How Personal Can CME Get?

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Is it possible to provide individualized CME for all practitioners? This question came to mind recently as our office has been busy arranging both remedial CME and CME electives. Remedial CME is professional development designed to remediate identified deficiencies. For example, in the past year, our office has provided communication skills training using standardized patients for physicians with:

- complaints to the regulatory authority,
- record-keeping skills,
- teaching using a trained physician,
- carrying out several structured visits to a practitioner's office and
- ER skills assessment and training for physicians new to rural practice.

Directed CME

We have also been referred physicians for directed CME. In the past, this directed CME has included everything from:

- attending already scheduled educational sessions,
- to directed reading,
- to attendance at specialty clinics,
- to spending a month in another physician's office or in a hospital ward.

Arranging such CME is on occasion difficult and time-consuming, but can ultimately be very rewarding.

The role of the CME Office is to help participants identify learning objectives and, if necessary, to arrange temporary hospital privileges.

CME electives

For physicians who have not been referred for obvious needs, we provide the opportunity to take part in a CME elective. A CME elective can last anywhere from a few hours to two months. Participants are encouraged to find their own preceptors. The role of the CME Office is to help participants identify learning objectives and, if necessary, to arrange temporary hospital privileges. The process is informal; at

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the end of the elective, participants simply receive a letter that wishes them well and hopes the experience was a useful one. There is no evaluative component and no letter attesting to competence in any given area or procedure. The aim of the program is to enable practicing physicians to pursue learning experiences in an area of interest, or in an area of self-identified need. The logistics around taking time out of a busy practice limit the numbers who avail themselves of this opportunity.

The other group of learners who receive more directed CME are those in our rural sites. The small number of physicians at each site means that participants are more likely to have their chosen topic presented and to have the opportunity to have their issues discussed. Ideally, the visiting speaker would also see a couple of consults while he or she was in the region, then offer CME/discussion around the cases. Logistical and political issues have meant that this latter scenario is still a dream rather than a reality.

Remedial CME, CME electives and visiting speakers to rural and remote areas, reach a very small percentage of the physician population. They also consume an inordinate amount of resources.

This year marks the 10th anniversary of the always successful "Bug Day." This day long academic program focuses on the fields of infectious diseases, public health and infection prevention and control.

Does this mean that personal CME (other than reading and corridor consultations) will remain out of reach for the majority of physicians? Both certifying Colleges want their members to link their CME and professional development efforts directly to their personal practice.

Linking professional development and personal practice

What might ensue if, as a profession, we were truly committed to continuing professional development that directly linked learning to practice? The computerization of medical practices and the availability of government databases will make personalized needs assessments more practicable. It will, among other things, tell us:

- how many patients with diagnosis X we see,
- what medications we prescribe and
- what tests we order in comparison with peers or with current guidelines.

How will university CME offices use that information to help physicians continually improve their practice? One model that comes to mind is the CME office as a broker or as a facilitator of CME. A physician might contact their university

CME office with a learning need. For example, they might say:

- "My management of hypertension is not up to date"
- "My type 2 diabetics have hemoglobin A1Cs that are not only higher than they should be, but are also higher than those of other physicians in my region"
- "That's the second fracture I've missed in the past month; is that a coincidence or do I need to do something about it?"

In response to these or to other identified learning needs, the university CME Office might:

1. Arrange for a physician to spend a couple of half-days in a:
   - physician's office,
   - a specialty clinic,
   - the ER,
   - a sports medicine clinic, or
   - in another area
2. Direct the learner to appropriate guidelines and other print resources
3. Direct the learner to pre-existing management flow-charts or help in developing or customizing a flow chart for that particular practice
4. Arrange for academic detailing
5. Direct the learner to their own or to others' upcoming CME programs. For example, the provincial informational database might have indicated that suboptimal diabetes management was a widespread problem. In this situation, the CME office would respond by developing a program to address the specific difficulties
6. Introduce the physician to an online community of practice
7. Determine that the missed fractures were due to excess life stressors
8. Encourage/suggest resources for self-care

This model might be more expensive than what we currently engage in, but should ultimately prove to be more effective. The same databases and other assessment tools that allow us to identify learning needs will also allow us to determine the effectiveness of our educational interventions.

The challenge remains: how "personal" can we get with those who come to us for their CME needs?

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10th Annual Bug Day

It is important to note that this month's issue of *The Canadian Journal of CME* focuses on an annual event at the University of Manitoba. This year marks the 10th anniversary of the always successful "Bug Day." This day-long academic program focuses on the fields of infectious diseases, public health and infection prevention and control. Every year hot topics are selected to help highlight the importance of these areas in ongoing medical education. The articles that have arisen from this year's Bug Day highlight the diverse nature of the program along wih important issues. Once again, this year's program was an overwhelming success and we're certain that future "Bug Days" will be equally successful.

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