University CME Units in a Changing CME Climate

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The changing climate of CME in Canada has me wondering if it's time to reconsider how we organize university-based CME. In this editorial, I will describe some of the changes we're seeing and, hopefully, provoke discussion with some suggestions.

A major role for CME has been to translate primary knowledge into practical forms physicians can use. The principal method of this translation has been through courses consisting of lectures and workshops.

The limitations of this format have become apparent. While we have a pretty good sense that lectures raise awareness of issues, they alone are unlikely to result in changes in practice. Along with their doubtful effectiveness, traditional face-to-face courses are expensive to provide and attend, especially for physicians working in remote communities.

Recent innovations, such as small, problem-based learning groups and academic detailing may prove to be more effective and practical.

In the provision of conventional CME, university units face competition on all sides. Many clinical departments develop their own CME offerings, which can be an important source of income while (hopefully!) enhancing a department's reputation.

As one might expect, these benefits may compete with similar goals of the faculty CME units. In some faculties, the parties have been able to negotiate mutually beneficial arrangements; in others, there continues to be un-constructive tension.

Specialty societies host their own annual meetings, workshops, and courses which, along with hospital rounds, may be the principal source of CME for many specialists.

The structured review is a new and likely more valid form of knowledge translation. Among the pioneering examples of structured reviews are those prepared by the Cochrane Collaboration. More recent examples include reviews prepared by the ACP Journal Club, NeoReviews (for neonatology), and the Evidence-

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Based collection of journals. These products provide rigorous, carefully constructed summaries, usually with bottom-line recommendations to guide practice. Clinical practice guidelines have a similar potential, but require quality assessment and collation such as that provided by the Ontario Guideline Collaborative. The College of Family Physicians of Canada and the Royal College are now promoting personal, reflective learning as a preferred form of CME. Mainpro-C activities and the Royal College's "Personal Learning Projects" are designed to encourage self-assessment of learning needs and the creation of personalized learning strategies. This approach may be feasible now that new knowledge, especially in the form of rigorous structured reviews, is electronically accessible.

So we find ourselves between technologies. While our traditional CME formats seem less relevant to physicians, new information technologies and learning strategies swirl around us. The third element in this Canadian CME perfect storm is the pressure on almost every university unit to be self-supporting, if not profit-generating.

If the climatic shifts I've listed above result in a warming toward self-education, and a cooling toward courses, what will be the role of university-based CME units and how will they survive financially? It seems to me two essential roles remain. The first is to provide academic oversight of CME activities offered by departments and faculty or sponsored by industry. Even in this accreditation role, we find ourselves "competing" with specialty societies and national colleges.

The second role is the advancement of the CME field. Education research is difficult at the best of times. Outcomes are likely to be subtle and incremental, therefore, large sample sizes or labour-intensive research methods are needed. Funding sources generally do not favour single-institution projects unless the institutions are large and well established. Provincial funding may be available to units that serve a whole province. Small CME programs, working separately, don't have the resources to conduct meaningful research, yet this remains an unrealistic expectation of accreditation.

How can we adapt to this changing climate?

My view is that it may no longer be sensible for every medical school to have a full-service academic CME program. Provinces with more than one CME unit should consolidate into no more than two. A faculty member at each school would serve as the faculty CME leader, presumably at the assistant or associate dean level. An important role for this leader would be to aid local physicians in developing personal CME strategies. Clinical departments might appoint one of their members to serve as CME resource. Co-ordination and development of the departmental CME resource people would be provided by the faculty leader. Clinical departments would be free to organize external CME activities with accreditation,

provided directly by the appropriate Royal College specialty society or the College of Family Physicians. While each faculty might maintain a conference services office to help with course logistics, the academic development would originate entirely within the departments.

A cluster of schools, through their CME leaders, might collaborate to develop larger courses, workshops, and web-based materials using the development and course delivery infrastructure of the one or two regional full-service units. A model for this might be the development of the CME web portal at Memorial University.

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What about research?

We are more likely to accomplish something worthwhile if we collaborate. We are also more likely to be funded. The regional CME unit would be expected to have the infrastructure to plan and conduct major research projects, with input and local support from the CME leaders at the smaller units.

This scheme takes the pressure off each CME unit to attempt everything, regardless of the facilities and available funding. CME programs at every medical school would not exist in their current form. Rather, the provision of CME courses would distribute to the clinical departments while the local CME leader focused on educating the faculty and helping community physicians to plan personal CME activities. Another potential role of the CME leader would be to work with like-minded physicians in community hospitals with the goal of each moderately sized hospital having its own CME leader.

My suggestions may be applicable only to Ontario and Quebec, where we have several university-based CME units in close proximity. In Ontario, we might only need two, one each in the north and south.

My sense is that medical faculties that are learning structures built around the triple- or quadruple-threat faculty member are no longer sustainable. Maybe it's time to look at our CME programs in the same way. CME

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