certification process bestowed upon me, I have embraced it, and I truly believe that Maintenance of Certification (MOC) matters.

Spring was pretty busy. I spent the entirety of April in the Tennessee statehouse, waiting patiently to provide a few words of education on the value of MOC to the house and senate members. They were attempting to pass an amendment to a bill that would have nullified the participation of Tennessee physicians in initial certification and the MOC program, and would have established that the standard hospitals could use to hire and credential physicians would be solely based on the CME hours required to maintain a Tennessee license.

As an ABR board-certified diplomate, I can attest that CME alone is insufficient for demonstrating competence. The technology and multidisciplinary evidenced-based knowledge in radiation oncology has dramatically changed since I was initially board certified. Following residency, I drew a two-dimensional picture of someone's cancer and their normal surrounding organs with colored crayons and a protractor on a bony radiograph, and then I designed a high-dose radiation treatment. Now, I am using advanced four-dimensional images and computer-rich technology to perform the same work. The passive nature of standard CME activities alone does not provide me with the rigor and constant assessment I need to master these new radiation delivery techniques and practices.

In my conversations with many Tennessee house representatives, I was amazed to discover the misinformation and general lack of understanding concerning MOC. One senator (a surgeon) noted that he had to pay $12,000 a year to participate in MOC. Interestingly, when I checked the American Board of Medical Specialties (ABMS) public website, he was not even listed as participating in MOC – not a surprise. There were also misconceptions that the Boards are just money-making corporate machines. Well, let me assure you that the ABR is a non-profit organization and has not made a profit on creating/delivering the initial certification and MOC exams in years – we survive on our reserves.

I realize that there will always be physician concerns about MOC's relevance to clinical practice, as well as its time and financial commitment. Recently, I was providing an MOC update at the

ACR meeting, and when it came time for audience questions, one radiologist shouted, “Did you ever ask me if I was in favor of MOC and wanted to participate? Where are the data to show that MOC works?” While it was ABMS that started this program more than a decade ago, the rationale was to maintain self-regulation before the public and payers became involved. Through an extensive and inclusive collaboration with physicians on the 24 ABMS member boards and other stakeholders (such as the patients we serve), standards for MOC were created. The standards provide a framework to ensure that the values of lifelong learning, professionalism, patient safety, and practice improvement are translated into day-to-day physician practices. And data supporting the value of MOC are finally emerging. Participating physicians have been shown to practice safer, higher quality medicine, and they tend to have fewer disciplinary actions by state medical licensing boards.

At the ABR, we listen to our diplomates’ MOC suggestions on our many surveys, and we continuously make refinements to the process so that MOC is relevant to a physician’s unique practice, more cost effective, and more convenient. Some of these recent enhancements include:

- more online enduring free materials (i.e., journal-based) for practice-focused self-assessment;
- expansion of quality improvement options to include numerous common clinical activities that diplomates perform in their practices (i.e., serving on the quality improvement committee); and
- moving to an Online Longitudinal Assessment (ABR-OLA), which will allow ABR diplomates to tailor and target learning opportunities and evaluation relevant to individual practice profiles and will eliminate the need for a formal examination at a test center every 10 years.

However, it is also important to consider that the value of MOC participation is proportional to the rigor of the process. The opportunity we have as ABR diplomates to be a self-regulating profession is otherwise at risk. While ABR-OLA will be developed to assess “walking-around knowledge,” it must also be appropriately rigorous so we may continue to be recognized as specialists who participate in MOC to our colleagues, the public, and, most importantly, ourselves. I take pride in my participation in ABR MOC. I truly believe that it challenges me to stay current with the rapid advances in my field and has helped shape my career as a physician and as your president.

## ABR Launches New Website

*2017;10[3]:48*

Almost a year ago, we began working with an outside vendor to help us revitalize the ABR website (www.theabr.org) with the goal of improving our users' overall experience. In addition to enhancing the "look and feel" of the site, we've worked hard to improve navigation so users can easily find the information they need.

The site has been designed to work well in desktop, tablet, and mobile views. We're excited about the new site and confident that it will provide our website visitors with a much more enjoyable user experience.

***Focus on MOC***

# MOC Advisory Committee

*2017;10[3]:49-50*

**by Vincent P. Mathews, MD**

The ABR instituted an MOC Advisory Committee several years ago to provide a means for diplomates to give us feedback regarding MOC. The committee is composed of 12 diplomates from varied career stages, as well as from different geographic and practice settings. The committee typically meets with ABR leadership during RSNA and ACR annual meetings, and we occasionally have teleconferences to consider various issues.

The discussions at these meetings have been integral to the development of our MOC program and help us understand areas where we can improve communication. Two such areas brought up at our recent meeting at ACR concerned the possibility of obtaining CME credit for ABR Online Longitudinal Assessment (ABR-OLA) participation and the future of our Chicago and Tucson exam centers.

Many diplomates view ABR-OLA questions as being similar to other online case reviews they do for CME credit, so they wonder if they can get CME credit for ABR-OLA participation. The ABR is not currently accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide educational material for CME credit. Becoming accredited would be quite expensive and would require significantly more staff and volunteer time. In addition, the ABR partners with various professional societies who are accredited CME providers, and ABR leaders are reticent to compete with those partners in this area. Instead, our ABR Board of Governors will explore the possibility that some credit for the MOC Part 2 Lifelong Learning and Self-assessment requirement may be achieved through ABR-OLA.

With ABR-OLA being initiated in 2019, some diplomates are asking about the future of our exam centers in Chicago and Tucson. The ABR had hoped we would be able to offer a distributed computerized exam at local testing centers throughout the country, but the national vendors have not provided the technology infrastructure to administer our image-intensive modular exams reliably. Therefore, the exam centers in Chicago and Tucson were developed. Even though most diplomates will no longer take an MOC exam after ABR-OLA is launched, computerized MOC exams will continue to be given for those who do not meet the Part 3 Assessment of Knowledge, Judgment and Skills requirement through ABR-OLA. In addition, the diagnostic radiology Core and Certifying exams will still require computerized testing. The number of computerized exams administered will be significantly reduced because of ABR-OLA,

and we are optimistic that we will be able to consolidate our testing to one facility in the coming years. Plans for this are currently being developed.

For more information, see the “Focus on Residents” article in this issue of *The BEAM.*

***Focus on Residents***

# Why Can't the ABR Deliver Diagnostic Radiology Exams at Local Testing Centers?

*2017;10[3]:51-52*

**by ABR Trustee Donald J. Flemming, MD and David J. Laszakovits, MBA**


Delivering our exams at local commercial testing centers has been a recurring topic of conversation for many years. It's impossible for us not to appreciate your discontent about incurring the added cost for travel and the stress of being away from families and training programs. We take this very seriously and are working hard to find more manageable solutions.

To that end, I'd like to share a little about what we're trying to accomplish, the unique features of the exams, and the obstacles we've faced attempting to secure a commercial testing vendor to deliver our diagnostic radiology initial certification exams.

**"Proctored and Secured"**

At the most fundamental level, we—and any other high-stakes testing organization—must achieve several basic exam delivery elements to ensure that our initial certification processes meet best practice standards. Perhaps the most important standard is that the exam be "proctored and secure."

Almost without exception, all exams used to evaluate professional performance, such as the SAT, MCAT, and USMLE, require the testing environment to be proctored and secured, which ensures the overall fidelity of the exam administration. This alone dramatically limits the viable options for exam delivery.

**Unique Features of Exams in Diagnostic Radiology**

In addition to this basic necessity, delivering an exam to assess the clinical competencies required to practice diagnostic radiology presents a number of other challenges. Because of the

nature of practice, the most appropriate way to present diagnostic radiology exam material is through clinical vignettes that have a patient history, a question to be answered, multimedia content, and answer options. As you know, the multimedia content usually includes several high-resolution images or a video file.

These delivery requirements have proven to be insurmountable obstacles for the numerous commercial testing vendors that we've engaged over the years. It's important to remember that the vast majority of these vendors' clients deliver text-based question exams with little or no multimedia content.

**Our Recent Attempts to Engage Commercial Vendors**

For almost a decade, we've sought the services of numerous local commercial testing vendors for the delivery of our exams. We've been successful in securing a vendor for delivering our radiation oncology and medical physics exams solely because they are text-based with little or no multimedia content.

Unfortunately, we've not been able to do the same for our diagnostic radiology exams; however, that is not for lack of trying. Just last year, we engaged two prominent commercial testing vendors to explore our goal of delivering the diagnostic radiology initial certification exams at local testing centers. Both vendors were given in-depth details of our exam delivery needs and asked to provide a proposal for our consideration.

Vendor #1 very diligently reviewed our requirements with its team for several months, but in the end declined to provide a proposal. The stated reason was that even our basic exam delivery requirements demanded too many modifications of their current delivery processes and workflows. This was primarily attributed to large multimedia content file sizes. Something else not said, but implied, was that our small delivery volume (~3,000 exams annually) was not significant enough to justify the required cost to take on our needs.

We participated in a similar process with Vendor #2, convening numerous conference calls and preparing detailed specifications over a period of several months. After the discovery period was complete, we waited patiently for the results of analysis and hoped for a proposal. Unfortunately, this wasn't meant to be. After dozens of unanswered phone calls and emails over a period of more than 90 days, we never received a proposal or any reason why.

**If at First You Don't Succeed . . .**

We are committed to making the initial certification process as facile as possible. While our past efforts have not been successful, we will continue to pursue our goal (and your wish) of delivering diagnostic radiology exams in local commercial testing centers. As we all know, technology is constantly evolving, and perhaps local exam delivery will become more feasible in the future.

***Focus on Diagnostic Radiology***

# A Tribute to Dr. Kay Vydareny

*2017;10[3]:53-55*

As mentioned by Dr. Lane Donnelly in his "From the Editor" article at the beginning of this issue, Dr. Kay Vydareny retired at the end of June after nine years of service to the ABR as associate executive director for diagnostic radiology and the subspecialties. For this "Focus on Diagnostic Radiology" article, we thought it would be appropriate to share some other tributes to Dr. Vydareny. As you can tell from the quotes that follow, she will be greatly missed!

♦♦♦

Kay was my panel chair during my first year as an oral examiner. I was a little star struck as she is such an icon of women radiology leaders. I remember she made me feel so welcome and took extra time to be sure I understood the process. The panel was very efficient, but we also had many stress-relieving laughs. That was the beginning of a wonderful friendship for me.

*—Cheri L. Canon, MD, ABR Board of Trustees*

♦♦♦

If you did a Google search with the terms dedication, honesty and integrity, Kay's picture should be the first hit that pops up. She has an incredible ability to distill complex topics down into solvable units.

*—Donald J. Flemming, MD, ABR Board of Trustees*

♦♦♦

Kay Vydareny has had a career (and easy to see a lifetime) punctuated by all those qualities a physician must have to be in the acclaimed (but rarely attained) marriage of an influential mentor and role model. And this is underscored and even more fortified by the constancy of grace. How fortunate the Board and profession have been to have her embrace us and help us to be better.

*—Donald P. Frush, MD, ABR Board of Governors; Chair, ABR Board of Trustees*

I have had the good fortune to work with Kay in a number of venues over the years. She has risen to the top of every organization she joined because of her hard work, dedication, common sense, and generous spirit. She has been a wonderful mentor to countless individuals, including me. Kay, thanks for all you have done to make the world a better place. We will miss you, but you will always be part of the ABR family!

*—Valerie P. Jackson, MD, ABR Executive Director*

♦♦♦

It has been wonderful to work with Kay! I admire her hard work and humor. She has a unique and valuable ability to take complex issues, distill them, and rephrase them in ways that help get to the essence of the issue. Kay has been a devoted volunteer and member of the ABR family for many years and will be missed.

*—Mary C. Mahoney, MD, ABR Board of Governors*

♦♦♦

I first met Kay while she was examining me on the oral boards. Her amiable and caring disposition showed through in that brief encounter and has been reinforced in every interaction since. She will be missed at the ABR.

*—Vincent P. Mathews, MD, ABR Board of Governors*

♦♦♦

Dr. Kay Vydareny has been, for me, a stupendous mentor and friend, both at Emory and within the ABR. She is unfailingly respectful, funny, kind, and helpful. As she nears retirement, Kay remains sharp as a tack! It is so clear as one spends time with her why she is revered by family, friends, and colleagues!

*—Mary S. Newell, MD, ABR Board of Trustees*

♦♦♦

Kay Vydareny is a rare and wonderful person, truly one of a kind, and I have been extremely fortunate to have had the opportunity to know her and work with her.

If they existed, Kay Vydareny would hold world champion titles such as *mentor extraordinaire, most able to guide discussions around potholes and danger zones,* and *best at distilling complex information into a cogent core.*

*—M. Elizabeth Oates, MD, ABR Board of Trustees*

♦♦♦

When I first came on the board, Kay was a member of the DR contingent. I had met her previously but as a spouse of Dr. Bill Casarella, whom I knew through interventional radiology

circles. Kay was (and is) incredibly kind and generous with her time. She was a wonderful mentor, always supportive and encouraging.

I then had the privilege to serve with her on the Radiology Residency Review Committee for the ACGME. During part of the time she was the chair, and she led a review and revision of the program requirements. Doing these revisions is a very time-consuming and sometimes frustrating project as different people have different approaches to the requirements. Kay handled it all with aplomb and good humor, and we ended up with very significant and important changes.

Since my return to the ABR as associate executive director for interventional radiology, Kay again has been so helpful to me in fitting in to this new role. Once again she has shown me the ropes.

I—and I know the ABR—will miss her kindness, humor, and wisdom. We wish her well with her new adventures!

*—Anne C. Roberts, MD, ABR Associate Executive Director for Interventional Radiology*

♦♦♦

Kay is a truly unique individual: soft-spoken but direct, never a hint of cynicism, incredible 'corporate' memory, and incredible stature and respect in the radiology community. Every time Kay speaks I learn something! She is irreplaceable!"

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

♦♦♦

The voice of reason and civility. An honor to have her as a friend.

*—Robert D. Zimmerman, MD, ABR Board of Trustees*

***Focus on Interventional Radiology***

# Attention Diplomates with Vascular and Interventional Radiology (VIR) Subspecialty Certification

*2017;10[3]:56*

October 15, 2017, will be a landmark day for interventional radiology. On this day, qualified interventional radiologists (IRs) will be issued a new board certificate that reflects their unique stature as IRs and their singular role in treating and managing patients through image-guided interventions.

The 2,765 ABR diplomates with subspecialty certification in Vascular and Interventional Radiology (VIR) are eligible to receive the new IR/DR certificate. The process is simple. The ABR will send VIR diplomates an email with instructions. All they need to do is follow the link and confirm that they do or do not want to opt in for the new IR/DR certificate.

Converting to the new IR/DR certificate is straightforward and will not require taking a test or paying a new fee. Please note that if you do not respond by October 15, 2017, the ABR will automatically convert your certificate to an IR/DR certificate.

***Focus on Radiation Oncology***

# Introduction of New Techniques and Technologies into Radiation Oncology Exam Content

*2017;10[3]:57-58*

**by Paul E. Wallner, DO; Lynn D. Wilson, MD, MPH; and Kaled M. Alektiar, MD**

Medicine is a constantly evolving profession, and technologically based specialties such as radiation oncology seem to evolve at a somewhat faster pace than more cognitively based fields. This evolution in techniques and technologies is also associated with advances in other clinically related disciplines such as diagnostic radiology, medical oncology, immunology, and surgical oncology. These changes often create uncertainty among curriculum developers and assessors of knowledge, competence, and skills, as to how and when to add new discoveries to their armamentariums.

For radiation oncology, residency programs are accredited, and requirements for those programs are determined by the Accreditation Council for Graduate Medical Education (ACGME) radiation oncology review committee (RO RC). Although the RO RC provides detailed requirements for program accreditation, many aspects of curriculum requirements related to techniques and technology remain purposefully less specific (1).

Current accredited program requirements indicate that residents "must demonstrate competence in treating adult patients with conventionally fractionated external beam radiation therapy," but they do not state how that must be accomplished or what equipment should be included. Similarly, the requirements specify that trainees "must demonstrate competence in performing five interstitial and 15 intracavitary brachytherapy procedures," again without specifying the type of procedures. Additional program requirement sections detail needs for training in "12 pediatric radiation oncology cases of which nine must be solid tumors," and unsealed source radiation treatments, based on requirements of the U.S. Nuclear Regulatory Commission for authorized user eligibility status (2).

Competence in treating adult patients with stereotactic radiosurgery (SRS) first became a program requirement in 2009, with a stipulation that residents participate in planning and administration of 10 SRS cases. In 2011, a requirement for five cases of stereotactic body radiation therapy (SBRT) was added, and in 2014, based on increasing use of these modalities, the requirements were raised to 20 and 10 cases, respectively (1).

Training requirements regarding disease sites are more specific and indicate that, "residents must have experience with lymphomas and leukemias; gastrointestinal, gynecologic,

genitourinary, breast, soft tissue and bone, skin, head and neck, lung, pediatric, and central nervous system tumors; and treatment of benign diseases for which radiation is utilized" (1).

The absence of ACGME RO RC training requirement specificity leaves the ABR with the task of determining how and when new procedures and technologies should be included in initial certification (IC) and Maintenance of Certification (MOC) assessment instruments. Thus, the ABR relies on input from volunteer category committee members recruited from academia and private practice, and from triennial clinical practice analyses (CPA) developed from randomly circulated surveys (3). In the past, these CPAs have indicated notable changes in clinical pediatric radiation oncology and brachytherapy practices, de-emphasizing pediatric cancer therapy and adding content related to high dose-rate brachytherapy.

A CPA completed in 2016 is undergoing analysis at this time and will be reported in detail in the future, but several early observations are important for considering technology to include in upcoming exams. Of 690 respondents, 90 (13%) indicated direct access to proton beam radiation in their practices, 530 (76.8%) indicated access to PET/CT, and 182 (26.3%) indicated access to PET/CT simulation (personal communication, American Board of Radiology, May 15, 2017). ABR exam developers anticipate use of these data for determining new items to include in IC and MOC assessment tools.

Ultimately, these decisions reside with the ABR trustees. In addition to the metrics noted above, other considerations include transformative developments, regardless of available literature. Such may be the case in the near future, with inclusion of items related to proton beam therapy for pediatric solid tumors. To assist IC candidates and MOC diplomates in understanding these changes in content, the ABR provides detailed study guides (4), which will be updated, as appropriate, with the addition of techniques and technologies to exam content.

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***Focus on Medical Physics***

# The Value of MOC for Medical Physicists

*2017;10[3]:59-61*

**by Geoffrey Ibbott, PhD; Jerry Allison, PhD; Matthew Podgorsak, PhD; and J. Anthony Seibert, PhD**

The American Board of Medical Specialties (ABMS) was formed in 1933, in part to support the professional development of physicians by setting standards for competency in clinical care and to verify through the board certification process that individual specialists meet these standards. Another goal was to provide information to the general public about the certification status of individual practitioners.

The vast majority of today's medical professionals agree that board certification is an important step in the professional development of any practitioner who will be involved in patient care. The American Association of Physicists in Medicine defines a "qualified medical physicist" as one who, among other criteria, holds board certification in the subfield in which he or she practices clinically (1).

Initial board certification confirms that an individual meets minimal standards for safe and meaningful delivery of clinical care. Clearly, these standards evolve as a result of technological advances and improvements in the knowledge base associated with a medical specialty. This is especially true for specialties like medical physics that are highly driven by technology. Therefore, documenting minimal competence at the time of initial certification may not be a good indicator of one's continued competence years later.

For board certification to indicate minimal competence throughout a practitioner's career, some sort of ongoing evaluation is needed. ABMS officially recognized this in 2000 when it mandated that all its 24 member boards stop issuing "lifetime" certificates. In parallel, ABMS directed member boards to implement Maintenance of Certification (MOC) programs that enable continued evaluation of the six competencies associated with initial certification: medical knowledge, patient care and procedural skills, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice (2). The ABR last issued lifetime certificates in 2001, and, starting in 2002, certificates became valid for 10 years only. In 2012, 10-year certificates were discontinued, and the ABR moved to "Continuous Certification." This allows ongoing verification that a practitioner has command of

the current treatment techniques and technologies associated with contemporary standards of care. The required level of competency is therefore on par with the standards that those attempting initial certification at that point in time need to meet.

The MOC program also brings value to diplomates by providing a method to continue professional development throughout their careers. The ABR's MOC program comprises a four-part framework that evaluates on a continuous basis the six competencies mentioned above, which define clinical practice:

- Part 1: Professionalism and Professional Standing
- Part 2: Lifelong Learning and Self-Assessment
- Part 3: Assessment of Knowledge, Judgment, and Skills
- Part 4: Improvement in Medical Practice

To meet the requirements of the ABR MOC program, a medical physicist must document:

- current practice in the subfield in which he or she is certified (Part 1),
- familiarity with contemporary practice through continuing education and evaluation (Parts 2 and 3), and
- commitment to improving patient care (Part 4).

Meeting the ABR MOC requirements, therefore, provides participating diplomates with feedback about their expertise with state-of-the-art technology, and any deficiencies can be addressed through focused self-study and follow-up evaluation.

It is not possible to know for certain whether or not an MOC program improves clinical care. In fact, some of our clinical colleagues, mostly in other medical specialties, have proposed arguments to suggest that at best, there is no value, and at worst, participating in an MOC program may actually distract specialists from providing quality care. To the contrary, we believe that based on its careful design, the ABR MOC program is meaningful and enhances the quality of care provided by participating medical physicists.

While many ABR diplomates with lifetime certificates who do not participate in MOC nonetheless engage in various continuing education activities throughout their careers, there is no systematic methodology or uniformly enforced professional obligation for them to do so. Therefore, some practicing medical physicists likely base their qualifications on board certification awarded many years or decades earlier and have not remained current with their skills and knowledge.

On the other hand, a medical physicist who is meeting the requirements of the ABR MOC program is very likely to be knowledgeable about state-of-the-art imaging, as well as treatment techniques and associated technologies. Most would agree that a medical physicist meeting MOC requirements has the potential to make more effective contributions to patient care than a medical physicist who has not remained current. This fact alone suggests very strongly that

over time, the ABR MOC program will enhance clinical care because the proportion of medical physicists who participate in the program will increase.

The value of the ABR MOC program, however, is not defined solely through attrition of lifetime certificate holders. One could argue that simply completing some quantity of CME activities annually is sufficient to enable maintenance of competency and knowledge of contemporary technologies. However, practitioners need more rigorous evaluation of cognitive expertise throughout their careers through useful feedback on their knowledge and skills. This enables focused continued learning on topics identified as problem areas. The ABR MOC program is designed to provide this feedback, thus enhancing the professional development of its diplomates and giving them the best possible chance to provide high-quality care throughout their careers.

Finally, to remain current and meaningful into the future, the ABR MOC program undergoes continual review and revision by the ABR Board of Governors and the ABR Board of Trustees. Recent results of this self-study process include the following changes to the four parts of MOC:

- Simplified attestation of Part 1: Professionalism and Professional Standing
- Simplified attestation of Part 2: Lifelong Learning and Self-Assessment
- Replacement of the decennial MOC exam associated with Part 3 with a more continual evaluation called Online Longitudinal Assessment (OLA), which will provide meaningful and direct feedback to diplomates
- Increasing the scope of how medical physicists can meet requirements for Part 4 of the framework (Participatory Quality Improvement Activities)

As professional standards and societal expectations regarding the competence of healthcare providers continue to evolve, we anticipate further enhancements will be made to the ABR MOC program to enable it to continue to meet the needs of patients and diplomates into the future.

References

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***It's So Easy Being Green!***

## Electronic Billing for All Starts January 1, 2018

*2017;10[3]:62*

Beginning in 2018, the ABR will "go green" with electronic invoicing for all who receive an annual billing statement.

We will notify everyone by email when statements are available in myABR. You will then be able to to review your statement and pay fees on the myABR payments page.

You will have access to your latest annual billing statement at any time throughout the year, so you won't need to contact the ABR for any replacement copies. This change will not affect the way payments are made, which can be done online using Visa, MasterCard, American Express, or eCheck.

***Announcement***

## Dr. Anne C. Roberts Hailed as Radiology Leadership Luminary

*2017;10[3]:63*

On May 15, 2017, in Washington, D.C., the Radiology Leadership Institute® (RLI) recognized the exceptional and demonstrated leadership of the American Board of Radiology's (ABR's) associate executive director for interventional radiology, **Anne C. Roberts, MD, FACR,** and of Jonathan S. Lewin, MD, FACR, naming them this year's Leadership Luminary Award recipients.

The RLI, an American College of Radiology (ACR) professional development and leadership program, will recognize the award recipients at this year's RLI Leadership Summit, September 7–10, in Wellesley, Massachusetts.

"Drs. Lewin and Roberts have devoted their careers to advancing the practice and science of radiology. Their leadership inspires us and their lifetime of achievement makes them true luminaries in our field," said Frank J. Lexa, MD, MBA, RLI chief medical officer and chair of the ACR Commission on Leadership and Practice Development. "In celebrating their achievements, we recognize their visionary leadership, passion, commitment to mentoring the next generation of medical imaging professionals and notable contributions to the specialty and to patient care," he added.

**Anne C. Roberts, MD, FACR**, is chief of vascular and interventional radiology at the University of California at San Diego (UCSD) Health. She served in many ACR leadership roles, including secretary/treasurer, vice president, and member of its Board of Chancellors. A past president and program director for the Society for Cardiovascular and Interventional Radiology (SCVIR, now the Society of Interventional Radiology), Roberts is the associate executive director for interventional radiology at the ABR. Her research is focused on advancing treatment techniques for uterine fibroids. She has been a member of several U.S. Food and Drug Administration panels, participated on study sections for the National Institutes of Health (NIH), and was involved in planning for the NIH National Institute of Biomedical Imaging and Bioengineering (NBIB).

# Spotlight on an MOC Participant

*2017;10[3]:64-65*

In today's *Spotlight*, we focus on **Richard L. Becker, MD**, a diagnostic radiologist and MOC participant in Pensacola, Florida. We asked Dr. Becker why he chose his specialty, to which he replied, "I chose radiology because I was fascinated with the technology and enjoyed the diagnostic aspect of medicine. I am a second career engineer who was naturally attracted to this specialty. Because of the nature of my medical training, I practiced clinical medicine for four years after medical school before residency and found that for me, the patients themselves often confounded the diagnosis, and therefore I appreciated the objectivity that radiology allowed.

"It definitely meets my expectations in terms of satisfying my diagnostic curiosity - every case is like the 'box of chocolates' of *Forrest Gump* fame, and I feel that as a radiologist, I am at one of the busiest crossroads and highest impact areas of medicine. As with all clinical medicine, the pace of this profession is much brisker than I had imagined before going to medical school."

When we asked Dr. Becker to give an example of how Maintenance of Certification (MOC) activities have helped him improve his practice, he said, "The most pervasive impact to my everyday practice has been acting as co-chair of our hospital medical staff quality committee, which meets the MOC Part 4 requirement. This committee receives cases to review and disposition via direct referrals of bad outcomes or near misses, indirect referrals from our patient safety system, and from patient complaints to our customer service representatives. This involvement has opened my eyes to a multitude of ways that mistakes can be made that either harm patients or make their experience unnecessarily poor, and it has given me a more in-depth view of the workings of each clinic and OR.

"I notice that I draw on this knowledge almost every minute of the day, whether it be in making a decision about the need for nonroutine communication about an imaging finding (partly because I know the referring provider and clinic better), knowing how to structure my impression to avoid missteps in the patient's workup, orienting a new radiologist to the department (what issues need to take priority), or talking with an irate patient. I can't objectively measure the benefit to our patients, but I know we have identified and fixed multiple safety vulnerabilities and have improved relationships with all our clinical staff as a result of just this single extradepartmental activity."

We next asked Dr. Becker to give us his thoughts about the ABR's recent Practice Quality Improvement (PQI) improvements and Simplified Attestation for MOC. "This was a huge improvement," he said, "and in my opinion a necessary one. The PQI requirement was too

prescriptive and narrow in scope. In fact, as I approached this most recent MOC milestone, I was worried that I would not be able to get any of the numerous process and quality improvement projects that I had initiated tweaked and documented in such a way as to satisfy the requirement without spending a huge amount of time. With the expanded Part 4 and the attestation process, it took only a few minutes as I had plenty of evidence on my hard drive and in my email of my participation in these other activities. I simply sequestered selected documents in my MOC directory/folder to ensure I would have them for future reference, and clicked yes on the attestation button."

The ABR's pilot program for replacing the traditional 10-year MOC exam with Online Longitudinal Assessment (OLA) sounds like a great idea to Dr. Becker. "I think it will help me identify weak areas and focus my CME, as well as help keep me regularly doing CME rather than batching. It is difficult to get this sort of feedback in other forums without paying additional fees, and otherwise I might tend to only do the CME that is most interesting or, quite honestly, most convenient. It seems more practice-relevant than a postcertification exam. Probably a lot cheaper in the long run, though likely complex and expensive to get started. It sounds like it will take very little time out of my day, and that will be a big factor in whether or not it is a success."

When we asked Dr. Becker to share a memorable interaction with a colleague, he told us, "One of the fondest memories I have of my early career in radiology is talking with one of our senior radiologists who had worked his way up from being an essentially destitute refugee from Cuba, learning to master English, earning his way through medical school, and passing the radiology oral boards. He was one of the most patriotic U.S. citizens I have ever met, always took more workload than he needed to (he was salaried), and always demonstrated that he was a doctor and not just a technician when it came to taking care of patients."

Dr. Becker and his wife got started on their family a little late, so they still have four children below the age of 10 whom they homeschool. "In my spare time there is sometimes pause enough to think about what I did when I had more spare time! As they get older, I plan to return to sailing, hiking, flying, local and overseas mission work, and riding dirt bikes. Until then, I enjoy telling the kids stories about what I have been blessed to be able to experience in life so far, and I hope that they have and learn to find similar opportunities."

# List of Society Attendance

*2017;10[3]:66*

The ABR sponsors a booth at numerous society meetings throughout the year. Printed materials are available, and ABR representatives are in attendance to answer your questions. To see a list of society meetings at which the ABR plans to have a booth in 2017, please click here.