EDITORIAL

Cocktails and absent friends?
Writing this editorial in the aftermath of the ICOH's Conference on Education and Training in Amsterdam, it was not too difficult to reflect on the differences from the Kitakyushu conference, some three years ago. One aspect is renewing old acquaintances and making new friends. It brings a sense of unity of purpose to our profession that is hard to find in other specialities or indeed at other professional meetings. It is the base spirit of the cocktail that makes up post-conference euphoria.

One area of difference between the two meetings was the total absence of any discussion on problem-based learning, which dominated the Kitakyushu conference. Problem-based learning as an approach has gathered support from countries as far apart as Scotland, The Netherlands and Australia. Yet there was no report of developments or studies of the approach. Could it be that problem-based learning has become too respectable to be of interest or has it withered on the vine?

This is not intended as a criticism. A conference can only be as good as the papers submitted for presentation. But, it is only right and proper that one should question the reasons behind its absence from the programme. The conferences organized by the ICOH's Scientific Committee on Education and Training have shown a steady increase in attendance since their inception, indicating the growing interest in the area. What we seem to be lacking is rigorous scientific investigation and evaluation of our educational approaches at undergraduate, postgraduate and intra-speciality levels. Problem-based learning approaches are a rich, powerful and fertile field for development and investigation. They should not be allowed to become merely a medical device for education and training, providing a useful vehicle for the education of managers and workers alike. They do not deserve to be left on the shelf to gather dust.

Neither was our attention turned to the question of continuing medical education (CME), despite the fact that the third age of medical training has come to assume an importance that outstrips its proven effectiveness. CME is beginning to have importance for quality, specialist accreditation and even registration. It cannot now be ignored. We have previously addressed the subject in this column and its increasing momentum gives us yet another excuse to address the matter. It is very clear that CME is an important issue, but rather more than that, it is a hallmark of our professional status that we assume the responsibility for defining and meeting our own learning needs.

For many years, occupational physicians have read this journal and attended meetings of the Society and Faculty of Occupational Medicine or sister organizations and publications, all in the name or at least the spirit of CME. A number of centres in the United Kingdom have attempted to address the subject, using local arrangements and initiatives. Some have even drawn up programmes related to perceived needs. Regrettably, they have not been subject to rigorous evaluation and there is little indication that such initiatives have contributed to the objectives of CME. Accepting the burden of organizing one's own CME is not a high priority compared to the pressure on the speciality today to demonstrate its value in the interests of survival.

Professional accreditation has been in existence for over a decade. How sure are we that education and training that leads to accreditation meets the needs of the practising occupational physician? Experience in other specialities suggests that it is likely that the majority of doctors will have unmet needs for additional learning after their formal training is complete. Most of these needs are likely to be in the areas of practical skills. Another element absent from the curriculum is management skills. This deficiency is being addressed by the innovative programme from Glasgow University. However, only two papers at the conference addressed management education for occupational health professionals.

The period of specialist training required for accreditation in the UK brings to occupational health the principle known to adult educationalists, that learning by doing is the most effective way of producing a change in behaviour. As the whole process of assessment is called into question, there is an increasing realization that producing lists of what trainees should have been taught, either during their training as doctors or as occupational physicians, means considerably less than
showing what they can do as a result. Hence, great interest was shown in the portfolio and dissertation requirements for Faculty examinations.

It has been suggested that education is a process of intellectual and emotional development concerned with problem-solving skills, synthesis and analysis and development. Medical education, it is argued, prepares doctors to adapt to change, to make discoveries and to innovate. This is distinct from training, which is concerned with the acquisition of knowledge, skills and attitudes to carry out previously identified tasks. Occupational medicine practice changes more rapidly than almost any other branch of the profession, being subject to social, political, legislative and scientific constraints. We really have only partially defined what knowledge, skills and attitudes need to be acquired during the period leading up to specialist accreditation. Should that period be more correctly termed 'education' rather than 'training'? Acquisition of the certificate of specialist accreditation should not be an end in itself, but a beginning.

Where trainee occupational physicians acquire their training will be important in providing the best model for professional learning in the future. Recognition of training posts may focus on issues of space, equipment and resources. Perhaps what is more important for the future vigour of the speciality is to emphasize the importance of the variety of teaching methods by which any aspiring occupational physician may acquire the necessary education in occupation medicine. Approval of training posts should not necessarily focus on the availability of teaching time, important though this is, but should instead focus on the use that will be made of it.

Attendance at relevant conferences and other professional events serves as an important model of behaviour for trainees. Trainees are likely to follow suit if they see their supervisors regularly involved in professional affairs, attending regular meetings, presenting papers, reading journals and submitting articles to them.

There are relatively few studies on CME for occupational physicians. One difficulty is that we are relatively small in number. Experience in other specialities suggest a high level of dissatisfaction with what is currently available, which includes a wide range of means of educational delivery. Evidence for the value of CME is questionable. To improve the situation, we must recognize that the educational needs of occupational physicians are different. CME in occupational medicine must be relevant, individualized, include self-assessment, be interesting, systematic and speculative.

New entrants to the speciality and aspiring specialist occupational physicians will learn from their clinical experience and professional colleagues only if the experience is made enjoyable and if participation in the process is facilitated. The problem of non-attendance at CME events will always be with us. However, by emphasizing the importance of attitude development during specialty education, future occupational physicians will accept that they have a responsibility for defining and meeting their own learning needs. With careful planning, they will also have the skill to put this aspiration into practice. Such strategic developments will be good for the profession, good for the speciality and good for the individual occupational physician. But, more importantly, they will be good for the working men and women everywhere, whom we serve.

Denis D'Auria
Honorary Editor

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