HOD ACTION: Council on Medical Education Report 12 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 12-A-10

Subject: Regulation of Continuing Medical Education Content
(Resolution 331, A-09)

Presented by: Susan Rudd Bailey, MD, Chair

Referred to: Reference Committee C
(Floyd A. Buras, Jr., MD, Chair)

Resolution 331 (A-09), "Regulation of Continuing Medical Education Content," introduced by the Organized Medical Staff Section, asked that our American Medical Association (AMA) in collaboration with the Federation:

> Oppose any and all efforts to specify the subject matter of continuing medical education (CME) requirements without evidence of efficacy, and also oppose efforts of other entities such as "governmental bodies" to regulate CME activity.

The resolution was referred due to concerns that the wording was too broad and may need to be more specific to avoid any unintended outcomes.

This report presents information about content-mandated CME requirements of state medical licensing boards and other entities, the efficacy of CME, AMA's current policies, and recommends actions to be considered by the House of Delegates (HOD).

STATE MANDATED CME CONTENT REQUIREMENTS

Sixteen states currently have content specific CME requirements for medical licensure in a variety of topical areas. Appendix A is a chart that details the specific requirements for each of these states. The following is a summary by content type and state:

Content Type	**State(s)**
Child/adult abuse	IA, NY
Controlled substances/prescribing	FL, OK, TN
Cultural competency	NJ
Domestic violence	CT, FL, KY
End of life care/pain management	CA, OR, RI, WV
Ethics	NV, RI, TX
Geriatric care	CA
Infectious disease/HIV/AIDS	CT, FL, KY, NY
Medical errors	FL
Office Anesthesia	IL
OSHA	RI
Patient Safety	PA
Risk management	CT, FL, MA, PA
Sexual assault	CT
Terrorism	NV, RI
Universal precautions	RI

Many of these requirements are the result of state legislated mandates that may apply to all physicians licensed in a state irrespective of the physicians' scope of practice. As a result, many physicians may be obligated to spend time and money on education that has no relation to the patients they see instead of focusing on CME activities that more appropriately address topics related to their professional practice. Thus, state legislated content-mandated CME may not be efficacious. Physicians have a limited amount of time available for CME activities and content-mandated CME may be harmful in that it competes for time needed for education that actually does apply to the physician's practice. A further problem of content-mandated CME is that even after completing a requirement in a given licensure period, physicians may need to repeat the educational requirement in subsequent licensure cycles, thus compounding the issue of ineffective utilization.

Mandated content-specific CME infringes on the medical profession's responsibility to establish appropriate educational content for lifelong learning. Consistent with AMA policy, state medical societies should oppose efforts to legislatively mandate specific CME content and should work toward rescinding or amending existing mandates. The AMA advocacy staff works in collaboration with state medical societies and has been successful in helping to defeat legislative proposals to mandate content-specific CME requirements. For example, in 2009, the AMA's Advocacy Resource Center (ARC) assisted the Ohio State Medical Association (OSMA) to draft joint AMA/OSMA talking points to oppose measures mandating cultural competency CME. The bill was ultimately defeated. The Council believes that state medical societies should invite groups with an interest in medical education to meet to discuss issues related to specific content before they rise to the level of a legislated mandate. At a minimum, state medical societies should work with medical licensing boards to provide exemptions to these content mandated CME requirements for those physicians for whom the specific content does not relate to their current practice and in cases where repeating the educational requirement for subsequent licensure renewals does not make sense.

OTHER CME CONTENT MANDATES

In addition to state legislated CME content mandates, other organizations, such as hospitals, malpractice insurers, health insurance providers, or certifying boards, may stipulate specific CME content for constituent physicians. Examples of such activities might be requirements to participate in a hospital-based grand rounds on nosocomial infection prevention to maintain hospital privileges, or a patient safety course that must be completed in order to be on a provider panel for a health care insurance company or to complete the requirements for Maintenance of Certification® (MOC). Many organizations have a legitimate interest in assuring that employed or affiliated physicians meet specific performance standards. When there is a reasonable expectation that an educational intervention related to a physician's practice will be effective in meeting the educational objective to improve patient care or increase patient safety, it may be appropriate for organizations to mandate a specific CME activity for a physician or groups of physicians and it would be imprudent for the AMA to object to this.

EFFICACY OF CME

It has been confirmed in multiple studies that well designed CME activities that address the specific learning needs of individual physicians or groups of physicians can improve knowledge, skills, attitudes, behavior, and patient health outcomes. Among these studies, Robertson et al., reporting on impact studies in continuing education for health professions concluded that: "…CME, which is ongoing, interactive, contextually relevant, and based on needs assessment, can improve knowledge, skills, attitudes, behavior, and health care outcomes." [1] In 2007, the Agency for Healthcare Research and Quality concluded from an evidence report on the effectiveness of CME that: "Despite the low quality of the evidence, CME appears to be effective at the acquisition

and retention of knowledge, attitudes, skills, behaviors and clinical outcomes."[2] In a 2009 study on the effects continuing education meetings and workshops on professional practice and health care outcomes, Forsetlund et al. found: "Eighty-one trials that evaluated the effects of educational meetings were included in this review. Based on these studies, we concluded that educational meetings alone or combined with other interventions can improve professional practice and the achievement of treatment goals by patients."[3] The Council finds the current literature concerning the effectiveness of CME to be compelling and clearly supportive of the premise that CME is effective when designed and used appropriately. The Council also believes that it is important to point out that the literature indicates that a physician's learning needs are best met when the CME provider develops an educational activity based on a robust needs assessment and the learner identifies herself or himself as part of the target audience for the educational activity.[4,5,6]

CURRENT AMA POLICY

The AMA has already established policy relevant to this issue. In fact, current AMA policy H-300.953 (AMA Policy Database), "Content Specific CME Mandated for Licensure," states that: "(1) The AMA, state medical societies, specialty societies, and other medical organizations should reaffirm that the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. (2) State medical societies should establish avenues of communication with groups concerned with medical issues, so that these groups know that they have a place to go for discussion of issues and responding to problems. (3) State medical societies should periodically invite the various medical groups from within the state to discuss issues and priorities. (4) State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate." In addition Policy H-300.994, "Support for Voluntary Continuing Medical Education," states that: "Our AMA supports individual physician responsibility for self-education."

SUMMARY AND RECOMMENDATIONS

The Council supports the concept that it is a physician's responsibility to establish the curriculum for continued self-education and agrees that the state medical societies should continue to oppose efforts to legislate CME content in their respective states. The Council also recognizes the legitimate efforts of organizations working on improving patient care or increasing patient safety. Mandated specific CME activity, when such education reasonably might be expected to be effective in improving patient care and safety and targets physicians whose practice relates to the content of the activity, may constitute a legitimate requirement.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 331 (A-09) and that the remainder of this report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-300.953, "Content Specific CME Mandated for Licensure." (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-300.994, "Support for Voluntary Continuing Medical Education." (Reaffirm HOD Policy)

3. That our AMA recommend that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians' practice. (New HOD Policy)

Fiscal note: Staff cost estimated at less than $500 for implementation.

Appendix A
MANDATED CME CONTENT BY STATE

State	Content-Specific CME	Reporting Time Period
California MD and DO	20% of credits in geriatric medicine or care of older patients for all general internists and family physicians who have a patient population of which more than 25% are 65 years of age or older	Included in 50 Category 1 credits required every 2 years
	12 credits in pain management and/or treatment of terminally ill and dying patients	One time requirement by second license renewal date or within 4 years, whichever comes first
Connecticut	1 credit each Infectious Disease (including but not limited to HIV/AIDS), Risk Management, Sexual Assault, and Domestic Violence	Included in 50 Category 1 credits required every two years
Florida MD	1 credit HIV/AIDS, 2 hrs prevention of medical errors	These 3 credits are the only CME required for the first license renewal
	2 credits prevention of medical errors; every renewal	After first renewal, all other mandated content included in 40 credit requirement
	2 credits domestic violence every 3rd renewal	
Florida DO	1 credit HIV/AIDS; first renewal only	All mandated content is included in the 40 credits required every 2 years
	1 credit each risk management, Florida laws & rules, laws on controlled substances; every renewal	
	2 credits prevention of medical errors; every renewal	
	2 credits domestic violence; every 3rd renewal	
Illinois	8 credits in delivery of anesthesia, including the administration of conscious sedation, for operating physicians who administer only conscious sedation in their office	Included in 150 credits required every three years
	34 credits in delivery of anesthesia for operating physicians who administer deep sedation, regional anesthesia and/or general anesthesia in their office	Included in 150 credits required every three years
Iowa	2 credits child and/or dependent adult abuse identification and reporting for licensees who regularly provide healthcare to children and/or adults. For licensees who provide care to both adults and children, it can be two separate courses or one combined 2 hour course	Every 5 years, included in the 40 Category 1 credits required every two years

State	Content-Specific CME	Reporting Time Period
Kentucky	3 credits domestic violence course	One time requirement for primary care physicians within three years of initial licensure; included as part of 60 credit total requirement for that three year cycle
	2 credits HIV/AIDS	Every 10 years; included as part of 60 credit total requirement for that three year cycle
Massachusetts	10 credits risk management, to include 2 hours studying board regulations. 4 of the risk management credits must be Category 1	Included as part of the 100 credits required every 2 years, of which 40 must be Category 1.
Nevada	2 credits in Ethics	Included in the 40 credits Category 1 total required every two years
	4 credits in the medical consequences of an act of terrorism involving a weapon of mass destruction	New applicants only within two years of initial licensure; in addition to regular CME requirement
New Jersey	6 credits in cultural competency	One time requirement, must be Category 1 or equivalent. For physicians licensed prior to March 24, 2005 it is in addition to the 100 CME credits required every two years; for physicians licensed after March 24, 2005 it can be included in the 100 credits total CME requirement
New York	Training in infection control and barrier precautions, including HIV and HBV. Course length may vary from provider to provider	No CME requirement per se, but this training is required for initial licensure and every four years thereafter. NY state programs meet the initial licensure requirement
	2 credits in identification and reporting of child abuse and maltreatment	Required for initial licensure. Some NY state programs meet the requirement
Oklahoma DO	1 credit prescribing, dispensing and administration of controlled dangerous substances	This content is required every other year and is included as part of 16 osteopathic Category 1 credits required every year
Oregon	One hour pain management course specific to Oregon	Both of these are a one time requirement due within the first 12 months of licensure, and may be included in the 60 credits required for license renewal
	6 credits in pain management and/or treatment of the terminally ill and dying	
Pennsylvania MD and DO	12 credits patient safety or risk management	Included in 100 credits required every 2 years

State	Content-Specific CME	Reporting Time Period
Rhode Island	2 credits in either universal precautions, bioterrorism, end of life, OSHA, ethics, or pain management	Included in 40 credits required every 2 years
Tennessee MD and DO	1 credit prescribing practices	Included in 40 credits required every 2 years
Texas	2 credits in ethics and/or professional responsibility	Part of 24 Category 1 Credits required every two years (out of 48 total)
West Virginia MD and DO	2 credits in end of life care, including pain management	One time requirement prior to first license renewal; included in 50 Category 1 credits required over 2 years

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3. Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA,Wolf F, Davis D, Odgaard-Jensen J, Oxman AD. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD003030. DOI: 10.1002/14651858.CD003030.pub2.

4. Davis DA, Fox RD. The Physician as a Learner: Linking Research to Practice: Chicago, IL: American Medical Association; 1994.

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6. Houle CO. Continuing Learning in the Professions. San Francisco, CA: Jossey Bass; 1980.