Leading Article

Challenges facing continuing medical education and the Saudi Council for Health Specialities

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ABSTRACT

As we leave the 20th century, continuing medical education faces many challenges in relation to its effectiveness, efficiency and quality. The young and promising Saudi Council for Health Specialties produces a document on accreditation of continuing medical education, which indicates its interest in this vital subject. This paper aims to enrich the approach to continuing medical education in Saudi Arabia by reviewing the main relevant challenges reported in literature and suggesting that the Saudi Council for Health Specialities may consider developing and implementing a continuing medical education charter that addresses the needs of all stakeholders and emphasizes high quality and cost-effective provision.

Keywords: Continuing medical education, accreditation of continuing medical education, professional development, Saudi Council for Health Specialities.

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The 20th century has witnessed a huge development in continuing medical education (CME) which includes establishment of many CME institutions, organizations, professional bodies and associations; provision of thousands of educational activities; and production of huge amounts of educational media including medical books and journals, scientific papers and meetings, symposia and conferences and recent revolution of electronic media (Internet). Despite all of these developments, challenges facing CME at the close of the 20th century are enormous.[1,2] It is, therefore, timely appropriate for the Saudi Council for Health Specialties (SCHS) to show interest in CME as demonstrated by its recent document on accreditation and monitoring of CME.[3] However it is vital, at this stage to take note of the challenges lying ahead while benefiting from the experience of developed countries in this field. This paper summarizes some of the main challenges and presents a personal view of the way forward.

Challenges. Literature review of the CME has shown that the following are the main challenges facing CME in almost every country.[2] Saudi Arabia is part of this world and from personal observation the same is applicable regardless of magnitude.

Coherence between educational activities and work experience. The gap between theory and practice in medicine was recognized a long time ago but little work has been done to bridge this gap.[4] The majority of the educational provision has little relevance and consequently its impact on the day to day work of doctors is minimal.[5] As a result of this dichotomy, CME does not respond appropriately and timely to the challenges and changes in health care services. For CME to have a real impact on clinical practice it has to stem from and build on the actual experience of doctors.[6] Education should be viewed as the intelligent direction and use of daily experience.[7]

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Cooperation and coordination among multiple providers of continuing medical education. It is common in almost every country to find many providers of CME: universities, health care institutions, professional bodies and associations and private sectors like drug companies. Such multiplicity of providers may be seen as a healthy sign but lack of cooperation and coordination among these providers in terms of planning, and evaluation of CME compromise effectiveness, create duplications and waste resources.

Resources for continuing medical education. Lack of resources is a worldwide phenomenon particularly in relation to CME and research. This is compounded by the inappropriate utilization of existing resources as explained above. However, for CME to be comprehensive , effective and continuous, appropriate resources must be identified and allocated. This can be done through allocation of new resources or more feasibly, reallocation and reorganization of existing resources in amore efficient way (or both). This of course depends on local circumstances of each country.

Continuing medical education based on needs rather than wishes. Challenging educational activities that address shortfalls in performance are usually neither common in CME provision nor attractive to doctors. It was shown also that learning needs are poorly identified by doctors[8] as they tend to choose educational events that fit in with what they already know.[9] Although this is a natural result of unrelieved pedagogic medical education, something has to be done to change this habit. Deficiencies in patients' care detected by research, audit, complaints procedures and litigation must be part of CME provision10. Moreover, there should be a process by which we can judge whether the doctors attend CME activities that meet their actual needs rather than simply their desires.[11-13]

Continuing medical education as a means of change. The aim of CME should be to enable doctors to adapt to change and to take part in change. Health care is changing constantly and rapidly. Thus, CME should be conducted in a way which helps practicing doctors to make their professional work more relevant to, and appropriate for, their populations' changing health needs.[12,13] It is unfortunate that most of current CME provision is not organized to achieve this aim. It simply transmits a huge amount of information, which has little impact on doctors' behavior and attitudes. This has to be changed into a more effective way of delivery, which adopts adult learning principles and encourages active participation of doctors in defining their needs and evaluating CME provision.[14,15]

Quality control of continuing medical education provision. Unless CME provision is based on a more secure and evaluated ground and integrated to health care delivery, many resources will continue to be squandered with doubtful outcomes16. Current evaluations are superficial and deal with here and now issues without going to evaluate the impact of CME on practice and patients' care. Evaluation of CME must address "both the intrinsic quality of the educational experience (including realistic behavioral outcomes) and the role of the learner in choosing it, making the most of it and subsequently applying what has been learned".[17] Literature contains many models of educational evaluation, which may be modified to fit the purpose of CME.[18] Whatever model is adopted, it is important to take into consideration not only the rigorous of the model but also the interest of different parties involved in CME.[17]

The major parties involved in any learning activities are usually learners/practitioners, teachers/ providers and accrediters/managers. Most educational activities do not take into consideration the interest of those stakeholders and therefore has little impact and or support. For example, it is rare to find educational activities which are concerned with educating professionals how to utilize resources properly and put into place an evaluation system to track the effects of such education on professionals' behavior at work. This is despite the general feeling that inefficient use of resources is a common practice amongst medical professionals working in government sectors.

The way forward: A personal view. The establishment of SCHS is a major land mark in the development of health care system in Saudi Arabia. So far many achievements have been attained through SCHS particularly in relation to training programmes and credentialing of doctors. Lately SCHS has produced a document regarding CME which indicates that doctors must attend certain number of educational sessions. It is more likely that this system, once established, will form the basis for re-accreditation in the future.[19] The underlying assumption of this system is being that attendance lead to learning and competence. Unfortunately this assumption is not true because attendance does not mean learning. Indeed, the experience of developed countries tell us that "the impact of credit hours of traditional courses on the quality of practice is disputable, and traditional CME may have impeded development of more effective ways of promoting continued learning the number of reported continuing education hours was found to correlate with lower competence."[20] If this is the case then it can be argued that it is wise to learn from their experience.

SCHS may need to consider developing a shared vision[21] for CME provision in SA that is of high quality, cost effective and address the needs of all stakeholders including managers who are concerned with costs. Such a vision may be formulated in a "Charter for CME"[16] that responds to challenges and provides the necessary guidance of how to deal with

them. Such a charter has to state clearly the rights and responsibilities of learners, providers and accrediters of CME. It has to emphasize that doctors have professional and ethical obligation to undertake further education. Moreover, it has to estate clearly the structure, process and outcome of CME that meets the needs of all stakeholders. Once developed, the charter has to be approved by higher authority and used as a policy statement for implementation.

We suggest that in terms of structure unifying and integrating existing multiple CME structures under the SCHS would form the first but essential step in addressing the challenges mentioned above and pave the way for the more difficult tasks of monitoring and evaluating the process and outcomes of CME. This is not to suggest that it is an easy task but certainly it is cost effective approach. The trend now to contain costs and enhance effectiveness is towards more integration of similar functions and organizations.[22,23] Saudi Arabia may will be the role model for the whole world if this integration takes place and delivers its potentials. While it is important to involve representatives from each organization to ensure smooth integration, we believe that the core of CME is to maintain and enhance professionals competence for the job in a cost-effective manner. As a result, patients care should improve with less cost for the organizations.

We acknowledge that establishing a robust CME structure to ensure meaningful monitoring and evaluation of CME is not easy and would take some time but setting the vision right from the beginning would certainly make the journey more safer, cost-effective and successful.[21,24]

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