Making CME even better!

By Dave Davis, MD, CCFP, FCCP

For almost 20 years, the University of Toronto has been proud of its "Saturday at the University" continuing medical education (CME) course for primary care physicians. For those of you who haven't heard about it, the yearly course consists of three days of CME lectures in the fall and three in the winter/spring. The goal of these lectures is to provide family physicians and other generalists with a regular systematic review of current concepts, preventive measures and treatments for a wide variety of common disorders. Naturally enough, the lectures are held on Saturdays. Over the years, reflecting the success of this event, our attendance has grown. Last year over 500 individual physicians and nurse practitioners registered for the program, of whom, over 300 attended most of the sessions.

I can already hear some of you saying, "Lectures – didn't I read somewhere that lectures aren't a very effective way to upgrade or help us maintain our competence. Besides, a series of lectures doesn't sound like a very interesting way to continue my learning." Well, you're right. Lectures, according to the literature review, don't seem to change physician performance by themselves. They may be entertaining, provide new information and an opportunity to talk with former classmates, but alone, these stalwarts of the CME staple just don't cut it. So if that's the

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Editorial

case, why would we, at the University of Toronto (and elsewhere), persist in developing continuing education lectures and courses? Why would we not heed the research about how physicians learn and change? In fact, we have paid attention to this literature (I've even contributed a little bit to it myself). Let me explore with you the ways in which we, at the University of Toronto, have incorporated some of this literature into our CME program.

Table 1

How to make CME more engaging:

Give lectures a 10-minute maximum in order to deliver bite-sized chunks of information.

Provide a lot of opportunity at the end of each 10-minute lecture for questions from the audience. In our case, the questions are written up, which facilitates the process with a large audience.

Use features such as touch-pads or coloured cards held by the audience. These tools can help the audience respond to questions raised by the speaker.

First, it appears that not all lectures are boring, dull and irrelevant. In fact, those lectures that are interactive do appear to change the performance of some physicians. Even with the large audience in attendance at "Saturday at the University," we have attempted to make our lectures more engaging in order to entice more attendees (Table 1).

Second, it also appears that if physicians receive feedback on their knowledge, it helps them gauge where they are in the learning process, and whether they're maintaining their own competence compared to their peers. We've attempted to do this in the last several years by encouraging physicians to fill out a self-assessment pre- and post-multiple choice quiz. These quizzes use the topics of the speakers from the previous month as the source of material for the multiple choice. This creates a rich source of information gathered by the physician under the heading "So how am I doing anyway?"

Third, CME literature highlights the fact that the course should only be the central point in the learning activity for the physician, and the so-called "enablers" of better practice should also be provided. We, at the University of Toronto, give extra materials to take back to practice settings. These "enablers" include flow sheets, reminders, patient education materials, and other tools that help us apply best evidence practice methods to make practice easier. This feature at "Saturday at the University" is becoming increasingly popular. In fact, the syllabus of learning and practice-enabling materials may be in some ways as important as the lectures themselves. In addition, we have been developing our Web site to post these types of materials in cyberspace. By the way, you are more than welcome to visit us at **www.cme.utoronto.ca**.

Fourth, there are a variety of other features of "Saturday at the University," which just by themselves, fit what we believe CME research tells us. These features include: the longitudinal nature of "Saturday at the University," in which physicians can spend time in the educational experience, go back to their practice environment to try out some

features, and then return to the educational experience. We also pay attention to something called "needs assessment." With this assessment we spend a lot of time figuring out what family physicians and general practitioners need to learn about, in as specific a way as we can. We do this by using very detailed questionnaires and focus groups. All of this, of course, makes our topics and lectures more relevant for the learner/clinician.

Finally, "Saturday at the University" owes its great success both to its founders, Dr. Yvonne Debuda (a family practitioner at the University of Toronto) and the late Dr. Colin Woolf (the former Assistant Dean for Continuing Medical Education at the University of Toronto) and especially to its wonderful, engaging and spectacular speakers, who inform and teach the audience year-in and year-out.

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There are a couple of more things to add before I close off this little piece of bragging about "Saturday at the University."

Clearly, we're not the only providers of continuing education for physicians across the country, and our Canadian colleagues are also attempting to improve CME. From UBC on the West Coast to Dalhousie University and Memorial University on the East Coast where distance education, video-conferencing and audio-conferencing have become more popular and more heavily studied, to our Quebec colleagues who have developed self-learning modules and small-group workshops, to the University of Calgary which has led the way in the development of MAINPRO-C courses, to our colleagues at McMaster who have instituted small-group learning, CME providers keep trying to do it better. The College of Family Physicians of Canada and its chapters, and other more regional organizations, have also helped and directed the process – often in very engaging and remarkable ways.

This leads me to my last word. What I've done is taken topics indicating areas where research shows that CME can be more effective and made them into a little checklist, which I have included adjacent to this piece (see page 5). You might find it helpful for deciding on your next course. Finally, if you think you'd like some really good CME and find yourself in Toronto, come visit us at "Saturday at the University." You are more than welcome.

For a list of the upcoming lectures at the University of Toronto, please refer to the Calendar section at the end of the book. CME

Dave's SIX–PICK: An Effective CME Checklist

- ❑ **1. Interactivity:** Is there room for me to ask questions or raise topics of importance to me in my practice? Are there other features of the educational format which will allow for interactivity, for example, audience response systems, small group sessions or workshops?

- ❑ **2. Relevance:** How close are the presented subjects related to the topics that are of importance to me and my patients? Is there any evidence of a needs assessment being done? Are members of the planning committee similar to me and my practice settings?

- ❑ **3. Feedback:** Is there a chance for me to receive some information on how up-to-date I am? (For example, by multiple-choice quiz or some other means.)

- ❑ **4. Sequencing of Learning:** Is there a chance for me to learn something, try to apply it in my practice, and come back for discussion?

- ❑ **5. Practice "Enablers":** Are there handouts, flow charts, worksheets, Web sites, patient education materials and other tools which I can use in my practice setting?

- ❑ **6. Speakers/Presenters:** Do I know them? Do they represent good speakers to me who understand primary care and the nature of my practice? Will they talk down to me?