

## CME is for our patients?

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Parents who take their young children shopping are often faced with the daunting task of explaining the vast difference in the terms 'want', 'need' and 'can have'. Although most providers of CME are no longer in their infancy, there is a tendency for these terms to continue to be confused. Perhaps typical of certain shopkeepers, there is a frequent misconception that the CME providers know best what is good for their customers. Perhaps it is time to act as a rebellious teenager who tells it as it should be. The time has come among our health professions to challenge old assumptions!

There has been much written over the past decade or two about adult learning<sup>1</sup> and its role within recertification systems.<sup>2</sup> But the message doesn't always get through to individual practitioners or providers of CME.<sup>3</sup> If learning is to be focused on new issues in a clinical specialty, or on areas of possible deficiency or weakness in an individual's practice, then the aim and the payoff is improvement of the quality of patient care provided. Yes, CME is for our patients.

To take the childish shopping analogy further, the thrust of CME should be on defined educational 'needs'. The Schon model,<sup>4</sup> on which much continuing education and professional development is said by its architects to be based, stresses just this. That is, the areas of clinical practice that are highlighted as the potentially most demanding and difficult through your contacts with patients, your reading, discussion and teaching are those likely to need attention. These are slowly and surely identified as educational needs, but how well are they defined? They cannot be defined by CME providers who know nothing of your daily contacts and pressures. And presumably if they are not well defined they are unlikely to

be met by simply attending sessions that are put on for diverse audiences. They can only be defined by knowing your own practice profile, through analysis of your own practice patterns, through matching patient outcomes with expectations at an individual patient level or through aggregation of data. Matching your practice procedures against local protocols or guidelines, as well as matching your outcomes against expected outcomes or established norms, is the basis of quality assurance. Quality means the quality of your clinical performance and the patient care that you provide.

So what is wrong with getting the CME that I want? Presumably nothing if the want matches a defined need. But, like young children, do we ever look at the match between these two, or even expect an authority figure to impose some professional judgment upon our interpretation of these two aspects of our patient care?

As part of a major review of the Maintenance of Professional Standards Program of the Royal Australasian College of Physicians,<sup>5</sup> 1021 respondents indicated both the range of CME activities in which they were involved and the perceived value of each to their clinical practice. These respondents were specialist Physicians in Adult Internal Medicine and Pediatrics, but their views could well be generalisable to other areas of clinical practice. Six types of CME activities led the list of nineteen in each case, but the order had significant differences.

CME activities most frequently engaged in:

1. Journal reading;
2. Attending clinical meetings;
3. Preparing for teaching and presentations;
4. Participating in grand rounds, departmental or hospital meetings;
5. Teaching undergraduate or postgraduate students in medicine;
6. Attending clinical workshops.

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CME activities perceived to be of most value:

1. Attending clinical meetings;
2. Participating in grand rounds, departmental or hospital meetings;
3. Attending clinical workshops;
4. Journal reading;
5. Preparing for teaching and presentations;
6. Teaching undergraduate or postgraduate students in medicine.

CME that meets defined educational needs can be any type of activity. The most common activity to keep abreast of developments in one's profession appears to be the solitary activity of journal reading or scanning, at least for specialists in internal medicine. Even journals are changing in their format, many of them now being designed, as is the *Bulletin of the Kuwait Institute for Medical Specialization*, with CME and self-directed learning activities.<sup>6</sup> But their value was not perceived to be as great as those other activities with relevant clinical focus, held in a professional social context and more active in their format. Surely this sends a message to CME providers to organize those more interactive types of activities that have the most potential benefit for those attending.

Perhaps it is the lack of availability of these potentially more effective CME activities that perpetuates less effective activities and reduces options for clinicians to attend only 'can have' CME. Where are the traditional formal lectures in this list? Surely they don't still exist as viable CME options!

The advent of Internet activities and the enormous amount of information that it makes available has contributed to an enlargement of the range of CME available to individuals, although the format and content of many of these activities may be very suspect unless properly evaluated. But CME is, or perhaps 'should be', principally a social activity within appropriate professional groupings. It is the interaction with colleagues, the feedback from them, the sharing of knowledge and skills within a relevant ethical context that helps define effective CME.

It appears that at this point the childhood analogy is breaking down. If a category of 'should be' CME activities is to be fostered, perhaps the educational 'needs' identifies the 'wants' in terms of types of activities that

should ultimately be structured into what professionals 'can have'. Is it being too idealistic to believe in a system of CME/CPD offerings that should be available, that will meet educational needs in a variety of ways, that health professionals can go to when they want to? Surely CME has now come of age!

In presenting a very simplistic approach to CME activities that will improve clinical practice and the outcomes for patients, there is a danger of being misunderstood. Let it be clearly stated that there is a huge range of CME activities available for clinicians to choose from that may help them to meet an educational need. And yes, lectures and other types of presentations will be on that list! But an appreciation of what an individual prefers to choose to do to learn a new skill, new knowledge, a better approach to patients or simply to gain more confidence in what he or she is doing implies that there must be a large range of options to select from. Personal learning styles and preferences vary, and will be considerably influenced by the task to be undertaken and the context in which that task will apply. Research into the effectiveness of various CME alternatives has given us some sound direction.

Please, please, please could CME programs offer individuals choice? Our patients deserve this.

## References

1. Knox AB. *Helping Adults Learn*. San Francisco: Jossey-Bass; 1986.
2. Paget N. Competence to practice: Whose responsibility? *Bull Kuwait Inst Med Spec* 2002;1:40-2.
3. Davis DA, Thompson MA, Oxman AD, Haynes RB. Changing physician performance: a systematic review of the effects of continuing medical education strategies. *JAMA* 1995;274:700-5.
4. Schon DA. *The reflective practitioner: how professionals think in action*. New York: Basic Books; 1983.
5. MOPS Evaluation Taskforce. *Review of the Maintenance of Professional Standards program*. Sydney: The Royal Australasian College of Physicians; 1999.
6. Slotnick HB. How doctors learn: Physicians' self-directed learning episodes. *Acad Med* 1999;4:1106-17.