Journal of Education and Practice
ISSN 2222-1735 (Paper) ISSN 2222-288X (Online)
Vol.4, No.8, 2013
www.iiste.org

CME Model of DMIMS (DU) Wardha: The 10 Point Action Program for Learning and Quality as the Outcome.

A Rawekar [1]*, V P Mishra[2], A Singh[3], T Srivastava[4], S Tankhiwale[5], N Samal[6]

1: Associate Professor Dept of Physiology

2: Chief Advisor and Ex Vice Chancellor

3: Professor and Head, Dept of Dermatology

4: Associate Professor Dept of Physiology

5: Director; Center for Health Professionals and Research

6: Professor, Dept of Pathology

Jawaharlal Nehru Medical College; Datta Meghe Institute of Medical Sciences (DU) Sawangi (M) Wardha. Maharashtra State. India

* Corresponding Author) E-mail- alka.rawekar@gmail.com Ph No. +919823916173

Abstract

Tremendous advances are taking place in the field of medical sciences, continuously changing the concept, approach to management and the outcome of several diseases. Maintenance of professional competence remains an exercise of lifelong learning and an essential requirement for evidence - based medical practice. This is in essence the concept of Continuing Medical Education (CME).

Datta Meghe Institute of Medical Sciences (DMIMS) is established as Deemed University (DU) in 2005. Since then CME has been a regular experience. To augment the efficacy of these activities University Center named "Center for Health Professionals Education and Research" (CHPER) identified 10 areas to attain the desirable outcome of CME activities held at DMIMS (DU). It offers a simplified and more rational approach to credit based CMEs and accordingly recommendations and actionable strategies are planned.

Keywords: Continuing Medical Education, Accreditation, Deemed University

Introduction:

Physicians' interest in keeping up can arguably be traced to Hippocrates. Because it is a conditioned response for physicians, their learning desire is sensitive to hearing about the latest development, be it a disease, a drug, or a device - anything they can incorporate into their practices[1].

One of the first reports on the state of medical education was published in 1910 in North America, with the support of the Carnegie Foundation, showing that the interest for Continuing Medical Education back at least a century[2],. Doctors (and nurses) are among the few professionals who managed to avoid for a long time any sort of evaluation of their knowledge and competence after the achievement of their diploma. But concern has been rising in society about the fast obsolescence of medical knowledge, particularly in the last 50 years when the development of research and technology in the field has been so fast. The concept of Continuing Medical Education gained growing interest after the Second World War as a necessity for health professionals, but also as a form of protection of patients, who have the right to be treated by competent and knowledgeable doctors and nurses[3].

Tremendous advances are taking place in the field of medical sciences, continuously changing the concept, approach to management and the outcome of several diseases. Maintenance of professional competence remains an exercise of lifelong learning and an essential requirement for evidence - based medical practice. This is in essence the concept of Continuing Medical Education (CME).

As the continuing medical education (CME) enterprise evolved over the last half century, a variety of rules, national and state regulations, and reporting requirements developed, with a resultant substantial variation in what is required of a physician. This involves educational methods and physician performance. It also involves the leadership of organized medicine in accreditation, certification, credentialing, licensure, and credit recording, reporting, and funding.

Although physicians spending a considerable amount of time in continuing medical education (CME) activities, studies have shown a sizable difference between real and ideal performance, suggesting a lack of effect of formal CME.

Datta Meghe Institute of Medical Sciences (DMIMS) is established as Deemed University (DU) in 2005. Since then CME has been a regular experience. To augment the efficacy of these activities University created "A Steering Committee for CME Implementation" which operates through the University Center named "Center for Health Professionals Education and Research (CHPER)".

The committee identified 10 areas to attain the desirable outcome of CME activities held at DMIMS (DU). It offers a simplified and more rational approach to credit based CMEs and accordingly recommendations and actionable strategies are planned.

CME Activities Approved By University Are:

1. **Conference:** International, National, State, Regional
2. **Workshop**: International, National, State, Regional
3. **Symposia** : International, National, State, Regional
4. **Seminar** : International, National, State, Regional
5. **Guest lecture** : International, National, State, Regional

The 10 Point Action Program Of CME At DMIMS (DU):

The Steering committee had approved 4 principles called LASO Principles to make this program more outcomes focused. The practical approach involves four steps indicated by the mnemonic LASO (learner, assessment, standard, outcomes): (1) define the learner population's characteristics, (2) create a learning needs assessment, (3) determine if the standard is met, and (4) state educational outcome for the CME activity[4].

Based on these principles, University approved The 10 Point Action Program of CME to make CME learner centered, relevant, and measurable.

1. Provision of Grants

Presently, the pharmaceutical industry funds about half of the costs of continuing medical education (CME) programs in the U.S.[5]. This contributes to the ethical problems that pervade the relationship between medicine and the pharmaceutical industry: trustworthiness and conflicts of interest1. Commercialism and commercial bias are highly visible at large CME gatherings, and available data, back up the view that physician attendees' subsequent prescribing practices are influenced by the commercial message. To trim down the authority of pharmaceutical industry new guidelines were instituted by the Accreditation Council for Continuing Medical Education (ACCME) in 2004 which succeeded in reducing excessive commercial influence[5].

In India the CME system of education is at its great dynamism but most commercially supported events shading more towards product promotion and the welfare of doctors than prioritized dedication to enhancing the care of patients'. Also it is a matter of concern that preclinical departments always find it difficult to conduct the CME for lack of funds and no pharmaceutical company approaches them. To facilitate these departments and to curb the influence of Pharmaceutical Industry in clinical departments for ethical concern, **DMIMS University** approves the annual budget for various activities of CME at the beginning of academic year. Depending upon the kind of activity the amount is released through CHPER. For each international activity the amount approved is Rs.1, 00,000/- and for regional activity it is Rs. 7500/-.

2. Needs Assessment

The difference between the practice standard and the current practice represents the gap in practice. We as a contributor can assist in the determination of need (self-assessment) by the physician, the delivery of education to meet that need, and the evaluation of education used to meet the need, especially as it relates to the practice performance of the physician.

The changing demographic profile of our country is accompanied by changing disease patterns, education profile and health awareness. While the doctors to population ratio has been steadily improving due to the exponential growth of Medical Institutions, the rapid pace of technological and scientific advances, and the looming threat of new disease clearly mandate a system of continuing medical education to keep the medical personnel current in terms of knowledge and skills.

The challenges are identified by individual department assisted by the steering committee of CHPER to find the gaps in practice thereby enhancing Medial Education and health care system to Global model.

3. Pre CME counseling:

Once the need analysis is through, objectives of CME are set. The more complex, more important and long-term objectives may only be achieved and assessable long after the educational programme is complete. Too often, the objectives become what are most readily and conveniently assessed. The more intricate and long term objectives are ignored or assumed to follow automatically upon for more modest and handy intermediate, short-term goals. With the consensus of departmental staff, short terms as well as intermediate objectives to be attained are set and CHPER takes the responsibility to validate them.

The activity is designed to meet the educational needs of physicians involved in overall management of patients.

Evidences assessed audience characteristics (internal factors) and external factors that influence the effectiveness of CME in changing physician behavior. However, given what is known about how individuals approach learning, it is likely that internal factors play an important role in the design of effective CME[6].

CHPER provides the guidance to the departments regarding preparation of CME (based on LASO principle) and subsequently prepare the note sheet to be sent to the University for release of funds which has been already approved.

4. Preparation of University Calendar of CME:

CME organizers have considerable responsibility in determining appropriate curriculum for their meeting. They need to organize activities that would consistently improve not only physician knowledge but also the competence. All the departments are committed to follow the SOP (standardized Operating Procedure) /guidelines issued to establish the set of standards in preparing the yearly schedule.

Continuing medical education traditionally avoids an integrative approach. Most of today's practicing physicians experience CME as knowledge transfer. An instructor delivers a lecture and answers a few questions, ending with the assumption that he has transferred his knowledge, to the betterment of his colleagues. Actually the CME sessions should be interactive, using multiple methods of instructions from various disciplines. These will definitely going to change physician knowledge and behavior[7]. Some evidences demonstrated that interactive CME sessions enhance participant activity and provide the opportunity to practice skills that can affect change in professional practice and health care outcomes[8].

University has made it mandatory for all departments to conduct minimum two activities per year with greater emphasis on *interdisciplinary CMEs*. CHPER prepares *Annual University CME Calendar* which then gets approval in the Academic Council of University along with budget. In this way CHPER makes, maintains and monitors the CME activities.

5. Accreditation and Credit Designation:

There are studies with regard to many aspects of accreditation of CME. Formal accreditation of CME providers is required in few countries, while in some other countries accreditation is focused on activities. Also private sponsorship is allowed in many countries [9].

In our University, all CME activity are planned and implemented in accordance with the essential areas and policies of the state medical council. JN Medical College and SP Dental College, the constituent colleges of DMIMS (DU) are accreditated by respective council to conduct all CME activities for next five years (till 2015)**.** Credit points are then allocated to the departments after submission of necessary information to state council.

6. Appointment of Observer :

To ensure the formal conduction of CMEs with regard to participants, time schedule of activity, evaluation and feedback, the CHPER appoints its observer designated departmentwise in the yearly calendar itself. The duties of observer are to assess the program according to predetermined criteria, along with informal evaluation. The observer is supposed to submit the report to CHPER in confidential manner.

7. Rapportier role:

Guidelines of University state that the role of Rapportier is to make deliberations from all sessions and present them at the end CME. Rapportier should be of the rank not less than Associate Professor from same department. His task is to bring the outcome of the activity which can be utilized as a policy in the future by the department /delegates or University. He has to submit the report directly to CHPER which help the center in evaluating the program.

8. Evaluation of CME:

Effectiveness of a CME program should be evaluated at all level beyond satisfaction. CME planners need to incorporate methods to determine the course beneficiaries, improvement of knowledge, skills and attitudes during the CME activities[10].

First two levels of evaluation of Kirkpatrics Model viz. reaction and learning are assessed by individual department. Pre and post test of participants using multiple choice questions form a useful method of assessment[10]. Course organizers need to ensure that the questions are appropriately constructed to assess the ability to use knowledge in real life situations. CHPER assists this activity in validating the questions.

9. Post CME Counseling

The reports submitted by department, the observer and the rapportier are then collated. Based on the analysis of reports, the steering committee of CHPER takes the responsibility to counsel the departments which fall short in attaining the desired outcomes.

10. Recommendations emerging from CME deliberations:

The recommendations emerged out of the activity are formulated under various headings as policy decision, intervention or any other suggestion to be implemented at various organization levels (departmental / university / National or International) or any other. Then the strategies approved by CHPER are submitted to University for policy intervention if any.

Conclusion / Further Recommendation:

Solution for CME activities that influence the way CME providers design is a dynamic process. Regulatory and professional organizations are providing new guidelines, mandates, and recommendations for CME activities that influence the way CME providers design and present activities. Policies for improvement in CME are adopted by six European countries to regulate both demand and supply[9]. The substantial variability in the organization and accreditation of schemes indicates that much could be done to improve effectiveness.

Change in behavior is the real impact of any activity. More research is needed to understand the impact of the factors in enhancing the effectiveness of CME. In the near future the joint venture of the CHPER and individual department will be able to bring out measurable effects. Although further analysis is needed to assess this *10 point action program*, to help clarify the weaknesses and strengths of our domestic policies in the perspective of CME harmonization. Rule for revalidation and re-certification of physicians is yet to put into force.

The world is developing into a global village, but there is a danger that in all CME sponsored, priorities may not be focused on National needs. The policy would require that the paramount nature of the priorities of the national health system and services as well as the ethics of international collaboration is ensured.

References

1. Paul R. Lichter, MD (2008). CME, Physicians, and Pavlov: Can We Change What Happens When Industry Rings the Bell? *Trans Am Ophthalmol Soc.* 106, 39–43.
2. Flexner A. (1910). Medical education in the United States and Canada: a report to the Carnegie Foundation for the Advancement of Teaching. New York: The Carnegie Foundation for the Advancement of Teaching,.
3. Costa A, Van Hemelryck F, Aparicio A, Gatzemeier W, Leer JW, Maillet B, Hossfeld DK. (2010). Continuing medical education in Europe: towards a harmonised system. *Eur J Cancer*. 46(13), 2340-3.
4. Wittich CM, Chutka DS, Mauck KF, Berger RA, Litin SC, Beckman TJ. (2012) Perspective: A practical approach to defining professional practice gaps for continuing medical education. *Acad Med*. 87(5), 582-5.
5. Brody H. (2009). Pharmaceutical industry financial support for medical education: benefit, or undue influence? *J Law Med Ethics.* 37(3), 451-60.
6. Lowe MM, Bennett N, Aparicio A. (2009). American College of Chest Physicians Health and Science Policy Committee. The role of audience characteristics and external factors in continuing medical education and physician change: effectiveness of continuing medical education: American College of Chest Physicians Evidence-Based Educational Guidelines. *Chest*. 135 (3 Suppl), 56S-61S.
7. Ghosh AK. (2008). Organizing an effective continuous medical education session. *J Assoc Physicians India.* 56, 533-8.
8. Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey (1999). A Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *JAMA*. 282(9), 867-74.
9. Garattini L, Gritti S, De Compadri P, Casadei G. (2010). Continuing Medical Education in six European countries: a comparative analysis. Health Policy. 94 (3), 246-54.
10. Saul J. Weiner, MD, Jeffrey L. Jackson, MD, MPH, and Sarajane Garten, MA. (2009). Measuring Continuing Medical Education Outcomes: A Pilot Study of Effect Size of Three CME Interventions at an SGIM Annual Meeting *J Gen Intern Med*. 24(5), 626–629.

This academic article was published by The International Institute for Science, Technology and Education (IISTE). The IISTE is a pioneer in the Open Access Publishing service based in the U.S. and Europe. The aim of the institute is Accelerating Global Knowledge Sharing.

More information about the publisher can be found in the IISTE's homepage: http://www.iiste.org

CALL FOR PAPERS

The IISTE is currently hosting more than 30 peer-reviewed academic journals and collaborating with academic institutions around the world. There's no deadline for submission. **Prospective authors of IISTE journals can find the submission instruction on the following page:** http://www.iiste.org/Journals/

The IISTE editorial team promises to the review and publish all the qualified submissions in a **fast** manner. All the journals articles are available online to the readers all over the world without financial, legal, or technical barriers other than those inseparable from gaining access to the internet itself. Printed version of the journals is also available upon request of readers and authors.

IISTE Knowledge Sharing Partners

EBSCO, Index Copernicus, Ulrich's Periodicals Directory, JournalTOCS, PKP Open Archives Harvester, Bielefeld Academic Search Engine, Elektronische Zeitschriftenbibliothek EZB, Open J-Gate, OCLC WorldCat, Universe Digtial Library , NewJour, Google Scholar