

A historical vision of CPD

Thank you for the invitation to attend your conference and also to offer my perspectives on this important topic of Continuing Professional Development.

Coming to your country is very special for me as an Obstetrician because I learned so much from one of your most important faculty who still has an international reputation that spans several generations, even after his passing. And of course, I refer to the late Dr R Caldeyro-Barcia of the Faculty of Medicine, University of Uruguay..

The main reason for us to review the history of CPD is to learn from successes and failures in countries with a long history of CME as you plan a national program of CPD for your country. As you will see from my presentation, we are at a most important era for CPD. Countries who are at the beginning of developing a national program have the advantage of adopting the successes and avoiding the failures experienced by countries with a long history of CME.

Slide 2

We need to remember that there are any three types of CPD and CME

First there is the formal CME to which we most often refer when we use the word CME.

Next there is what I call Practice or just in time CPD which refers to the activity physicians undertake when to seek information to manage a patient. I will shortly try to differentiate between traditional CME and what has come to be known as CPD.

The third type of CPD is self-directed learning we undertake when we read journals and discuss advances in medicine with our colleagues. Of course, our self-directed CME is driven often by questions raised in practice as well as from information gained at formal CME, so the three types are interdependent.

As we will see there has been significant changes in all three types of CME and CPD over the past century to which I am sure Dr Toews will refer. It is interesting to note at this stage that as self-directed CME and practice based CPD were shown to enhance practice and health outcomes, there has been a tendency for these types of learning to be incorporated into the formal CME credits systems.

Slide 3

I have chosen to take a snapshot of CME at four periods of time and review what I consider to be the significant milestones in CME in each of these periods.

Before 1900, physicians were trained and returned for further training in the apprenticeship system. They learned mainly from observing their masters.

In the most part of the last century formal CME took place in large classrooms in hotels.

The American Medical Association was the first to set educational standards and by 1960 had developed a credit system to reward physicians for attending. I have provided a handout on the history of the CME Credit system in the USA.

In my opinion, four significant changes were made in CME in the last half of the 20th Century. First, the majority of US states adopted mandatory CME, making it necessary for physicians to earn 150 credits every three years in order to maintain a license to practice. Second, research into CME started in this period, focusing on measuring impact

on practice. The bad news was that classroom CME was shown to have limited impact on helping physicians to change their behavior and even less impact on health outcomes. The results from research showed the need to move from CME which was simply updating doctors practices with advances in medicine to CPD which involved helping physicians to acquire skills such as communication and collaboration in order to better serve their patients. I will return to this definition of CPD. So from this era onwards most programs adopted the term CPD. Internet learning and online CME started during this period and of course has flourished since.

Finally I wish to summarize what I consider the significant changes in CME since 2000. First, there has been a significant increase in learning in the workplace. Mostly, this has resulted in more classroom learning in the form of grand rounds in hospitals. But there has also been significant movement promoted by colleges and Academy's in practice based learning and improvement (PBLI). There is the desire for PBLI to be interdisciplinary and involve nurses and other professionals, but this has proven difficult for postgraduate colleges and boards who see their mandate as focused on physicians only. Also in this period in the history of CPD, we have seen the development of simulation training and specialized databases that resource just in time learning at the point of care. And finally we are at an early stage of developing computer programs and Web platforms for physicians to keep records of educational activities and also to communicate with each other in communities of learners.

This has been the picture in North America, Australasia and the United Kingdom. CME in many European and South American countries is being significantly revised as countries try to learn from what has happened in North America.

Slide 4

I think we would better understand the changes that have taken place in CME if we look at the forces that have driven these changes over time, referring to the three types of CME and CPD shown here.

Side 5

First, let us look at the motivation for physicians to do CME.

Before 1900, a combination of curiosity, competition and pressure from the masters & mentors motivated physicians to keep up to date, a task easily achieved. In the first half of the 20th century the concept of taking a holiday with one's family and doing CME became attractive. It was also the era that CME credit started and this created a motivation for physicians to participate. By the 1970s, recertification every 10 years had commenced in four disciplines in the USA. CME was mandatory to maintain a license although there was little evidence that this motivated physicians to keep up-to-date and even less evidence that it changed physician behavior. Increasingly, insurance companies and hospitals were mandating focused CME and licensing authorities were mandating remedial CME for physicians who were shown to be incompetent. A minority of licensing authorities had screening programs to identify poorly performing physicians. Finally, in 2000 we see the development of maintenance of certification replacing recertification in all postgraduate boards in USA and at the Royal College in Canada. The issue of medical errors was raised by the Institute of Medicine and this has increased physician motivation for workplace directed CME as had programs that promote

improved performance and cost controls in health care. The important issue is that workplace CME, as we shall see, is moving faster than traditional CME which still takes a format at annual meetings of colleges which is similar to the classroom CME that we have seen for 100 years.

Slide 6

Now let's look at how the incredible increase in the knowledge base in health care has affected CME over the past century.

Before 1900 when textbooks were limited in number, physicians heard of new information from lectures only. There was a significant increase in the number of medical journals and medical libraries in the first half of the last century and physicians also depended on classroom CME for new information. Of course by the 1960s, the number of new investigations and treatments were increasing at an alarming pace. In response, there was a dramatic increase in the number of CME programs, mail-outs and CME journals, mostly financed by the pharmaceutical industry. The amount of new information was overwhelming and this led to the development of needs assessments and specialized databases as it became obvious that the doctor's brain could not hold all this information. There was more formal CME programs in most western countries but you remember that this was the era that CME research showed us the limitations of classroom CME to change physician behavior. As the information explosion continued in this century, now called the information age, we continue to see more formal CME programs and indeed there is now an international CME industry with reciprocal credits. Workplace CPD is aimed at providing information when it is needed and promoting collaborative practice. Its financing, unlike most CME of the past which was financed by pharmaceutical companies, is often provided by hospital administration and insurance companies.

Side 7

I want to introduce a third factor that has and will continue to impact CPD. And that is the changes we have seen in the nature of practice in the past two decades.

Increasingly our practice is moving from applying to patients something we learned in a classroom, to what Johnson et al (2005) in a recent McKinsey report refer to as TACIT work, and Colin Coles (2000) has defined for medical practice. In reality, health professionals are required to make judgments in complex and unpredictable circumstances. We are increasingly responding to situations where there are high levels of uncertainty and where paradox is ever present. Doctors are challenged to make the diagnosis earlier and earlier and to detect subtle changes in disease status.

This requires us to develop the capacity to know what is 'best' in any particular circumstances rather than what is 'right' in some absolute sense. We must learn to 'read the situation' and to improvise through 'on-the-spot experimentation'. Professional judgment is central to what, how and why we recommend advice to patients.

This has set the scene for CPD to assist physicians in their goal to provide patient centered care. Clearly traditional classroom CME at a holiday center is at a disadvantage in providing CME that meets this new practice. And, interdisciplinary learning in the

workplace is likely to be the most effective learning environment. I will be returning to this issue when we talk about workplace learning on Friday afternoon.

Slide 8

In this slide I summarize the major differences in CME and CPD between the first and second halves of the 20th Century.

The typical CME format of the conference room at a holiday resort did not change but the quantity of programs and brochures coming across the desks of doctors increased dramatically, most of them financed by the pharmaceutical industry in North America. Also in North America the accreditation Council for CME was under government pressure to set standards to eliminate pharmaceutical bias from programs and a number of companies were fined for providing gifts for physicians and paying them to attend meetings.

In the second half of the century CME research brought us the news that traditional CME was very limited in its impact on changing position behavior and improving health outcomes. This era also saw the introduction of the term continuing professional development or CPD. CPD extends beyond traditional CME, which is perceived to be teacher driven and focused on updating medical knowledge. In CPD, practitioners define competencies that they see as relevant to their practice needs. As well as traditional educational themes, CPD education covers subject matter such as doctor–patient communication, interdisciplinary team skills and risk management.

Slide 9

In this slide I summarize the changes we have seen in CME in the last part of the 20th century and the increasing emphasis after 2000 on practice based learning and improvement, just in time CME and the proliferation of simulation training centers. There has been an explosion of online CME and physicians are increasingly using this medium to earn CME credit. Finally, we are beginning to see increasing interest in the management of CPD using eLearning tools.

Slide 10

But the most significant shift is taking place at the point of care and is shown on this slide. It was predicted by Dr. Ron Cervera in 2000 that health care managers will reposition CPD from a developmental tool for individuals to a strategic tool for the care delivery unit. This provides an alternative source of funding for CPD, namely from institutions where the focus is on practice enhancements and reduction of medical errors.

Slide 11.

I want to introduce a new concept on this, my final slide. And that is the concept of embedding CPD in practice. I have left it for the last because it could be an important goal to be achieved in a new system of workplace education.

I do not have to tell you that doctors are already overworked, and there is every indication that the workplace will become busier, shorter staffed, technology is driving us

faster each year; and some are already saying we will have to do more CME/CPD and possibly be evaluated for maintenance of certification and licensure.

The commonest reason for missing a CME event or being behind in our reading is that we are pressured at work. Industry has learned that workers need more continuing education when they are requested to work faster and they need help to enhance performance. This cannot be left to the altruistic motivation of a few individuals - many of whom are in this room.

Finding a way of embedding learning in practice is vital to our future as the learned profession. Embedding learning in practice means identification and implementation of practice enhancements that take place without much time and conscious effort on the part of the doctor.

Our job is to focus on high quality, safe patient care and to have a system in place in our clinics and departments that manages practice enhancements.

So, in the new approach to education we need to devise a system that assists the health professional in this goal. It must not take the professional away from practice. How do we create a practice enhancement system that works in parallel with the rate of work? We will talk more about this concept in the session on Workplace learning on Friday afternoon.

Slide 12

Thank you for your attention. I would be pleased to participate in a discussion with you on these issues. I'm also including my e-mail address and would be pleased to send you any articles to which I have referred and also a copy of my slides