Not All Learning is Structured...

Nor Does it Need To Be

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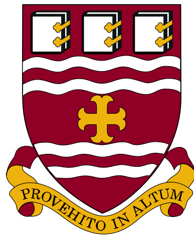

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Continuing medical education (CME) is an important component of continuous professional development (CPD). However, the distinction between these two concepts is not always clear, as illustrated by a colleague who recently asked, "How are things in the CME office, CPD office, or whatever you guys call yourselves, these days?"

Both the Royal College of Physicians of Canada and the College of Family Physicians encourage and expect their members to document participation in CME activities, though the process does not always capture all the learning taking place.

Society expects physicians and all professionals will stay up-to-date in knowledge-acquisition in their particular areas of expertise. Yet, we must also continue to enhance and expand our base in all areas of professionalism as well.

Hospital boards and provincial medical boards deal with concerns from the general public on a regular basis. The concerns may arise from an apparent deficiency in one's knowledge base, but often, the concerns centre on other aspects of professionalism.

- How do we know where our weaknesses lie?
- How do we decide where to spend our CPD time?
- Do we attend well-organized, accredited meetings run by our respective national societies?
- Do we perform our own needs assessments and then allocate our time to enhance our area of potential deficiency?
- Do we use other methods to help us decide?

I suspect physicians do all these and more, though in an informal way. We may go to a national meeting even though only a small part of it is in an area truly new to us.

In a recent discussion paper, Norman *et al*,[1] highlight the differences between learning needs of an individual and educational needs identified by organizations for inclusion in course offerings. The authors suggest possible strategies to identify learning needs, including such tools as individualized audits using electronic office records and facilitated note-keeping with reflection around sentinel patients.

Much of real learning takes place in short bursts of activity that

are then examined and conceptualized by the learner, if deemed appropriate. The stimulus for this learning or the environment in which it takes place may not be considered by some to be appropriate if it occurs under the influence of pharmaceutical companies. We need to maximize our ability to capture and document all forms of learning as we continue to demonstrate our commitment to CPD as individual learners.

Let me attempt to illustrate my points with an example. I was recently asked to facilitate an evening CME event sponsored by a pharmaceutical company. The local representative surveyed invitees as to their areas of interest in gastroenterology. As a result of this mini needs assessment, I prepared a talk centred on the recently published Canadian Association of Gastroenterology consensus guidelines on colon cancer screening. We reviewed the recommendations and discussed some of the evidence supporting these suggestions. In short, we attempted an evidence-based review of a specific topic in a small group setting with an interactive, case-based format.

I believe some of the participants experienced new learning. I also suspect, however, some of the attendees saw the exercise as an enunciation of yet another set of guidelines. I doubt many of the participants would be able to discuss all of the nuances in the consensus document if questioned individually several weeks later. Why then would we go through this exercise?

Gabbay and le May[2] explore how primary care clinicians derive their health-care decisions. As a result of their research, these authors feel clinicians rarely access and use explicit evidence directly, but rely on what they describe as "mindlines." This term is defined as guidelines that are collectively reinforced, internalized and tacit. This process involves an interaction between the clinician's own knowledge base, the knowledge of colleagues and of local opinion leaders, as well as of patients and pharmaceutical representatives. The resultant larger base, they suggest, is mediated by organizational demands and constraints. This process of iterative negotiation results in the "mindline."

As I reflect on the interactions that occured at the event, I realize I have been educated. There was, however, other learning that also took place that night.

As part of our discussions at the event, we explored the possible role of chemoprevention of colorectal neoplasia. As a result, we reviewed the cyclooxygenase (COX)-2 inhibitor trials. This led to a question-and-answer session around the recent withdrawal of rofecoxib from the marketplace. Topics explored included the strength of the evidence surrounding cardiovascular thrombosis and whether it was unique to this agent or represented a class effect.

This inevitably progressed to a discussion of appropriate gastric cytoprotection with, for instance, a proton pump inhibitor (PPI), if one chose to use a traditional non-steroidal anti-inflammatory drug rather than a COXIB. One of the attendees related a concern expressed by his patient surrounding the risk of pneumonia with the regular use of a PPI. His patient was aware of the possibility as a result of an evening news report and was requesting discussion and reinforcement surrounding the safety of the medication. The physician in question had not previ-

ously been aware of the report. This sequential exploration of topics was driven by environmental issues and direct patient contact.

I am aware of the ongoing discussions surrounding the influences of the pharmaceutical industry and CME in this country.[3,4] I believe the debate is healthy, but we would be remiss if we were to dismiss all pharmaceutical-sponsored activities as biased and unworthy of recognition for their educational value. In the above example, it is quite possible for a pharmaceutical company-sponsored event to function as an educational conduit to explore the areas in question.

Even though some may believe it occurred in a less than perfect environment for unbiased learning, I believe exploration and learning took place at the CME event. The learning was not based on the needs assessment and the discussion strayed from the stated objectives, but true learning did take place and, after all, isn't that the real purpose of any CME event?

There are many ways to determine our individual learning needs and equally numerous ways to fulfill them. Let us continue to explore how we define learners' needs and how to best address them in an arena of open and thoughtful debate. Society expects it and regulatory bodies may soon demand it.

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