CME is Here to Stay –
An Interview with
Dr Dennis K Wentz

By Dr Tan Hooi Hwa

The CME system has to recognise the self-directed learning that a doctor undertakes. If we limit it to only straight forward CME, we will miss the boat.

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Dr Dennis Wentz is the Director of the Division of Continuing Physician Professional Development (CPPD), formerly the Division of Continuing Medical Education (CME) of the American Medical Association (AMA). He is a subspecialist trained in gastroenterology, but gave up clinical practice to commit himself fully to change the United States (US) system to reflect the premise that CME/CPPD must be relevant to a physician's practice needs. Dr Wentz was in Singapore to give a talk on "CME - The American Experience: Lessons to Learn" on 7 Nov 2000. The SMA News took the opportunity to interview him.

Q. Could you give a historical perspective of the development of CME in the US?

A. In 1935, the state of Virginia conducted the first survey on how doctors kept up to date. In 1955, the AMA council on medical education commissioned a national survey on continuing education. It called for the creating of a register of recognising hospitals and institutions that did continuing education. The AMA then started this system in the 1960s. In 1968, there was the need to recognise doctors participating in CME. So the AMA created the Physicians Recognition Award - AMA PRA. This was given to doctors who had completed 50 hours of CME a year, over a 3 year period, i.e. 150 hours was required. In those days, it counted for formal courses and lectures.

The AMA still believes that CME should be voluntary; it is part of the physician's ethical obligation to their patients. Then, we had a crisis in the USA of malpractice, and the legislators and politicians demanded for evidence that doctors are up to date. They started to make CME mandatory. Presently, 36 of the 50 states have mandatory CME requirement to register the licence to practice.

In the USA, there is another credentialing mechanism which, for most doctors, is very important, i.e. admission privileges in hospitals. Most GPs have admission privileges so that they can admit patients, and follow up management with consultants. These privileges are renewed every 2 years. Again, there is 20 to 25 hours a year of required education but here, it is relevant to your specialty which has to be documented by the credentials committee of the medical staff. They also look at other things viz, are you a good doctor, are your medical records up to date, malpractice suits, etc, but the CME is absolutely crucial.

This began in the early 70s when the hospitals have a system that they must follow, set by the Joint Committee on the Accreditation of Hospitals and Health Care Organization (JCAHO). If you don't have JCAHO approval, the government won't pay you. These are the 2 mechanism which require CME.

Q. How do you motivate doctors to participate in CME?

A. What really helps is feedback to doctors with performance related things. It is a combination of peer pressure and the department they belong to. They come because they want to be recognised by their colleagues as being up-to-date.

Q. What about the solo practitioner?

A. That is the problem. That's where the minimum requirements of the hospitals and the state comes into effect. It is not easy as you have to get a locum. We have adapted our CME so that credit is given for reading journal articles - you can get 1 CME per week if you read 3 articles. Feedback from doctors is positive as they do their CME on their own time. Slowly but surely, there are materials on the internet. 45% of our doctors have access to the internet. The new doctors are all very comfortable with this. There are a variety of media techniques that doctors can study on their own – we call them "enduring material", e.g. a monograph, and at the end of it, you will have to answer some questions and you mail it in. If you pass 70% of it, you can get credit of so many hours of CME. They are also in videotapes and audiotapes.

We don't always insist on an examination as we have trust in the

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honour of the physicians when they sign a declaration of physician participation. Asking questions about the effect of CME on their practice will tell us affirmatively that they did do the exercise. Most doctors have access to hospitals, clinics, group practices. The best CME is when the doctor has a patient with a problem and he calls his colleague or an expert about it. This is not a formal CME and is called a "Category 2" CME, a self-directed physician learning. It can actually count for up to half of those 50 hours; if you can document that. However, most doctors don't, so they go to formal seminars to get their points.

There is a new pilot project that AMA is working with Stanford University that can lead to CME credit. The doctor can enter on the Internet, 2 or 3 words when he sees a patient, and within 8 seconds, the computer can come up with a simultaneous search of the medical literature and 2 textbooks of medicine, Scientific American being one of them, practice guidelines and drug database, about 15 things all hooked in. The doctor can choose from the display which way to go. This may help them manage their patients. This system is called "Standford Skolar" and it is brand new. A learning exercise involves more than asking a question; you can ask for some questions to be downloaded. The computer will give you 10 questions you are required to answer for CME credit. There is no failing grade, but you have to keep at it until you get them right. What is not decided is how much credit is to be awarded. If it is based on time spent, then 15 minutes is the basic requirement.

Also you can find our about a particular topic, e.g. oesophageal reflux, and medical information and relevant guidelines will be given. At the end of the study period, questions will be given. CME credit will be given on how you answer them.

The most important thing is that when a doctor gets information immediately about a patient they have and they can apply that to the management of the patient, it is more likely to remain in the memory.

Q. Is credit given for teaching?

A. In teaching, we recognize that if you teach students, nurses or other health professionals, it can be reported in "Category 2". It may not be at the level recognized for credit, 2 hours may be accredited for each hour of teaching activity, in the belief that you have to prepare to give that presentation. Journal articles, if it is in a peer review journal, listed in the Index Medicus, and you are the first or second author, you can get 10 credits per article, but you can only use it once a year.

Q. How about overseas work?

A. Generally not but we are working with the Union of European Medical Specialist, UEMS, located in Brussels, which has set up a European credit system. For 3 years, negotiations have been going on about how credits can be exchanged. I hope someday we will have standards that are shared around the world, so that no matter where a qualified doctor goes, he can come back with credit we would recognize, and vice versa. Presently, those who attend medical meetings in the USA may not have their credits recognised back home. To reach this, it must be verified that attention is paid to education quality, whether the needs of the learner were identified, whether the objectives of the courses were clearly stated, or the appropriate teaching modality used and whether an evaluation was done both for the course director, and for the doctor to decide whether it was valuable to them.

Q. How about commercial sponsorship?

A. Commercial influence is a factor also. We do have commercial companies which support CME, but the control must always be with the CME provider. We, as well as Europe, do not allow companies to sponsor CME. They may support it. We also agree that the speakers must disclose to the audience if there is a conflict of interest. It does not mean that there is anything wrong with that, e.g. an expert on hypertension may have been supported by a grant from a drug company, but he should mention it.

Q. How do you monitor the success of a CME programme?

A. Through research, we have found that formal CME does not lead to a significant change in clinical practice. What makes the difference is on-the-job CME, supplemented by reminder systems. There was an excellent article by David Davis in JAMA 1995 that pointed it out. The CME system has to recognize the self-directed learning that a doctor undertakes. If we limit it to only straight forward CME, we will miss the boat. A lecture is efficient because it can get to 150 or 500 people but everyone sitting there will have a different learning trend. Emphasis is placed more and more on physicians who set learning goals, and then do whatever study needed to fulfil these goals. The American Board of Medical Specialties has suggested that the doctor continually maintain certification with CME by having their practice analysed by himself or by others. This is where the computer will help us a lot, because the doctor can keep track of how he is doing with his patients and contrast it with a group of peers. The Academy of Paediatrics has just unveiled their "Pedialink". A doctor can enter details about his patients with asthma, and compare his care with a computer selected 100 other paediatricians in the country. That makes it exciting and this is the best CME.

Q. Why was the name changed from CME to CPPD effected?

A. CME implies a more restrictive medical education pertaining to clinical practice only. Whereas it is recognised that the computer, cultural diversity and communication are important in the professional development of the physician. The change was first mooted in 1993 and adopted in the USA in 1999. ■