Participants representing various stakeholders, including medical schools, pharmaceutical companies, medical education companies, international regulatory bodies, and independent consultants from 17 countries, attended the annual meeting of the Global Alliance for Medical Education (GAME) in Barcelona between 9 and 11 June 2013. The attendees took part in small-group exercises to explore the use of a 10-step empirical procedure as part of an instructional design model applied to the planning and implementation of educational activities in continuing medical education and continuing professional development (CME/CPD). The strategic focus of GAME was presented to highlight areas of interest in patient safety, inter-professional education, and adult learning theory in CME/CPD. These areas were also underlined during presentations of abstracts by representatives of the World Health Organization, academic institutions, and medical education companies. These presentations demonstrated the wide array of educational activities and formats being conducted around the world, with live links to Rwanda and Uruguay emphasizing the global reach of GAME.

Keywords: continuing medical education, global, proceedings, 2013, instructional design, continuing professional development

During three intensive work days in June, representatives of 17 different countries attended the 2013 annual meeting of the Global Alliance for Medical Education (GAME) in Barcelona, Spain; participated in sessions dealing with instructional design of continuing medical education and continuing professional development (CME/CPD); and were updated on a range of projects that are being conducted in some of the countries represented.

Outgoing GAME president Dr Robert Galbraith introduced the conference by highlighting the progress that the organization has made in developing a strategic plan to provide more educational resources for its members. Planned educational offerings such as high-quality webinars would reflect the similar healthcare trends, including malnutrition and type II diabetes mellitus, that affect both developed and emerging nations around the globe. Dr Galbraith also provided a recap of discussions from the two previous annual meetings in Munich and Toronto that have broadened the focus of GAME to include areas of interest such as patient safety, interprofessional CME/CPD, and the principles of adult learning theory.

The first of these stated areas of interest was introduced by Dr Agnes Leotsakos, team leader for patient safety education at the World Health Organization.
Organization (WHO), whose overview, presented in collaboration with Dr Dina Baroudi, provided a set of comprehensive perspectives on patient safety, education, and training. The presenters’ central focus was on the need to build a culture of safety, and this was illustrated by a number of case studies and a summary of the WHO’s Multi-Professional Patient Safety Curriculum Guide that supports the training of healthcare professionals on priority patient safety concepts and practices.1

Dr Baroudi provided further illustrations of building a culture of safety as opposed to a culture of blame, using case studies from the United Kingdom, Australia, and her own workplace in Saudi Arabia.

**Instructional design exercise**

Adult learning theory linked neatly to the core theme for this year’s conference, which was embedded in its title —*The Necessary Interaction of Outcomes, Instructional Design and Assessment*—with sessions facilitated by representatives from North America and Europe, namely, Dr Don Moore, director of the Division of Continuing Medical Education at Vanderbilt University School of Medicine, USA, and Dr Jeroen J. G. van Merriënboer, professor of learning and instruction in the Graduate School of Health Professions Education at Maastricht University, the Netherlands.

From the outset, the facilitators encouraged participant involvement by using a number of linked exercises conducted over 2 days that were designed to illustrate the component steps of an instructional design model promulgated by Dr van Merriënboer and his colleague Paul Kirschner of Utrecht University.2 Dr van Merriënboer presented his published theory, which has been applied in various educational settings, and provoked much thought and debate among the audience about how the theory might apply to CME/CPD in healthcare. In this systematic approach to instructional design, four main components and 10 steps have been identified, as shown in Figure 1.

Each of the four components was described as being part of an interrelated whole with the following specific characteristics:

**Learning tasks should:**
- integrate nonrecurring and recurring skills, knowledge, and attitudes
- be organized in an easy-to-difficult sequence of task classes
- have diminishing support as each task class is tackled
- provide a broad variability of practice

**Supportive information should:**
- support the learning and performance of nonrecurring aspects of learning tasks
- provide cognitive strategies and mental models to tackle problems
- be specific to the task class and always available to learners

**Procedural information should:**
- be prerequisite to the learning and performance of recurring aspects of learning tasks (i.e. practice items)
- specify precisely how to perform routine aspects of a task (e.g. through step-by-step instruction)
- be presented just in time during the mastery of the learning tasks and can be reduced as learners acquire more expertise

**Part-task practice should:**
- provide additional practice for selected recurring aspects of a task in order to reach a very high level of automaticity
- provide a high level of repetition
- only begin after the recurring aspect has been introduced in the context of the whole task

By use of case studies and small-group discussion and feedback, the conference participants worked through the application of the 10 steps outlined in Fig. 1 and emerged with a method for analyzing components of instructional design to produce a strategy that addresses specific learning needs of healthcare professionals. A follow-up exercise was suggested for participants to try to apply the model in their own particular work domain as part of the planning and implementation of a CME/CPD activity for healthcare professional learners.

**Abstracts session**

The final session of the conference consisted of abstract presentations that exemplified the diversity of the participants and the considerable amount of CME/CPD being conducted around the world. The presentations comprised the following.

**Telehealth: A mutually beneficial tool to complement global collaborations in clinical care, capacity development, and continuing education.**
India.

CME regulation and its effectiveness: The missing link in the workplace of the healthcare professionals being trained. The sentences of Gulf Medical University’s courses are relevant to development, implementation, and evaluation has made it useful of learning outcomes in the different phases of program and master’s degrees) was emphasized, and this extensive comes match the levels of various qualifications (bachelor’s Medical University. The requirement that learning out-
sessment items during curriculum development at Gulf used to design all of the courses, lesson plans, and as portability of the higher education degree programs offered as level descriptors to help measure the equivalence and cations Framework that utilizes generic learning outcomes description of the various strands of the National Qualifi-
cations, based at Mumbai, India, highlighted the shortage of physicians in India, with a ratio of 1 per 1700 of the population compared with a global average of 1.5 per 1000. They described deficiencies in the quality of CME available to their country’s healthcare professionals, which is based on voluntary self-learning and self-assessment and has proved to be inadequate and ineffective. They further dis-
cussed the growing move towards CPD and lobbying efforts by various medical associations for mandatory CME/CPD requirements, although the Indian government has not yet implemented a framework for the regulation of CME. Some progress has come from the medical profession itself, with the Medical Council of India having established a code of ethics stating that members should complete 30 hours of CME every 5 years in order to re-register as doctors. A few State Medical Councils have begun to adopt the code, resulting in improved attendance at CME conferences, and in this hopeful climate, the presenters felt that opportu-
nities abound for CME providers to develop cutting-edge multidisciplinary programs to help lead the way towards improved clinical practice in India.

Conducting a global needs analysis in orthopedic trauma for practicing surgeons.

Newly elected GAME Board Member Michael Cunningham, PhD, representing the AO Education Institute headquartered in Switzerland, presented information on the background and results of a recently conducted three-stage needs assessment that involved face-to-face interviews, an online questionnaire, and follow-up interviews with practi-
cing orthopedic surgeons from around the world. This expansive approach provided quantitative and qualitative data sets that were analyzed by AO’s educationalists to provide strategic planning information to an international commission, regional and national committees, and sub-
specialty curriculum task forces. These groups have used the data reports as the basis for recommendations for the development of global standardized education that incorporates regional and national variations.

Aligning the 10-level National Qualification Framework with the learning outcomes of degree programs in a UAE university.

Professor Gita Ashok Raj, provost of Gulf Medical University in Ajman, UAE, provided a comprehensive description of the various strands of the National Qualifications Framework that utilizes generic learning outcomes as level descriptors to help measure the equivalence and portability of the higher education degree programs offered in the country. She demonstrated the common template used to design all of the courses, lesson plans, and as-
essment items during curriculum development at Gulf Medical University. The requirement that learning out-
comes match the levels of various qualifications (bachelor’s and master’s degrees) was emphasized, and this extensive use of learning outcomes in the different phases of program development, implementation, and evaluation has made it possible to ensure that generic and professional competen-
tes of Gulf Medical University’s courses are relevant to the workplace of the healthcare professionals being trained.

CME regulation and its effectiveness: The missing link in India.

www.jecme.eu.
Implementing and evaluating a blended course for GERD across Latin America.

Alvaro Margolis, MD, MS, joined the conference via a video link from his base in Uruguay and commented on the fast pace at which online CME is becoming the educational vehicle of choice for many physicians. The extended reach of online CME to remote and international settings provided the background for a blended CME intervention related to gastro-esophageal reflux disease (GERD) that Dr Margolis and his team have conducted in five countries across Latin America. The grant-supported CME intervention was designed with academic support from the World Gastroenterology Organisation, and it included the synchronous launch of activities, either face-to-face or via the Internet, and a 2-month asynchronous phase via the Internet, with case discussions, study materials (written and audio-visual), as well as tests and commitment-to-change contracts. The course was piloted in Uruguay, then rolled out during 2012 to Mexico, Colombia, Venezuela, Argentina, and Uruguay. A global design was adapted for each of the participating countries, with local institutions and leaders being involved in adaptation and implementation. When credits were mandatory, local CME accreditation was obtained, and participation was free for invited physicians. Although the completion rate for the course was only 30% of the 1143 physicians who started the course, Dr Margolis concluded that the high rate of satisfaction and a 20% increase in pre- and posttest scores made the global design and local implementation of this multi-country CME course model feasible and worthy of enhancement and replication.

At the end of the conference, attendees were left with much food for thought in relation to the focus areas set out by GAME, many global networking opportunities, and an invitation from incoming GAME president Maureen Doyle-Scharff to reconvene for the 2014 meeting from May 18–20 in Miami, FL, USA. Full details on the organization and its activities may be obtained from the GAME website: www.game-cme.org.

Declaration of interest

I have no financial relationships with any commercial interests.

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