



Delivering Effective Continuous Medical Education in Saudi Arabia: Some Critical Issues

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Abstract

Purpose: Continuous Medical Education (CME) is growing fast in Saudi Arabia as part of health practitioner's commitment to professionalism. It furnishes the means to maintain the practitioner's ability to provide quality and safe patient care. However, major issues regarding the process of conducting CME in the country have not been investigated before. The purpose of this study is to describe the CME practice in Saudi Arabia.

Method: The method utilized in this qualitative study was focus groups. Leaders of CME departments in various hospitals in Riyadh area participated in the study. Hospitals were categorized to different levels according to their governing systems.

Results: In total 17 representatives of various CME bodies responded to 16 questions related to four main themes. Their responses varied according to several factors. The results provided new and insightful understanding of CME practice in Saudi Arabia.

Conclusion: The CME practice in Saudi is facing several challenges at both financial and administrative levels. Suggestions for facing such challenges were provided. Moreover, further studies in this area are needed.

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Keywords: Continuous Medical Education; Saudi Arabia; Focus group

1. Introduction

Knowledge and skills are dynamically changing and expanding in the medical profession. Therefore, continuous learning and development is essential to ensure quality health care corresponding to the latest trends and cutting-edge technologies. The use of Continuous

Medical Education (CME) is a sound approach to achieve such a development. The first conference on medical education held by the College of General Practice of Canada in Toronto in the fall of 1962 produced the following consensus: "Continuing Medical Education is an essential feature of the practice of modern medicine, as it maintains the doctor's ability to provide quality patient-care. This concept of 'life-long learning' must be actively developed in the undergraduate medical student and sustained in the graduate doctor, both practitioner and teacher".¹ The Accrediting Council of Continuous Medical Education (ACCME) defines CME as the "Educational activities which serve

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to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession".²

In most countries, accredited CME activities are measured in credit hours. These activities can be divided into three main categories: 1) organized by national or regional professional bodies (e.g. courses, seminars, conferences, meetings); 2) organized in the context of the work place (e.g. practice-based activities, case conference, grand rounds, journal clubs, teaching, consultation with peers/colleagues); and 3) based on electronic materials provided by various bodies (e.g. CD ROM, web-based materials).³

Establishing an effective CME activity requires careful planning and design. A number of factors determine the design of CME activities. These factors can be divided into macro-level and micro-level forces.⁴ Broad macro-level factors are the social and regulatory environment, health care setting, culture of education and improvement, funding, accreditation requirements, credit hours regulations, etc. Equally important are the micro-level forces including the willingness of the individual learner to engage him- or herself in CME, the attitudes of team members towards CME, time management, amount of professionalism, etc.

The process of designing CME activities commonly goes through different stages, starting with the assessment of needs and ending with outcome evaluation. The two common methods of assessing needs are (1) assessment in which the focus is on the services that are being used and (2) survey assessment where practitioners identify their perceived educational needs.⁵

Although CME is growing in Saudi Arabia, it has not been studied in detail. The aim of this paper is to provide a baseline understanding of CME practice in Saudi Arabia. Particularly, it will describe CME practice in Saudi Arabia, as viewed and discussed by directors of CME departments. This might help in obtaining the needed insight on CME in Saudi Arabia with the aim of improving it.

1.1. CME in Saudi Arabia

CME practices in Saudi Arabia are not different from international trends related to CME. Historically, Saudi Arabia had no mandatory system of professional registration until 1995, when it imposed an accreditation system that counts CME activities for the purpose of licensing and re-licensing. The regulatory body for registration and licensing health professionals and all related Medical Education programs in Saudi Arabia,

Table 1

Numbers of accredited educational activities and continuous education hours in Saudi Arabia for the period from 2002 to 2010.⁶

Years	Number of activities	CME hours [*]
2002	1036	–
2003	1688	–
2004	1991	–
2005	1963	–
2006	2357	–
2007	1211	–
2008	2358	–
2009	3381	26,726
2010	5601	41,735
Total	22,086	68,371

^{*}The system for registering CME hours was not implemented until 2009.

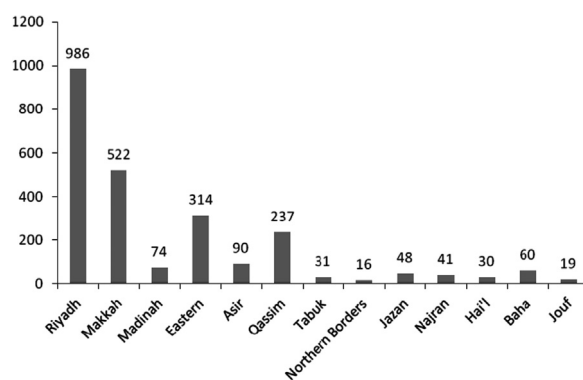


Fig. 1. Accredited CME activities per regions in 2008.⁶

including CME, is the Saudi Commission for Health Profession (SCHS). Since establishing the accreditation regulations, there has been a strong and steady increase in the number of accredited CME programs in the country. For example, the Saudi Commission for Health Specialties approved 1036 CME activities in the year 2002, compared to 5601 CME activities in 2010.⁶ Table 1 shows the number of approved activities by the Commission during the years 2002 until 2010.

The SCHS rarely rejects a submitted proposal for CME approval. For example, in 2010, it rejected less than 1% of applications.⁶ However, little is known about trends, barriers, main tools used, educational strategies, and effectiveness of CME activities in Saudi Arabia. We do know however that calls for better CME in Saudi Arabia have been published over the last 10 years.^{7–9}

For example, Al-Shehri et al.⁹ suggested that there is no evidence CME is subjected to quality assurance measures. Location might also be an issue. Most CME activities are provided in large cities where large

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