Lifelong Learning

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In order to practice medicine in accordance with current evidence, a physician must adopt some method of lifelong learning. Unfortunately, studies repeatedly show that physicians are extraordinarily slow to incorporate new medical knowledge into their practice, even when that evidence is incontrovertible. These observations helped to support the American Board of Medical Specialties (ABMS) in their decision that mandatory re-certification of medical specialists would be necessary to assure a basic level of current knowledge and practice competence across all certified specialists in each of its 24 member boards. The American Board of Anesthesiology (ABA) has offered voluntary re-certification since 1993, but it was among the last of the specialty boards to make re-certification mandatory (2000). The ABA also has among the longest re-certification cycles, extending the period for each certification over 10 years.

ABA Re-certification Process

The ABMS expects four components to a Maintenance of Certification (MOC) process; evidence of Professional Standing; Lifelong Learning and Self-Assessment (LL-SA); evaluation of Practice Performance; and a Secure Examination. These elements have been embraced by the ABA and adapted into their MOC for Anesthesiology (*i.e.* MOCA). While mandatory participation in this process is limited to those who were certified in 2000 or later, we do see increasing trends on the part of a few payers and some states to require re-certification even when the specialty board might not. However, **from the standpoint of the ABA, those awarded primary ABA certification before 2000 will never jeopardize that status by participation in MOCA**. Those diplomats of the ABA holding permanent (*i.e.* non time-limited) certificates who face external requirements for re-certification, can still satisfy that requirement with the voluntary ABA re-certification examination until 2009 or MOCA. Beyond that date, MOCA will be the only means by which ABA will grant re-certification.

The four MOC elements have been adapted by ABA according to its 10-year certification cycle. Professional standing will entail the demonstration of a valid, unencumbered medical license in at least one U.S. or Canadian jurisdiction at two points during the cycle, years 6 and 10. LL-SA entails 350 CME credits spread over the 10-year cycle. More details about this component can be found in the next section. A secure cognitive exam is given once during the cycle. It can be taken as early as year seven, provided the diplomate has completed at least 200 of the required CME credits, and met ABA requirements for Professional Standing and Practice Performance. The latter component is not yet finalized, but conceptually entails a periodic evaluation of each diplomate's practice and quality improvement activities. As currently proposed, this would entail an attestation by a Department Chair or Chief of Staff twice over the 10-year cycle, years 5 and 9. This proposal has been submitted to ABMS and should be finalized by December 2004.

As MOCA enrollment only began in January 2004, those diplomates who became ABA certified between 2000-2003 have less than 10 years to complete the cycle. Thus their LL-SA requirements have been prorated. Diplomates who allow their time-limited certificate to lapse can go on to complete the re-certification process by meeting all the MOCA requirements in the 10 years leading up to re-certification. In other words, any CME credits obtained in year 1 are no longer valid toward re-certification in year 11.

Lifelong Learning Component of MOCA

Shortly after ABA initiated a time-limited certification process, they began to work collaboratively with the American Society of Anesthesiologists to formalize a lifelong learning strategy. A joint advisory committee was formed, the Council for the Continual Professional Development of Anesthesiologists (CCPDA) with representation from both organizations. The goals for CCPDA were to develop a LL-SA curriculum and timeline for MOCA. As a part of this responsibility, CCPDA would develop criteria for the types of activities that would satisfy LL-SA requirements. It was even contemplated that CCPDA might be engaged in evaluating specific CME programs periodically. Finally, CCPDA was asked to develop methods to evaluate the impact of ongoing participation in LL-SA activities.

The CCPDA proposed, and the ABA has adopted a LL-SA requirement of 350 credits over the 10-year MOCA cycle. At least 250 of these credits must represent ACCME-approved Category 1 activities. The diplomate may attest to as many as 100 credits for other formal or informal medical education activities. As many as 35 CME credits may be related to non-cognitive core competencies, such as professionalism, ethics, patient safety, practice management and quality improvement. The ABA recommends that diplomates engage in some CME activity in at least 5 of the 10-year cycle.

In the broader sense, however, lifelong learning strategies should be driven by a desire to transmit evidence-based practice to the anesthesiologists engaged in daily clinical practice, rather than abstract board re-certification requirements. In concept, CCPDA continues to work to incorporate that which is known about adult learning and effective CME in order to make the ABA requirements reflect best education practice. Unfortunately, the tools necessary to achieve the optimal lifelong learning outcome are not widely available as yet.

Adult education is most effective at achieving a change in behavior when the learning is self-directed. Hence self-assessment represents a key component to an optimal lifelong learning program. The ASA has several offerings designed to address this need for anesthesiologists. The Anesthesiology Continuing Education (ACE) program is being launched this month with the expressed goal of providing a self-assessment tool that enables the practicing anesthesiologist to test their own knowledge of core concepts in the specialty (http://www.asahq.org/conted/ACE2004.pdf). ASA has also offered a Self-Education and Evaluation (SEE) program for a few years whose focus is more on recently published “emerging knowledge” in peer-review journals and refresher courses (http://www.asahq.org/publicationsAndServices/continuing.htm).

Another important tenant of adult learning is that interactive methods are more effective than passive plenary lectures. Although one can find workshops and problem-based learning discussions as far more regular constituents of CME programs, they remain rather peripheral on the agenda of the average conference participant. In fact, they types of engaging discussions that actually influence clinical care deliver are far more likely to occur at a department or hospital level than the major national society meetings. Thus the immediate challenge we face is integration of three formerly independent, parallel processes: specialty board certification and re-certification, CME, and local quality improvement initiatives. Ideally, the most effective settings for changing clinical practice will simultaneously be informed by current, evidence-based principles and simultaneously recognized and incorporated into the LL-SA component of the re-certification process.

Future Possibilities

The roles to be played by ABA, ASA and other subspecialty societies, such as the Society for Pediatric Anesthesia (SPA) in LL-SA remain incompletely delineated. In order to prevent any perceived (or real) impropriety in administering board certification, the ABA cannot endorse any specific CME curriculum or preparatory course. They have endorsed an overall CME target with broad categories of curriculum and content types that can meet that target. It is conceivable that these target values of CME credits might evolve to a weighting system that encourages participation in the types of interactive activities that are known to be most effective.

The ASA, SPA, and other specialty and subspecialty have a long heritage in CME programs. While they would seem ideally positioned to adapt the principles of LL-SA into new, effective CME products, they also confront myriad political, logistical, financial, and perhaps legal challenges in so doing. While the ASA has made some strides toward self-assessment, the need for targeted, authoritative CME content to address deficiencies identified in self-assessment remains. Technologic advances have given us a set of tools that make plausible the vision that interactive, evidence-based LL-SA content could be distributed to any practicing anesthesiologist with an identified need and functioning computer. The specialty and subspecialty societies have relatively ready access to content experts, but marrying them with this sort of technology will require an investment in time and money the likes of which most CME providers cannot muster.

Finally, this system will already impose additional costs on the ABA diplomate. Outcome measurements will become critical for them to evaluate the manner in which they apportion the additional investment required by LL-SA activities. Narrowly speaking, that outcome would at least entail the benefits of a particular program on achieving re-certification through MOCA. Ideally, this goal will be intimately linked with a broader societal objective to enhance the delivery of optimal care to patients. An objective mechanism by which these outcome measures will be developed and tracked has yet to be established.

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Information and registration for MOCA can be obtained from the ABA website (www.abanes.org) **or** (www.theaba.org) as well as the MOCA home: https://secure.abanes.org/portal/AboutMOC.asp