Continuing Medical Education—Not Enough to Simply "Show Up"

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Of all the practicing orthopedic surgeons in the United States and around the world, a high percentage will attend the annual AAOS annual meeting in San Francisco next month. Many of us make the annual pilgrimage for social and business reasons, but our primary motivation tends to be Continuing Medical Education (CME). No other specialty in medicine matches our commitment to continued learning, and I have noticed a recent trend in this process.

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I am chairing a symposium on venous thromboembolism (VTE) prophylaxis, currently a "hot topic" on the agendas of several specialty societies this year because of the 2007 VTE prophylaxis guidelines published by the Academy this spring.[1] These guidelines differ substantially from the widely recognized 2004 guidelines recommended by the American College of Chest Physicians.[2] This symposium will include an interactive question-and-answer session with the audience, assessing how well the participants have absorbed and understood the information presented by each speaker—rather like an immediate "open book" quiz from our grade school days. Making audience response systems integral to CME courses is becoming more frequent, and this trend will continue to grow as sponsors of CME programs strive to document that the audience actually learns the content of the educational event. Learning and understanding thus become an active, not a passive process.

The emphasis on "participatory" learning has been a natural development in our profession over the last 20 years or so: beginning with the active process of American Board of Orthopedic Surgery (ABOS) re-certification exams every 10 years and continuing with the American College of Graduate Medical Education (ACGME) requirement that teaching programs document that residents and fellows master the core competencies, the AAOS self-assessment examinations, and even the recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements that departments provide evidence confirming the competency of attending surgeons considered for the periodic reappointment to the hospital staff.

Those involved in developing CME programs now emphasize that the ultimate goal of continued learning is for such an educational process to lead to actual changes in surgeon practice that consequently improve patient care. This has been a very clear priority of our current AAOS President, James H. Beaty, MD, as related in my November 2007 editorial.[3] Documenting how CME courses might alter and improve surgeons' practice is admittedly a great challenge but has been made a priority of such programs.

So, as you attend next month's AAOS annual meeting, be prepared to participate in audience response systems in the symposia you attend. Get involved, be interactive—it is no longer enough to be a passive observer and simply "show up."

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References

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2. Geerts WH, Pineo GF, Heit JA,Bergquist D, Lassen MR, Colwell CW, Ray JG. Prevention of venous thromboembolism: the seventh ACCP Conference on Antithrombotic Therapy. *Chest.* 2004; 126: 338S-400S.
3. McCann PD. A conversation with AAOS president James H. Beaty, MD. *Am J Orthop.* 2007;36(11): 580-581.