

AMEE GUIDE SUPPLEMENTS

Continuing medical education: Guide supplement 35.2 – Viewpoint¹

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Continuing medical education (CME) refers to a field of knowledge oriented by a critical analysis of trends of continuity and the emergence of educational approaches for the development of medical professionals. Its major strength lies in its capacity to recognize needs for keeping up with exponential information change and to value the benefits of current practices that allow professionals to stay up to date by obtaining information through a variety of media. AMEE Guide No. 35 presents a careful review of CME, including its concept, history, planning processes, and ongoing practices (Davis et al. 2008). The guide poses thought provoking questions about the limits of CME and reviews deeply rooted practices still in use that are known to be ineffective in terms of changing practices.

Traditionally, CME is focused on the individual, the physician. It is, however, the collective health team, more than the individual physician that is the key to improving healthcare practices. We present a Brazilian approach to CME, permanent education for health (PEH), (BRASIL) initially developed by the Pan American Health Organization (Brito et al. 1994), that is a reflective educational strategy for transforming collective work and improving the quality of health services and that leads to specific actions framed by responses to a series of questions (Brito et al. 1994; Box 1).

The main focus of PEH is to recognize the educational potential of workplace scenarios and the inextricability of education and management in the workplace within institutions committed to the quality of care. In PEH, the gaps or problems are a key to building collaborative educational initiatives that focus on the differences between the desired quality and the realities of practice. The PEH perspective is one in which problems are not 'identified' as if they were there, 'given,' to be discovered. Rather, they are understood to emerge from reflection on experiences. Their features depend on who is part of both the experience and the reflection. There is no problem without a subject 'problematizing' reality (Freire 1997). Problems are a complex network of 'causal' interactions within which educational gaps may be relevant. The definition of a problem, or what may be seen as a problem, varies according to the subject problematizing it. A group of physicians would come up with a problem fairly different from the one constructed by the members of a health team.

A key difference between PEH and CME is that in PEH the assessment of needs involves a commitment to care management that is not an exclusive responsibility of managers; just as professional development and education are not only a problem for educators (Table 1). Practice change is understood as a collective way of dealing with problems of care in an institution that learns from experience and changes the way

it functions. Changes in the processes of professional development (education) are effective when there is also a commitment to changes in healthcare practices; a recognition that both are inextricable and complementary.

Permanent education is understood as the educational component of the management of quality considered as a process of continuous monitoring of achievements of health teams towards their ultimate goal, i.e., meeting the needs of patients and communities for whom they are responsible. Health teams seek explanations for problems faced in their practice through collective reflection. Gaps identified as part of the problem become the beginnings of educational plans rather than the end point. The process of identification of educational needs is a distinctive feature among initiatives of professional development in both CME and PEH. Individual demands for CME are often far removed from the problems professionals face in their daily practices.

Permanent education captures practical dimensions within the institutional context that embody culture, history, conflicts, contradictions, and power relationships among professionals of different health teams, all of which are embedded in the practices to be transformed. The knowledge recognized as key to dealing with problems identified by the team becomes meaningful to the whole and leads more fully to practice change in which scientific knowledge is broadly contextualized. The functional relevance of scientific concepts depends less on their intrinsic validity than on the capacity and desire of professionals to use them. Their use is determined by context and the way knowing emerges linked to the concrete problems regularly encountered by professionals.

Knowledge is a verb, i.e., knowing is an action of continuously becoming rather than a state of being and meaning cannot be characterized apart from how learning occurs and is applied. Knowing emerges from reflection on experiences with continuity (Dewey 1934, 1938; Doll 1993). The introduction of a concept requires that it be contextualized according to the milieu in which the subject interacts (Eraut 1994). The milieu/context includes the entire health team, not only the physician. In PEH, the collective team frames the context, interpretation, and action in which learning experiences take place as the core for reflective professional development.

Another distinctive feature of permanent education is the fact it recognizes that practice change involves teams, not isolated professionals of different categories (Table 1). Health work is a collective enterprise, as are most of the problems professionals face daily. Building expertise and competence are considered as collective rather than individual (Schwartz

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Box 1. Questions for PEH.

1. What constitutes quality for us and for our patients?
2. What problems do we have achieving the patterns of quality? (includes data from patients, evaluation projects, outcome analysis, group experiences, etc.)
3. What is going on? How are things working?
4. Whose problem is it? Who is involved and who must be present (including colleagues from other units/services (labs, imaging, etc.)?)
5. What do we need to know to understand the problem? What explicative framework can we construct?
6. What are the necessary interventions (educational and other) to move from where we are now to where we need to be?

Table 1. Key differences and features of CME and permanent education.

	CME	Permanent education
Objective	Actualization of knowledge	Health practice change for quality achievement
Assumption	Linear relationship – more knowledge/better practice	Nonlinear and linear relationships – health practice as a social construct
Scenarios	Teaching scenarios/relatively low degree of contextualization	Work settings high degree of contextualization
Targets	Professionals individually	Health teams
Educational strategies	Mainly transmission of information/knowledge	Problematization/reflection about quality of services
Responsible	CME planners/providers	Health teams + managers
Educational techniques	Learning tends to be more passive; individual learning	Learning tends to be more interactive; team work
Identification educational needs	By individuals	By health teams, according to explicative net of problems
Content	Mostly clinical	According to explicative net of problems

1998). The efficiency of a group is not the sum of the individual competencies (Schwartz 1998). Effective group work emerges as a self-organizing synergic event, as the *mis en scene* of a synthesis of diverse individual interactions.

Traditional medical models reinforce the idea that the problems physicians deal with are solved by individuals with scientific knowledge and that practice is the application of theory. It is understandable that a strong linear relationship exists between new information/knowledge and improved practice. In contrast, PEH treats practice as the space of interlocution and of the emergence of knowing through collective framing and action.

Caring for others is transformational. The articulation of such dimensions is key to understanding the methodological approach of PEH and the management of the interrelations between theory and practice and of quality and education in the workplace. Knowledge is necessary but not sufficient to change practice. PEH recognizes the social nature of health work and of the production of health services as well as the significance of the social nature of health problems and healthcare. The challenge to the medical education community is to expand its conceptual and practice framework to include PEH as a powerful and coherent approach to the transformation of healthcare practices.

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Note

1. This AMEE Guide was published as Davis, namely, Davis, David and Block, Ralph (2008), Continuing medical education: AMEE guide No. 35. *Med Teach* 30:652–666.

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