Editor’s Notes

Educating Anesthesiologists: Process, Opportunity and Evolution

By Stephen Jackson, M.D., Editor

The CSA Bulletin has always focused on education, intending to communicate an eclectic spectrum of new and relevant information that can enhance both the professional and the personal lives of our readers. We aim to assist CSA members in their quest to fulfill our ethical obligation for lifelong learning, particularly regarding issues of quality of care, patient safety and practice management.

In November, together with fellow Californians Mark Singleton, Stan Stead and Randolph Steadman, I had the opportunity to attend the ASA’s “Educational Summit” (the brainchild of Dr. Arnold Berry, ASA Vice-President for Scientific Affairs), part of the ASA’s first-ever, long-range education planning. I was startled to learn that even though we all recognize the ASA to be a highly credible and effective provider of educational information, there is evidence that it can take as long as 17 years to effect widespread adoption of new practice guidelines! The natural follow-up question to this disquieting “shot across the bow” is: How can the ASA and CSA better deploy their considerable educational resources to inculcate best practices, while concurrently reducing this disturbingly prolonged adoption time?

The AMA lists seven recognized learning formats that are eligible for the AMA’s Physician’s Recognition Award (PRA) credits. They include live activity, enduring materials, journal-based CME, test item writing, manuscript review, performance improvement CME, and Internet point of care.

Live educational activity occurs at a specific time, one in which participation may be in person or remote, and may be offered through a variety of delivery mechanisms, including conferences, workshops, seminars, regularly scheduled conferences, journal clubs, simulation workshops, structured learning activities presented during a committee meeting, and webinars. However, it is important to appreciate that a live activity’s presentation of information, concepts, or principles in a general lecture or traditional classroom format is highly inefficient and ineffective. The principal advantage of general lectures is that they are useful for disseminating knowledge and skills to large groups in a single time frame, but their downside is that most information is lost, the average retention rate for this passive reception format being only 5 percent!
This meager percentage can be improved somewhat by including discussion, demonstration and clinical application, but not enough to label this method an effective learning modality.

Enduring educational material is a learning format that persists over a specified time, including print, audio and video (CDs and DVDs), and Web-based formats (such as online versions of journals, monographs, and other print materials; podcasts; and archived webinars). Printed information has served as a staple of learning since our childhoods. Its advantage is that it allows us to participate in activities at different times, advancing at our own pace and in our preferred environment. However, once again, the average retention rate is low: only 10 percent, although the addition of audiovisual components increases that paltry figure to 20 percent. An encouraging note is that when practice exercises with immediate feedback to learners are added, there can be dramatic enhancement of retention to as much as 75 percent! The use of case studies also can be effective for achieving higher-level cognitive objectives.

Next, we have the time-honored journal-based CME activity, in which an article appearing within a peer-reviewed, professional journal is certified for AMA PRA Category 1 credit prior to its publication. The CSA Bulletin’s educational modules (free of charge for members) presented for CME during most of this past decade dwell in this category. Nonetheless, it is disappointing to learn that despite the obvious advantages of being self-directed, self-paced, and engaging the reader to become informed about emerging science or best practices, the average retention rate for journal-based CME is still only 10 percent, just like enduring materials!

So, where does the CSA (and for that matter, the ASA) go from here? The answers are not easy to come by, but I am hopeful that Dr. Berry will provide us with some direction. In the interim, with the guidance and assistance of our Educational Programs Division, we plan to continue with our program of Bulletin-based CME. In this issue, we present a particularly challenging module written by Dr. Samuel Wald, one that addresses pregnancy testing of adolescents and its associated thorny nexus of science, politics, our multiple legal and regulatory systems, and—most important to my way of thinking—ethics. In fact, your editors expect to receive energetic and even vociferous correspondence regarding this module.

This Bulletin also contains two important articles on clinical practice. Dr. Kenneth Pauker considers the revised ASA Standards for Basic Anesthesia Monitoring with respect to the newly mandated monitoring for exhaled carbon dioxide during moderate and deep sedation (pages 40–46), while Drs. Linda Hertzberg and Beverly Philip elucidate the complicated historical evolution
of the ASA document on deep sedation provided by non-anesthesiologist practitioners (pages 72–75).

In addition, we have a current exposition of the Maintenance of Certification in Anesthesiology (MOCA) process that affects all diplomates of the American Board of Anesthesiology (ABA) who were certified beginning with the year 2000. Moreover, all grandfathered ABA diplomates who are not part of the MOCA process (as well anesthesiologists who are non-boarded) might be interested in becoming familiar with MOCA, because the Federation of State Medical Boards (FSMB) has approved a report (www.fsmb.org) that paves the way for strengthening the medical license renewal process by implementing new standards for lifelong learning by physicians. Under the FSMB’s proposed system, known as Maintenance of Licensure (MOL), current requirements will be expanded by mandating that physicians participate in a more robust program of continuous professional development relevant to their specialties, and one that is measured against objective data sources with the goal of enhancing performance over time. When fully implemented, MOL will require physician lifelong learning and create a system to confirm practice improvements. This will align with and incorporate the ASA and CSA educational activities that promote enhanced quality and patient safety through promotion of education.

What is more, this issue also contains an extraordinary article, hopefully the first in a series of such, on Stanford’s Department of Anesthesia. Dr. Ronald Pearl, the department’s chair, briefly reviews the department’s history, and then enlightens us in greater detail about current research activities; innovative educational programs not only in the residency and fellowship arenas, but also at the undergraduate and medical school level; simulation and immersive learning activities; pain management services; critical care activities; and pediatric, cardiac and other clinical services.