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Transforming Learners' Engagement: Reflections on a Continuing Medical Education Program

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Abstract: Continuing education at most medical meetings rely heavily on didactic methodologies. Attendees expect this approach in a Continuing Medical Education (CME) program and are surprised when another approach is taken. This roundtable paper briefly examines how adult educators can begin changing the culture of CME for physicians.

Cervero (2003) suggests an approach using the best principles of adult education to create an interactive learning environment for programs for health professionals. Continuing education can improve knowledge, skills, attitudes, behavior and patient health outcomes (Cervero, 2003). Why some programs are more effective than others is less clear and a more complicated matter. Grant and Stanton (2000) reviewed 16 studies related to continued professional development noted that no one single individual method worked best and that effectiveness was more a function of the process and the context in which it occurred. Wensing and Grol (1994) examined 75 studies of educational strategies for implementing changes in physician practice routine and observed that the most effective single interventions for continuing education involved one-on-one methods, feedback and reminders. Group education and educational materials, typically provided at national medical meetings, combined with individual strategies, was the most effective combination strategy. Of particular relevance to the workshop that we discuss is the impact of didactic versus interactive versus combined strategies in the CME venue. Davis et al (1999) found that programs using didactic strategies alone did not alter performances of participants and group size had no impact. The majority of interactive and mixed programs (didactic combined with interactive) impact performances. Active educational strategies are more effective than passive ones (Cervero, 2003); however, what defines something as active versus passive is debatable. Most effective is the combined approach, using active and passive strategies because it best accommodates differences in learning style preferences of participants. As this involves the interaction of multiple complex factors and outcomes, which are challenging to measure, the issues surrounding what defines an effective CME program are multiple and may be participant dependent, with ultimate success resulting in a change of attitude, belief or behavior.

This research presents a qualitative reflection by the presenter on the efficacy of introducing an adult education focused session at a recent meeting of a national Pathology organization. Usually, 95% of meeting sessions focus on the traditional organ-based approach of presenting material directly pertinent to the medical knowledge and practice of the field. The remaining workshops focused on other subjects related to developing communication skills, management issues, quality control, and education. A colleague and myself presented a two hour workshop entitled "Effective Clinical Interactions: How your Learning and Teaching Techniques Impact Communication with the Health Care Team." The workshop description indicated that the session would focus on thinking about communication in the workplace from the perspective of learning style preferences and learning theory. The session was described as interactive and

participants were encouraged to complete the Felder Learning Style Preference inventory prior to attending.

Fifteen individuals (nine women and six men) attended, divided between physicians and nonphysicians (laboratory managers and technicians). The workshop consisted of a mixture of short didactic pieces outlining learning styles and the basic principles of learning theory (behaviorist, constructivist, and social) (Merriam, Caffarella, & Baumgartner, 2007). Twenty-eight Power Point slides were used. The didactic parts were broken up with activities including : 1) a reflective exercise encouraging attendees to describe their teaching and learning philosophy and share this with the larger group; 2) a case discussion in which attendees were asked to identify the learning style of the two main individuals described in a scenario; and 3) a group activity asking attendees to either construct a teaching activity or plan a strategic planning session, taking into consideration the need to consider varying learning style preferences and learning theory perspectives **OR** asking attendees to critique the workshop they were attending in how it addressed or did not address learning style preferences.

The initial findings of this reflective research in a CME setting examine the opportunities and challenges that occur when educators introduce a new paradigm into the conference presentation. They provide insights about changing the culture of CME. Six individuals left at the breakpoint during the workshop. Of those who participated for the whole course, all were actively engaged in discussion and stayed after the workshop to continue the discussion. Overall, the session, although a paradigm shift for the participants, was well received. Eleven attendees completed formal written feedback on the workshop. Attendees were asked to rate the workshop on a scale of 1-5 (5 = excellent, 1=poor) on a variety of parameters including 1) meeting learning objectives; 2) usefulness of content to the participant 3) workshop was well organized; 4) appropriate level of difficulty ; 5) the content was applicable to practice; and 6) content had educational value. Scores for all the parameters ranged from 3.9-4.2. Nine attendees rated the quality of the session with a 4 or 5. Nine indicated they would recommend the session to their colleagues while eight thought the session helped increase their confidence in their ability to do their job.

We observed that most learners were willing to engage in active learning, particularly when encouraged to draw from personal experiences. In addition, modeling this approach to learning appeared key to the successful learning for the participants. One challenge lies in encouraging participants to move out of their comfort zones. From this experience, our initial conclusion is that a cultural shift is possible but requires those engaged in CME to think outside of the box and be risk-takers

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