

## *Continuous Professional Development; Have we planned for it ?*

Based on observations of various Medical Educationist in the 1980's it can easily be said that a Continuous Medical Education (CME) programme was in which fixed instructional objectives were defined and available resources were utilized using set methodologies to reach those objectives; the information given in those programmes varied as did the skill of the lecturer and the effect on the medical practice of the participant was little or none even if the event was considered good on the criteria's given. This can probably be considered the infancy of CME's and various registration and regulatory authorities in North America, Europe and UK encouraged implementation of these programmes to advance medical education. Although some form of CMEs were practiced by various societies and professional bodies like the Pakistan Medical Association, Society of Surgeons Pakistan etc by holding regular clinical meetings or seminars, they were never given the formal structuring as it was done in the West indeed what most surgeons do with their time is, indeed, continuing professional development but it may not previously have been recognised as such.

The important and critical change seen in CME programmes in the 1990's especially in North America is that these programmes were based on the principle of teaching as facilitation for learning with the learner being the focus. This sea change in CME programmes was guided by studies on adult learning which were focussed on improvement in clinical practices so that better patient care could be provided; thus rather than instructions, facilitation of learning was the objective of these educational events. The consensus that emerged from research into the area of medical education was that the purpose of continuing medical education was to facilitate change in clinical practice of the participants, the natural processes learners use to change should be the basis of all CME's. Medical Educationist found that three interconnected systems were used in making changes: self directed curriculums, small group interaction, and organisational learning CME must construct systems to complement and support the learning of practice based learning. The role of CME providers were shown to provide facilitation for self assessment for acquisition of knowledge and skills with reflection on clinical performance, provide correct and authoritative information and to support the health care delivery system in its development. With the increasing use of electronic means especially

the internet at the turn of the century the wealth of information in the fields of biomedical and health care was structured into courses for CME's which were easy to distribute electronically.

The widespread use of computers and information technology has created a dynamic environment which breached traditional boundaries with the availability of large repositories of information generally and specifically on the World Wide Web. These included graphical representation of the human anatomy including both real and simulated. The availability of interactive videos with text, sounds and images, not only provided the participants a chance to re-evaluate their existing clinical skills yet also gave them a chance to learn new skill like minimal access techniques without exposing the patient to any kind of possible harm. This has shown to be of huge value in the development of endoscopic, laparoscopic, thoracoscopic and arthroscopic procedures.

The student or participant needs to be guided in a way that effective learning occurs minimizing the risk of information overload. The need for large scale investment was reduced with the ease of availability of information to the user at their convenience with integration and application of basic and clinical disciplines, and the development of appropriate cultural perspective and attitudes to the practice of medicine as a caring profession. Trainers and trainees responded favourably to the computer applications and the Internet. This project demonstrated the feasibility of computer-aided learning and the advantages of distance teaching over the Internet.

Ludvigsson in 1999 broadly defined the goals of medical education along certain lines. The first being understanding biomedical concepts related to disease mechanisms, second developing interpersonal and hands-on skills, including forming productive partnerships with patients and healthcare team members and demonstrating appropriate professional values. The third point identified was applying a logical reasoning process to solving individual or community problems and to critical review of new information, fourth was accessing information resources appropriately to support high quality practice to these might be added a fifth point (partly covered by the second), willingness to empathise with patients' (or relatives') predicaments and anxieties.

These aims defined the development and implementation of CME programmes for the next generation of medical

practitioners and probably the paradigm shift of Continuous Professional Development (CPD) occurred. The National Health Service in 1999-2000 directly spent about £1bn (\$1.6bn) on CMEs and CPDs. Researchers and CME/CPD providers have been looking at the cost effectiveness of the programmes. In a 2001 study by Brown and his colleagues of these programmes in the UK concluded that at that point in time, not with standing the substantial resource commitment to CPD, evidence on the cost effectiveness of CPD is completely inadequate.

The need for evaluation of CME and CPD programmes has been an ongoing process and not only have these programmes been evaluated by the providers and the authorities who have in some conditions made them mandatory, but also by the participants. The study in 2006 by Davies and co-researchers into this area after analysing 725 articles through searches on MEDLINE (1966-2006), EMBASE (1980-2006), CINAHL (1982-2006), PsycINFO (1967-2006), the Research and Development Resource Base in CME (1978-July 2006), concluded that while these assessments were suboptimal in quality, the preponderance of evidence suggested that physicians have a limited ability to accurately self-assess. The processes that are used to undertake professional development and evaluate competence may need to focus more on external assessment. The central questions that needs to be asked in implementing these CPD programmes in Pakistan is what of kind model do we need to follow; the North American one where certain number of Credit Hours need to be accumulated by the practicing clinician as they may be required to demonstrate that they have obtained CME credit by state licensing boards, medical specialty societies, ABMS specialty boards, hospital medical staffs, the Joint Commission, and insurance groups as advised by the American Medical Association, or let it be a volunteer approach regarding attendance or should it be linked to process of re-validation. At times questions have been raised regarding the ethical manner of actually attending and gaining something academically and development of skills by practising clinicians as these CPD activities can be sponsored by the health authorities or at times pharmaceutical industry may directly or indirectly be involved. A lot of other issues will come to light if brainstorming is done and it is time the directions for these activities is decided before a half hearted flight occurs and then a downward spiral follows.

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