Changes in CME

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As this will be my last editorial for the Canadian Journal of CME, it may be fitting to reflect on some of the major developments in Canadian CME over the past decade. Canadian CME is a dynamic and vital aspect of medical education. It's safe to say that the academic approach to CME in Canada has put Canadians at the forefront of CME internationally. This academic approach arises from the fact that there is a long history of support for CME from faculties of medicine. Also, our accreditation system requires that CME offices in medical schools be academic units. We also benefit from close relationships between faculties and the two national colleges (the College of Family Physicians of Canada [CFPC] and the Royal College of Physicians and Surgeons of Canada [RCPSC]). It is gratifying to see an increasing alignment of the CMA policy, Physicians and the Pharmaceutical Industry, with the latest revision of Canada's Research-based Pharmaceutical Company's Code of Marketing Practices. This provides similar guidelines for joint projects between CME offices and industry partners.

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Online education

Ten years ago, e-learning in CME was in its infancy. We anticipated rapid adoption by physicians whose working days were so rushed, they would engage in e-learning in the evenings and weekends. However, the adoption of e-learning by physicians has been more gradual than expected. One reason for this is that many of the initial programs, and too many of the current programs, are "shovelware" (*i.e.*, digitized conference presentations distributed electronically). If a lecture is not very effective in changing practice, a talking head on a small computer screen late in the evening holds even less promise of impact on physician behaviour.

In more recent years, we have learned that course content originally designed for in-person learning must be reformatted for e-learning. Careful attention must be paid to the appropriate use of multimedia, combined with sufficient e-discussion-devoted time. The moderator of the course must be skilled at creating a welcoming environment, where participants feel comfortable engaging in Web-based discussion.

E-groups must be small enough to allow adequate discussion, and because material will be discussed asynchronously, it will be covered more slowly.

It is important to note the major contribution the CME office at Memorial University has made to the development of e-learning courses, aided by a consortium of CME offices across the country. We predict that, as we gain experience with the electronic medium, the number of physicians enrolling in e-CME programs will increase.

What advances have been made?

Both of our national Colleges have had a major impact on CME in Canada. The standards for MAINPRO-C courses have had a major impact on CME in Canada. Standards for excellence in CME programming have been established through:

- the requirement for adequate needs assessment,
- extensive learning experiences in small groups, and
- post-course reflective exercises.

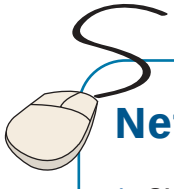
The fact that a certain number of MAINPRO-C credits were a requirement for CFPC members exposed many family physicians to higher-level programs. The fact that a post-course reflective exercise was required set the stage for more effective course evaluation.

However, there were initial problems with having enough MAINPRO-C courses available to allow practicing family physicians to meet the requirements of the College. Consequently, in 2003, the CFPC removed the need for MAINPRO-C credits as a prerequisite for membership, making them a fellowship requirement instead. The effect of this change is not fully known at this time. One hopes that the principles of MAINPRO-C courses are so well-established that they have become a part of much of CME programming, whether or not credits are collected.

In 2001, the RCPSC introduced its own continuing professional development (CPD) program for specialists. The program requires 400 credits to be accumulated within five years in order to maintain one's RCPSC fellowship. The centrepiece of the program is evidence of reflective practice. Hence, personal learning projects, self-evaluation examinations, and audits of practice are included.

Over the last decade, the programs of both national colleges have developed more commonalties. While both institutions recognize that CME events, such as meetings, continue to be sought after by the profession, both are increasingly emphasizing the importance of reflection on practice as a key component of their programs.

One can only assume that change will continue as our approaches evolve to fit new knowledge, different technologies, and emerging issues. These advances will be based on the solid foundation developed thus far. It is a truism that our clinical practice is our best teacher. The reflective practitioner will remain key to successful CME, and methodologies will increasingly support learning from practice. CME



Net Readings

1. CME Courses for Physicians
   www.MDcme.ca
2. Canadian Medical Association
   www.cma.ca