



## The Ramblemuse

By Keith Eric Grant, PhD, NCTMB

[About the Columnist](#)

[Other Articles](#)

### Why Most CE Courses are Dead on Delivery

*One faculty member in a professional school referred to continuing education as "shouting out of windows," and an analysis of the programs at his institution shows the aptness of his metaphor: Faculty members who can be persuaded to do so give lectures on subjects of their own choosing to audiences they do not know, who have assembled only because they want to put in enough hours of classroom attendance so that they can meet a relicensure requirement. As a result, every profession now has members who vigorously oppose what they regard as the excessive promotion of continuing education. -Cyril O. Houle, 1980<sup>10</sup>*

What's the purpose of requiring continuing education classes? How do we know that they accomplish what we expect?

In order to answer the second question, you have to start with the first one. In a review of continuing medical education (CME), [Cantillon and Jones](#) declare that "The primary purpose of continuing medical education is to maintain and improve clinical performance."<sup>6</sup> I've heard others say that continuing education helps increase professionalism. Professionalism, in turn, gets defined by the [American Board of Internal Medicine](#) as "a set of standards for physician competence in regard to knowledge, skills, attitudes, and behavior in the care of patients."<sup>1</sup> This pretty much agrees with the scope of competence defined by [Epstein and Hundert](#) that includes clinical skills, interpersonal skills and attitudes.<sup>9</sup> So, does continuing education effectively improve professionalism? In most cases, the answer is (sadly) no, as implied in my opening quote by Houle.

What is refreshing is that the medical profession has been doing a lot of reflection on CME. Thus, we have reviews by [Cantillon and Jones](#),<sup>6</sup> [Davis et al](#),<sup>7</sup> [Donen](#),<sup>8</sup> [Mazmanian and Davis](#),<sup>12</sup> and [Oxman et al](#).<sup>13</sup>

There's also a review by [Brennan et al](#) on the effects of continuing education on physical therapy treatment of neck pain.<sup>2</sup> In general, [Mazmanian and Davis](#) give a good summary of the conclusions<sup>12</sup>:

"The factors identified in these studies that are most effective include assessment of learning needs, a necessary precursor to effective CME<sup>7</sup>; interaction among physician-learners with opportunities to practice the skills learned; and sequenced and multifaceted educational activities. Continuing medical education strategies that enable and reinforce change are more likely than other more traditional, passive activities to influence behavior. Physician learners and CME providers should design and select strategies to optimize improvement of both physician performance and health care outcomes. Assessment of learning needs is crucial for effective CME... Educational activities that use interactive techniques such as case discussion or hands-on practice sessions generally are more effective in changing behavior and patient outcomes. Interactive workshops can result in changes to knowledge or skills; didactic sessions alone are unlikely to change professional practice."

Basically, sitting for a few hours listening to someone lecture is a waste of time. Creating change in attitudes or skills requires active participation over multiple sessions. Interestingly, participants themselves can often educate each other by sharing stories. The stories contain both tacit information in context and frames of thinking. This concept is supported both in applications to nursing reported by [Klein](#)<sup>11</sup> and in technical problem solving talked about by [John Seely Brown](#).<sup>5</sup> Narrative stories are also a crucial aspect of learning and problem-solving in the widely used World Cafe process.<sup>3</sup>

We need to move, as [Donen](#) suggests,<sup>8</sup> from thinking about continuing education to thinking about interactive professional development. They are not the same. We need to both have well-defined goals for CE and use effective methods, or forget about it.

In a longer [article on the differences between information and knowledge](#), John Seely Brown again sets the challenge<sup>4</sup>:

"Knowledge is like an iceberg, where 10 percent is explicit and visible, and 90 percent tacit and invisible. Perhaps a more useful metaphor for knowledge--or the dimensions of knowledge--is that it is like a tree that has a trunk, branches, and leaves that you see. But for the tree to endure, it has to have a root system. ... So the challenge we face in education is not just looking at how to add new leaves and new branches to the tree, but sometimes going back and thinking about the root structure, the tacit structures, the social practices underlying the explicit. ... Learning that lasts stems from enculturation into a practice. These are not terms

we usually use to think about learning environments, but we should. So how do you build environments that facilitate our ability to enculturate into a practice?"

## References

1. Project Professionalism. American Board of Internal Medicine, 2001.  
<http://www.abim.org/pdf/publications/professionalism.pdf>
2. Brennan GP, Fritz JM, Hunter SJ. Impact of Continuing Education Interventions on Clinical Outcomes of Patients With Neck Pain Who Received Physical Therapy. *Phys Ther*, 2006;86(9):1251-62.  
<http://www.ptjournal.org/cgi/content/abstract/86/9/1251>
3. Brown J. *The World Cafe: Shaping Our Futures Through Conversations That Matter, 1st ed.* Berrett-Koehler Publishers, 2005. ISBN: 1576752585.
4. Brown JS. "The Social Life of Learning: How can Continuing Education be Reconfigured in the Future?" *Continuing Higher Education Review*, 2002;66:50-69.  
[http://people.ischool.berkeley.edu/~duguid/SLOFI/Social\\_Life\\_of\\_Learning.pdf](http://people.ischool.berkeley.edu/~duguid/SLOFI/Social_Life_of_Learning.pdf)
5. Commencement Speech by John Seely Brown at Claremont Graduate University, May 15, 2004.  
<http://www.johnseelybrown.com/CGU.pdf>
6. Cantillon P, Jones R. Does continuing medical education in general practice make a difference? *BMJ*, May 1999;318:1276-9. <http://www.bmj.com/cgi/content/full/318/7193/1276>
7. Davis DA, Thomson MA, Oxman AD, Haynes B. Changing Physician Performance -- A Systematic Review of the Effect of Continuing Medical Education Strategies. *JAMA*, 1995;274(9):700-5.  
<http://jama.ama-assn.org/cgi/content/abstract/274/9/700>
8. Donen N. No to Mandatory Continuing Medical Education, Yes to Mandatory Practice Auditing and Professional Educational Development. *CMAJ*, 1998;158(8):1044-6.  
<http://www.cmaj.ca/cgi/content/abstract/158/8/1044>
9. Epstein RM, Hundert EM. Defining and Assessing Professional Competence. *JAMA*, 2002;287:226-35.  
<http://jama.ama-assn.org/cgi/content/abstract/287/2/226>
10. Houle CO. *Continuing Learning in the Professions*. San Francisco: Jossey-Bass, 1980, 266.
11. Klein G. *Sources of Power: How People Make Decisions*. MIT Press, 1999. ISBN: 0262611465.
12. Mazmanian PE, Davis DA. Continuing Medical Education and the Physician as a Learner -- Guide to the Evidence. *JAMA*, 2002;288:1057-60.
13. Oxman AD, Thomson MA, Davis DA, Haynes RB. No Magic Bullets: A Systematic Review of 102

Trials of Interventions to Improve Professional Practice. *CMAJ*, 1995;153(10):1423-31.

<http://www.cmaj.ca/cgi/content/abstract/153/10/1423>

Page printed from:

[http://www.massagetoday.com/mpacms/mt/column.php?c\\_id=613/&no\\_b=true](http://www.massagetoday.com/mpacms/mt/column.php?c_id=613/&no_b=true)