PERSONAL VIEW

Continuing medical education one year on—how was it for me?

Cilla Reid

Abstract

Over the period of a year I have systematically recorded any episodes of continuing medical education (CME) that I have attended, and reflect on the effectiveness of this system in terms of whether it has achieved its objective, that is, has my behaviour changed, and whether the existence of the need to record CME has influenced this effect. I consider which aspects of CME have been most beneficial. I conclude that the proposed level of CME is readily achievable, useful, but costly. The way in which I learn most or best is in preparing presentations or teaching sessions. There has been some debate on the usefulness of keeping a record of CME to which I would like to add my opinion. I also recommend the form of record keeping I have used as an impetus to reflection and research on the topic of education received, as this reinforces and enhances the educational experience.

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As a newly appointed consultant in October 1996 I found myself falling off the conveyor belt of training, theoretically knowing everything I needed for my profession. In their wisdom the powers that be have decided (quite correctly) that the following day the slippery slope to becoming out of touch with current practice would begin. In an attempt to audit continuing medical education (CME) annual reports were instituted. There was not to be the haphazard accumulation of knowledge that had presumably happened in years gone by. In the NHS of 1996 education must be recorded, measured, assessed, and audited. Within a month of appointment I was invited to fill in and return a form documenting what education I had undertaken. I deferred this for a year. However I decided at that time to record and review my educational experiences for that year, not only for the purpose of form filling, but to try to accurately assess the benefit which I derived from those experiences.

This report can only be subjective. I realised as I wrote up the first meeting that I attended that the fact of recording it immediately

increased any benefit that might accrue. To record it I had needed to make some notes. Unable to decipher all my jottings I then had to ask my extremely helpful librarian to look up any references I had made a note of to further elucidate topics.

I found myself writing to presenters asking for further details of aspects of their presentations which had not been fully discussed. The decision to keep this detailed record would over the course of the year lead to a considerable amount of reading and reviewing of topics. It may be that many of my colleagues would normally take this sort of action after attending a conference or meeting. I have the personality type of an activist pragmatist, who will try anything without too much thinking¹ and for me this researching and reflecting was a change in behaviour. Educationalists often define teaching as an attempt to achieve a change of behaviour. This approach to CME can be said to have been successful in achieving this for me.

My CME return for the year is shown in table 1.

You may note the absence of some headings from this. I believe that not everyone can do everything, and that it is better to strive to do some things well.

Findings

- Has CME improved my knowledge? *Yes*
- Inspired reading? *Yes*
- Changed my clinical practice? *Yes*
- Inspired research or audit? *Audit yes. Research: it would if I was less lazy, more imaginative, had more time, less clinical work, less teaching, less administration to do.* (These are clearly all excuses for just not being a “researchy” sort of person.)

Has the need to report CME altered my practice?

Filling in of CME returns is time consuming and onerous and has led to some irritation

Table 1 CMR return for the year

Internal CME		External CME	
Postgraduate meetings	90	External meetings	39
Journal clubs	10	External courses	67
Other (x ray meetings)	42	Visiting another unit	7
Independent study	56*		
Clinical audit	20*		

* An underestimate, doesn't include “leisure” reading journals, or opportunistic time spent within the working day.

Consultant in Accident and Emergency Medicine, Lister Hospital, Stevenage SG1 4AB

Correspondence to: Miss Reid.

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among consultants who feel that it is yet another pressure to be borne.² This chore could be justified if it could be shown to change practice. In my case I don't believe that it has. The fact that an educational episode was approved for CME was never uppermost in my mind when deciding to attend it. Indeed I have attended several events which were not so recognised because of personal interest and I have also "Clocked up" more than the recommended number of hours. It is perhaps in the nature of the specialty of accident and emergency (A&E) medicine that I need to undertake substantial amounts of education as our field is so broad. This may also reflect the outlook of a newly appointed consultant.

Which aspect of CME was most beneficial?

(A) GIVING PRESENTATIONS

I found that the preparation for these required focused research and thought and in depth understanding of the subject. To me, the stress of performing to one's peers is a great stimulus to get it right. On one occasion the fact that I had to give a presentation at a grand round greatly enhanced my absorption of knowledge and ideas from a day's conference that I attended on a similar topic.

(B) TEACHING OR TAKING PART IN A TEACHING ACTIVITY (FOR EXAMPLE AS A MEMBER OF FACULTY ON A COURSE)

Again preparation to teach a subject requires in-depth knowledge to be able to stretch if necessary outside the confines of the topic to answer questions or satisfy the demanding or know-it-all student. At some format courses, for example Advanced Trauma Life Support (ATLS), although the core material should be well known, attending the sessions given by other faculty members always rewards with gems of knowledge together with educational tips, tricks, anecdotes, or humour that enhance presentations and in turn my teaching skills.

(C) ATTENDING MEETINGS AND CONFERENCES

It is usually a pleasure to go to these, meet up with friends and colleagues, and share the intellectual and social experience. The quality of meetings can vary enormously. By luck or careful selection those meetings I have attended this year have in my opinion been of the highest standards. Presentation skills at such meetings seem to have improved considerably

over the last few years. I believe that this can be attributed to the emphasis that is increasingly being put on the importance of developing the teaching skills of clinicians. "Calmanisation", the introduction of CME reports, and initiatives such as the Royal College of Surgeons teaching the trainers' programme have stressed the importance of providing good quality medical education at all levels.

In addition to hearing the presentations at such conferences my impression is that an equal share of the educational experience is gained from the "social" interchanges outside the lecture theatres, where topics and presentations are further discussed in the context of the experience of one's colleagues. This "networking" reinforces and modifies and often extends the learning that has taken place. To maximise educational gain it is therefore essential that conference organisers plan adequate "free" time to allow this interchange to take place.

(D) DEPARTMENTAL TEACHING SESSIONS

In our department it is the practice that the teaching is shared between the A&E consultants and middle grades, invited specialists, and the senior house officers (SHOs) themselves. These sessions are always attended by at least one if not both consultants, to supervise, correct errors, emphasise important facets, and of course to learn. The SHOs appreciate (according to their appraisals) that they learn well from having to prepare and give talks, and while this is done in an informal setting it is useful practice in presentation technique and small group work.

(E) PERSONAL READING

My practice is rarely changed by something I read. One occasion on which this happened this year was when I introduced the use of nasal diamorphine for paediatric analgesia to our department following an article by Jason Wilson *et al* in this journal (thank you, it's brilliant).³ More usually my practice is changed when I read something brought to my attention at a conference or by a colleague (laziness and lack of originality again). However in this year my practice of reading up conference topics has led on several occasions to significant changes in practice and enhancement of knowledge.

(F) DRUG REPS

I learn a lot from these much maligned professionals. In A&E one needs at least a surface knowledge of a vast array of subjects. It is easy to lose track of new preparations and although we are unlikely to prescribe many of these, we may well see patients who are taking them and might be suffering their side effects. I often find that my introduction to such drugs is from representatives with their displays at meetings, or when they give short presentations at our teaching sessions. More often than not they are invited to meetings to obtain sponsorship, but they can provide useful information.

Cost

There has been discussion in the medical press as to the funding of CME.⁴ I have been fortunate in that such meetings as I have

Table 2 Cost

	Time (days)	Cost	Additional expenses
BAEM conference	3*	£315.00	£140.30, accommodation and travel
Sheffield meeting	1*	£88.00	£56.00, accommodation and travel
ATLS update day	1	—	£30.20
ATLS update (instructing)	2	—	£35.20, travel (paid by Royal College of Surgeons/ATLS)
Instructing			
Royal Society of Medicine	1	£30.00	£30.20, travel
Registrar training days	3	—	£40.20, travel
ATLS courses	12	—	£120.00, travel and child care (paid by ATLS)
ALS courses	9	—	£40.00, travel (paid by ALS)
Teaching the teachers	4.5	—	£285.00, travel, child care (paid by course)

ALS = Advanced Life Support; ATLS = Advanced Trauma Life Support; BAEM = British Association for Accident and Emergency Medicine.

Table 3 Time

Nominal half day sessions away from my base hospital	44
Nominal half day sessions hospital based CME	46
Total work half day sessions spent on CME over one year	90
Equivalent to 13 working weeks as I am employed for 7 sessions a week	
Nights away from home attending CME	20
Nominal half day sessions personal study in "off duty" time	16
Nominal half day sessions attending courses in "off duty" time	29
Total "off duty time" = 20 nights + 45 half days	

attended have been fully funded by my department or occasionally from other sources. I have tried to break down a realistic list of actual outlay. In addition there are other factors, such as the time when I am undertaking educational activities but being paid by my employer and the costs fall invisibly to the department. In addition there are personal costs which cannot be recouped, for example child care and home related expenses additionally accrued when I am away at a meeting or conference. Listed here (table 2) are the external educational activities, but equally time spent on internal CME can have an inherent cost to my department.

The expenses payments my department has made to me total £729:90; this sum comes out of the departmental budget. I should add that this total has been kept down by second class rail fares, and economical accommodation. I have borne the additional cost of child care. Total expenditure over one year is £1210:10 (see table 2). Although this was paid by various sources eventually it came out of the public purse (for example ATLS funding from course fees funded from study leave paid by trusts or postgraduate education budgets).

Time

Both internal and external CME take up a lot of time, some of which implies being away from my department, and some of which away from

my home and family (see table 3). CME thus accounts for over one quarter of my working time and also makes considerable inroads into family time (probably more so as I work only part time).

Conclusion

Over the period of my first year as a consultant, CME has been beneficial, has given food for reflection, and has changed my practice. Attaining the necessary number of hours has not been onerous but has been costly in terms of both time and money. If this education is to be provided then hospital trusts must provide for this in the budgets of their departments, and similarly the funds must be made available to the trusts to enable them to do so. Some specialties such as A&E require a large continuing educational input and this now needs to be recognised in consultant job plans as it has been in junior doctors schedules. If postgraduate medical education is to be successful then it will require input from interested and competent educators, and those seniors who take on this role must have it recognised in their contracts and also possibly in the discretionary awards system.

Finally keeping a record of CME has given me an increased benefit in terms of the reflection and the further learning that the task of keeping a record necessitated.

1 Honey P, Mumford A. *The manual of learning styles*. Published by Peter Honey, 10 Lindon Avenue, Maidenhead, Berkshire, 1982.

2 McIrvine AJ. Clinical audit and CME [letter]. *Bulletin of the Royal College of Surgeons* 1996;78:208-9.

3 Wilson J, Kendall JM, Cornelius P. Intranasal diamorphine for paediatric analgesia. *J Accid Emerg Med* 1997;14:70-2.

4 CME, who pays? *Hospital Doctor* (ongoing debate) June, July 1997.