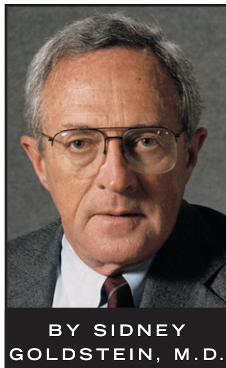
HEART OF THE MATTER

Getting CME Back on Track

There was a time in the distant past—well, slightly less than a half a century ago—when academic physicians and medical schools took responsibility for the postgraduate education of their alumni and their community doctors. Faculty members were actually sent out to give talks and clinics—without pay. One of the benefits of this process was the communication between the medical center and its community of physicians. Although information was shared, the most important aspect of this interaction was providing a name and a face and a telephone number, so physicians could find help to solve the problems of their patients.


BY SIDNEY GOLDSTEIN, M.D.

Along the way, something knocked this continuing medical education train off the rails: the pharmaceutical industry. Medical schools and teaching hospitals were quick to pass the responsibilities on to pharma in an atmosphere where the profit motives of both were intermingled. Since then, medical educators have been trying to get that train back on track after realizing the dubious nature of the relationship between industry and CME.

The pharmaceutical industry, under intense pressure from Congress, is pulling back its support for CME. Medical educators are trying to develop a new framework for the support of practicing physicians, in an increasingly complex environment where instant education is critically needed. In some instances, industry is establishing open-ended grants to medicals schools, such as the recent offer by Pfizer to Stanford University (New York Times, Jan. 11, 2010). Critics have rightfully voiced suspicion about this relationship.

Other institutions such as Harvard Medical School have come to realize that their cozy relationships with industry over the last half century may have compromised the medical message. Harvard no longer allows its faculty to give industry-supported lectures, and has limited the fees received by faculty leaders for a variety of services including board member ship (New York Times, Jan. 3, 2010). And not surprisingly, the Institute of Medicine is proposing the creation of a Continuing Professional Development Institute to ensure that the workforce is prepared to provide high-quality and safe care (search cpdi at www.nap.edu). It proposes that it will "focus on improving regulation including accreditation, certification, credentialing and licensure." The institute will include public and private partners that will provide national standards and certification of CME for medical professionals, and thereby provide uniformity of the educational process.

Whatever happened to the idea that the teaching hospitals have a responsibility to provide CME support to their medical communities? This should be particularly important to state medical schools, which have a moral and administrative responsibility to provide an educational framework for physicians to meet their licensure requirements without depending on the pharmaceutical industry or the federal government. Medical systems that provide large parts of community care also have a responsibility to provide an educational structure that supports quality care. Instead of advertising on television, they should spend their money on supporting the needs of the community, and provide the much-needed link between the family doctor and the consultant, without using the emergency department as the conduit.

In the meantime, large gaps are occurring in the CME structure as the pharmaceutical industry withdraws from the arena. Many physicians are turning to the Internet for information. The explosion of new technology and therapy occurring in medicine calls for a major changes in how we provide CME. Missing in many of the proposed CME changes are methodologies to strengthen the communications between the consultant and the primary care doctor. We must meet the challenge, if we are to translate medical research to the bedside and improve the quality of care. ■

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Correction

The article "Congenital Disease Survival to Adulthood at 89%" (February 2010, page 11) should have stated that survival (not mortality) in the 1990-1999 group during follow-up was 99% in patients with mild congenital heart disease, 90% in those with moderate disease, and 59% in patients with a complex abnormality.

Cardiology News

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Address Changes Fax change of address (with old mailing label) to 973-290-8245 or e-mail change to subs@elsevier.com
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POSTMASTER Send changes of address (with old mailing label) to CARDIOLOGY NEWS Circulation, 60 Columbia Rd., Bldg. B, 2nd flr., Morristown, NJ 07960.

CARDIOLOGY NEWS (ISSN 1544-8800) *is published monthly by Elsevier Inc., 60 Columbia Rd., Bldg. B, 2nd flr., Morristown, NJ 07960, 973-290-8200, fax 973-290-8250. Subscription price is $109.00 per year.*

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