Continuing Medical Education

Dокументation of continuing medical education (CME) credits has become routine and accepted by the American Medical Association, state medical societies, and licensing boards. Indeed, the AMA Physician’s Recognition Award will validate a physician’s acquisition of CME credits for most other regulating agencies.

My assumption is that this documentation is necessary to assure that physicians keep up with advances in their specialty. Whether attendance at courses, national meetings, etc., really accomplishes this goal has rarely been studied.

Unfortunately, identical standards are set for physicians in private practice and for those academicians teaching in medical schools. It seems to me that virtually all medical school activities would qualify as CME, and repeated further documentation of course attendance would be unnecessary.

Let’s face it. Teaching rounds, performing clinical research, delivering lectures, writing papers, reviewing articles and chapters, and accomplishing the rest of what constitutes the daily activities of the medical school faculty members are all CME activities. In fact, in some areas of the country, the time spent preparing for and delivering a lecture that you are giving does not qualify for CME credit. Those physicians who attend your lecture can obtain the credit. This is “goofy” thinking. If anything keeps one up to date on current advances in medicine, it is the act of preparing one’s own lecture on the subject.

I would like to see some sense incorporated into the calculation of CME credits. If a member of the medical school faculty can demonstrate that he or she teaches students and house officers on a weekly basis, this alone should be satisfactory evidence of CME. Those in private practice may run some risk of practicing the same medicine year after year and should be required to demonstrate some meaningful attempt to keep up to date.

Similar arguments could be made for quality assurance documentation. There are few procedures done by faculty members in medical schools that are not observed by students, fellows, residents, and others. Also, cases are discussed with colleagues daily and presented at conferences. It is very unlikely that a physician on a medical school faculty will be an “outlier,” performing the same procedure incorrectly time and again without being promptly recognized.

I do not wish to give the impression that medical school faculty members are without fault and do not need supervision. There are certainly researchers who spend 11 months a year in the lab and emerge for 1 month to do clinical work, and they might need some CME attention. A faculty member with this type of schedule should be required to document his CME credits. I simply wish to point out that there are certain job activities in the teaching of medicine that are inherently CME and should be recognized as such. This recognition could be one small step in the elimination of burdensome and unnecessary paperwork heaped upon all of us by the overregulation of medicine. If the teachers of medicine are not current in their medical knowledge, who is?

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On the Management of Malignant Pleural Effusions

Pleural effusions, particularly malignant effusions, are a significant cause of morbidity. The most common cause of exudative pleural effusions in patients over the age of 60 is malignancy. The majority of patients with large pleural effusions are symptomatic and experience either cough, chest pain, or dyspnea on exertion. While most patients require pleurodesis, a small number of patients may have resolutions of the malignant effusion in response to systemic chemotherapy; included among this subset are patients with breast cancer, malignant lymphomas, germ cell malignancies, and ovarian cancer.

Thoracostomy tube drainage and instillation of a sclerosing agent into the pleural space is the most widely used means of pleurodesis. Over the past three decades, many agents have been employed in achieving pleurodesis: quinacrine, nitrogen mustards, and doxorubicin were all highly effective but toxic. Corynebacterium parvum was also effective; however, pain and fever limited its clinical use. Tetracycline is effective, has a favorable toxicity profile, and has been the preferred method of chemical pleurodesis in