Opinion Leaders: The Future of CME

Lewis Tomalty

Medical education takes on many forms depending on the target audience. We have defined curricula in undergraduate medicine which is delivered in modes ranging from problem-based learning to didactic-classroom learning. As our students move to clerkship and residency, principles of adult learning gradually emerge. Despite this, the content is still fairly prescriptive with the overall learning objectives guiding the way. However, once into medical practice the curriculum disappears.

Academic continuing medical education (CME) offices struggle to provide educational offerings with sufficient breadth to cover key areas identified by need. Yet, academic CME offices are only able to reach limited audiences and physicians must find alternate means for enhancing their educational requirements.

Community physicians in particular are at a disadvantage because there are few organized CME events at their disposal. These individuals must rely, to a great degree, on reading and research as resources for gathering new diagnostic, therapeutic and procedural information. There exists one other common means of acquiring updates and this occurs through direct communication with peers and colleagues. The informal corridor consult that takes place on a regular basis, within hospitals, becomes even more important in the community.

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As personal communication with colleagues is known to be an important source of information gathering, medical educational programs have now emerged to use this mode of delivery. This means of knowledge translation is known as the opinion leader model.

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Opinion leaders may be formally trained consultants or they may be informal consultants. Informal opinion leaders are the colleagues to whom physicians turn for information and advice during regular work days. Formal opinion leaders are those physicians known to be experts in their field, either from self-teaching or a defined training program in a particular area.

In 1999, the Ontario government announced a five year strategy aimed at improving the quality of life of individuals with Alzheimer's disease and related dementias (ADRD). The physician training initiative was one component of this program. Its goals were to enhance the training for family physicians, undergraduate medical students and residents in the early detection and diagnoses of ADRD.

Formal opinion leaders were identified to their community, where they acted as educational leaders in a variety of formats, ranging from one-on-one interactions to group discussions.

The program hoped to do this through improved practice patterns and through the optimal use of community and specialized services. This was a major CME undertaking and it required the development of an extensive educational plan in order to reach a large and diffused target audience.

One arm of the plan was to develop an opinion leader program. Opinion leaders were developed through a process of formal education, combined with linkage to a mentor specialist. These formal opinion leaders were then identified to their community, where they acted as educational leaders in a variety of formats, ranging from one-on-one interactions to group discussions.

At the conclusion of the formal part of the initiative, evaluation of the opinion leader program provided results that showed how successful the program actually was. The majority of individuals who interacted with an opinion leader reported that they had changed the way they practiced as a result of this educational program.

There are difficulties in developing an effective opinion leader program. The network must be extensive and strongly supported. The Ontario experience was successful because it was adequately funded through the Ministry of Health and Long Term Care. Building other networks would be costly and this challenges CME offices that are, to a great degree, based on a cost recovery revenue stream.

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Development of an effective opinion leader network could be an important adjunct to traditionally organized academic CME. CME offices are challenged in the way that they operate, but they must become more responsive to the community physician's needs by building novel and effective educational delivery models.

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