Reflections from Eight Years on the American Board of Radiology
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My Early Days with the ABR

Approximately eight years ago, I received a call from the late and beloved Steve Leibel, MD, informing me that I had been selected to serve as a radiation oncology trustee of the ABR. I was highly honored that my peers had selected me to serve in such an important organization involved in the certification process for our specialty. Other than my experience in occasionally writing questions for the written examinations and serving as a periodic oral examiner, I knew little about the ABR, its operations, or the substantial evolution it would undergo over the next eight years.

Re-organization of the Examination Committees

When I first joined the ABR radiation oncology trustees in 2005, an expert trustee in each category essentially oversaw both the written and oral examination process for the initial certification (IC) exam. The trustee was also the primary reviewer for written examination questions that were submitted by a broad group of volunteer radiation oncologists. In addition, the trustee oversaw the assembly of the written exams and compilation of the oral exam, with periodic input from other oral examiners.

Since 1995 was the first year of issuing time-limited certificates in radiation oncology, Maintenance of Certification (MOC) was already mandated for “time-limited” certificate holders. However, 2005 was just the beginning of MOC awareness and formal implementation, which at that time involved not much more than taking a recertification exam every 10 years.

From approximately 2005 on, as noted below, the American Board of Medical Specialties (ABMS) rapidly began to roll out a more robust and comprehensive MOC program. In addition to the work related to oversight of the primary exam; creating, structuring, and monitoring the MOC programs; working on a growing number of ABR committees; and serving on ABMS committees, the workload for trustees expanded to the point where additional volunteer help was needed in order to maintain high-quality, relevant, and current IC written examinations, oral examinations, and written MOC examinations.

Written and oral examination chairs were recruited to work with the trustees in this process, and, more recently, each category established examination committees.

These committees represent a diverse group, from a gender, geographic, and interest perspective, that oversees the content and quality of the written IC and MOC examinations, as well as the oral examinations. The trustees manage the examination committees, which are headed by the written and
oral examination co-chairs. This structure has been essential in ensuring that the content of all ABR exams is current, fair, relevant, and balanced. It should also be emphasized that professional psychometricians who work full time for the ABR, consistently evaluate and rate the validity, reproducibility, and quality of each component of the exams. This ensures a fair, balanced, and robust process is in place and provides reassurance to patients and other stakeholders regarding the credibility and quality of ABR examination processes.

**Rapid Evolution of Maintenance of Certification**

As noted above, in 2005 MOC involved little more than taking a re-certification exam every 10 years. The ABMS, which oversees all 24 specialty boards, was rapidly gearing up and moving toward a more rigorous and meaningful MOC program. Shortly after I arrived in 2005, the ABR and all of the other medical specialty boards submitted for approval to ABMS a robust MOC program that complied with guidelines for MOC established by ABMS.

Each board was asked to demonstrate that its diplomates maintained qualifications in their respective specialties by fulfilling requirements in four areas: professional standing (active license to practice), lifelong learning (CME and self-assessment modules), cognitive knowledge (passing a secure examination), and practice quality improvement (PQI). How each board defined, monitored, and implemented these programs varied, but committees within the ABMS attempted to provide direction and some consistency among specialties. The intention was to demonstrate to the public and other stakeholders that both primary certification and Maintenance of Certification by any ABMS specialty board ensured a fundamental level of professionalism, skills, knowledge, and competency.

Not only was practice improvement implemented, but patient and peer surveys are currently being integrated into the process. In an effort to incorporate practice improvement and quality projects in which entire departments or institutions may be involved, the ABR and many other boards are offering group or institutional quality improvement projects, and all participants in the project can receive credit for the project toward their MOC requirements.

Another major effort that has been implemented is recognition of participation in MOC—with completion of MOC activities beyond what is usually required—by the Centers for Medicare and Medicaid Services (CMS) for additional payment incentives. Over time, it is hoped that active and meaningful participation in MOC may also fulfill all requirements for state license renewal and could also serve as deemed status for other credentialing processes. Given that MOC is a robust and rigorous process that incorporates many aspects of what is expected of all medical professionals, including CME, self assessment, periodic examinations, and practice improvement, the concept of meaningful active participation in MOC serving as deemed status for other licensing and credentialing programs is a reasonable goal that the ABR and all specialty boards of the ABMS are striving to achieve.

Many specialty boards have moved to a process termed “continuous certification” for their MOC programs. Nothing has really changed with respect to the requirements, but this procedure monitors individuals for meeting their requirements through shorter cycles, assuring that diplomates will not fall behind and lose certification. Additionally, diplomates are provided greater flexibility in meeting some of the program requirements. Clearly, the MOC program has evolved significantly for the ABR as for all of the specialty boards, and it will continue to evolve over time.

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Focused Practice Recognition in Brachytherapy

Another major change that was recently implemented is the pilot program of Focused Practice Recognition in Brachytherapy, headed by the efforts of Beth Erickson, MD; Paul Wallner, MD; and a dedicated group of volunteers with interest and expertise in brachytherapy. Although not a bona fide subspecialty within radiation oncology, brachytherapy is an area where many diplomates focus their practice and have added expertise. Provided diplomates meet certain requirements, such as a minimal caseload of brachytherapy procedures in their practices, this pilot program allows them to provide evidence of additional competence in brachytherapy. It also offers a mechanism for practice quality improvement in this focused area of radiation oncology.

A core element of the pilot program is a national brachytherapy registry that will provide data to individuals for PQI projects, and to investigators for research into various aspects of brachytherapy. The pilot program will be reviewed by the ABMS in five years to determine the added value of Focused Practice Recognition in Brachytherapy and, if successful, it could pave the way for additional focused practice recognition programs.

Future Directions

Move to a Modular Maintenance of Certification Exam

Reflecting on our continuous certification process, it is clear that if diplomates maintain an active clinical practice, continue to participate in meaningful CME and self-assessment activities, and periodically evaluate critically and attempt to improve practice through practice quality improvement projects, they will remain up to date and competent, and the quality of patient care will improve. The dreaded “cognitive examination,” while clearly the element of MOC that is most feared, in my view is probably the least critical of the four fundamental elements. Nonetheless, this requirement creates the most angst among our diplomates.

One issue that arises about the cognitive written examination throughout all specialties is that many diplomates subspecialize, and a general examination may not be relevant to a practitioner who focuses his or her practice on one or two areas. Although radiation oncology does not have formal subspecialties, there are certainly practitioners who specialize in one or two disease sites. To address this issue over the next few years, the ABR trustees are committed to creating a modular, practice-oriented examination. Since one is expected to maintain some fundamental knowledge base across all of radiation oncology and our certification is in general radiation oncology, there will still be a requirement to take a portion of the examination in general radiation oncology. However, much of the examination can be devoted to one or two areas where a diplomate emphasizes his or her practice. We anticipate that these modular examinations will roll out over the next few years.

Transition from Louisville

While the entire ABR (diagnostic radiology, radiation oncology, and medical physics) underwent all these major transitions over the past decade together, our colleagues in diagnostic radiology (DR) experienced an even greater transformation in moving away from the oral examination to a final certification exam that is entirely computer based. This June will be the last full oral examination for the DR group in Louisville.

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Although we in radiation oncology considered the possibility of transitioning to a computer-based examination, we have decided that given the nature of our specialty, an oral examination should remain an essential component in our certification process. In 2015 we will move from Louisville to an examination center in Dallas, which was designed specifically for oral examinations by the American Board of Obstetrics and Gynecology. Although we will all miss the traditions and stories of our Louisville experiences, we look forward to transitioning to this state-of-the-art oral examination venue.

**Concluding Remarks**

Clearly, substantial changes have taken place over the past decade. Keeping up with these changes and communicating to all our stakeholders regarding the evolution of the certification process has been a significant challenge for the ABR and its diplomates. In an effort to improve communications not only from the ABR to its diplomates, but from the diplomates and other stakeholders to the ABR, we have recently implemented Initial Certification and Maintenance of Certification Advisory Committees. These groups are composed of a broad diversity of diplomates, including private practitioners, academicians, residency directors, and others. These committees serve to provide enhanced, regular dialogue and communication between the ABR and all its stakeholders.

Since its inception in 1934, the ABR for most of its history provided a primary certificate demonstrating that at a single point in time, a diplomate had successfully completed training and achieved a fund of knowledge and a skill set to competently practice the specialty. Thereafter, except as volunteers and in some unusual circumstances, diplomates rarely dealt with the ABR.

Currently, we are committed to an ongoing relationship with the ABR throughout the duration of our professional careers. Demonstration of professional standing, lifelong learning, self-assessment, cognitive knowledge, and practice improvement continuously throughout a diplomate’s professional career entitles the diplomate to continuous certification by the ABR. This carries with it acknowledgment and trust in our professionalism and competence by our patients, the public, and other stakeholders.

Although the process is involved and requires effort on the part of the diplomates as well as the volunteers and staff of the ABR, given our robust, high-quality processes, the public and other stakeholders will continue to value board certification as an essential validation of their physicians.

When I first came on the board in 2005, I had no idea how much effort the trustees, staff, and all of the dedicated volunteers of the ABR invest in this rigorous and worthy process. But I also did not appreciate how much impact the work we do has on the integrity of our specialty and, ultimately, on the quality of care we offer our patients. Without question it has been the most rewarding experience of my professional career, and I look forward to the continued health, prosperity, quality, and integrity of our specialty.