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The American Board of Nuclear Medicine

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Message from the Chair—*Harvey A. Ziessman, M.D.*

Harvey A. Ziessman, M.D.
Chair

I have recently returned from the 81st Meeting of the American Board of Nuclear Medicine. The meeting is always stimulating and tiring. The ABNM meets twice a year for about 4 days. Many hours of preparatory work are required by the Board members (Directors) and the Executive Director and his staff to make the meeting a success. We spend much of that time evaluating and discussing new exam questions, reviewing recent examination results (Certification, MOC, and In Training), and discussing many issues and policies regarding certification and MOC, as well as future goals and direction of the ABNM and Nuclear Medicine.

How are Board Directors selected? Twelve physician Directors sit on the Board, usually for two consecutive 3 year terms. Each year two Directors rotate off the board and two join the Board. At this meeting we chose two new Directors. Nominations for new Directors are made by past and present ABNM Directors and then elected by the current Directors. Each year the Board has many excellent nominees. In selecting new Directors, the Board takes into consideration not only the nominee's academic, clinical, and teaching experience, but also aims to maintain a geographic balance and include on the Board experts and generalists from both academics and clinical practice who encompass the broad spectrum of Nuclear Medicine practice.

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Executive Directors Report—*Henry D. Royal, M.D.*

The Value of Maintenance of Certification

Henry D. Royal, M.D.
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This newsletter is for you, our diplomates. We want to address issues that are of interest and importance to you. In response to my last article where I asked what issues you would like to have discussed, one diplomate asked the board to provide the evidence that MOC had value. If you are interested in this topic, google "value of maintenance of certification". I got 3,540 hits. Make sure you put it in quotes otherwise you will get 765,000 hits.

The value of MOC falls into 3 domains; professional, economic and healthcare value.

Professional value

In order to self-regulate, the public has to trust the medical profession. Public trust requires a credible system to document the varied expertise of physicians and there must be organizations where physicians make decisions based on what is best for patients and not out of self-interest.

Leaders in medical societies are elected by society members and act in the interest of their members. In contrast, boards were established to set training standards for the profession that are credible to the public. Board members are not elected by diplomates because board members respond to the needs of the public rather than the needs of its diplomates. Indirectly this benefits diplomates because it provides a credible system to document the varied expertise of physicians.

The previous system of certification – a lifetime certificate - is no longer credible to the public. The profession and the public recognize that the education of a physician never ends. The increasingly rapid changes in medicine emphasize the importance of lifelong learning. In order to be credible to the public, lifelong learning needs to be documented through CME (Part 2 of MOC) and a cognitive exam (Part 3 of MOC). Increasing concern about the need for improvement in the healthcare system has lead to practice performance assessment (Part 4 of MOC), a practical program to identify areas for improvement in your own practice and to document that improvement has occurred (see Dr. Segall's article in this newsletter). *continued on page 2*

The Value of Maintenance of Certification—*continued from page 1*

The value of MOC in the professional domain is that standard setting organizations are necessary to maintain the public's trust of physicians. Without this trust we will become increasingly regulated by non-physicians. This would not be good for our patients nor would it be good for physicians.

Economic value

There are at least 4 examples of the potential economic value of MOC. First, some malpractice insurance carriers have begun offering discounts to physicians in some specialties who are participating in MOC. As evidence accumulates documenting that physicians who participate in MOC have fewer malpractice claims, more malpractice insurers are likely to offer this discount to more physicians in more specialties.

Second, state medical licensing boards have recognized that the current standards for renewing medical licenses are no longer credible to the public. In the next few years, more states will likely require a recent cognitive exam as a condition for maintaining your medical license. Participation in MOC will be accepted in lieu of a state medical licensing exam.

Third, it is likely that hospital credentialing committees will increasingly require participation in MOC in order to gain hospital privileges.

Finally, part 4 of MOC is currently mentioned in some versions of healthcare reform bills as being equivalent to participating in the Physician Quality Reporting Initiative (PQRI). Physicians participating in PQRI receive a 2-3% increase in Medicare payments.

Healthcare value

Ultimately, the goal of MOC is improve healthcare. MOC alone will not achieve significant improvements in healthcare. Many experts think significant improvements in healthcare can only be achieved with significant changes in physician incentives. These experts believe that our current fee for service encourages quantity and does not reward quality or efficiency. That said, MOC is currently the most viable process to measure improvement at the level of the individual physician. The boards believe that the medical profession must be very involved with developing measures of quality. If physicians do not measure markers of quality, improvements in healthcare delivery cannot be measured. Measurement of quality and improvement is too important of a task to be left solely to the judgment of others.

Residency Committee Report—*Leonie L. Gordon, M.D.*

In Training Examination (ITE)

Nuclear medicine residencies are required to participate in the ITE in order to evaluate the performance of their residents using a national benchmark. For the 2010 ITE, the ABNM has moved the exam date to early February. This earlier exam date will allow program directors to more promptly initiate a remediation plan when deficiencies in knowledge are identified. The 2010 ITE will be administered on either Friday, February 5th or Saturday, February 6th depending on the preferences of the program director. Below is a table of the number of the candidates and programs participating in the 2009 ITE.

2009 ITE Exam Candidates:	
Residents-US	154
Residents-Canadian	7
Non-trainees:	8
Total Candidates:	**169**

Nuclear Medicine Training Programs Participating	
US Programs:	57
Canadian Programs:	5
Total Programs:	**62**

What is that new symbol?—*Henry D. Royal, M.D.*

ABMS MOC™
American Board of Nuclear Medicine
Certification Matters

You may have noticed the new symbol in the last newsletter. What is it and what does it mean?

This six pointed symbol is the American Board of Medical Specialties' (ABMS) symbol for maintenance of certification. The six points are a graphic representation of the six competencies (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice Based Learning, Systems Based Practice) identified by the Accreditation Council for Graduate Medical Education (ACGME) that have been adopted by the Residency Review committees, ABMS and its 24 member boards. The loop on the top indicates the requirement for continuous lifelong learning.

By displaying this symbol, the ABNM is showing that its MOC program meets the standards established by the ABMS. This allows ABNM diplomates to benefit from the work of all boards and the ABMS.

Part IV Projects In Development—*George M. Segall, M.D.*

Part IV of Maintenance of Certifications (MOC) is Practice Performance Assessment (PPA). An ABNM-SNM Task Force is developing society-based projects, as well as a template for individual-designed projects, that may be used to satisfy the requirements of Part IV. The purpose is to allow physicians to assess their performance in a clinically relevant area of their practice, and to provide a framework for measurable improvement. Society-based projects will not be subject to audit if successfully completed. Physicians must complete a minimum of one project every three years. The projects in development are:

Myocardial Perfusion Imaging

This project is designed to improve diagnostic certainty (fewer equivocal reports) and interpretative accuracy (higher sensitivity and specificity) of myocardial perfusion imaging. The project is designed for physicians performing and interpreting myocardial perfusion studies performed with SPECT (single photon emission computed tomography).

Physicians who complete this project should:

- Improve diagnostic certainty so that > 80% of reports will be reported as normal or abnormal (i.e. < 20% equivocal interpretations)
- Improve diagnostic accuracy compared to coronary arteriography (abnormal studies) or normalcy rates (normal studies) so that overall accuracy is > 80% per patient

18F-FDG PET-CT in Patients with Cancer

This project is designed to improve diagnostic accuracy of 18F-FDG PET in patients with newly diagnosed or suspected cancer. The project is designed for physicians performing FDG PET-CT and includes interpretation of CT done as part of PET-CT for anatomic registration, as well as optimized CT for diagnosis.

Physicians who complete this project should:

- Improve sensitivity in patients with cancer so that >80% of exams will be positive for malignancy
- Improve specificity in patients without cancer so that >80% exams will be negative in the absence of malignancy.
- Improve accuracy for lymph node staging so that >50% of exams will be correct for N stage.
- Improve accuracy for detection of distant metastases so that >80% of exams will be correct for M stage.
- Improve overall staging so that >80% of patients with malignancy appropriate for localized therapy (surgery or radiation, plus or minus chemotherapy) are correctly identified

Minimizing Radiation Dose to Patients From Diagnostic Nuclear Medicine Studies

This project is designed to reduce radiation dose to patients from radiopharmaceuticals used in diagnostic Nuclear Medicine studies to as low as possible reasonably achievable (ALARA principle) without compromising the quality of the study. This project is designed for physicians who are Authorized Users (AU) of radioactive materials for clinical practice and prescribe radiopharmaceuticals, or are otherwise responsible for the performance of diagnostic Nuclear Medicine studies.

Physicians who complete this project should:

- Reduce radiation dose to patients from diagnostic Nuclear Medicine studies
- Ensure best practice through the principle of ALARA.
- Decrease incidence of reportable medical events involving radionuclides

Template For Creating a Practice Performance Assessment Project

The template is designed to help physicians design a suitable project that is relevant to their own clinical practice. The project must be intended to improve quality. The project must be relevant to your practice (decide where quality improvement could reasonably be made in your own practice setting). Data collection must be achievable within your practice (choose a practical project for which data will be available). The data must be measurable and suitable to be re-measured/trended over time.

The project may focus on an Institute of Medicine (IOM) dimension of quality of care (e.g. safe, timely, efficient, effective, patient-centered, equitable) or may focus on one or more of the six core competencies (e.g. patient care, knowledge, communication, professionalism, practice-based learning, system-based practice). The project may be designed to be completed by an individual or a group of physicians.

Feedback

The ABNM welcomes comments from diplomates and residents regarding issues raised in Tracers or any other issues affecting the practice of nuclear medicine or certification processes. Please email your comments to Henry Royal M.D. (royalh@mir.wustl.edu), Executive Director, American Board of Nuclear Medicine.

2008 ABNM Examination Results

2008 Certification Examination

Number of Candidates who took exam	95
Number who passed	72
Pass rate	**76%**

2008 Maintenance of Certification Examination

Number of Candidates who took exam	55
Number who passed	54
Pass rate	**98%**

ABNM Examination Dates

2009 ABNM Examinations

Certification Examination Dates	October 5 to 9, 2009
Maintenance of Certification Examination Dates	October 5 to 9, 2009

2010 ABNM Examinations

In Training Examination	February 5 or 6, 2010
Certification Examination Dates	October 4 to 8, 2010
Maintenance of Certification Examination Dates	October 4 to 8, 2010