EDITORIAL

Continuing Education
Perspectives from a New Assistant Dean

Greg Peachey, MD, FRCPC

The year 2005 might not be viewed as one of those hallmark years with massive significance. It is not the beginning of a new millennium, nor is it the beginning or end of a decade at which time there is pause to reflect about what has happened or what might transpire. Instead, it is a year between other landmark years, allowing us to transition from one major event to another.

For me, however, 2005 does have particular significance, since this is the year I was offered and accepted a challenging opportunity at McMaster University as Assistant Dean of Continuing Health Science Education.

It seems strange that an anesthesiologist would embark on what one might consider a bit of a career shift, but my background in education has followed the usual path through the three phases of medical education.

First, there is ante medical education. This is the period before medical school when we gather the building blocks for our future education. It is composed of the elements so eloquently described by Robert Fulghum in *All I Really Need to Know I Learned in Kindergarten*. In this short essay, he describes the importance of how to play in the sandbox with others, the merits of living a balanced life, the lessons of the little seed, being aware of wonder and remembering to look—all of the essentials of life and the basics of learning that are easily extrapolated to the sophisticated world of adult learning.

I have taught these same things to my two boys and, to this day, I have Robert Fulghum's words of wisdom hanging on the wall in my office for continued inspiration and the occasional need to refer back to the basics.

The second stage is beginning medical education (BME). This is the time when friends, colleagues, professionals, educators, mentors and many others expose you to knowledge, facts and techniques to guide you on your way through a structured education curriculum. An appropriate sequel would have been *All I Ever Needed to Know About Medicine*, but to my knowledge, Mr. Fulghum has not completed this work.

At some stage, there is the realization that there is absolutely too much to learn in the BME stage to assimilate in

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the three or four years of medical school. There is the recognition that, after finishing medical school, or whatever formal education, there will be new things to learn and old things to relearn. This is when one enters the third phase, continuing medical education (CME).

During the transition to this phase, decisions are made regarding what is important in terms of your patients, career, profession and yourself. This is the phase that eventually shapes you into the professional health-care provider, able to balance the demands of time, pressure technologies and an ever-increasing wealth of knowledge to function effectively in your chosen profession.

During the transition to CME, decisions are made regarding what is important in terms of your patients, career, profession and yourself.

The migration through these various stages is an individual course. From an individual perspective, the direction may vary over time and the emphasis or attention given to this journey may change, but I believe it is a journey that all health-care professionals take over the course of their careers. However, while the journey may be individual, the trip is not made without traveling companions. We do not learn in isolation; the best learning is timely, interactive and reflective. The challenge for continuing education (CE) programs is to facilitate this process for the individual and the group as a whole.

The process of facilitation through CE programs has two pursuits. One involves the provision of an educational environment and opportunities that permit the traditional activities associated with CE—workshops, conferences, courses, programs, *etc.*, which disseminate information based on the tenants of "evidence based" or, more accurately, "best evidence" medicine. It involves a process of educational needs assessment for the defined target audience, the packaging and delivery of accurate and appropriate information and, more recently, an added element of assessment to determine if the learning exercise has had an impact on clinical practice or outcome measures.

The methods of delivery of CE offerings come in a variety of forms, from large group sessions to individual studies, one-time events to series offerings, didactic to interactive and directed versus self-directed. This is effectively the structure and scope of activities of the CE program in which I am involved and it probably mirrors most other CE programs in the country and North America.

This format or style of facilitation is the result of a number of factors that have shaped the business of CE. Professional and regulating organizations have embraced the concepts of clinical and professional competencies. Health science education has, in addition to the traditional role of the health expert, added emphasis on the roles of communicator, professional, advocate, manager and collaborator. There is increased emphasis on interdisciplinary interaction and learning, yet the development of programs and CE events that transcend traditional boundaries of education specialties is still difficult, since the trend toward group learning still reflects professional groupings of medicine, nursing and allied health professions rather than an interdisciplinary mix with shared educational goals.

The second aspect of the facilitation process is anticipating how future consumers of CE material will shape their individual learning styles. We must examine how the

learners at the junior levels are currently acquiring the techniques and the professional skills to continue their life-long learning. This is particularly relevant in the McMaster Faculty of Health Sciences, where the undergraduate training program has undergone a major revision.

Comfort with and reliance on technologies, such as the Internet and e-learning, may significantly alter how CE evolves to accommodate the learners of the future. The decision to invest in developing these new learning strategies must be carefully considered, since development and implementation costs will be high. There is no doubt that Internet or e-learning opportunities will be attractive to those who have difficulty accessing traditional CE events due to distance, timing and availability factors. Still, such techniques may not appeal *en masse* to an audience that may still desire and benefit from traditional styles of CE. Some individuals may not benefit from individual, self-directed e-learning modules as much as from opportunities that permit interprofessional interaction.

I still find comfort in being able to review a printed article or topic in a text book rather than relying on electronic versions of journals and books that have been developed for my convenience. I enjoy interacting with colleagues at conferences and workshops, and would not like to limit my CE to interactions with a computer terminal. I am sure this is a reflection that I have carried over from my BME training and the skills and techniques I adopted for my own CE strategies. Still, the junior learners of today may be developing different styles and techniques and, as leaders in CE, it is critical that we keep pace with the innovations in learning so that we can provide the best CE programs to meet the needs and the demands of future consumers of CE material. Failure to invest resources now to change the way we do the business of CE in the future may put us in a position where we are unable to meet the needs of the future health-care providers.

The planning and resource investment for continuing health science education will be done in a health-care environment that continues to present challenges. The scope will range from local to international and will be interdisciplinary, with technologies that are just beginning to be developed. As professions define future directions, as governments and regulators develop policies and as resources are allocated for health-care provision, the challenges for programs of continuing health science education will be to respond in a way that we are able to fulfill our mandate and meet the life-long learning goals and objectives of current and future health-care professionals.

With limited history and experience in this position to date, I am not sure how things will unfold. As we face the challenges noted above and others I have not mentioned, or which are yet to be identified, I cannot predict the future impact on health-care education. However, I am excited about the prospects and happy to be a part of the process, and expect to refer to Robert Fulghum's work frequently.

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