Innovations making CME more clinically relevant, attractive

Kate Cottrell

In brief

EDUCATORS ARE RISING TO THE CHALLENGE of making continuing medical education relevant, valuable and enjoyable for physicians. Lectures are being replaced by small-group, interactive sessions that try to ensure physicians come away with clinically relevant information that will affect daily practice. Community-based programs also allow physicians to fit learning into their busy lifestyles.

En bref

LES ÉDUCATEURS RELÈVENT LE DÉFI qui consiste à rendre l'éducation médicale pertinente, utile et agréable pour les médecins. On remplace les cours magistraux par des séances interactives en petits groupes qui visent à assurer que les médecins en sortent avec des renseignements pertinents sur le plan clinique qui auront une incidence sur la pratique quotidienne. Des programmes communautaires permettent aux médecins d'adapter l'acquisition du savoir à leur style de vie occupé.

Can continuing medical education (CME) be relevant, valuable *and* enjoyable? With the learner taking priority over the lesson in new-age CME programs, more physicians are finding that lifelong learning can be an attraction rather than a chore.

"Educators are going to great lengths to ensure that CME is relevant to problems that physicians need some education to solve," says Dr. Robert Woollard, past chair of the CMA's Council on Medical Education. "If physicians can participate in the development of the program, it will be more effective. [And] the program must recognize competing demands on physicians' time."

CME that is applicable to clinical practice not only has the greatest impact on improving patient outcomes but also offers physicians a greater sense of satisfaction. But this goal will not be reached without an accurate pre-assessment of educational needs and postcourse evaluations to determine the impact on daily practice. Accordingly, CME providers have called on "cutting-edge adult learning theory" to propel physicians gently down the road of lifelong learning.

Today, that journey may be less arduous. The emphasis on small-group, interactive learning, whether at a workshop or on a computer, can free physicians from hours of lectures that may not be relevant. To promote the outcome approach to CME, both the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada (CFPC) are revising their systems of accreditation to encourage new adult learning principles.

The Royal College's MOCOMP program recently introduced PCDiary and a new way of assessing what constitutes an accredited item of learning: it must have an effect on medical practice. Physicians who tested it for 6 months "frequently reported that their learning activities are now much more intentional, focused and systematic than prior to diary use," Dr. John Parboosingh wrote in the Royal College bulletin. "The process has enabled some to cut quickly through information that can be retrieved when needed to focus their learning on questions that will have an immediate impact on their practices. Several reported a sense of relief from their past feeling of information overload."

The CFPC's MAINPRO has injected "greater flexibility and higher standards of quality into the process of accrediting CME activities," says Dr.

Features

Chroniques

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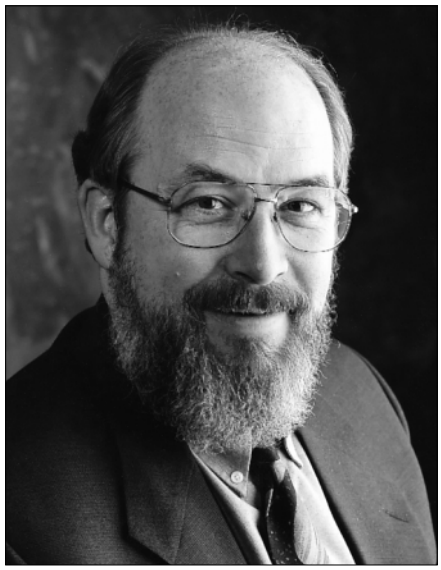
Richard Handfield-Jones, the college's director of CME. That has included adding a new area of accreditation, MAINPRO-C. It differs from other credits in that learning must be based on an individual assessment of participants' needs and skill levels, and generally involve small-group, interactive learning. Because computer literacy is fundamental to learning to access information instead of memorizing it, both colleges give CME credits for computer training.

Dr. Rick Ward, head of the CME committee of the Alberta chapter of the CFPC, has first-hand experience of this focus on needs assessment. As an example, he cites a bottleneck in assessing and diagnosing children with attention deficit/hyperactivity disorder (ADHD) that was identified by a consortium of "all the players in attention deficit, including schools, learning centres, pediatricians, psychiatrists and Alberta Mental Health. They decided that the appropriate point of entry for screening was the family physician. The next step was developing a specialized program to bring FPs up to speed, and MAINPRO-C fit in quite nicely."



Woollard: CME must recognize competing demands

Each FP underwent a chart review and precourse test based on their observation of a videotaped ADHD assessment interview; they were then streamed. "Those with high skill levels who wanted to be 'tuned up' were separated from those with high interest but lower skill levels," said Ward; he believes this approach is unique in Canadian CME. Ward said the college is designing courses on male sexual dysfunction, family violence and advanced psychiatric skills for FPs using MAINPRO-C criteria.

Design your own CME

Although time consuming and relatively costly, this approach addresses the gap between physicians' real and perceived needs. There are other ways to make sure that education covers real needs. The Alberta chapter of the CFPC, in partnership with 2 pharmaceutical companies, offers a program called "Design your own conference" (DYOC), in which physicians use a questionnaire to identify their areas of interest. Then, said Ward, "we can massage the case studies to bring out important learning issues that we know are being under-recognized so we actually integrate real needs with people's perceived needs."

The profession has identified some topics to help practising physicians keep current with more recent graduates. These include physician–patient communication — an area in which many older medical school graduates had little or no training. "It used to be thought that interaction with patients would help physicians become better communicators, so there was no need to teach those skills," says Dr. Moira Stewart, who is leading a University of Western Ontario initiative to develop such a program.

Funded by the Canadian Breast Cancer Research Initiative, the 3-year project aims to improve communication between health professionals and cancer patients. "One of the key innovative features is that breast cancer survivors will be invited to tell their stories and participate in the discussion. We think that will be a powerful experience in itself."

Patient feedback will be used to create the program and assess its effectiveness. Cancer patients will help identify important communication issues; after the course has been pilot tested and refined, 42 physician volunteers (including FPs, surgeons and oncologists) will be divided into 2 groups to compare the course with a standard lecture-format CME.

"We'll assess the impact on each group by audiotaping them with standardized patients both before and after the courses," says Stewart. "We'll be asking patients to use validated scales to indicate their perception of the doctors' communication skills and their satisfaction with the level of information and emotional support. What we hope to achieve is a program with a known degree of effectiveness that includes manuals for teachers and the educational resources such as videotapes, case studies and patient stories."

Effective communication

One communication program that has proved effective and popular began as a pilot project in 1992 by the Collège des médecins du Québec (CMQ) in partnership with the CFPC and Merck Frosst. It has since expanded to include 90-minute workshops on communication skills and issues of physician–patient intimacy (Keeping the right distance) and Approaches to a difficult relationship. A fourth workshop, Breaking bad news, has been pilot tested and is to be launched in June.

Although many medical educators consider communication skills a tough topic to promote, Dr. André Jacques,

director of CME for the CMQ, says these workshops have been given 170 times to 2500 physicians. The workshops are free but must be requested and organized by interested physicians. One attraction may be the program's accessibility: "We go where the physicians are. The program is integrated to their normal CME activity. We can do it over a lunch break, or any time they choose."

The small-group approach is crucial to the success of the workshops, adds Jacques. Participation is limited to 25 physicians, nurses and other health care professionals, typically colleagues in a hospital or clinic. "There's discussion about emotions of patients and physicians, so it's important that participants know each other and can speak freely." The key component of the communications workshop is the viewing and comparison of 2 video interviews.

In the second workshop small groups solve a problem involving physician–patient intimacy and then act out the solution, with each participant playing the roles of patient and physician. The physicians play the patients to the instructor, which Jacques said makes for lively interaction. Each workshop wraps up with a brief lecture that includes references for those seeking more information.

The effectiveness of the workshops is assessed both immediately and 6 months later through open-ended questions about the principles learned and how physicians have applied them in practice. Jacques says the satisfaction rate has been high and the level of retention has exceeded expectations. Demand for such workshops has come from outside Quebec, and as far away as Europe. The model will be used for future communications workshops in Canada, Jacques says.

The "local expert"

Medical educators are responding to demands for up-to-date information on other topics not formerly covered in medical school, such as HIV/AIDS, health care reforms and alternative medicine. Bev Kulyk, executive director of the BC College of Family Physicians, has observed "quite a dramatic change" in CME delivery since 1988, when the BC chapter introduced "travelling road shows"; in that case a GP trained in the detection and treatment of HIV/AIDS went to more than 65 rural communities to educate physicians and nurses. "Now we pull in 7 to 10 family physicians with an interest or expertise in a topic, train them . . . and they go back to their areas and become the local expert."

Dr. David Davis, associate dean (continuing education) at the University of Toronto's Faculty of Medicine, suggests that training opinion leaders to help bring their communities up-to-date is an intervention that will grow in popularity.

The CFPC is testing the efficacy of similar CME interventions. Handfield-Jones said volunteers complete the college's Practice Self-Assessment Program (PASS), which is part of CFPC certification. The control group receives the PASS printout, which compares the physician's practice to criteria statements and to others in the database. The other group receives the printout, a visit from someone trained to analyse the PASS results and a tailored CME prescription. This study may point to more personalized CME in the future.

"In this context PASS is being used as research tool," Handfield-Jones said. "In general, it is too expensive to offer physicians a practical means of identifying their learning needs but the CFPC is also working on a self-applied practice assessment which would be more cost-effective."

PBSG learning popular

Of all the new CME theories, the most popular may be practice-based, small-group (PBSG) learning. Developed by program director Dr. John Premi and colleagues at McMaster University, PBSG recognizes that self-directed, lifelong learning is not an innate skill or natural consequence of formal education. The program, which was initiated in 1992, has since been endorsed by the CFPC and implemented across the country. Groups of 5 to 9 physicians, helped by a trained learning facilitator, spend 1.5 hours twice monthly, 8 months a year, discussing case material relevant to practice. Although the program is quite structured, Woollard suggests that "as medical care has shifted from hospitals and there's less natural clustering of physicians, this creates . . . the kind of collegial interactions that used to happen as a matter of course."

Although Premi cautions that further evaluation is needed, preliminary assessment of more than 150 physicians has been positive. The 1200 members of the CFPC who have participated must be promoting the initiative because Handfield-Jones says "it is probably already one of the most popular choices for our members' maintenance of certification, even without much promotion. Over the next 2 to 3 years we expect it to become a standard for CME." ❦