CONFERENCE REPORT

A new day for CME/CPD in Canada: proceedings from the
1st Canada Regional Conference of the Global Alliance
for Medical Education in Montreal, Canada

Suzanne Murray1 and Lisa Sullivan2

1AXDEV Group International, Montreal, Canada
2In Vivo Communications (Aust) Pty Ltd, Surry Hills, Australia

Abstract

The Global Alliance for Medical Education (GAME) is a not-for-profit organization founded in 1995, with the aim of advancing innovation in medical education. The 1st GAME Canada regional conference was held in Montreal on May 22, 2015, under the leadership of Suzanne Murray, who acted as programme chair, and GAME president Lisa Sullivan. The conference brought together a broad array of speakers and panelists, including experts from academic centres, health systems, accreditors, private organizations, and industry. Thirty-one key stakeholders participated in the event, demonstrating a strong commitment towards the improvement of best practice in continuing medical education (CME)/continuing professional development (CPD). The conference included diverse presentations providing opportunities for reflection and discussion throughout the day. The participants actively took part in stimulating discussions that covered a large range of topics, including the need for enhanced networking and opportunities to learn from others, the challenges of assessment and the potential solutions, interprofessional education and competencies, and, finally, the future of a Canadian CME/CPD organization.

Keywords: continuing medical education, continuing professional development, GAME, performance improvement, Canada, collaboration, accreditation, assessment

Introduction

The Global Alliance for Medical Education (GAME) is a not-for-profit organization founded in 1995, with the aim of advancing innovation in medical education. Its activities include an annual conference as well as several regional GAME conferences: China (28 November 2013),1 India (October 18, 2014),2 and Argentina (November 6, 2014).3 Three additional regional conferences have been confirmed for 2016: India 2nd Regional Conference (February), South America 2nd Regional Conference (March), and North America Regional Conference (March).

In Canada, continuing medical education (CME) and continuing professional development (CPD) professionals have an unmet need for a credible national organization that would provide them with opportunities for networking with Canadian and international colleagues and would support their own improvement and use of best practices in CME/CPD.

It is in this context that the 1st GAME Canada Regional Conference was held in Montreal on May 22, 2015, under the leadership of Suzanne Murray, who acted as programme chair, and current GAME president Lisa Sullivan.
Thirty-one key stakeholders, including experts from academic centres, health systems, accreditors, private organizations, and industry, participated in the event, demonstrating a strong commitment towards the improvement of best practice in CME/CPD. Through the publication of the conference proceedings, the authors aim to stimulate discussion of the conference topics within a larger audience, ultimately contributing to a higher quality of CME/CPD for healthcare providers.

Conference direction and programme

The final programme of the Canada regional conference included opening statements from the regional conference chair (Suzanne Murray), the GAME president (Lisa Sullivan), and the GAME international programme chair (Jann Balmer).

The speakers’ presentations were centred around one crucial question: How is GAME responding to the changes in CME, CPD, and performance improvement (PI) on a global scale? Reflective questions were developed and provided to invited speakers in advance in order to guide their preparation and ensure alignment of each presentation with the conference aim and themes.

Three expert-facilitated interactive dialogue sessions were inserted between the presentations, where attendees were first divided into smaller groups, before all participants regrouped to share thoughts and challenge other groups’ perspectives. Facilitators summarized the broad array of points of view. The final programme closed with a summary of the day and closing remarks from the regional conference chair.

Session summaries

Session 1: The College of Family Physicians of Canada

Dr Janice Harvey, a physician advisor for the Professional Development and Practice Support division of the College of Family Physicians of Canada (CFPC), provided an overview of the activities of the CFPC, including their initiatives in support of competency-based education. Of note, a new learning framework (Mainpro +), used for credit reporting and certification, will allow members to access more practice-relevant CPD. The system includes four steps to raise the bar on certification: 1) additional emphasis on CanMED’s roles), 4) introduction of a Quality Criteria Grid to ensure consistency between CME/CPD programmes; 3) systematic assessment of impact, providing learners with an opportunity to reflect after each learning opportunity; and 4) increased investments in programme development.

Dr Harvey insisted on the importance of competency-based education, “an outcomes based approach to the design, implementation, assessment and evaluation of medical education programmes, using an organizing framework of competencies.”

The CFPC also supports numerous other CPD activities, such as the Patient’s Medical Home (PMH) website, the Regional Educators programme, the Prevention in Hand programme, and Certificates of Added Competence. The PMH is meant to be the hub for the provision and coordination of all the health and medical services needed by each of its patients. It puts the focus on patients, aiming to enhance their participation in their own health and their access to care, ensuring better prevention and well-being, leading to better health outcomes.

Session 2: Rx&D – National Association of Canada’s research-based pharmaceutical companies

Ms Carolyn Dougherty, a representative of the Rx&D Medical Education Expert/Working Group and a customer learning team lead at Pfizer Canada Inc., provided an overview of Rx&D and its guiding principles and discussed the role of industry in the development of education.

Rx&D has over 50 member companies, who joined together for the socially responsible promotion and undertaking of research, as well as ethical and self-regulated delivery of information on member products and services; all members must commit to respect the Rx&D code (created in 1988 and revised in 2012). The Rx&D pharmaceutical self-regulated authorities impose increasing financial fines with each subsequent infraction, and all offences are rendered public. Repeated infractions can lead to probation or even expulsion.

Ms Dougherty emphasised the seventh guiding principle of the Rx&D code eight guiding principles: ensuring access to accurate and balanced education and information about the appropriate uses of products and services. She summarized the Rx&D board objectives of “improving patient access to new medicines/vaccines by driving recognition for their value as levers to better health outcomes and system sustainability” and of “strengthening Canada’s position and capacity as a preferred destination for global life science investment.”

The Rx&D Ethics Committee has a crucial role in the timely and proactive assessment and response to emerging ethical business issues and practices, increasing awareness of environmental trends and international ethical standards, ensuring consistent interpretation of the Rx&D code, and raising awareness and understanding of the code with healthcare providers, faculty, governments, and other stakeholders.

Although many CME/CPD initiatives put in place by Rx&D members have demonstrated quality and value, and very little evidence of bias has been documented, many stakeholders continue to believe that industry funding support of learning programmes has a moderate or large potential for bias. This is one perception Rx&D is hoping to change in the future, so that industry can still play a role within CME/CPD, beyond the allocation of funds.

Session 3: Responding to changes in CME, CPD, and PI globally

Ms Della Croteau of the Leslie Dan Faculty of Pharmacy at the University of Toronto discussed the evolution of CME/CPD/PI for Canadian pharmacists. She began her
Presentation with a summary of the CME/CPD requirements for Canadian pharmacists. She identified five drivers of change for Canadian pharmacists in relation to their CME/CPD/PI behaviour: 1) expanded scope of their practice; 2) new legislation; 3) influence of mentors and colleagues; 4) flexibility; and 5) expected impact on practice. She also identified specific challenges that Canadian pharmacists and CME/CPD/PI providers are facing: 1) scarce resources to establish and sustain programmes over time; 2) audit and feedback systems identifying needs for guidance or mentorship.

Canadian pharmacy has contributed to the evolution of the field of CME/CPD/PI by the use of practice assessments instead of accumulating continuing education (CE) units, peer coaching for remediation through constant involvement in interprofessional education (IPE), and introduction of progressive levels of leadership. She explained that it is essential to demonstrate the clarity of expected outcomes, their applicability to practice, and impact on practice. Canadian pharmacists benefit from advanced practice skill programmes, where therapeutic knowledge is combined with “soft” skills such as leadership, decision-making, and teamwork.

Regulatory standards are needed to support these changes in the CME/CPD/PI environments such as legislation for quality assurance programmes, definition of the scopes of practice and mandatory requirements for IPE, and the recognition of new specialties or sub-specialties.

Session 4: How is your organization contributing to national and international CME, CPD, PI initiatives and why?

Ms Cynthia Lebovics, a national continuing education manager at Sanofi Canada, presented a few examples of how her organization is contributing to national and international CME/CPD/PI activities.

Although continuing education is under the marketing department of the company, firewalls are in place to ensure that only the CE professionals are involved in the development of the educational initiatives. The mandatory internal process for the development of CME/CPD initiatives requires that programme content be reviewed by a regulatory advisor, to ensure it respects all applicable legislations and regulations. A medical advisor also ensures that content-related references are appropriate and that scientific content is credible, accurate, and non-biased. This process is followed for both accredited and non-accredited programmes.

Three factors are crucial for developing CME/CPD that is relevant: 1) pre- and post-activity assessment to assess the learning and programme impact on practice; 2) steering committees comprising experts from the targeted participant population; and 3) accreditation acquired from associations that are overseeing the targeted participant group. In Ms Lebovics’s experience, representatives of commercial organizations (the pharmaceutical industry, communication firms, etc.) are not permitted to participate in, nor attend the meetings of, the scientific and content planning committees for accredited programmes. However, programme committees that are primarily concerned with logistics are allowed to include representatives of commercial interests.

Three key changes in the Canadian healthcare environment are having an impact on CME/CPD: 1) more women in the medical field, which implies different learning approaches; 2) reduction in funds for education; and 3) increasing scarcity of resources, which puts pressure on healthcare providers (HCPs) to prioritize time for education.

Session 5: The Royal College of Physicians and Surgeons of Canada

Ms Jennifer Gordon, CPD associate director for the Royal College of Physicians and Surgeons of Canada (RCPSC), provided an overview of the RCPSC’s priorities and activities, focusing on the support, development, and accreditation of continuing education. The RCPSC Maintenance of Certification (MOC) programme supports lifelong learning and professional development of Canadian specialist physicians and ensures sustained competence and up-to-date knowledge and skills.

The RCPSC has set four priorities for Canadians to benefit from timely, high quality, evidence-based specialty care by 2020: 1) adapt and strengthen specialty medicine to meet society’s health needs; 2) support members throughout their education, profession, and retirement; 3) advance specialty medical education and lifelong learning; 4) build the capacity, effectiveness, and accountability of the RCPSC. Ms Gordon then presented Dreyfus & Dreyfus’s spectrum of skills acquisition (1980),6 followed by Cathe’s general curve of skills acquisition (2010).7 She then explained the CanMeds 2015 Competence by Design (CBD) Continuum model, which breaks down specialist education into a series of interrelated stages, through which specialists move during their careers, beginning with the first transition into a discipline as a junior resident and moving all the way to the transition from practice into retirement.8 The Royal College ePortfolio for an education continuum, an online hub designed to support specialists in managing their lifelong learning (Figure 1), was also presented.

Session 6: The Physician Performance Improvement system: update from the working group

Dr André Jacques presented the Physician Performance Improvement (PPI) system, which is the result of a collaborative effort from the Working Group on Physician Performance Improvement (WG-PPI) of the Collège des médecins du Québec, a working group over which he presides. The WG-PPI includes stakeholders from the Federation of Medical Regulatory Authorities of Canada, the Association of Canadian Academic Healthcare Organizations, the Association of Faculties of Medicine of Canada, the Canadian Medical Association, the Canadian Medical Protective Association, the CFPC, the Medical Council of Canada, and the RCPSC.
The main goal of the WG-PPI through this initiative was to maximize the ability of physicians to provide high quality patient care and the protection of public safety. They are envisaging reaching that goal through the development of a pan-Canadian strategy to assist all practising physicians in identifying opportunities for improvement. Furthermore, this strategy will assist all medical regulatory authorities in identifying physicians who may benefit from focused assessment and enhancement and all stakeholder organizations in identifying their roles and responsibilities in physician performance enhancement.

The PPI system was defined as “a life-long quality improvement and assurance system, that is feasible and sustainable, and that has demonstrable, positive impact on the quality of patient care.”

The PPI model developed by the WG-PPI details three steps of monitoring, enhancing physicians’ performance, as well as clarifying the responsibilities of each group of stakeholders – the “who” and the “what.” The PPI framework defines the “when” and the “how” (Figure 2). Extensive and thoughtful feedback from a first round of consultations has already led to changes to the PPI system description, clarification of some of the partners’ roles, and inclusion of definitions for some of the terms.

At the end of the discussion, Dr Hayes presented a slide on the many parameters of continuing education assessment, concluding the discussion with a summary of the complexity of assessment (Figure 3).

Summary of the interactive dialogue sessions

Four key themes emerged frequently throughout the day’s three interactive dialogue discussions; they are summarized below.

Theme 1: Collaboration and learning

There is an underlying expectation from all participants to learn from their participation in a GAME conference, to gain insights into what has been done elsewhere and how it could be applied in practice globally: what has worked in Australia or in India that can be applied in Canada, or what has not worked, why, and what were the lessons learned?

A key question is to define what we can learn from. Should only best practices be shared, for participants to learn from the best? Could participants also learn from initiatives that were good despite some limitations? The point was made that failures must also be shared, to allow participants to learn from each other’s mistakes. However, presenting one’s mistakes requires a high level of collaboration.

In Canada, there seems to be a growing opportunity in terms of exchange, dialogue, and collaboration between different stakeholders, such as specialty societies, accrediting bodies, universities, industry, and CE providers. Still, despite that apparent openness, there are clearly challenges to overcome. Canada is in urgent need of a credible organization that will be in a position to facilitate the expansion of Canadian expertise into the international environment.
Some participants wondered whether they were truly in an era of collaboration, while others questioned the feasibility of collaboration in the context of downsizing and increasing regulations. However, although collaboration has its barriers, it is essential to assess what will be lost by not collaborating.

Concerns were raised with regard to the high representation of the industry among GAME board members. There is a need to find a balance that benefits everyone, recognizing that the industry’s expertise is not limited to funding, while at the same time avoiding potential conflicts of interest (COI), or even the appearance of potential COI.

The importance of common terminology was also discussed, as it became apparent that not all participants had the same definitions of CME, CPD, and PI. All participants agreed that common understanding was a prerequisite for enhanced collaboration.

Accreditation is another aspect where there are opportunities for more collaboration. Participants shared a vision of standardization among accrediting bodies and national or international recognition of accreditations that could facilitate, for example, the US accreditation process of an already-accredited Canadian programme.

Theme 2: Improving assessments
There is definitely a need to work on how assessment is communicated to learners. For example, the term audit has a negative resonance for most physicians, while assessment is perceived as less threatening. It is essential for HCPs’ acceptance of assessment to reassure them that the aim is not to judge their practice, but rather to identify

---

**Figure 2.** Physician Performance Improvement (PPI) model (upper portion) and draft framework (lower portion) developed by the Working Group on PPI and presented by Dr Jacques (© Federation of Medical Regulatory Authorities of Canada; used with permission).
where they would need support and/or education to be able to provide better care.

Assessments should be developed with the targeted audience of the educational activity in mind (i.e. individuals or teams). CE providers tend to focus mainly on the measurement of perceived needs; however, they should also attempt to identify unperceived needs and practice gaps unknown by healthcare professionals. Self-reporting is often insufficient to identify unperceived gaps or needs (providers don’t know what they don’t know). Although possibly the most used tool, a survey might not always be the best tool, certainly not for all variables, and certainly not when used in isolation: it is one of many data collection techniques that should be part of an assessor’s arsenal.

It behoves CE providers to develop formative assessments further, which will contribute to each individual’s learning. Undergraduates are prepared to receive feedback and formative assessment during their preparatory years, but are they prepared to receive feedback and assessment throughout their career?

It was debated whether the linkage of performance assessment to quality measures should occur in Canada as it is occurring in the United States, where Medicare will reimburse organizations at higher rates where quality is measured (accountable care organizations), providing a strong financial incentive to participate in quality and performance assessments. The RCPSC have standards that encourage quality and are already moving in that direction, with individual performance assessments and practice assessments, within a framework that includes credits for systems learning. One obstacle is that health electronic records and electronic medical records are not always connected. Pharmacists look at it from a different angle, using workplace performance assessments, with the ultimate goal of improving patient outcomes. The biggest struggle is for a change in attitude, to consider performance assessment as an ongoing process.

Theme 3: IPE and competencies

It was stated that the distinction between interdisciplinary education and IPE needs to be reiterated, as the two terms are often used interchangeably despite not meaning the same thing. Interprofessional should be used for activities being organized for, by, and/or with two (or more) different professions, such as physician, psychologist, pharmacist, nurse, and so on. Interdisciplinary should be used when different disciplines of medicine are involved, such as endocrinology, pathology, radiology, and so on. It is also essential to clearly distinguish between multiprofessional and interprofessional. Whereas the former simply implies HCPs from two or more professions practising or learning side by side, the second term goes one step further and implies that HCPs from two or more professions learn about, from, and with each other, enabling effective collaboration.

Interprofessional care is increasingly important in the organization of healthcare, and CME/CPD must reflect that. For that reason, many participants stated the importance of including all health professionals, not just medical disciplines within the Canadian CME/CPD organization.

The word team is also one that needs a more consistent definition, the term having different meanings to different professionals. A common point between definitions is that in order to become a team, it is necessary to be able to collaborate.

Competencies were discussed, both in terms of the competencies of CME/CPD professionals and in terms of developing and deploying competency-based activities for healthcare providers. If CME/CPD professionals expect HCP learners to enhance their competencies, they need to
lead by example and develop competency-based training for themselves as well. Moreover, in order to be successful, competency-based activities for HCPs should be integrated into more traditional knowledge-based modules, because competencies, such as communication, are often not perceived as a learning need by HCPs (i.e. unperceived need).

Theme 4: The future of the organization
The idea of changing the name of the GAME organization was debated for two reasons: 1) similarity to words used by other organizations; and 2) the need to evolve from medical education, perceived as restricted to physicians, and to include all health professionals. The audience was clearly divided on that question.

Planning of the next regional GAME conference was a recurring theme. A post-conference survey was proposed to ascertain participants’ perspectives on the attainment of the conference objectives, which would serve as a needs assessment for the next programme, a key component of which would be to look at implemented changes, if any, or changes committed to, by the participants. Issues discussed included the need for early planning, the potential for expansion of the group, and the composition of the organization committee. Inclusion of political decision-makers and policy influencers was perceived as crucial, as was the need to include all health professions and not solely medical doctors.

The level of influence that GAME should have over a GAME chapter was also discussed. On the one hand, International GAME would not have a clear role in the directions taken regionally, but on the other hand, there was a strong willingness to exchange and learn from international experience. It was mentioned that over recent years, GAME has taken very deliberate and thoughtful steps to become more international and that the recent alignment with the Association for Medical Education in Europe is evidence of that.

There are plans for the organization of a second GAME conference in India, where a new GAME chapter is under discussion. There are also plans to work towards chapters in Asia and South America within the next 2 years and perhaps also in the Middle East.

Authors’ contributions
SM is a GAME board member and was regional conference chair of the 1st Canada Regional Conference of the Global Alliance for Medical Education (GAME). LS is the current president of GAME. Both SM and LS took part in critical discussions around the manuscript content and reviewed the final manuscript.

All co-authors contributed sufficiently to this article to be considered as authors, as per the authorship requirements detailed by the International Committee of Medical Journal Editors.

Acknowledgements
The authors would like to thank everyone who took part in the 1st Regional Conference of the Global Alliance for Medical Education (GAME) in Montreal, Canada. They acknowledge the contribution of Jann Balmer, GAME International programme chair, and Paul Piché, Regional Conference Support (marketing and logistics) and GAME board member. Invaluable support was provided by Niki Reboulis and Marie-Aimée Fournier (AXDEV Group, Brossard, Canada) in the organization of the conference and by Mathew Sebastiao and Patrice Lazure MSc (AXDEV Group, Brossard, Canada) in the redaction of this conference report.

Conflict of interest and funding
The authors have not received any funding or benefits from industry or elsewhere to develop these proceedings.

References
1. Anonymous. GAME Regional Meeting: balancing innovative science and improved patient care – report on Proceedings of the 1st Regional Meeting in China of the Global Alliance for Medical Education Shanghai, November 28, 2013. 2014. Available at: http://www.game-cme.org/meetings/1520360, accessed July 29, 2015.
2. Srivastava V, Sullivan L, Sanghvi S. CME/CPD in the Indian Subcontinent: proceedings from the 1st regional meeting of Global Alliance for Medical Education (GAME) in Mumbai, India. J Eur CME 2015;4:27499, doi: http://dx.doi.org/10.3402/jecme.v4.27499
3. Anonymous. Preliminary report: first GAME Regional Meeting in Latin America (Buenos Aires, November 6, 2014). 2015. Available at: http://www.game-cme.org/meetings/3213067, accessed July 29, 2015.
4. Royal College of Physicians and Surgeons of Canada. The CanMEDS framework. 2005 [updated 2013]. Available at: http://www.royalcollege.ca/portal/page/portal/rc/canmeds/framework, accessed July 30, 2015.
5. Rx&D. Code of Ethical Practice. 2012. Available at: http://canadapharma.org/wp-content/uploads/2015/06/2012_CodeofEthicalPractices_ENFinal-1.pdf, accessed July 30, 2015.
6. Dreyfas SE, Dreyfas HL. A five-stage model of the mental activities involved in directed skill acquisition. Washington, DC: Storming Media; 1980.
7. ten Cate TJO, Snell L, Carraccio C. Medical competence: the interplay between individual ability and the health care environment. Med Teach 2010;32:669–675.
8. Royal College of Physicians and Surgeons of Canada( RCPSC). The “competence by design” competence continuum. 2015. Available from: http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/framework/competence_continuum_diagram_e.pdf, accessed July 31, 2015.
9. IOM (Institute of Medicine). Measuring the impact of interprofessional education on collaborative practice and patient outcomes. Washington, DC: The National Academies Press; 2015.
10. Thannhauser J, Russell-Mayhew S, Scott C. Measures of interprofessional education and collaboration. J Interprof Care 2010;24: 336–349.
11. Paradis E, Reeves S. Key trends in interprofessional research: a macrosociological analysis from 1970 to 2010. J Interprof Care 2013; 27:113–122.
12. Murray S, Silver I, Patel D, Dupuis M, Hayes SM, Davis D. Community group practices in Canada: are they ready to reform their practice? J Contin Educ Health 2008;28:73–78.