American Society of
Anesthesiologists™

Residents In a Room
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VOICE OVER:

This is residents in a room, an official podcast of the American Society of Anesthesiologists where we go behind the scenes to explore the world from the point of view of anesthesiology residents.

Not only do we expect anesthesiologists who are board certified to have a medical license, have CME, finish MOCA minute, be involved in quality improvement, but also have a commitment to professionalism.

It's clear that this is something that you've worked extremely hard on and are passionate about.

Something that I would ask the ABA to consider at all junctures when you're making decisions is how to be more inclusive.

DR. JAKE GAMBOA:

Welcome to Residents in a Room, the podcast for residents by residents. I'm your host for today's episode, Dr. Jake Gamboa, currently a global health fellow at the University of Colorado. I'm here at ASA's annual meeting in San Francisco with several other residents, and we're going to ask our guest, Dr. Alex Marcario all about MOCA. Before we get started, let's meet the other residents.

DR. KELSEY REPINE:

Hi everyone. My name is Kelsey Repine. I'm at the University of Colorado and I'm CA3. Thanks for having me.

DR. JORDAN FRANCKE:

Morning. My name is Jordan Frankie. I am CA3 at UCLA.

DR. JEFF CANNON:

Hi, my name is Jeff Cannon. I'm a critical care fellow at the Massachusetts General Hospital.

DR. GAMBOA:

And Dr. Macario, thank you for being here. Can you introduce yourself briefly and tell us a bit about your role?

DR. ALEX MACARIO:

Yes, absolutely. Well, it's so fun to be here today with all of you. Thank you for the very nice invitation to participate in the podcast. I live in Palo Alto, which is only 30 miles away from here, so I also want to welcome you to the San Francisco Bay area and to the annual meeting here for the ASA, which is a spectacular place to learn and to see old friends and to develop career wise. At Stanford I'm vice chair of education for the department. We have 300 faculty, 100 residents, 100 fellows and a couple of hundred staff. So it's a big operation, and I'm in charge of all of the education footprint. That includes the medical students, the undergraduates, the residents and the fellows, and even our faculty who are lifelong learners. Since last year, I've also been the secretary for the American Board of Anesthesiology, and I've been a director on the American Board of Anesthesiology, board of directors for seven years. And it's been a really life changing professional experience to work with the ABA and to really deliver on our mission, which is to advance the highest practice standards in anesthesiology. And so the ABA really works with all of you to help anesthesiologists be as strong as clinicians as they can.

DR. GAMBOA:

To get us started, I'm hoping you can just explain to us what MOCA is, what MOCA Minute is, and how this all impacts residents.

DR. MACARIO:

So up until the year 2000, after you finished residency, you would take a written exam, which we call the advanced exam. And then you would take an oral exam, and then you would get board certification that would be for the rest of your career. After the year 2000, the ABA, along with the other medical boards, changed to this continuing certification model, where there was a need to show that people were staying up to date after they finished the residency. Now, the ABA is one of 24 medical boards that are

part of the American Board of Medical Specialties, the ABMS. And so we follow the guidelines and rules and requirements that the ABMS sets for medical boards. So if you're a surgery resident and you finish your surgery training, you take your surgery boards. And the American Board of Surgery sort of follows you during the career. And they follow a lot of the same guidelines that we do.

So MOCA is a maintenance of certification of anesthesiology, which is the program that you'll enter as soon as you become board certified, which is as soon as you pass your oral and OSCES, which we call the applied exam, which it sounds like for a couple of you will happen in the spring. So congratulations and good luck with that. The maintenance of certification program now is sort of being rebranded as continuing certification. And the whole idea is to have some expectations about what clinicians should be doing so that when someone says that the board certified, the patient understands that that means something.

Currently, there are four elements to board certification. One is you have to have an active medical license. So for example, you can't call yourself a board certified anesthesiologist if you don't have a medical license. The second piece is continuing medical education. You need to do 125 credits of CME every five years. You can do those by coming to the ASA or going to a conference, any which way you want. The idea there is to try to stay current with things. The third element of continuing certification is what we call kind of an assessment piece, which is the MOCA Minute. So what that means is that as soon as you become board certified, you will get 30 questions every three months that are knowledge that we would expect every clinician to sort of know, kind of walking around knowledge, not necessarily something you'd want to look up in a book. And in the second three-month period, you get another 30 questions and there'd be a total of 120 questions over the course of the 12 months. And then the fourth piece of maintenance of certification is what we call health improvement, which is kind of quality improvement. So the ABA has an expectation that part of our job as an anesthesiologist is to do something in our practice to help improve the quality of patient care. It could be something as simple as writing a protocol for ponv prophylaxis that systematically done for all patients. Or it could be something as complex as reorganizing how the care is delivered in your hospital. So those are the main pieces of maintenance of certification.

DR. REPINE:

As residents and fellows, when do we need to start paying attention to MOCA? Do we need to start worrying about MOCA credits immediately after our training ends?

DR. MACARIO:

The current situation is that as soon as you become board certified, after you pass the exams, you enter what is now a five-year cycle. It used to be a ten-year cycle. Just to give you some background. In 2017, because there was sort of this perceived need to really revamp all of the continuing certification programs, a national workgroup was put together that included stakeholders, including patients and hospitals and clinicians, and came up with some guidelines for all the boards that are part of ABMs to follow. And one of those was to change the cycle from ten years to five years. The idea being medicine is changing so fast now that we really want to measure things in a five-year period, not a ten-year period. The other thing I'll tell you is that before MOCA minute in the ten-year cycle, part of the maintenance of certification program was a kind of one time high stakes, 200 question, multiple choice question exam. And I remember taking it before we started with maintenance of certification in the MOCA minute. And you had to answer 200 questions and you could tell the machine which 50 weren't part of your practice, so that if you didn't do pediatric anesthesia and there was a question about pediatric anesthesia, you weren't expected to know that, but you had to answer 150 questions. There was a lot of angst about that high stakes exam. Imagine you're in practice for eight years, and now you want to keep your board certification. So you've got to go to a testing center. You might actually prepare because we're all high achievers and we want to do well on exams. And more importantly, the idea was that it's not optimal to be cramming for a test when you're a practicing clinician. The idea is you want to be learning every day. And so we transitioned from kind of this one time every ten years high stakes exam to what we do now with 30 questions every three months. And I think people have really enjoyed that. In fact, we're very proud at the ABA and as a specialty, we should be very proud also because we were the first medical board to institute this knowledge assessment plan, which is the MOCA Minute question. A lot of the other boards are still using this sort of one big test every ten years, and have slowly transitioned. So for all of you, when you become board certified, you'll start your five year certification cycle with those four elements, and I think you'll enjoy it.

DR. FRANCKE:

You've talked about the various ways to earn MOCA credits. How do these questions work? Like what are the formats of the questions? How many do you need to get right? How many can you get wrong? Et cetera. Et cetera.

DR. MACARIO:

The ABA has several committees, and one of the committees is called the MOCA Minute Writing Question Committee. And there are about 12 people on the committee. And there are people in all types of practice, and they get together in person in Raleigh,

which is where the headquarters are, in a room kind of like this one, and have had homework to prepare before then, where they're asked to take the content outline that we have and write questions from the content outline. Now the questions then go through extensive review to make sure that they're properly written. And we have very specific guidelines as to how to write good questions. One major change last year, you may know, is that we went from having four possible answers to three possible answers, because it turns out that it's well known in the education theory that having a fourth potential answer doesn't really add much, because it's always difficult to come up with a fourth answer that's plausible. So all the MOCA Minute questions now are only three answers, which I think simplifies the question quite a bit. And so the questions then go through a review, and then they go through some pilot testing, and then they end up on the MOCA Minute and you get your 30.

Now, what's really neat about that program is that before you start answering the questions, the program will ask you what kind of practice you're in. So for example, I only do mostly multi-specialty anesthesia, so I don't do cardiac or pediatrics or OB. I do mostly kind of neuro, ambulatory and ortho for example. So I click in my practice profile that those are my areas of interest. And so the questions that I get are really specific to those areas. So I'm not going to get a question about a neonate who's having some major abdominal surgery because I don't take care of those patients. And that seems pretty straightforward to all of you that we would be doing that. But believe me, most of the other medical boards don't do the customization of the questions that we do. And so there's a lot of pushback by their practitioners. You know, why are you asking me about something that I don't really do? And we did a little analysis of the MOCA Minute questions. And last year, 90% of the time, the person answering the question indicated that the question was relevant to their practice. Can you imagine getting a question that's not relevant to your practice? That would be a waste of everyone's time.

And then in terms of the percent you have to get right, I think there's this weird dynamic that goes on with the MOCA Minute questions. So I like to get all my questions right. The problem is that if I get them all right, I haven't really learned anything because I already know the answers to all the questions. So in a weird way, you have to get comfortable getting a question wrong because it just points out sort of a piece of knowledge that maybe you're not familiar with. And so the ones that I don't get right are the ones that I get the most value from. And as soon as people can get comfortable with that, the whole thing becomes more fun and relaxing. Now, what's also neat about the MOCA Minute question is that after you answer it, there's kind of like a little debrief after the question. So if I get a question wrong, it'll sort of give me a 2 or 3 paragraph summary of what the issue is with some references. And then some key points. That's the value of the continuing certification program. And MOCA Minute in particular is that it keeps you up to date.

I can't tell you how many times I've gotten personal anecdotes from someone who's in community practice, and they will say something like, oh, I was doing this case the other day, and this thing came up that I had just answered a MOCA Minute question about, and it helped me take care of the patient. And I know for myself that happens in my practice, too. And the reason I think that happens is because a lot of the MOCA Minute questions come from policy changes. So, for example, the ASA has a bunch of policies that get updated every year, and maybe they changed what the requirements are for anesthesia supplies in an outpatient surgery center. Well, if you're in practice for a long time, you don't even realize that the ASA was working on this. And now they've updated a guideline. And you have to be very proactive to stay on top of all this. So the MOCA Minute will take all of these updates in our guidelines and then put questions in. And those are easy to get wrong because you knew what they were before. But now they've changed. So we're really proud of that program. And we've got a whole committee that is looking to see how we can make it even better.

And answer to the question, how many you have to get right. I think the focus isn't so much on the percent correct. The focus is more on making sure that you get some value out of it. The other thing we should mention about the MOCA Minute program, which is really exciting, is this opportunity to be dynamic in how we create questions. So one example was during the pandemic, there was a lot of uncertainty about a lot of things related to how to take care of patients or how to take care of ourselves. And the MOCA Minute Committee did a really nice job sort of figuring out what was known at the time about how to take care of patients with Covid in a very difficult situation, and they put out many questions that were about Covid and the pandemic. And it was a nice way for people to get up to date. And I think that was well received. And it seems like every year there's something that's sort of a hot topic that we can include in the MOCA Minute to stay current. And it also signals to the people answering the questions that we're actually on top of things that we're sending out, stuff that's relevant to them. I think people really appreciate that.

DR. CANNON:

What are the ways that we can earn and attest our CME credits?

DR. MACARIO:

Currently, with the five-year cycle, a person would be expected to get 125 CME credits, which basically correlates to 125 hours of continuous medical education learning. If you go to most conferences that are issuing CME, for example, like the ASA, they have an agreement with the ACCME, which accredits all of the institutions that give out CME.

And through a system called Pars, once you register for a meeting like the ASA and you get your CME credit, the Pars system will sort of automatically deliver updated information into your ABA account that you completed this ABA course and got eight hours of credit, for example. Now where that doesn't happen is if you take a CME course at, for example, your hospital that doesn't have an official arrangement with the ACCME and Pars to deliver the credit, in which case you would have to enter it manually. Say I went to this course, it's not part of the Pars system, and I did this and attest to it, and you would get your credits.

Now, if you think about it, so five year cycle, 125 hours of credits is about 25 hours of CME per year. And so in a perfect world, you're doing about 25 hours per year. Sometimes people get busy with lives and end up doing a lot of those hours in their fifth year, which we understand happens, but ideally over time you kind of build those hours, and then once the five year cycle is over, then you can restart the new five year cycle. It's really pretty easy to get CME hours. There's lots of things that you can do to earn and meet that requirement that we have for continuing certification.

DR. GAMBOA:

For example, at the ASA annual meeting, how much CME credit could you potentially get from coming to one meeting a year?

DR. MACARIO:

It's interesting, I think when you're a resident or a fellow, maybe you don't get this at the end of the meeting, but once you're finished training, you will get a list of activities that you signed up for, and then you will have to attest that you participated in all those activities, because ASA wants to make sure that you actually went to the talk. So I think the number of hours you can get is quite high. If you go to all of the activities that are available for a five-day meeting, I think most people sort of do a few hours each day, and so maybe 15 hours or 20 hours, maybe 25 is a reasonable goal. It's sort of up to you to figure out what the best balance. I find myself that after a couple of hours worth of lectures and learning, I get saturated and I need to maybe try something else.

But yeah, I think the other thing you probably know already is that in order to have a medical license in most states in the country, you have to have a CME amount every year. So in California, we are required to attest to the fact that we have met the requirement for CME in the state. It turns out that there are other states where there is no requirement. And the way you attest for it is different in each state. So sometimes people get frustrated because they have a state requirement for CME that's variable depending on what state you're in. And then you've got the ABA requirement. But

generally if you're meeting your state requirement for CME, you're meeting your ABA requirement. And the nice thing about the ABA go portal, which is the website where you will have your account, the way it works in California with the state medical license, is that you tell the state that you've met the requirement for CME, but you don't have to actually submit the details of what your CME were. If the state audits you, which it does regularly on people to maintain some compliance, and you need to produce documentation about the CME programs that you participated in, you can use the stuff that's been entered in your ABA account to kind of inform the state medical board about what you've done in CME. So that's kind of a neat way to track it.

DR. GAMBOA:

Should we be doing anything now during our training or during residency to prepare for MOCA?

DR. MACARIO:

Well, I think this podcast is a phenomenal way to spread the word about all the work the ABA is doing to help promote lifelong learning. I think all of you are probably pretty committed to lifelong learning. I mean, I think you don't go into medicine unless you sort of accept that the amount of medical knowledge that's out there is limitless, and we have to sort of stay current. So I think the way to prepare is to be open minded about the importance of continuing your knowledge and skills about anesthesiology. It's easy to get into a practice where you sort of take care of the patients that you're taking care of, and you don't come to the ASA, or you don't participate in CME, or you don't get involved in quality improvement. So I would love it if every person that's finishing training was super excited about being part of the ABA and the continuing certification. The nice thing about board certification, it's got a really strong brand. I mean, when you say you're a board certified anesthesiologist, that really means something. It means a lot to the patients. It means a lot to the surgeons whose patients you'll be taking care of. It means a lot to the hospital. Most health systems require board certification to practice there. So all of those groups believe that board certification provides value. And so that's been really exciting for us.

DR. REPINE:

It's clear that this is something that you've worked extremely hard on and are passionate about. In your opinion, why is lifelong learning so important for anesthesiologists?

DR. MACARIO:

Believe it or not, all of you are in training kind of either in residency or fellowship. And to you, it's pretty natural to learn things because you're in training and you're in learning environments where people are keen on staying up to date and teaching the most up to date things and moving the specialty forward and innovating. It turns out that in a lot of practices, it's really a clinical service where that same culture of learning doesn't really exist, right? So, for example, all of you, I bet, are really good with nerve blocks and ultrasound. Well, that's something that came out way after I finished training. And so my challenge is how do I learn how to use ultrasound for nerve blocks, which to all of you is like second nature. But to people that trained after the development of that technology requires some effort. And it's easy to say, oh, you know, I know how to do nerve blocks with that ultrasound. And it's worked fine. And then you realize, wow, it's a game changer. Although it appears straightforward that you're going to stay up to date with things, unless there's a concerted effort to get the additional training as the specialty evolves, one can get a bit outdated and left behind. And it's not only the anesthesia stuff that changes. Every year there's a medication on every patient that I don't recognize. It's just a new medication. How do you stay on top of that? So you've got to stay on your game continually because our patients deserve that, right. We have to know everything as best we can.

DR. FRANCKE:

Do you have any specific changes planned for the MOCA program? I know it's this kind of new innovation still in its nascency. What are kind of the additions or changes, modifications that you want to make to it?

DR. MACARIO:

I think it's pretty obvious that unless the continuing certification program evolves, it gets stale pretty fast, and people notice when it's not changing for the better. So we're always looking for ways to revamp, improve, adjust, modify the continuing certification program. So this year we have a new committee at the ABA. It's called the Continuing Certification Committee. There's four directors on that committee. And then there's also six people who are not part of the ABA, five of whom are in community practice. And so they've been charged at looking at the continuing certification program and saying, you know, what can we do better?

So one output of that is likely going to be the way we think about the improving health care component of continuing certification. So as I said, the four pieces the medical license, the CME, the MOCA Minute and the quality improvement. So currently, once you become board certified, in order to meet the quality improvement piece, you'll have

to attest simply with a signature that you've been participating in some activities. And there's a list of things that you can be doing. Clinical pathway, would be an example. And we don't ask for further documentation. And there's a possibility of an audit where we would say, okay, you've attested to doing this. Please let us know what your activities are. And in some ways that has worked reasonably well. But I think there's an idea that we want to make it even more robust and even stronger. I mean, all of us, every day when we take care of patients, they're doing quality improvement activities. And so the question is, how do we capture all of that work in a way that's sort of seamless and easy for everyone. Because the last thing I think I want, or the ABA wants, is to sort of have two separate activities, all the work that you do in quality improvement in your practice, and also this other thing that you have to do for the ABA. They really should be the same, because the stuff that you do at your local hospital or local facility is really crucial. So how do we do that? Well, one example could be something as simple as tomorrow I have a patient that's on some medication I've never heard of so I do a literature search about the medication and its impact on anesthesia and the patient. And I learned that I probably shouldn't do this or probably should do that. Well, that's a personal quality improvement thing. If there was an easy way to get that noted on the ABA quality improvement thing, that would be incredible, right? Or even take it a step further. Let's say I learn about that medication, and then I talk to my partners about medication and how we should think about it. And all of a sudden now there's a document with some policy that says, if the patient comes in with this medication, please think about these things. Fantastic. That's a lot of work. Real value added with your local group. How do we make it as simple as possible for all people to get kind of credit for that? And so now with technology it should be pretty straightforward. You have an app, maybe you click on something and you get credit for it. We don't want people to have to say, oh, I have to do quality improvement, you know, how am I going to get this busy work done? So that's pretty exciting.

The other really late breaking news piece is that the first piece of continuing certification, which is the medical license, we're also adding a professionalism expectation where we expect board certified anesthesiologists to behave in a professional way. And it's difficult to define professionalism, but it sort of indicates to the public and the hospital and the health system that not only do we expect anesthesiologists who are board certified to have a medical license, have CME, finish MOCA Minute, be involved in quality improvement, but also have a commitment to professionalism that we're excited about as well.

DR. CANNON:

Where can we go to learn more about the MOCA Minute and the MOCA program? And does the ABA have resources for continuing certification?

DR. MACARIO:

Well, we have a terrific website and there's lots of information about maintenance of certification on there. The website was completely redone last year, and I think it's much more user friendly and has a lot of really great content. In terms of other places to learn about, maintenance of certification, yesterday we had a session with the practitioners where people were invited to come and do like a little Q and A to learn more about continuing certification, because I think for all of you, the challenge is you're entering this new program. So it's like thinking about what that involves. Imagine for people that have been out in practice for a long time, they also have to be updated as to the changes. And they have a lot of the same questions that you all have. So we have lots of communications that go out via email and social media platforms about the maintenance of certification and making sure people are familiar with it. It's super exciting for us to have people excited about participating in the program and helping us make it even better.

I really appreciate you all taking the time to do this, and it's so great. You know, being a program director at a residency, the best part of the job is just seeing people, you know, come in the first day of residency and not know much about anesthesiology and then finish 3 or 4 years later and just be able to take care of a wide range of really sick patients. I mean, the transformation that occurs is just all inspiring. So congratulations. Every day when I go to work, I'm just in awe of what people are doing, taking care of patients because the challenges can be really big.

In terms of questions for you, I think one thing that you all can help us with is that obviously there's a new generation of people in our society. So the question that we would love to get your input on, for example, is, as a generation of millennials who learn in maybe ways that are different than I do, what else can we do with the continuing certification program, either from a technology point of view, from a clinical, lifelong learning education point of view, like if you were to build your own continuing certification program and the goal would be to be the best doctor you can be when you're taking care of patients, you know, what would that look like? And I know that the entire ABA would be delighted to get any input on that. And maybe it's not totally obvious what that should be now, but as time goes on and you kind of enter this new part of your career, you know, let us know what things could be improved. So I'd be curious, based on what little you know about all of this, you know, is there something that you're like, hey, have you thought about this?

DR. GAMBOA:

I believe there's a lot of resources already online to help us with this. We're all very familiar with ABA's role in helping us with the basic and the advanced boards exams. And so the resources are provided for. That is very useful for us to to know what's on the test and know how to prepare and ways in which we can prepare better. I think in addition to that, just with MOCA as well, I think we really are connected online and we like having tutorials and things that we can go through, how to videos or just explanation videos on the website, things that we can access that we can use to inform ourselves. Our learning is very self directed. And so I appreciate the changes have been made for the MOCA Minutes and the questions we can do on our own time, and to really individualize our learning.

DR. MACARIO:

So an example of something that we're doing is we're going to put a video on the website about your day when you take the oral exam on the OSCE all the way from the hotel to the exam room to the process, so that you'll kind of have a visual idea of what actually happens and maybe take some of the stress off. So that's a really good idea. This concept of making resources available online so people know what's happening is really powerful. Thank you.

DR. CANNON:

When I think about some things that the ABA can do to support us as we're kind of emerging from training, whether we're just now finishing medical school and starting residency or finishing residency, finishing fellowship is, when I think about a normal day in the OR, or maybe prepping for the next day in the OR, there's a lot of organic learning that goes on in terms of things I'm looking up on my own, whether I'm consulting a textbook, whether I'm looking up an online resource, whether I'm having a conversation with my attending. So some of my thoughts on the way we can capture that, especially for CME, even if it's not specific to some niche practice of anesthesiology, is ways that we can continue to capture CME and the process of online learning. So I know during the the Covid pandemic, obviously there was a lot of concern with physically going and participating in exams. And I know the ABA was able to really pivot and move to the online format for the applied. So what are your thoughts on on that and is there any room for that in the future of having a virtual option for the applied? It's something that I've thought of a little bit as I've organically kind of moved through residency and realized how many things were able to be done online in a controlled and quality fashion.

DR. MACARIO:

So for the longest time, all of the exams were administered in person, and then during the pandemic, we had to administer them via zoom, basically. And that took a huge effort by the organization. And I'm so proud that we were able to pull that off. Can you imagine saying we're going to examine 2000 young anesthesiologist virtually in a six month period? I mean, just the logistics of that. And so it's a natural question to ask, you know, why aren't we continuing with that? And I think the most fundamental reason is something I'll tell you. So I live on Stanford campus and my neighbor is a retired nurse. And so we chat every now and then, as you would with any neighbor. And we actually started talking about this very question somehow I'm not really sure why. And you know what she said? She said doctors take care of patients in person, so we should be assessing them in person, right? I mean, if all of our care was virtual, then you'd want to make some assessment of people's performance and ability via zoom. Right. But you're taking care of patient in person, right? So when you're with a patient in person, you have to talk to the patient in person and you have to establish a relationship. Or when you're talking to a surgeon about having to cancel their case because the glucose is 400, you're doing that in person. So the fundamental reason, from my point of view, that we've gone back to the in-person exam because we are trying to simulate the reality of everyday practice, which is we're taking care of people in person. Now, that's sort of the fundamental reason.

There's other reasons which I think are important. One of them is that even though 98% of the time the virtual exam sort of worked, there are enough situations where there is some problem, like technically that was very stressful. Can you imagine for the, you know, the candidate, but also for the examiner because they're trying to give a good exam and and a lot of times it has it's just you know how it is. Zoom sometimes doesn't work or you know, there's a power failure, or the bandwidth that we thought was adequate now all of a sudden, isn’t. And there was enough of that that it made it not 100% reliable.

Another piece of it too is that, for example, one of the OSCE stations and you probably are figuring this out now as you prepare for the applied exam, is a ultrasound section where you actually take a probe and you put some gel on it, and you have an actor and you scan some basic structures. Well, we think that's a pretty important thing to assess. You can't do that, you know, virtually. And as we move forward, I think there's excitement about doing more technical things with patients. And it's only going to be able to do that if we're live in person.

Another piece of it, which I think to all of you may not be so important, but from the ABA is, is that imagine the examiners are all volunteers. So basically the people that are doing the exams give up a week of their professional life and they give the exam for a week. And that experience, we would not be able to do exams without these volunteers.

So we have 600 people who are board certified around the country who come in to do six weeks of exams. And to examine 2000 people, you need a lot of volunteers. And one of the things we found with the virtual was that the community building and the connection and the learning about how to give exams was lost via zoom. Right. Because you're just kind of by yourself in your house or office. You're not part of this bigger community. And I think the caliber or the ability to give a good exam suffers if you're not interacting in person with other people, sort of the real human element. I think those are the main reasons.

DR. FRANCKE:

I think something on my mind as one of the millennials on this panel is thinking about ways in which we can make the field of anesthesiology more equitable and inclusive of people of all types of backgrounds. You know, historically, anesthesiology was a field dominated by white men. And over the years, we've seen an increase in the number of female physicians, physicians of color. And I think that's definitely exciting and a change, but nevertheless still at the top of the pyramid and a lot of academic anesthesiology departments around the country, it's predominantly white men. It's very few female chairs and even fewer chairs of color. And so something that I would ask the ABA to consider at all junctures when you're making decisions is how to be more inclusive of the language that you're using in communications, the resources and amenities you have in Raleigh, for example, like do you have a lactation room for a provider who is breastfeeding and has to take pumping breaks during the test? Do you have the tests set up to accommodate those kinds of needs? Do you have standardized patients that reflect the backgrounds of providers that we hope that our specialty will someday have? Do you have pronoun tags for people to be able to feel comfortable expressing their pronouns if it's not clear? Do you have gender neutral bathrooms at the testing sites? That's just something that I would encourage you at the ABA to constantly try and think about. Within your MOCA questions, do you have diversified patients or are you, you know, things like that? That's just something that comes to my mind.

DR. MACARIO:

Awesome point, and I'm glad you pointed it out. And I think most of the things that you mentioned, I think we are doing. Believe me when I tell you that the ABA is completely committed to diversity, equity and inclusion. I think every person on the board of directors is committed to that. And we've had a task force for the last few years sort of working to review all of our activities. And you mentioned one that's really right on point, which is the OSCEs, where you have your standardized patients. Those scenarios have been changed to include things like diversity, equity, inclusion. So it's a journey. And I think if you see something that you think we're missing related to that topic, you know,

let us know. We pride ourselves on being responsive, but very well taken point. Thank you.

(SOUNDBITE OF MUSIC)

DR. GAMBOA:

This has been a great conversation. Thanks for sharing your expertise, Dr. Marcario. We learned a lot and hope our listeners did too. And thanks to the listeners for joining us. Come back next month for another episode of residents in a room, the podcast for residents by residents.

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