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2004 Meeting Report The Global Challenge: Proving CME's Value

NEW YORK -- Building a global CME community was the theme of the Ninth Annual Meeting of the Global Alliance for Medical Education held from June 20-22 at the Westin Times Square hotel here.

Over 100 continuing medical educational professionals from all over the world heard the meeting's keynote speaker and plenary session speakers discuss the globalization of continuing medical education and also listened to updates on CME requirements, perspectives and trends from different regions of the world.

Globalization's Effects

Globalization has both positive and negative effects on healthcare, said Yank D. Coble Jr., MD, President, World Medical Association, during his keynote address to attendees. On the plus side, technology enables healthcare professionals worldwide to communicate rapidly. On the other hand, diseases also move with increasing speed—AIDS and malaria can travel from Outer Mongolia to the United States in 24 hours. Therefore, CME providers must help the medical community respond to international disasters. "It's very important to get information out to physicians and healthcare professionals as quickly as possible," Dr. Coble said.

During the rest of the conference, attendees and faculty from the U.S., Canada, Europe, and as far away as Malaysia and China, discussed how to develop CME that effectively responds to health crises and improves patient care. Although systems vary widely from country to country, with an increasing trend in Europe toward mandatory CME, there was a consensus that education should be free of commercial bias and evidence-based.

The challenge for CME professionals around the world is how to maintain their programs' independence while relying on pharmaceutical industry funding. Malaysia has taken an interesting approach—allowing pharmaceutical companies to develop 25% of the content for CME events. "We recognized that it was important for the pharmaceutical industry to present information on drugs and their efficacy," said Dr. P. Krishnan, President, Commonwealth Medical Association, Kuala Lumpur. However, pharmaceutical firms cannot register as CME providers.

In the U.S., guidelines regulating relationships between pharmaceutical companies and CME providers are about to grow much stricter. The Accreditation Council for Continuing Medical Education's (ACCME) proposed new Standards for Commercial Support of Continuing Medical Education, which will probably be ratified in September, require CME providers to identify and resolve any conflicts of interest. Under the current ACCME standards, conflicts must be disclosed, but providers are not required to take action.

To further protect CME's independence and credibility, providers should make sure content is evidence-based. One evidence-based education trend is point-of-care learning, where the patient presents a problem and the doctor uses a computer to search available evidence for the answer, explained Daniel J. Ostergaard, MD, Vice President, International and Interprofessional Activities, American Academy of Family Physicians, Leawood, Kansas. The physician can later document behavior change based on that experience. To assign credit for point of care learning, the credit metric must change, he said. "The new metric will be based on practice impact, not just on time. The challenge is to come up with the right measurements."

When planning CME meetings, small-group education is more effective than lectures in changing doctors' attitudes, said Göran Sjönell MD, PhD, Familjeläkare, Medical Director, Familjemedicinska Institutet, Stockholm. In Norway, physicians must earn 50 out of their required 300 CME credits in small-group sessions. Even when producing large conferences, CME providers should introduce small-group learning activities, such as reflection, said Bernard A. Marlow, MD, Director of CME/CPD, College of Family Physicians of Canada, Mississauga, Ontario.

Regardless of the education format, providers must prove CME's effectiveness, speakers stressed. With the passage of the Medicare prescription drug benefit bill, the U.S. government will become the largest single payer of pharmaceuticals and medical devices by 2006, which means the current environment of government scrutiny will intensify.

These U.S. trends will affect pharmaceutical funding of CME worldwide, said Maureen Doyle-Scharff, Executive Director, Professional Alliances, Johnson & Johnson Pharmaceutical Services, Piscataway, New Jersey. By demonstrating improved patient outcomes, the CME industry can help mitigate the risk drug firms now face when investing in CME, she said. "Outcomes measurement is the value proposition for industry support of CME in the future. We need to be thinking about quality, not quantity, and we must start to invest in programming that is evidence based, practice based, and focuses on quality improvement. We need to always look to the end point of improved patient outcomes."