The American Model in CME*: Lessons to Learn

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**Continuing Medical Education*

CME and the USA

•The United States of America has the longest tradition of formal Continuous Medical Education (CME), practiced for more than 35 years now.

•CME is currently awarded on the basis of hours

•American States that require CME for relicensure require between 12 and 50 hours per year.

The AMA Award

- The American Medical Association's physician recognition award defines the type of activities a physician may undertake to gain credit:

•Category 1 activities include formal CME programs, journal-based or enduring materials, international conferences approved by the American Medical Association (AMA) and passing a re-certification examination.

•Category 2 comprises of other activities, for example consultation with peers and experts, reviews, small group discussions, journal clubs, researching, writing etc.

Reading and CME

- Reading as a required activity was introduced as late as 1990 and is defined as reading "authoritative", medical literature- that is peer reviewed journals or textbooks.

•Self-selected reading is a creditable activity only for the standard certificate of the AMA **but not** for the "certificate with commendation for self directed learning"

CME EVALUATION

- Didactic interventions have no impact on the more relevant end points of physician behavior and patient outcomes

• Didactic educational meetings are ineffective at promoting physician behavior change

• Interactive educational interventions, such as case solving discussion groups, and role-play, can improve physician's behavior and patient outcomes

Effectiveness of CME

While the Accreditation Council for Continuing Medical Education requires only that **effectiveness of CME activities** be measured in terms of **"satisfaction, knowledge, or skill**"they recognize that **"exemplary"** CME will be effective in terms of **"practice application and/or health status improvement"**.

The core competencies

The American Board of Medical Specialties along with the Accreditation Council for Graduate Medical Education have defined **6 core competencies** that every resident must acquire and every practicing physician must demonstrate.

These are:

1) **Medical knowledge**
2) **Patient care**
3) **Inter-professional and communication skills**
4) **Professionalism**
5) **Practice based learning and improvement (PBLI)**
6) **systems-based practice**

FROM CME to CPD

Continuous Professional Development (CPD):

•Emphasizes ongoing professional development of individuals across the continuum of their careers.

•Relies on self-assessment to identify specific learning needs.

•It is learner centered and self-directed.

•It is comprehensive in scope and extends beyond the clinical domain.

Key Differences CME and CPD [3]

Table 1. Key Differences Between Traditional Continuing Medical Education (CME) and Continuous Professional Development (CPD)

CME	CPD
Episodic Interventions designed to address the educational needs of groups of learners	Lifelong Learning based on ongoing self-assessments designed to address the educational needs of individuals
Generally teacher centered and teacher driven	Generally learner centered and learner driven
Principally encompasses the clinical domain	Comprehensive in scope, encompasses the clinical domain as well as practice management, leadership, administration, education and an entire spectrum of professional activities
Lecture based format frequently used in educational activities	A variety of learning formats and media used in educational activities
Most often conducted in formal settings, such as lecture halls or conference rooms	Conducted in a variety of different venues, including locations other than lecture halls and conference rooms

Integration of CPD with PBLI

Continuous Professional Development activities should be integrated with the core competency of Practice Based Learning and Improvement (PBLI).

4 major steps are required.

Step 1: Identifying areas for Improvement

- The first step must be self-assessment and reflection in assessing specific learning needs.
- Reviews of the current literature, practice guidelines, expert opinions, evaluation of new procedures and technology and its appropriateness for the physician's practice. Ongoing assessment of clinical outcomes and comparing these outcomes with national, regional or local data are key to identifying areas for improvement

Step 2: Engaging in Learning

- Ongoing educational activities that are directly related to patient care are likely to be more effective than episodic educational activities
- Only 23% of the online CME sites are based on interactive case-based learning
- effective CME requires not only increased interactivity but also improved applicability to users' specific learning needs
- Learning portfolios can serve an important role in helping learners pose relevant question and reflect on how answering such questions impacts their practice
- Cllinical medical librarians or informationists

Step 3: Applying New Knowledge and Skills to Practice

- Insight into one's performance and motivation to change one's practice are of paramount importance. Following participation in a course, a period of structured preceptorship is critical to safely apply the new skill to practice.

Step 4: Checking for improvement

- The impact of CPD and PBLI activities on physicians' learning, physicians' performance, and patient care outcomes needs to be evaluated through valid and reliable assessment methods.

•Assessment of a physician's (especially a surgeon's) performance in real setting is important but a very delicate task:

- –Audits through medical record reviews
- –Assessment by peers & other health care professionals
- –patient surveys

•Patient care outcomes are often used as a proxy for assessment of performance

CONCLUSION

The American Model of Continuous Medical Education (CME) has been improving the last years by adopting the concept of Continuous Professional Development (CPD).
CPD activities should be integrated with the core competency of practice based learning and improvement (PBLI), which involves a cycle of 4 steps identifying areas for improvement, engaging in learning, and checking for improvement.

The effectiveness of CPD and PBLI should be objectively evaluated by assessing their impact on physicians' learning and performance and above all on patient care outcomes.

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