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Preserving Continuing Medical Education in a U.S. Community Hospital: A Successful Model and an Alert

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ABSTRACT

The decline in the number of accredited Continuing Medical Education activities over the past decade is multifactorial but is contrary to many principles of adult learning. This article describes how one small hospital in a larger hospital system has been able to preserve its long-standing programme as a Regularly Scheduled Series which is considered beneficial not only to its medical staff but to other healthcare providers who also are participants. It may serve as model for other smaller institutions facing this issue.

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Despite the overall growth of Continuing Medical Education (CME) in the U.S. reported by the Accreditation Council for Continuing Medical Education (ACCME) [1] and growth of the CME enterprise in Europe [2] and elsewhere, there has been a marked reduction in the number of smaller American hospital state-accredited venues to sponsor these activities over the past decade. For example, when the Massachusetts Medical Society (MMS) began intrastate CME accreditation in 1974, 121 providers were part of the programme. Currently, the number has fallen to 45. Other states have seen a similar decrease (Personal communication by Muir D, on January 14, 2019). There are many reasons for this change. These include hospital mergers, hospital closures, time constraints that limit commitments from Directors of Medical Education who are often non-salaried volunteers, and burdensome additional clerical responsibilities for part-time coordinators in small institutions. Growing numbers of large hospital systems have taken over the responsibility for provision of activities in their smaller member facilities.

The proliferation of a variety of online accredited CME activities has given busy practitioners the ability to acquire learning at a distance at their own pace. The development of hospitalists has lessened the numbers of primary care physicians making daily hospital rounds, thereby removing the opportunity for person to person interchanges at live activities and opportunities for face to face interactions with peers and faculty. Of equal concern is that this developing change in CME is in contrast to

long-established concepts that adult education should be collaborative and/or participatory in nature [3] and may well contribute to the worrisome issue of physician burn-out so prevalent in the U.S.

This report demonstrates how one American community hospital has preserved its commitment to providing its medical staff with its own CME programme despite these changes and may serve as a model for others both in the U.S. and worldwide.

Baystate Wing Hospital (BWH) was founded in 1913 as Wing Memorial Hospital in Palmer, MA, to provide health care for people throughout the Quaboag Hills and the Pioneer Valley of Central Massachusetts. Soon after the MMS began accrediting providers offering CME, Wing became one of its earliest members. However, when Baystate Health Systems (BHS), a tertiary academic centre, and now the site of the second campus of the University of Massachusetts Medical School acquired the institution in 2015, it renamed it as BWH and made it one of the two hospitals in its Eastern Region.

BHS, as a provider holding triple national U.S. accreditation (ACCME, American Nurses Credentialing Center (ANCC) and Accreditation Council for Pharmacy Education (ACPE)), made a decision to terminate state accreditation at the Palmer campus when an intrastate MMS reaccreditation survey was due. The author and the medical staff at BWH recognised that the needs and learning gaps at a community hospital required preservation of its long-standing CME programme because of staff

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differences from those at tertiary academic centres. With agreement from the administration of BHS, the CME programme has been allowed to continue at Baystate Health Eastern Region with activities on the Palmer campus now a Regularly Scheduled Series (RSS) in the BHS programme.

Faculty is recruited not only from the larger health system but also come from other qualified additional local, regional and national sources. Topics often include those that are required by the MA Board of Registration in Medicine for Maintenance of Licensure. *Palliative Care, Euthanasia and Hospice: (Approaches to End-of-Life)* is an example. Additional ones such as *The Resurgence of STDs* are derived by traditional means and serve the diverse learner audience of primary care providers, local specialists and other attendees. The RSS is presented following a monthly medical staff dinner meeting which helps to ensure attendance. With the added advantage of triple accreditation, attendance by nurses, pharmacists and other healthcare providers for continuing professional development is strongly encouraged. This fosters team building so vital in the care of patients. Medical staff members who no longer visit the hospital daily now may continue to congregate and learn both formally and informally, preserving long established theories of social learning [4]. The timing of the CME activity allows attendees a time that does not conflict with busy practice commitments, one of the reasons why attendance at traditional CME activities has fallen in the U.S.

These local activities may also be used for maintenance of licences and maintenance of certification. Attendees from other BHS hospitals and practices as well as all healthcare providers are welcome and do attend which enhances both professional and social relationships. Shared CME administrative responsibilities requires less Wing-dedicated coordinator time allowing more time for other responsibilities. All financial commitments are undertaken by BHS. Activities tend to foster provocative questions to presenters and brisk discussions between attendees, sometimes long after the activity ends which often enhances the learning experience well beyond the formal presentations in collaborative and participatory ways. Early attempts at distance learning tried to preserve such interactions [5,6]. However, they are no longer emphasised in today's Internet modalities, magnifying loss of the ability for participants to interact in a collegial manner with peers and faculty. Preserving and enhancing traditional CME may in part rectify this loss.

In an era when few U.S. practitioners visit their institutions daily, where hospitalists provide most day-to-day

care and where doctors' lounges – places to congregate, discuss cases, learn and socialise have nearly disappeared [7], preserving a CME programme in a community hospital as part of a larger health systems encourages attendance, camaraderie and emphasises long appreciated advantages of group learning as well as providing the ability to respond to idiosyncratic needs and issues. Current levels of accreditation further encourage attendance by other healthcare providers for continuing professional development which strengthens team building in the care of shared patient populations. An RSS such as ours at BWH may additionally serve as a means of coping with physician burnout by bringing together practitioners, now too often isolated from their peers. We hope that other institutions in the U.S. similar in structure will be encouraged to develop similar programming and preserve the social and learning advantages of shared CME experiences. Furthermore, the evolving European and worldwide CME market can learn from the U.S. experience and take steps to assure that similar reductions in the number of smaller community venues providing accredited CME programmes will not be allowed to occur.

Disclosure statement

No potential conflict of interest was reported by the author.

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