American Board of Psychiatry and Neurology, Inc.
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How to *Not* Peak at the End of Training, Part 1: Lifelong Learning

Transcript:

Hi, I'm Jeff Lyness from the American Board of Psychiatry and Neurology, and this is the first of two relatively short videos that we're offering in an attempt to spark conversations among trainees, residents, and fellows, and your teachers, your faculty colleagues, in thinking about how to avoid what I'm sure some of you have heard mention of the risk of kind of peaking in our skills by the time we conclude our training.

Well, we don't have to peak then as much as we might be at one of our peaks then. And the question is how to maintain things throughout our careers. And how does that then relate to specialty certification, such as in psychiatry, neurology, child neurology, and their subspecialties from the ABPN. So, in this first video, we're going to talk about lifelong learning.

And the second video will talk more about the role of specialty certification and how that relates to lifelong learning. So, let's dive in the game plan. The outline for this first lecture is actually pretty simple. I would like to think with you a little bit about the why we need to think about lifelong learning and then how to do so.

But I'm going to begin by prefacing since we will be talking about the evidence base with kind of a defining evidence-based medicine paper, one of my favorite papers from the British Medical Journal, and I will end the second lecture with another defining paper along those lines. So, to start with, this is a paper that appeared some years ago now, as you can see.

This is a real paper from the BMJ, as you can see from the illustration here. And as important as evidence-based medicine is, the authors proposed seven alternatives to evidence-based medicine, which I will list here. I'm not going to read them. You can see them here. You can get a sense of the tongue in cheek nature of the paper here.

And they kind of walk you through this in some detail in the paper. They talk about markers and measuring devices and units of measurement for evidence-based medicine. And then for some of their alternatives. So, in eminence-based medicine, it's really the most senior prominent presence in the room who care, whose opinion carries the day.

And we measure that by a luminometer and the radiance of their white hair. In vehemence-based medicine. It's the loudest opinion in the room measured in decibels for the level of stridency. I won't read all these here, but my personal favorite in providence-based medicine. We use a sextant to measure the angle of genuflection as we appeal to a higher authority.

I don't know why American medical journals can't carry papers like this every once in a while, the way that they do in Britain, but there you have it. So, okay, let's talk about the 'why' of lifelong learning. Well, for one thing, as I'm sure you have heard from your colleagues or seen perhaps yourselves, even in the years that you've been in medicine already, the evidence base is going to change, and practice will change in relatively short order in all of what we do.

So, even if we are completely competent, completely skilled in our expertise in the moment, that will change just because the world around us is going to change. And as one marker of kind of how much practice needs to change, this is a study that looked at 10 years' worth of papers in the New England Journal of Medicine.

And of 363 articles that tested an established medical practice, 40 percent reversed, that is, their findings were contradictory to that established medical practice, and only 38 percent of them reaffirmed the established medical practice. So, the evidence base is going to change, their practice is going to change.

In part because of that, but also for other reasons, the other thing is that our skills naturally tend to decline as physicians or experts in any field without paying attention to sustaining our expertise. That's just a natural human thing. It's true for all realms of expertise. To be clear, I'm not saying that our skills will inevitably decline.

But they will decline unless we pay attention and exert some effort, which, of course, is why we're thinking about lifelong learning in these lectures and in our conversations. There are other reasons to think about the importance of lifelong learning, including recognizing that the reality is that many patients in the real world, for a variety of reasons, some of them patient factors, but some of them physician factors, do not, in fact, get optimal care as judged by the current state of the evidence.

There were wide variations, geographic variations in practice patterns, which are not based in evidence. There's lots of studies that have shown that when practices are discredited, they actually persist in the real world and practice for many years before they eventually die off, the practices that is.

When new evidence becomes available, it often can take years before patients get that in, in day-to-day real patient care practices. Lastly, I also will note that our attention and our skills in judging the quality of the evidence and applying that to our patients is part of what makes us experts as physicians, parts of what we bring uniquely to our interdisciplinary healthcare teams alongside of our colleagues from other disciplines. And I would add that I think that the rigor of board specialty certification is also part of what makes us uniquely qualified. So, I think there's real reasons to think about these things in terms of scope of practice.

Okay, so those are the reasons why we need to think about lifelong learning. The barriers, though, the reasons that it can be challenging to keep up with lifelong learning are many. A lot of them do come down to time and money. That is time spent paying attention to our own self development is time taken away from delivering patient care or doing other things that that support our salaries and bring in revenue for our practices or for the systems in which we work.

There are other barriers as well, though. It is human nature for us to tend to gravitate toward learning opportunities around the things we're most interested in. But the problem with that is that the things we're most interested in are often the things we already know the most about. And we're much less likely to be interested in the things we know less about and in fact actually really ought to be going to.

And I know for myself, you know, I tend to go to national meetings in areas of my subspecialty interests, rather than other areas. Even when I go to those meetings, I'm much more likely to go to sessions about things I already know quite a lot about and have to kind of think about pushing myself to go to sessions about the things I'm less expert in.

It's also difficult to critique the primary research literature when we're not already well versed in that literature, when we're not an expert, and that's another challenge. Lastly, I've kind of alluded to judging our own areas of need. It's important we pay attention to that and reflect on our areas of need, but the reality is that as human beings, and like experts in all fields that have been studied, including physicians, we are not very good at noticing our own most areas of need. That is our biggest areas of deficit. This has been called the Dunning Kruger effect after a couple of authors who wrote a lot about this and did research on this going back some years now. So, this is one of their seminal papers looking at grammar ability. And as you can see, people tend to perceive their grammar ability as being above average.

But if they're actually, as judged by test scores, actually well below average, there's this delta here, this very dangerous delta where people overestimate their abilities when they're actually the least competent. And this is a test of grammar, but studies have shown this among physicians as well. So, this paper looked at this in several different specialties, including in psychiatry.

They didn't look at neurology in this, in this paper, but in all specialties that have been studied around patient management. Around clinical assessment around communication skills and then looked at those domains for all the specialties they examined. Notice that the shapes of the curves are similar for all of them.

And again, in that most dangerous direction. In this case, where peers judge people to be the least competent. Physicians were most likely to overestimate their abilities on average. So, there are real limitations to our abilities to notice and be aware of our own areas of need. And so, to guide our learning, we need to look for education that provides some kind of feedback, some kind of external check on what we know or how we reason and what our areas of need are.

So, I mentioned continuing education. When we think about how to maintain our competence, how to maintain our skills, CME, continuing medical education, is critical in that, of course, and there is a wealth of CME activities out there, live in-person activities, hybrid and virtual live activities. And of course, enduring materials that are available in written form in online form, this enormous amount of education that's out there available to us, but it is important, as I said, that we need to look for some of that that provides us feedback on what we what we need.

Beyond formal CME, we also need to plan time to read and keep up with some literature ourselves, and this is a challenge. I'm sure you found this to be so during training. It doesn't get easier for most of us in practice, and we need to figure out what makes the most sense at any given point in time in our professional and personal lives.

Is it time in the early morning? Is it time in the afternoon or evening? Is it time on the weekends? But we need to provide some, schedule some time for ourselves to do this. I will put in a plug here that in the Continuing Certification Program from the ABPN, one option in lieu of a 10-year recertification examination, we offer something called the Article Based Continuing Certification Pathway, and the ABCC offers curated articles from the literature and open book quizzes that obviously then provide feedback.

So, in addition to helping satisfy the requirements, instead of a recertification examination, it also provides the learning and the feedback that we're talking about other ways to think about kind of sustaining our skills include teaching. I'm a little bit biased here, given how important teaching has been in my own career and personal development, but it seems to me that very few things really push us to learn something as much as needing to be able to share it with other people and help other people understand it as well.

And as I mentioned, when we do learnings, we want to try to keep in mind pushing ourselves to the things that are less familiar. or less comfortable. And since I've been giving lectures like this one, I've done a little bit better actually at going to meetings or going to sessions at meetings that I might not otherwise have attended so I can kind of practice what I'm preaching here.

I use the word competence there, which may seem like a pretty uninspiring word, but really, competence has a long literature in thinking about teaching and learning, defined broadly. It really is a high aspirational goal to think about competence. This is from a classic paper in JAMA that defined this by a couple of colleagues, Ron Epstein and Ed Hunter.

And when we think about competence, of course, that's competence at multiple developmental levels. Many people refer to various versions of the Dreyfus model. By the time we finish training in our specialty or subspecialty, we should be, at the very least, competent in all the major areas of that field.

And most of us will be more than that, will be proficient or expert in at least some areas within those fields. Now, as we gain that expertise, this is another version of kind of defining levels of expertise and levels of competence. Once we become truly expert at something, we can then kind of go on autopilot and then sort of just, you know, continue at that level and plateau.

But if we continue to press ourselves and supplement our own self judgements by external validations of what we need, we can continue to develop deliberate expertise and continue to progress. And if you're thinking, well, what's wrong with plateauing if you're already at that level of expertise?

Remember skills tend to decline over time without attention paid. So rather than this kind of flat line, actually what happens is that expertise tends to decline, but if we continue to practice deliberate expertise and develop it further, we can push off that decline and stay at a level of competence throughout our career and then reinforce that with ongoing learnings over time.

And so that then leads me to think about the kind of the cycle of professional life, right? We ought to assess our skills in some ways, both self-assessment and external assessments of some sort, reflect on what they mean, think about how we can then grow based on those assessments, and then around and around this goes throughout our careers.

So, I hope I've given you some things to think about, to discuss with colleagues, if you're using this as a springboard to conversation with your faculty, with your teachers and colleagues, or your program director. And I also hope you'll go on and look at the next video but thank you very much for your attention.