

The American College of Radiology, with more than 30,000 members, is the principal organization of radiologists, radiation oncologists, and clinical medical physicists in the United States. The College is a nonprofit professional society whose primary purposes are to advance the science of radiology, improve radiologic services to the patient, study the socioeconomic aspects of the practice of radiology, and encourage continuing education for radiologists, radiation oncologists, medical physicists, and persons practicing in allied professional fields.

The American College of Radiology will periodically define new practice parameters and technical standards for radiologic practice to help advance the science of radiology and to improve the quality of service to patients throughout the United States. Existing practice parameters and technical standards will be reviewed for revision or renewal, as appropriate, on their fifth anniversary or sooner, if indicated.

Each practice parameter and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review and approval. The practice parameters and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document. Reproduction or modification of the published practice parameter and technical standard by those entities not providing these services is not authorized.

Revised 2022 (Resolution 5)*[_](#)

ACR PRACTICE PARAMETER FOR CONTINUING MEDICAL EDUCATION (CME)

PREAMBLE

This document is an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. Practice Parameters and Technical Standards are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care.¹ For these reasons and those set forth below, the American College of Radiology and our collaborating medical specialty societies caution against the use of these documents in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner in light of all the circumstances presented. Thus, an approach that differs from the guidance in this document, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in this document when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of this document. However, a practitioner who employs an approach substantially different from the guidance in this document is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to the guidance in this document will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of this document is to assist practitioners in achieving this objective.

¹ *Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing* 831.N.W.2d.826 (Iowa 2013) Iowa Supreme Court refuses to find that the *ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures* (Revised 2008) sets a national standard for who may perform fluoroscopic procedures in light of the standard's stated purpose that ACR standards are educational tools and not intended to establish a legal standard of care. See also, *Stanley v. McCarver*, 63 P.3d 1076 (Ariz. App. 2003) where in a concurring opinion the Court stated that "published standards or guidelines of specialty medical organizations are useful in determining the duty owed or the standard of care applicable in a given situation" even though ACR standards themselves do not establish the standard of care.

I. INTRODUCTION

The American College of Radiology (ACR), as evidenced in its Mission Statement, strongly values continuing medical education (CME). The purposes of the ACR include advancing the science of radiology, improving radiologic services to the patient, studying socioeconomic aspects of the practice of radiology, and providing continuing education for radiologists, radiation oncologists, interventional radiologists, and medical physicists.

The ACR, through its Commission on Publications and Lifelong Learning, has consistently provided a variety of CME programs to meet the needs of radiologists, radiation oncologists, interventional radiologists, and medical physicists. Medical physicists may document their Continuing Education activities (Medical Physics Continuing Education Credits) with the Commission of Accreditation of Medical Physics Education Programs (CAMPEP).

II. APPROACHES TO DETERMINE CME REQUIREMENTS

There are several approaches to determine the number of hours, format, and content of CME.

A. The American Board of Radiology (ABR), the American Osteopathic Board of Radiology (AOBR), and the American Board of Nuclear Medicine (ABNM)

In past programs, the ABR, the AOBR, and the ABNM awarded lifelong certification in General Radiology, Diagnostic Radiology, Radiation Oncology, Medical Physics, and Nuclear Medicine. Under current programs, the AOBR and the ABNM have awarded time-limited specialty certificates. The ABR and AOBR also issue time-limited subspecialty certificates (formerly called Certificates of Added Qualifications or CAQs). To retain board certification, diplomates with time-limited certificates must enroll and participate in a Maintenance of Certification (MOC) program (for ABR-certified physicians) or Osteopathic Continuous Certification (OCC) (for AOBR-certified physicians). (See <http://theabr.org/>, <http://www.aobr.org>, and <http://www.abnm.org/>.)

The MOC programs evaluate 6 “essential competencies” on a continual basis:

1. Medical knowledge
2. Patient care
3. Interpersonal and communication skills
4. Professionalism
5. Practice-based learning and improvement
6. Systems-based practice

To evaluate these 6 competencies, MOC uses 4 components:

1. Evidence of professional standing
2. Lifelong learning and self-assessment
3. Cognitive expertise
4. Practice quality improvement

The OCC programs evaluate 7 “essential competencies” on a continual basis:

1. Osteopathic philosophy and osteopathic manipulative medicine
2. Medical knowledge
3. Patient care
4. Interpersonal and communication skills
5. Professionalism
6. Practice-based learning and improvement
7. Systems-based practice

To evaluate these 7 competencies, OCC uses 5 components:

1. Unrestricted licensure
2. Lifelong learning/CME
3. Cognitive assessment

4. Practice performance assessment and improvement
5. Continuous American Osteopathic Association (AOA) membership

Participating in CME conforming with the MOC/OCC program of one's certifying board(s) is encouraged.

B. The American Medical Association (AMA)

The AMA promotes CME and issues a Physician Recognition Award (PRA) for physicians who document that they have met the requisite CME. Details can be found on the AMA website (<http://www.ama-assn.org>). CME is classified by the AMA as either Category 1 or Category 2.

C. The American Osteopathic Association (AOA)

The AOA requires 120 CME credits within a 3-year cycle. CME credit may be obtained with either Category 1-A, 1-B, 2-A, or 2-B. Details regarding AOA CME requirements may be found on the AOA website (<http://www.osteopathic.org>).

D. Licensure and Accreditation Requirements

Many states require CME to obtain and/or renew licensure, most hospital credentialing boards require CME to maintain hospital privileges, and some medical societies require CME to retain active membership status.

Many accreditation programs have educational requirements specific to their area(s) of focus. ACR members are strongly encouraged to know and comply with the educational requirements of their state jurisdictions, hospital medical staffs, professional associations, and accreditation programs.

E. Lifelong Learning

ACR members are strongly encouraged to participate in lifelong learning and to arrange self-directed study programs.

III. EDUCATIONAL REFERENCE WEBSITES

In addition to the ACR (<http://www.acr.org>), many other organizations provide information on CME. The websites listed below are provided for informational purposes only. This list is only a small sample of the many available websites offering information on CME related to radiology or the radiation sciences. The ACR does not attest to the accuracy of content on the websites of other organizations.

The American Board of Radiology
<http://theabr.org>

American Osteopathic College of Radiology
<http://www.aocr.org>

The American Board of Nuclear Medicine
<http://www.abnm.org>

American Osteopathic Board of Radiology
<http://www.aobr.org>

American Roentgen Ray Society
<http://www.arrs.org>

American Medical Association
<http://www.ama-assn.org>

Radiological Society of North America
<http://www.rsna.org>

CME gateway site administered by the Radiological Society of North America
<http://www.cmegateway.org>

ACKNOWLEDGEMENTS

This practice parameter was revised according to the process described under the heading *The Process for Developing ACR Practice Parameters and Technical Standards* on the ACR website (<https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards>) by the Committee on Practice Parameters – General, Small, Emergency and/or Rural Practice of the ACR Commission on General, Small, Emergency and/or Rural Practice.

Writing Committee – members represent ACR in the initial and final revision of this practice parameter

ACR

Derrick Siebert, MD, Chair
Rachel F. Gerson, MD
Nathan J. Rohling, DO

Committee on Practice Parameters – General, Small, Emergency and/or Rural Practices (GSER)
(ACR Committee responsible for sponsoring the draft through the process)

Candice Johnstone, MD, Chair	Steven E. Liston, MD, MBA, FACR
Lynn Broderick, MD, FACR	Nathan J. Rohling, DO
Justin P. Dodge, MD	Samir S. Shah, MD
Brian D. Gale, MD, MBA	Derrick Siebert, MD
Rachel Gerson, MD,	Michael Straza, MD, Ph.D
Carolyn A. Haerr, MD, FACR	Jennifer L. Tomich, MD
Charles E. Johnson, MD	Samir S. Shah, MD
Mallikarjunarao Kasam, PhD	

Robert S. Pyatt, Jr., MD, FACR, Chair, Commission on General, Small, Emergency and/or Rural Practice
David B. Larson, MD, MBA, Chair, Commission on Quality and Safety
Mary S. Newell, MD, FACR, Chair, Committee on Practice Parameters and Technical Standards

Comments Reconciliation Committee

Kurt Schoppe, MD – CSC Chair
Kristin Kelly Porter, MD, Ph.D – CSC Co-Chair
Catherine Margaret Appleton, MD
Timothy A. Crummy, MD, FACR
Rachel F. Gerson, MD
Candice Johnstone, MD
Amy L. Kotsenas, MD, FACR

David B. Larson, MD, MBA
Paul A. Larson, MD, FACR
Robert S. Pyatt, Jr., MD, FACR
Mary S. Newell, MD, FACR
Nathan J. Rohling, DO
Derrick Siebert, MD
Roland Wong, ScM

*Practice parameters and technical standards are published annually with an effective date of October 1 in the year in which amended, revised or approved by the ACR Council. For parameters and standards published before 1999, the effective date was January 1 following the year in which the parameter or standard was amended, revised or approved by the ACR Council.

Development Chronology for This Parameter

1991 (Resolution 8)

Revised 1994 (Resolution 2)

Revised 1996 (Resolution 27)

Revised 2000 (Resolution 15)

Revised 2005 (Resolution 38)

Revised 2011 (Resolution 53)

Amended 2014 (Resolution 39)

Revised 2016 (Resolution 11)

Revised 2017 (Resolution 11)

Revised 2022 (Resolution 5)