JACC Vol. 27, No. 7
June 1996:1815–6

ACC NEWS

President's Page: The New CME

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Professional education is the cornerstone of the American College of Cardiology (ACC). The College was founded and is incorporated for this purpose, and has a mission statement that begins, "The mission of the American College of Cardiology is to foster optimal cardiovascular care and disease prevention through professional education. . . ." I feel privileged to have been part of the College's continuing medical education (CME) activities for many years, both as a learner and a teacher. This experience leads me to conclude that the traditional methods of CME are changing and that new methods are rapidly emerging.

Physicians have always been accountable for maintaining their professional knowledge base and learning new procedures. In fact, most of the concepts and technologies I use every day were developed after my formal training. Throughout formal medical education, our best teachers served as role models, sharing with us how they approached and solved problems. The resolution of clinical problems remains a central feature of our learning during our years of active practice.

It has become recognized that adult learning differs, and the following principles aptly characterize physician CME (1):

1. **Learners seek solutions to problems they recognize they have.** Physician awareness of deficiencies of knowledge usually occurs through self-assessment. Informal assessment methods include comparing one's own practice to the practice of others, to guidelines, to expert recommendations or to approaches defined by the scientific literature. Formal assessment methods include the completion of self-assessment products, such as the College's Adult Clinical Cardiology Self-Assessment Program (ACCSAP), or self-assessment examinations, such as the College's New ECG Examination.
2. **Physicians want to be directly involved in their own learning.** The College was a pioneer in acknowledging and supporting active learning through its programs in the Learning Center Classroom. These CME programs, which feature case studies, panel discussions, ready access to faculty, an interactive response system and "hands-on" practice, in addition to the excellent lectures from recognized experts, receive the highest evaluations from program registrants.
3. **Adult learners have many demands on their time.** This has always been true for physicians, and the demands have become even more severe. If there is one statement that can be made with absolute certainty, it is that CME must be provided through methods that are time efficient as well as effective.

It is ironic that despite the emphasis on clinical problem solving during formal medical training and what we know to be true about adult learning, CME continues to occur through programs that are predominantly lecture based, with little or no opportunity for learner interaction. These methods have not proven to be very effective in bringing about appropriate changes in physician behavior. A recent comprehensive review of the effect of CME strategies (2) concludes by noting that these widely used CME delivery methods have little direct impact on improving professional practice. Interventions that appear most promising in affecting performance change include practice-enabling strategies (e.g., reminders), reinforcing strategies (e.g., chart review audit with feedback), support from local physician opinion leaders and CME that includes peer discussion and active participation. To assure effective professional education at the lowest possible cost, it is likely that future CME will be very individualized and will be directed toward the identified clinical needs of each physician based on patient outcomes.

The College is responding to this changing environment. Our traditional CME programs will continue but are likely to become more differentiated. The 45th Annual Scientific Ses-

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0735-1097/96/$15.00
PII S0735-1097(96)00166-0

JACC Vol. 27, No. 7
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sion of the ACC in March 1996 featured an incredibly diverse program that was highlighted by state-of-the-art lectures, the latest clinical trials and, importantly, many hands-on sessions, such as meet the experts, luncheon panels and fireside panels. Nearly 15,000 physicians attended ACC'96, which breaks all records for the College. The annual meeting is perhaps the most efficient learning opportunity available to the practicing cardiologist. In a three-day period, each individual registrant can find exactly those topics and speakers that are of most personal value. I believe that the Annual Scientific Session will remain a fundamental component of the College's CME activities.

The College's smaller meetings, which occur in the Learning Center Classroom at Heart House and throughout North America as extramural programs, will also continue. The committees that guide these program areas routinely review evaluations. Based on participant feedback, these committees are increasingly suggesting to program directors that they use methods to actively engage the participant in the learning process. The Learning Center model will gradually become the standard for all College programs.

As travel becomes more costly and time-consuming, our members will seek more opportunities for office- or home-based learning. During the past four years there has been an explosion of interest in College CME products, which include an expanding self-assessment library as well as videotapes and multimedia CD-ROMs. At the present time the College has more than 48 educational products available for members' use, with another 28 "in the pipeline." A highly successful Learning Center teleconference was held in 1995, another is planned for 1996, and two more are scheduled for 1997. The Internet promises even more exciting new avenues for delivering CME on an "as-needed" basis to our members worldwide.

College members will define their needs by using data from many sources. Technology now supports the acquisition, storage and review of incredible amounts of information about clinical practice patterns. Individual physicians are receiving feedback about their own practice relative to standards and to their peers that directly identifies CME learning needs. One example of this use of data is in Maine, under the direction of the Maine Medical Assessment Foundation. National data collection systems, such as the College's data bases, are another very important source of CME information. The ACC data base library is rapidly changing from a procedural to a disease management orientation and is also becoming easier to use. The greater the duration of follow-up on these data bases, the more valuable they become in revealing actual practice patterns of participants. This information is reported not only to the individual physician, but to the College where it can be used for CME curriculum development and guidelines review. The College's data bases are the "feedback loop" that has so long been needed but never been available.

The College leadership is aware that the changes occurring in our members' clinical practice setting will inevitably change their CME practices. A needs-assessment survey was approved by the Board of Trustees to collect current information and to identify methods of maintaining ongoing information about changing CME needs and practices of College members. At the same time, the Executive Committee is about to launch a strategic planning process so that current and future College priorities will be identified and realized.

Education has always been an important part of my medical career, yet at no time have I felt so optimistic about the future of CME as I do at this moment. Everything is in place to improve what is already excellent. The ACC has the financial and member resources to create a diverse array of educational activities. Technology not only can support new methods for providing CME, but can also provide information to guide College and individual planning. Outcomes of CME can be measured and thereby result in improvements. The ultimate benefit is that the College will better meet its mission to foster optimal cardiovascular care and disease prevention.

References

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