Accreditation Council for Continuing Medical Education
learn well

January 15, 2019

Richard E. Hawkins, MD
President and CEO
American Board of Medical Specialties (ABMS)
353 North Clark Street, Suite 1400
Chicago, IL 60654

Re: Continuing Board Certification: Vision for the Future Commission Draft Report

Dear Dr. Hawkins:

On behalf of the ACCME and our accredited CME community of educators, I commend the ABMS for convening The Vision Initiative and for your commitment to reimagining a system of continuing certification that fulfills our obligation to the public and places patients' interests first. We respectfully offer the following observations and opinions. We have also attached a short list of recommended edits.

We fully support the creation of a framework for a system of continuing certification that ensures that diplomates remain current in their specialty and that provides a specialty-based credential that is valuable and meaningful to diplomates, patients, families, the public, and healthcare institutions. The framework should not only express a *commitment* to the principles of competency and safety; it must capture the intent of the credential to convey accountability and carry meaning, requiring *ongoing demonstration* of competency and safety.

The report should acknowledge that the Boards' primary responsibility is to assess and certify, while educators across the community of accredited CME providers (including professional societies) have the primary responsibility of educating, optimally using assessment findings to provide individualized support. Boards should prioritize their responsibility of making valid and reliable assessments over the expectation of providing formative feedback. Naturally, formative feedback should be provided when doing so does not compromise the primary assessment.

Recommendation 1
Recommendation 1 should more clearly express and delineate the separate roles and responsibilities of the Boards and accredited CME providers. The Boards are responsible for setting competency expectations and are accountable for determining initial certification and continued competency. CME providers are responsible for delivering educational programs that support diplomates in achieving the Boards' competency expectations.

The accredited CME community is well-positioned to support the goals of continuing certification. CME providers represent a range of organizational types, including professional societies, hospitals/health systems, government agencies, medical schools, and publishing and education companies. These providers deliver 160,000 educational activities each year, comprising one million hours of instruction, and 28 million interactions with physicians and teams.

Recommendation 2
In line with best practices in certification, both the Guiding Principles and Recommendation 2 should be modified to add "Ensure that assessments are fair, valid, and reliable." The absence of such a statement would represent a capitulation from the primary purpose of a certificate to represent a valid evidence-based determination.

Recommendation 4: Value and Role of Accredited CME
The findings in Recommendation 4 note that CME activities are self-directed and variable in quality. The word "diverse" should replace "variable in quality." The diversity, flexibility, self-direction, and choice that accredited CME offers physicians are strengths, not drawbacks, and increase the value and relevance of CME for physicians. Accreditation standards that encourage diversity of curricula and flexibility in educational design enable CME providers to nimbly meet the changing needs of physicians.

Accredited CME plays a key role in managing professional competence in the changing healthcare environment. In our shared system of physician accountability, accredited CME providers are responsible for identifying learners' gaps, designing educational activities to address the gaps, and leveraging the principles of adult learning to give physicians the skills, competencies, and intellectual fulfillment that help them practice to the best of their abilities. Educators promote self-awareness through formative assessment, using a variety of approaches, including adaptive learning. As part of their professional responsibility, physicians are expected to take ownership of their learning agenda, choose activities that are relevant to their daily practice, and increase their self-awareness.

The line on page 18 beginning "The ACCME....should be encouraged..." should be stricken; it is a redundant appeal since ACCME already consistently performs this work.

The language of Recommendation 4 should be updated to add that ABMS Boards are encouraged to reduce the burden on diplomates by allowing CME/CPD/QI completion reports to be shared between accredited CME providers and the Boards.

Recommendation 7: Collaboration between ABMS Boards and the CME/CPD Community
We concur about the importance of collaboration between the ABMS Boards and the CME/CPD community. It is important to note that successful collaborations are not only a future goal—they are already well-established. The ACCME and six ABMS Boards (ABA, ABIM, ABO, ABOHNS, ABPath, and ABP) currently engage in collaborations that have measurably increased the number and diversity of accredited CME activities that meet the requirements for continuing certification, reduce burdens, and streamline the process for accredited CME providers and physicians.

Recommendation 7(c) should be modified to include "CME/CPD providers," as already appropriately included in 7(b).

ABMS Boards should also be encouraged to construct and maintain expectations for the skills and competencies required for their diplomates in each specialty based on evolving and changing subspecialty requirements. These competency expectations can then form the basis for curricula developed and delivered by accredited CME providers.

The findings for Recommendation 2 note that the ABA MOCA Minute program is an exemplar of a longitudinal assessment program that is highly rated by physicians. As described in "Evolving

Board Certification—Glimpses of Success," published in *NEJM* (see attached), the ACCME/ABA collaboration enables ABA to recommend targeted CME to physicians based on their assessment results and CME providers can map their activities to the ABA's content outline.

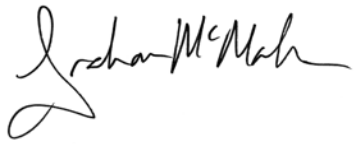
Data strategy: The data strategy outlined in the findings for Recommendation 7 is also well-established. As part of the collaborations with ABMS Boards, the ACCME modified its Program and Activity Reporting System (PARS) to enable CME providers to register activities that count for continuing certification and to submit learner participation data required by the Boards. This data is transmitted seamlessly to the Boards, reducing burdens for physicians; over 10 million MOC points have been earned by ABMS diplomates for completing accredited CME activities. All available activities are displayed in CME Finder, an online resource for physicians seeking to earn continuing certification credit by participating in accredited CME. There are over 2,300 accredited activities currently listed in CME Finder.

The ACCME stands ready and willing to leverage the existing educational and technological framework to support expansion of the collaboration strategies in Recommendation 7.

Accountability: Roles and Responsibilities
We believe it is important to clearly delineate the roles and responsibilities of educators and Boards. As I described in the attached article, "Inspiring Curiosity and Restoring Humility: The Evolution of Competency-Based Continuing Medical Education," published in *Academic Medicine*, the primary role of accredited CME is to offer physicians an educational home where they can build longitudinal relationships with colleagues and participate in multiple interventions that support change. The Boards are responsible for setting competency expectations for physicians in their respective specialty areas, assuming responsibility for summative assessment, determining physician competence, and awarding or withholding certification. As individuals and as a profession, we must be held accountable for our continuing competency. A shared system of accountability is essential for fulfilling our obligations to our profession, the public, and the patients we all serve.

I was honored to serve on the planning committee and to offer testimony. I look forward to continuing to work together to improve our system of accountability with the ultimate goal of making a positive difference in the health and safety of patients, families and communities across the nation. We would be happy to provide more feedback to support your deliberations.

Sincerely,



Graham McMahon, MD, MMSc
President and CEO

Enclosure:
"Evolving Board Certification — Glimpses of Success"
"Inspiring Curiosity and Restoring Humility: The Evolution of Competency-Based Continuing Medical Education"

Recommended Edits

We respectfully suggest the following edits to the draft report. Recommended deletions are shown in red and strikethrough, additions are shown in blue.

Purpose
The purpose of continuing certification is to serve the diplomates, the public and the profession by providing a system ~~to~~ to determine and recognize the continuing competency of diplomates ~~that supports the ongoing commitment of diplomates to provide safe, high-quality patient-centered care~~ to provide safe, high-quality, patient-centered care."

Recommendation 1
The Boards are responsible for setting competency expectations and are accountable for assessing competency. CME providers are responsible for delivering educational programs that support diplomates in achieving the Boards' competency expectations.

Guiding Principles and Recommendation 2
Ensure that assessments are fair, valid, and reliable.

Recommendation 4: Findings
Continuing Medical Education (CME) activities are self-directed educational programs that diplomates must participate in for continuing certification. They are ~~variable in quality~~ **diverse**. CME providers represent a range of organizational types, including professional societies, hospitals/health systems, government agencies, medical schools, and publishing and education companies. These providers deliver 160,000 educational activities each year, comprising one million hours of instruction, and 28 million interactions with physicians and teams.

Testimony reflected that the quality of CME activities ~~needs to continue to improve to increase its effectiveness and relevance. The Accreditation Council for Continuing Medical Education (ACCME and their CME providers should to be encouraged assess CME activities, identifying high quality activities and addressing lower quality activities~~.

Due to the pressures and pace of medical practice, diplomates ~~often~~ **sometimes** choose CME activities based on convenience, efficiency, interest, and location, and not directly related to their particular specialty. For this reason, ~~self-directed CME alone does not sufficiently meet the standards for continuing certification~~ while diplomates can, and do, earn continuing certification credits by participating in self-directed CME, this participation alone does not confer Board certification.

ABMS Boards should be encouraged to reduce the burden on diplomates by allowing CME/CPD/QI completion reports to be shared between accredited CME providers and the Boards.

Recommendation 7

ABMS Boards should continue to collaborate with professional and CME/CPD organizations to create a continuing certification system that serves the public while supporting diplomates in their commitments to be better physicians.

b. ABMS Boards, specialty societies, CME/CPD providers, and other organizations should continue to work together with ACCME and other sources on a uniform data strategy to create seamless transfers of information to ease diplomate burden in reporting what they have done, ensure patient privacy, minimize cost, and enable meaningful engagement (e.g. diplomate feedback, gaps in knowledge, registries).

c. ABMS boards should have structured, at least annual, meetings with major specialty/subspecialty organizations and CME/CPD providers to receive input and feedback about initial certification and continuing certification decisions and programs.

ABMS Boards should also be encouraged to construct and maintain frameworks for the skills and competencies required for their diplomates in each specialty based on evolving and changing subspecialty expectations. These frameworks can then form the basis for curricula developed and delivered by accredited CME providers.

Evolving Board Certification — Glimpses of Success

Alex Macario, M.D., M.B.A., Ann E. Harman, Ph.D., Tamar Hosansky, Mary E. Post, M.B.A., C.A.E., Huaping Sun, Ph.D., and Graham T. McMahon, M.D., M.M.Sc.

Physicians are busier than ever: the complexity of patient care has increased, patient expectations have evolved, production pressure is substantial, administrative burden is high, time is limited, and yet everyone is somehow expected to balance personal and professional responsibilities. Although physicians in practice acknowledge the fast-paced evolution in medical knowledge and skills and are generally committed to their professional responsibility to continuously improve their abilities, errors in decision making are commonplace and physician performance is variable. We believe a key to overcoming these interconnected challenges is to create lifelong learning experiences that promote self-awareness and leverage principles of adult learning to provide the skills, competencies, and intellectual fulfillment that help physicians practice to the best of their abilities.[1-3]

Educators and certifying boards are working together to integrate education and assessment, applying a variety of techniques that are effective and efficient in engaging physicians, such as simulation, small-group problem solving, reflective exercises, and adaptive learning. One effort to create experiences to better meet physicians' needs in a changing practice environment is the redesigned Maintenance of Certification in Anesthesiology (MOCA) program from the American Board of Anesthesiology (ABA), known as MOCA 2.0. A collaboration with the Accreditation Council for Continuing Medical Education (ACCME) has enabled the ABA to link assessment with continuing medical education (CME) opportunities to support lifelong learning and skill maintenance.

The MOCA Minute, a longitudinal assessment program introduced in 2016, enables anesthesi-

Educational Rationale for the MOCA Minute Question Program.

Relevance
Questions are preferentially focused on professional practice areas identified by the physician.
Item selection is based on the perceived importance of the learning objective.
Questions are written by clinically active peer physicians.
Convenience
Available anytime by smartphone app
Can be done quickly
Can be done incrementally
Email alerts available
Retention
Items answered incorrectly or with low confidence are repeated.
Items are retired after multiple correct attempts with moderate confidence.
Efficacy
Feedback is immediate.
Feedback is explicit.
Information results in immediate learning.
Efficiency
Amount of irrelevant material is minimized.
Repetition is tailored to individual needs.
Accumulation of data over time allows creation of physician profile — identifying areas of strength and areas for growth.
Engagement
Personalized feedback (correct/incorrect) is intrinsically engaging.
Comparative feedback creates engagement by driving self-awareness.
Repetition of items answered incorrectly prompts engagement, as physicians attempt to improve their responses.
Individual correction of knowledge deficits
Shared data allow connection with related CME activities once gaps are identified.

ologists to identify their scope of practice and answer 30 practice-relevant multiple-choice questions per calendar quarter to continually assess their knowledge and problem-solving skills (see table). The ABA provides immediate and specific feedback for each question answered, connects the physician to targeted CME resources, and tracks the physician's performance longitudinally. The questions focus on relevant information that physicians should know without having to consult references, so only 60 seconds is allotted for answering each question. After responding, physicians rate their level of confidence in their answer using a three-point scale (very confident, somewhat confident, or unsure). This system helps clarify what physicians know, when they are merely guessing, and where their blind spots lie. When physicians realize they have responded confidently yet incorrectly, they are more likely to engage in further education and retain knowledge. This process creates a data-driven basis for seeking out and completing appropriate CME.[4] Questions answered incorrectly or with low confidence are repeated at varying intervals to maximize reinforcement and retention. After each response, physicians are told whether their answer was correct and are given a critique that includes the key point of the question and offers more information about the topic, literature references, and connections to corresponding CME.

In October 2016, the ABA (with which three of us are affiliated) and the ACCME (with which two of us are affiliated) began a collaboration to help connect physicians to relevant CME activities. The ACCME allows CME providers to map their activities to the ABA's MOCA 2.0 content outline, communicates these opportunities to physicians, hosts a CME activity search tool (cmefinder.org), and shares information on physicians' completion of CME with the ABA. The ABA intends to provide the CME community with high-priority topics based on aggregate MOCA Minute performance data so that CME providers can design new offerings. In addition, because questions are mapped to the MOCA 2.0 content outline, the ABA can recommend targeted CME on the basis of the physician's assessment results. Neither the ACCME nor the ABA produces CME or financially benefits from physicians' participation in CME activities.

Physicians who actively participated in a pilot MOCA Minute program scored higher on the traditional high-stakes written cognitive examination taken to meet certification requirements than those who were not enrolled in

the program.[5] In 2016, when the program was formally launched, 21,074 anesthesiologists participated, of whom 18,366 had time-limited (every 10 years) board certification; 90% of these physicians answered all 120 questions. In 2017, a total of 24,277 physicians participated, and among the 21,334 with time-limited certificates, 19,916 (93%) completed all 120 questions. Only a small number of physicians did not meet the minimum performance standard established by the ABA.

As of November 2018, 53% of MOCA Minute questions were linked to at least 1 CME activity, and more than 110 accredited CME providers had linked a combined total of 3261 activities to the content outline. ABA-certified physicians have access to 18,314 credits, or an average of 5.45 credits per linked activity. In the 2 years since its launch, more than 22,000 ABA-certified physicians have earned CME credits through this collaboration.

A 2017 survey conducted by the ABA found that 89% of the 4000 respondents who had taken the previous MOCA certifying exam considered the MOCA Minute a better approach for demonstrating their knowledge and problem-solving skills — 82% indicated that the program had served well as an assessment tool, 91% believed it effectively identified knowledge gaps, and 88% acknowledged the usefulness of the links to relevant CME.

We believe that the ABA's experience offers some generalizable lessons for other accreditors and certifying boards. First, relevance and efficiency are essential. Physicians welcome self-assessment and learning materials targeted to their self-identified scope of practice and are more willing to engage in programs customized to their needs. Repetition of missed or guessed materials maximizes efficiency and ensures that each interaction with the program is engaging.

Second, it's important to identify blind spots. Physicians are motivated to perform well and willing to engage in remediation when their knowledge gaps are identified. Assessment programs can help physicians become more aware of their gaps and link them to easily accessible, accredited CME options to close those gaps. An additional benefit is that longitudinal assessment creates a powerful and ongoing connection between individual physicians and the accredited CME community.

Third, it is helpful to allow learners to take frequent small bites: intermittent, spaced repetition and retrieval maximize learning and retention. In contrast, bingeing or cramming diminishes retention. With MOCA Minute, for example, physicians are encouraged to answer their 30 quarterly questions in blocks of 3 to 5 at a time and then to read and later review the feedback materials and references for the questions, particularly for questions they initially answered incorrectly.

Fourth, research demonstrating the effectiveness of adaptive systems and educational technology suggests that boards and accreditors should clearly communicate the program's goals and outcomes, solicit and listen to users' feedback, continuously improve their education and assessment programs, and adapt their offerings to changes in the art and science of clinical practice.

Educational technology is rapidly advancing and enabling increasingly sophisticated insight into a range of individual competencies. Available technology can help educators and certifying boards to personalize assessments that promote greater self-awareness and support participation in CME and will further improve physicians' competency and skills. Certifying boards can, like the ABA, find new ways to give credit to physicians for their engagement in workplace learning (alone or in teams, in person or online) and in quality assurance and quality improvement work in collaboration with CME initiatives.

As our collaboration has shown, certifying boards and accreditors can work together to incorporate adult learning theory into systems that facilitate effective, efficient learning that is acceptable to physicians. To be successful, collaborating organizations will need to nimbly adopt a variety of new approaches that reflect a commitment to continuous improvement. By creating frameworks that inspire and nurture physicians, they can support physicians' accountability to their patients and the public, increase their access to meaningful learning experiences, and help them to remain current and to achieve their full potential.

Disclosure forms provided by the authors are available at NEJM.org.

From the American Board of Anesthesiology, Raleigh, NC (A.M., A.E.H., M.E.P., H.S.); the Department of Anesthesiology, Perioperative and Pain Medicine, Stanford University, Stanford, CA (A.M.); and the Accreditation Council for Continuing Medical Education, Chicago (T.H., G.T.M.).

1. McMahon GT. What do I need to learn today? The evolution of CME. N Engl J Med 2016;374:1403-6.
2. Steadman RH, Burden AR, Huang YM, Gaba DM, Cooper JB. Practice improve-

ments based on participation in simulation for the Maintenance of Certification in Anesthesiology Program. Anesthesiology 2015; 122:1154-69.
3. McMahon GT. The leadership case for investing in continuing professional development. Acad Med 2017;92:1075-7.
4. De Champlain AF. A primer on classical test theory and item response theory for assessments in medical education. Med Educ 2010;44:109-17.
5. Sun H, Zhou Y, Culley DJ, Lien CA, Harman AE, Warner DO. Association between participation in an intensive longitudinal assessment program and performance on a cognitive examination in the Maintenance of Certification in Anesthesiology Program®. Anesthesiology 2016;125:1046-55.

DOI: 10.1056/NEJMp1809322

Inspiring Curiosity and Restoring Humility: The Evolution of Competency-Based Continuing Medical Education

Graham T. McMahon, MD, MMSc

Abstract

Dr. David Price and his colleagues, in their article in this issue of *Academic Medicine*, summarize the findings from recent studies regarding the association of Maintenance of Certification and physicians' learning and improvements in care. Their evaluation demonstrates that physicians often changed their practice because of these educational interventions. In this Invited Commentary, the author argues that, although this finding is reassuring, it may be the right answer to the wrong question. The critical questions the profession faces are whether physicians have the humility to routinely submit themselves to the judgment of their peers, whether they will accept responsibility for managing their professional competence and that of their colleagues, and whether they are willing to create a process for identifying and remediating underperforming clinicians.

If certifying boards assume responsibility for this system of accountability, then each would need to set the competency expectations for physicians in its specialty areas, allow clinicians to self-identify their core scope of practice, assume responsibility for summative assessment, provide formative feedback to participants, and link physicians to recommended professional development activities. Continuing certification must be sensitive to the burdens it puts on physicians and recognize engagement in a spectrum of learning activities that are integrated with daily practice, including continuing medical education. By assuming responsibility for their own continuing competency and that of their colleagues, physicians can manifest their commitment to their patients and their profession.

Editor's Note: This is an Invited Commentary on Price DW, Biernacki H, Nora LM. Can Maintenance of Certification work? Associations of MOC and improvements in physicians' knowledge and practice. Acad Med. 2018;93:1872–1881.

Dr. David Price and his colleagues,[1] in their article in this issue of *Academic Medicine*, describe their effort to collect and summarize the findings from recent studies regarding the association of Maintenance of Certification and physicians' learning and improvements in care. These varied continuing medical education (CME) activities included self-assessment, simulation, and other modalities. Evaluations of these activities demonstrated that physicians can and do learn and that they often changed their practice because of these educational interventions. Although this finding is expected and reassuring, it may be the right answer to the wrong question.

We know that physicians are motivated to achieve mastery but that this motivation is subject to countless competing pressures for their time and attention. The breadth and depth of new information make it very difficult for clinicians to reliably manage their own competency. Overconfidence and poor self-awareness can lead physicians to make errors of which they may be unaware and to be complacent about their own professional development. The process of unlearning outdated practices and then relearning new practices necessitates real effort—effort that accomplished professionals are unlikely to apply if they are overwhelmed, are burned out, or believe that they are already practicing to the best of their ability.

Just as meaningful learning does not occur without effortful work, effective assessment is time-consuming and challenging. We clearly need to evolve our profession's approach to assessment as it is currently deployed by the certifying boards. This evolution is occurring, facilitated in part by increasingly sophisticated educational technology. The certifying boards of the American Board of Medical Specialties and the American Osteopathic Association are currently debating these issues as they reconsider their approach to supporting professional competency. Several certifying boards are debating whether to focus on assessing and ensuring competence in areas that can be measured or to focus on encouraging excellence and building an educational framework that gives useful feedback to clinicians who participate. Would we, and our patients, really benefit if the certifying boards conceded to the anticertification rancor by lowering standards?

If the certifying boards assume responsibility for a system of accountability, then each board would optimally set the competency expectations for physicians in their respective specialty areas; allow physicians to self-identify their core scope of practice within that discipline; assume responsibility for summative assessment (increasingly deployed longitudinally using educational technology); continuously provide formative feedback to participants; and link physicians to recommended

G.T. McMahon is president and chief executive officer, Accreditation Council for Continuing Medical Education, Chicago, Illinois.

Correspondence should be addressed to Graham T. McMahon, Accreditation Council for Continuing Medical Education, 401 N. Michigan Ave., Suite 1850, Chicago, IL 60611; telephone: (312) 527-9200; e-mail: gmcmahon@accme.org; Twitter: @accreditedCME.

Acad Med. 2018;93:1757–1759.
First published online June 26, 2018
doi: 10.1097/ACM.0000000000002339

professional development activities when needed, recognizing engagement in a spectrum of learning activities, including those that help physicians reflect on and improve their practice. Physicians who engage, achieve those competency thresholds, and provide performance data to registries would likely have little interaction with their board, while those who are not achieving minimal competency would be supported through a personal learning plan or relinquish their certification.

The certifying boards' responsibility would encompass monitoring the changing practice environment and reassessing the meaning of continuing competence. As the practice patterns of many individuals narrow over time and more subspecialties emerge, what is measured and what is required to demonstrate competence needs to evolve; ultimately, some of these assessments will be made passively using patient outcomes data. In addition, interprofessional collaborative practice is increasingly integrated into our health system; thus, we will need to consider and develop means of assessing team competence in addition to individual competence.

If our colleagues at the certifying boards maintain standards for board certification, then we as a profession will be asked to engage for the benefit of our community and the patients we serve. Participating in an accountability system may not personally benefit each of us; however, our participation is critical to make the system meaningful for all. This accountability is essential if we are to maintain the public's trust. Our contract with society depends on the integrity of each clinician and the profession as a whole; it involves placing patients' interests first and setting and maintaining standards of competence and integrity.

Continuing certification is one aspect of a much bigger framework for managing professional competence in a changing environment. CME plays a key role in that process. Education can effectively address health care challenges, support lifelong learning and clinician well-being/resilience, and ultimately transform health care. Flexibility in educational design to meet learners' needs is essential to relieving the burden, motivating clinicians to engage in this process, and improving the long-term effectiveness of education. Institutional leadership and investment in their people are key to achieving these aims.[2]

We have learned that professional development is most effective when the clinician is engaging in it for a purpose and when the material is meaningful and relevant to her or his scope of practice; is presented by a trusted authority; engages learners actively; and includes feedback, reflection, and reinforcement. There need to be mechanisms in place to measure changes in individual performance, processes of care, patient safety, and health outcomes. In an evolved system, a community of practice supports clinicians not for their resistance to change but for their active participation in interventions that drive measurable improvement. Clinicians should engage in CME activities intentionally; they should be able to easily find activities that meet their needs; there should be a convenient, online system for tracking and reporting participation; and participation should count for multiple regulatory expectations. CME systems in the United States are quickly evolving to meet these expectations.

In their article, Price and colleagues note the challenges in translating knowledge to practice and sustaining that change. This is the role of CME—to offer clinicians an educational home, where they can build longitudinal relationships with colleagues and participate in multiple interventions that support change.

Continuing certification needs to be sensitive to the burdens it puts on physicians without compromising on its purpose to make accurate summative decisions. Compelling physicians to participate in mandated education engenders resentment and is therefore much less likely to motivate or facilitate change. For this reason, compliance education tends to fail at its very foundation. Instead, in addition to completing necessary assessments, physicians should be given the choice of how to demonstrate their competency, intentionally choose activities, take ownership of their learning agenda, and promote their self-awareness. CME can support this process. Engagement in meaningful education can help to restore joy in learning and in our profession. Aligning CME and continuing certification can help relieve burdens: The more certifying boards recognize participation in meaningful learning programs where CME (and continuing certification) is integrated with routine daily practice, the less burdensome this process will be. Participation data can be readily and securely shared between accredited educational providers and the boards using existing systems. Price and colleagues note the critical nature of relevance in educational design. This relevance can be addressed by recognizing the contributions and expertise of local accredited education providers and professional societies that work with their clinicians to design practice-relevant activities.

As Price and colleagues note, continuing certification can be associated with positive outcomes, but, as is typical of educational interventions, the evidence does not establish causation. As always, future research can help determine the comparative effectiveness and efficiency of CME interventions in improving patient safety, patient–physician communication, patient engagement, functional outcomes, team-based care, and population/community health outcomes. Each of these aspects of effective educational design is addressed in new CME accreditation criteria.[3] Further collaborations with emerging physician–leaders interested in education, quality improvement, program evaluation, and assessment research are essential.

It is useful to be reminded that we all have the capacity to learn and improve and that educational programs can be effective. But the question we should ask is not, Can we change by participating in Maintenance of Certification and educational activities? Instead, it is, Who is accountable for our individual and collective performance? Perhaps the legacy of this and related work is that it will encourage us to consider our shared responsibilities for redesigning professional development. We are privileged to serve as members of the medical profession. By assuming responsibility for each other's attainment and continuing competency, we manifest our commitment to our

profession and to the people who trust us in their time of need.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

References

1 Price DW, Biernacki H, Nora LM. Can Maintenance of Certification work? Associations of MOC and improvements in physicians' knowledge and practice. Acad Med. 2018;93:1872–1881.
2 McMahon GT. The leadership case for investing in continuing professional development. Acad Med. 2017;92:1075–1077.
3 Accreditation Council for Continuing Medical Education. Accreditation Criteria. http://www.accme.org/accreditation-rules/accreditation-criteria. Published September 29, 2016. Accessed July 9, 2018.