President’s Page: Redefining Continuing Medical Education

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“The first and foremost goal of the American College of Cardiology is to provide a comprehensive and innovative program of high-quality continuing education for cardiovascular health care professionals.”

In just the last few years, we have reaffirmed this sentence from the College’s continuing medical education (CME) mission statement at least twice. First, in the recently approved ACC Strategic Plan, we included this as one of the 10 goals that comprise the crux of the plan. The second affirmation of this goal occurred in August of this year, when the Executive Committee met and identified CME as this year’s top strategic priority.

Strategic initiatives grounded in improving the College’s CME offerings are not new. For the last 50 years, the College’s primary purpose has been to offer high-quality educational programming so that its members can provide optimal cardiovascular care to patients. The Executive Committee has, however, put a new spin on this strategic initiative. Specifically, we have assigned ourselves the task of “redefining” CME so that we can respond to a new paradigm taking hold in education.

This paradigm is described by Barbara E. Barnes, MD, who is the associate dean of continuing education, an associate professor of medicine, and the director of the Center for Continuing Education in the Health Sciences at the University of Pittsburgh School of Medicine. In an article recently published in Academic Medicine, Dr. Barnes writes about a new “practice–learning model” for CME (1).

The practice–learning model is based on fostering an environment in which information technology makes “seamless” clinical practice and learning possible. Dr. Barnes supports the need to implement this new paradigm with examples reminiscent of comments that we have seen in the results of our most recent ACC Needs Assessment Surveys. Physicians need to be able to “access optimal information when and where it is needed,” writes Dr. Barnes, specifically, “during the process of patient care . . . permitting scientific evidence to be incorporated at the time clinical decisions are made.” She recommends applying learning to practice in new ways, including through resources available at our fingertips, such as the World Wide Web, computer simulations, and computerized learning portfolios. She goes on to cite results of programs that have adopted this model of CME. One program developed learning activities that are “more focused, intentional, and systematic,” and physicians who participated in this program reported greater feelings of control over their CME planning and a decreased sense of information overload. This model should not seem foreign to us, as many medical schools adopted the problem-oriented curricula pioneered by McMaster University, and most postgraduate training experiences have been based on this model.

Dr. Barnes’ article was published at an ideal time for the College. We have recently completed a Needs Assessment Survey, and we are implementing our Strategic Plan. Both of these processes, as well as the evaluation forms garnered from every ACC program, have been invaluable sources of information about the types of educational programming wanted by all and how the College should deliver CME.

So, how much “redefining” will be necessary? I believe that gradually, during the past decade, ACC educational programming has been evolving in the direction of the practice–learning model described by Dr. Barnes. Consider that, as of the late-1980s, almost all of the College’s CME offerings were in the form of expert-led lectures paired with slide presentations in settings other than our offices. Certainly this format has and will continue to work well for many of us. Our state-of-the-art Learning Center and our wide range of extramural programs offer extraordinary opportunities for learning in interactive, small-classroom settings. By the mid-1990s, however, information technology had moved into our homes and our offices, thereby broadening our opportunities for education. Following the 1991–92 Needs Assessment Survey, the College began offering a wide variety of videotapes, more self-assessment programs, including ACCSAP—which quickly became the ACC flagship product; and a number of videoteleconferences. Now, at the end of this change-filled decade, from the 1996 Needs Assessment Survey, we have learned that you want CME that has been synthesized from multiple sources, prioritized by experts, and personalized for your needs. We

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have also learned that you may be experiencing information overload because of the vast amount of new information, research, and requirements you are facing daily. These findings are remarkably like the rationale behind Dr. Barnes' new paradigm for CME, which leads me to believe that there is still more work and more redefining for us to do.

I would like to suggest that we do not need to change the College's CME component completely. We must be careful not to undervalue our face-to-face meetings in the Learning Center, at extramural sites throughout the United States, Canada, and Mexico, and at our Annual Scientific Session; these venues provide us with tremendously useful opportunities to share and learn alongside our colleagues, and they are irreplaceable. Rather, we need to further expand our offerings and delivery options. Our goal should be to offer something to meet every member's needs and wants. Meeting that goal is not a small undertaking. After all, there are more than 24,000 of us, and each of us has a different set of issues, learning style, knowledge base, and expectations for CME. I do, however, believe that this goal is attainable. Already our educational programs have changed somewhat, more often featuring a clinical focus and review of patient cases. We are continually adding more information to our Web site, such as the recently added Washington Update—Weekly, which provides us with bite-size updates on issues unfolding on Capitol Hill and in our states. We are finding new ways to bring the Annual Scientific Session to you, for example, via ACC '98 News Online and ACC '98 Highlights on CD-ROM. And we have a whole track of "special topics" that will be offered at ACC '99 in New Orleans.

In addition to the American College of Cardiology Interventional Symposium (ACCIS '99), which will include live sessions transmitted from international and domestic sites, there will be a coding seminar, a Health Policy Symposium, and sessions devoted to estate planning and organization.

The College has also formed a working group on cardiovascular professional development. This group will be exploring possibilities related to coding sessions for chapters; more programs like the Strategies for Success extramural program on practice management that was offered earlier this year; find ways to offer education focused on practice, personnel, office, and risk management. What this group and I need now is to hear from you. I would appreciate your thoughts about what you want from CME and how you want to receive it. I would like to know if you personally believe that we are on the right track and whether the synopsis I have offered above seems to be an accurate representation of your wants and needs. Please write to me at Heart House, 9111 Old Georgetown Road, Bethesda, MD 20814-1699, or fax your feedback to me at 301-897-9745. I look forward to hearing from you and to continuing our work on this important strategic initiative.

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