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Continuing Medical Education: Adult Resistance Against Learning

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Abstract: Information flow between the different corners of the continents made patients in the developing world more aware of the health care quality and the standard of medical professionals. The matter became of great concern to the public and subsequently to the authorities. The aim of this paper is to identify some of the important factors that may have influenced the lack of progress of a group of doctors practicing in regional hospitals. Study group comprised of (25) orthopaedic residents, who failed to show the expected level of career progress, consistent with what would be expected of a (35) year old medical practitioner. Their career progress was observed over a period of (15) years. Nine continued in orthopaedics. Only two of them reached the level of consultant posts. (16) pursued different careers within the health care services. (8) were happy with their progress in the alternative career, while the other (8) were dissatisfied. As many other doctors were able to progress under similar circumstances, adult resistance against learning was considered an important reason to explain the lack of progress in this group. The factors considered important for failure to progress include; resistance to change, selective attention, negative attitude, indirect communication, frustration, and failure to obtain recognised higher qualifications. The commonest excuses used to explain their lack of progress were: discrimination, financial requirements, family responsibility and work overload. Conclusion is, training programmes and professional career guidance are urgent considerations in many developing countries. There is a need for modifications and reformation to ensure effective future developments, modification, effective future.

Keywords: Adult education, resistance against learning.

المستخلص: نتيجة لثورة المعلومات وطفرات تكنولوجيا انتقالها بين أركان العالم، إرتقى الوعي الصحي في الدول الناميه. وأصبح سكانها على دراية بمستوى الهيئات الطبية والخدمات الصحية في العالم الأول، مما يعنى جسامة مسئولية الهيئات الطبية والمهنيون في الطب بالدول النامية. تستهدف هذه الدراسة تحديد أسباب تقاعس بعض الأطباء والإرتقاء بمستوياتهم المهنية حتى يتسنى لهم تقديم الأفضل لمرضاهم. شملت الدراسة (25) طبيباً في جراحة العظام تجاوزت أعمارهم (35) عاماً لم يسجلوا تطوراً بالقدر المتوقع منهم. حيث إستمر (9) منهم في جراحة العظام إرتقى منهم إثنان فقط إلى درجة إستشاري. أما (16) طبيباً الآخرين، فقد إتجهوا إلى وظائف آخرى في الجهاز الطبي، سجل (8) منهم نجاحاً فيها. وهذا يعني أن هناك (15) طبياً من عينة الدراسة (25) لم يحققوا تطويراً يتلائم مع إمتداد سنواتهم بالعمل في التطبيب، مما يستلزم تحليل المعوقات المتسببه في ذلك، والتي من أهمها إفتقاد المرونة، عدم القدرة على التأقلم، السلبية وعدم الإهتمام بالدراسات العليا كالزمالة أو الدكتوراه. تتخلص مبرراتهم في إدعاءات التميز بينهم فضلاً عن الأعباء وضغوط العمل. من هنا تبرز ضرورة مراجعة برامج التعليم والتدريب الطبي وتقييم القائمين على أمرها والملتحقين بها لمعالجة هذه المعوقات وتفادي فاقد التأهيل الطبي المتواصل.

كلمات مدخلية: التعليم الطبي المستمر، تقاعس الأطباء، التأهيل، المواكبة.

Introduction

The traditional relationship between patients and their doctors is changing under the influence of the media and the increasing easy access to medical information. With revolution of information technology and availability of Internet, new knowledge has become available to many people all over the world. There is an increasing number of patients armed with up-to-date information about their illness and lines of management. Patients expect doctors to be competent and to provide a good quality of health care.

Health care professionals in developing countries must be willing to adapt to the changes. They need to critically assess their experience and to look into the experiences of developed countries. Reforming medical education for students and doctors, as well as the development of new strategies has become unavoidable.

(Colin and Des Marchias, 1996) discussed the strategies for successfully completing a major change, taking into consideration the factors inviting changes and the characteristics of the changing process. They stated that there is no single formula for success. The outcome of changes will depend on commitments, trust, professionalism, intuition and dedication.

One of the important factors to influence the quality of future doctors is, quality of the academic staff in the universities. (Martenson *et al.* 1998) reported on a set of portfolia of competences developed to define more clearly the requirements for academic appointments. It is important to appropriately include education, clinical practice, research and administration abilities. (Ogundele 1996) stressed the need for the reassessment of post-graduate medical education in West Africa. Based on the outcome, applicable changes were recommended.

Looking into the development of health care in the Gulf States over the last fifty years, there has been noticeable progress when compared to many other developing countries. Prior to that, there were efforts supported by missionaries, which were very useful but on a smaller scale. In the last three decades, institutions, universities, medical conferences and in-service training existed and developed over most of the Gulf States. Structured training programmes started with the major medical specialities and gradually expanded to cover most medical disciplines. Many nationals and expatriates adapted themselves to the development and progress through Continuing Medical Education (CME). Unfortunately others did not.

While developing training programmes, there was a shortage of local human resources to design, supervise and run programmes. Some of the highly qualified national professionals organized training programmes. Senior medical consultants from the more developed countries were recruited to take part in health care services and in the development of structured programmes. Due to differences in the set up among developed and developing countries, there were problems in applications and a distinct gap existed between theoretically written and applied programmes.

This study was initiated in the early phase of developing structured training programmes in the regional hospitals. It explores the problems of training medical practitioners above the age of 35 years and suggests modifications for future improvement.

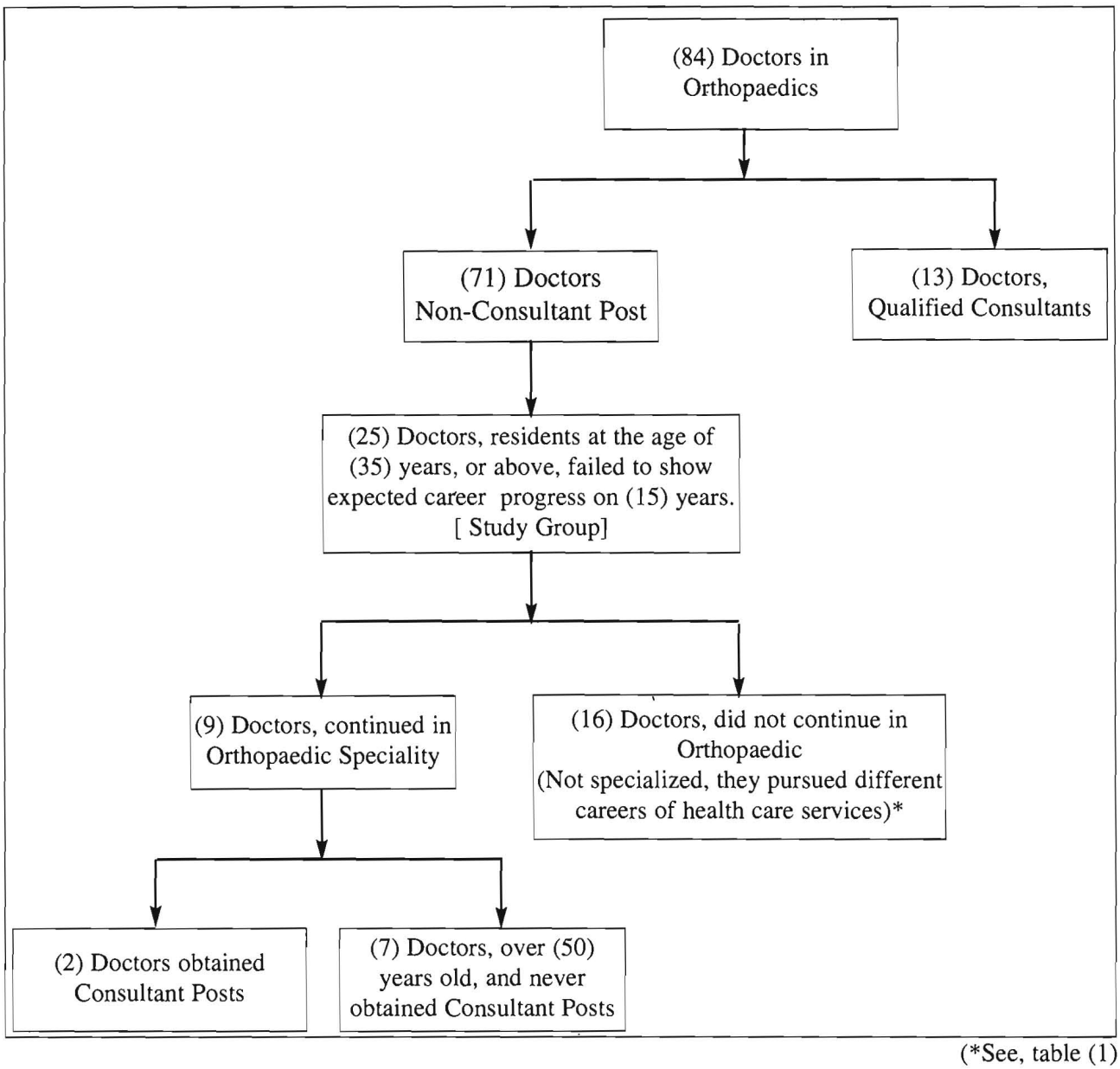
Methods and Findings

In 1985, when a structured post-graduate orthopaedic training programme was planned in five regional hospitals, it was necessary to evaluate the available manpower. There were (84) doctors in orthopaedics, (13) qualified consultants and (71) non-consultant posts. In the non-consultant posts, there were (25) residents at the age of (35) years or above. The study group was composed of these (25) doctors who failed to show the expected level of career progress consistent with what would be expected of (35)-year-old practitioners. Their career progress was followed up over a period of (15) years.

Nine continued in orthopaedic speciality, two of them obtained consultant posts. The other seven, now all of them above the age of (50) years, never made it to consultant posts. Two of them have reached the retirement age.

Out of the (16) practitioners who did not continue in orthopaedics, four entered hospital administration (the first one after obtaining a diploma in hospital management, the second became a shareholder in a private hospital, the third through indirect personal influence, the fourth did not settle in one job). The first two were satisfied with their posts. Three became general practioners; one obtained a diploma and two attended short courses. Two were satisfied and successful, and one of them was appointed to run a major primary health care centre.

Three switched to sports medicine, two attended courses and adapted comfortably to the job. The third practiced in sports clubs. He is doing part time accident and emergency sessions in a hospital beside his sports medicine commitments.



(*See, table (1)

Fig. (1) Follow up of the (84) Doctors in Orthopaedics, GCC Regional Hospitals,1985.

Two joined geriatric and disabled care. The two were satisfied and one of them is devoted to the job, obtained a postgraduate diploma and progressed to the running of a rehabilitation unit.

Two became interested in private business in addition to part time calls in clinics and hospitals. One is involved in the real estate business and suffered several attacks of angina before the age of (50) years. The other one became a boutique shareholder and died at the age of (54) years.

Two suffered from addiction to alcohol and never settled in a particular job.

As many other doctors were able to upwardly progress under similar circumstances, individual adult resistance against learning was considered among the important factors in not progressing.

Through individual informal interviews and communication over the years the following factors were involved in the problem of progress: resistance to change, selective attention, suspended organization, negative attitude, indirect communication, escape from professional commitments and failure to obtain further professional recognized higher qualifications.

Stress and frustration were observed among most of them. This was not attributed to any specific factor. Among the many factors used to justify their stress and frustration, the following were mentioned: discrimination, family commitments, financial requirements, problems of workload and quality. Furthermore, they were uncomfortable sleeping in the hospital at this age when on call. The same factors, stress and frustration, were used as excuses for a lack of progress in comparison to successful candidates of the same age group. The excuses were directed at: family, department, institute, community and above all to oneself.

The outcome was as follows: from the (9) who

continued in orthopaedics, only (2=22%) reached consultant posts. (16) candidates did not continue in orthopaedics, eight of them (50%) were satisfied and successful in their alternative careers (table 1).

Table 1: the follow-up of the 16 doctors who did not continue in orthopaedics

Alternative career	Satisfied	Not satisfied	**Total**
Hosp. Administration	2	2	**4**
G. Practioners	2	1	**3**
Sports Medicine	2	1	**3**
Rehabilitation	2	0	**2**
Private business	0	2	**2**
Unidentified	0	2	**2**
Total	**8**	**8**	**16**

Discussion

Adult learning is based on many factors including the individuals motivation, use of resources available and access to relevant information. Although a major part of adult education is based on self-learning, it is important to recognize the role of departments, institutes and society.

Competition is increasing among health care professionals, and public expectations are getting high. The public would like to be assured of the standard of health care they receive (Crossley, 2001). Therefore, Continuing Medical Education (CME) and higher studies became common practice to meet the vast expansion of knowledge and the fast changes in technology. Post-graduate learning, training and recognised higher qualifications are pre-requisites for progress and upgrading of candidates. Life-long (CME) became a necessity as a result of the impact of changing education, societies and political forces on medical practice (Bennett *et al.,* 2000).

In developed countries, (CME) and structured training programmes for medical professionals were developed and reached a good deal of maturity through flexible long continuous processes of assessments, changes and modifications (Black & McDonald, 2000); (Davis *et al.,* 1995); (Roter *et al.,* 1998). The selection of candidates to join programmes, followed by regular assessments at the beginning, during and at the end of the programmes, were recommended and implemented (Ritchie, 2001). Feedbacks from and concerning the candidates, trainers and supervisors were obtained and used to develop priorities and to improve the quality of the programmes (Kingston & O'Brien, 2002).

In the developing countries, there are significant efforts and trials to assess, improve and further develop medical educational programmes and recognised higher qualifications. The progress in the developing world varies within and between countries.

A study from Malaysia (Shahabudin & Edariah, 1991) stressed that lack of time and resources make (CME) inaccessible even to motivated doctors. The progress was compromised by too many commitments at work, family responsibilities and inaccessible (CME) activities. Less participation in (CME) was observed among doctors between the ages of 34 and 45 years. More participation came from doctors with higher qualifications, members of professional societies, hospital based practitioners and journal subscribers.

Some of the developing countries were able to progress faster than others. In the Gulf States with a wealth from oil production, the financial resources were not obstacles. When looking to the future and further development of training programmes for medical professionals, it is important to use and modify the experiences of the developed countries. Furthermore, it is necessary to objectively assess the current situation. Three important aspects have to be addressed; manpower assessment, developing flexible programmes, and developing a mechanism for continuous assessment.

(**I**) Manpower assessment

Manpower assessment should consider:
- (**a**) Candidates under training,
- (**b**) Trainers or supervisors, and
- (**c**) Policy makers.

Assessment of the candidates in training posts has to include the age, qualifications, training experience, motivation, expectations and face-to-face honest discussion. Depending on the evaluation, some candidates may join or continue in speciality training programmes, others may be trained for non-consultant intermediate grade posts, which have to be developed and recognised. Some may be counselled for an alternative career within the health care services.

In this study, (25) doctors passed the age of (35) years without achieving the expected progress for their age. Nine continued in orthopaedics, and only (2) reached consultant posts. Out of the (16) doctors who did not continue in orthopaedics, (8) were successful and satisfied (see, fig.1). That outcome occurred without the availability of enough professional teams of trainers or career advisors.

However, the system had been broad-based and flexible to allow alternative careers for the candidates. Would availablity of enough trainers and career advisors change the outcome? This may have changed the career of some of them. However, it has been reported that some severely incompetent doctors may not benefit from further training programmes (Hanna et al., 2000).

The availability and selection of trainers, supervisors and career advisors is essential for acceptable outcome from any training programmes. There is no point gathering a large number of candidates for training in the presence of a small number of efficient devoted trainers. Many of the programme supervisors are trained and qualified in developed countries, and many of them reached a high standard of professional abilities. However, it is important to realise the difference between societies concerning candidates, resources and objectives. Many of the candidates are products of old non-flexible education systems at schools and universities. Therefore, trainers have to meet with the trainees at some point of understanding to make programmes work, rather than developing an unbridgeable gap between written and applied curricula.

Hired experts who were not appropriately informed about the existing difficulties, and nationals who were abroad for training and recognised qualifications, designed many of the programmes in the developing countries. It is possible that many of those programmes lacked an understanding of the existing local needs and ways of thinking.

Many of the health care policy makers in the developing countries are selected by, or belong to, young democratic political systems. It is understood that they have to show some early results and effects to satisfy the political set-up. Health care professionals and policy makers have to meet at a point of understanding to admit the political need for short term plans, and the professional need for future changes based on long term well structured plans. Even in developing countries, the success of health professionals' education programmes depends in part on the ability of educators to influence the politicians (Huntington, 2001).

(**II**) Development of flexible programmes

Writing impressive programmes or copying programmes from advanced institutes in the developed countries will never be the best solution. Many candidates joining the programmes may not appreciate the contents of the programmes. It would be more pragmatic to assess the available (CME) activities and bring about gradual effective changes and modifications until the programmes reach an acceptable level. At the same time, structured programmes from the developed institutes are to be used as a flexible outline to upgrade educational programmes for developing countries. Engineers cannot decorate the 10th floor of a building where the lower floors have not yet been erected. Why should medical professionals in developing countries construct training programmes from the top? Long lists of curricula, which they might not appreciate, deter candidates from joining or continuing in programmes. Candidates should be represented and take part in formulating and assessing programmes. The introduction of a guided self-assessment concept may lead to more participation in the learning activities (Fox & Harvill, 1984). Efforts from supervisors are needed to convince candidates of the required developments and changes.

On designing programmes, as it is necessary for the trainers to direct the trainees into the process and mechanism of learning, it is also important to direct themselves, as well as the candidates, to the process of cleansing processes to the mind concerning old knowledge, concepts and behaviour. (Wilson 1988) stated that we must develop a method for getting permission to unlearn. The goods at the back of our mental warehouse not only gather dust and deteriorate, but also actively infect new stocks with old concepts.

(**III**) Mechanism of continuous assessment

Many programmes are well written and begun in a satisfactory way. It is important for a programme to start with defined responsibilities of particular supervisors. However, there are risks of deterioration if the programmes are not designed with inherited mechanisms of continuous assessments. Assessments have to be partially independent and based on what is taking place in reality and with frank, constructive feedback from candidates and trainers. Further changes in the programmes have to consider the speed of progress. To get younger candidates committed, the CME activities have to contain structured programmes to prepare candidates for recognised higher qualifications and specialisation. Obtaining a higher qualification, and the quality of the graduates, should be taken into consideration during the process of a programme's evaluation.

Conclusion

Career guidance should start early, preferably at the medical schools but certainly in the early stage of professional training programmes for specialization. CME and educational programmes need a lot of consideration in developing countries. It is important to be lucid about the assessment of the current situation and to design carefully the future steps. In evaluating the current circumstances it is necessary to analyse the quality and motivation of manpower, developments of flexible programmes and mechanisms of continuous assessments. Closing the gap between the current circumstances and the future goals needs motivation, hard work, focus, a pragmatic approach, and challenging decisions.

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