

Continuing Professional Development in Sensitive Cultures

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Many cultures of the world face threats to their existence due to the homogenizing effects of the global commercial pop culture. These same influences present challenges to vulnerable cultures that seek the benefits of modern medicine, while attempting to preserve their unique identities. This paper briefly reviews some of these challenges and presents one novel approach to providing continuing medical education that minimizes the potential for adverse influences on the sensitive culture.

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The Context

It is no secret that much of the world suffers from a shortage of physicians, especially primary care physicians.¹ This results in an overextension of existing personnel and an inadequate access to proper medical care for large segments of the world's population. Many of the challenges facing poorer nations are directly or indirectly linked to the paucity of health care providers. Even wealthy nations face shortages of health care providers due to either supply or distribution of personnel.

In addition to the challenges this shortage presents in meeting the medical needs of the people, there are other related difficulties as well. Less visible, and perhaps ascribed a lower degree of importance by policymakers, is professional development. If physicians are sparse, opportunities for them to keep current in their profession are even more so. Medicine is continually changing. There are those whose perception is that "Outdated care is better than none," but this is not necessarily the case. Techniques of care become more efficient and/or more effective. Old treatments are replaced by new. Some costly interventions are found to offer little advantage over less costly ones. Some old ways are discovered to be not only ineffective but harmful. A prime directive in medicine is to "first do no harm." It is imperative to the world's population that their physicians keep abreast of current developments in the field of medicine through continuing educational activities.

Resources for continuing education are scarce. Textbooks and journals for self-study are expensive and rare in much of the world. Online self-study efforts are stymied by a lack of reliable computing equipment and unreliable Internet connectivity. Perhaps a majority of self-study intentions are precluded by the sheer volume of clinical demands every day and most nights. Medical conferences at centralized locations, when available and attendance is logistically feasible, often require physicians to leave their community without a physician due to the lack of an available replacement during the educational leave.

Provision of medical education in local communities is also limited—often by issues of culture. Cultures and languages are disappearing in many developing nations.^{3,4} Most of these endangered cultures are small, indigenous sub-national groups, but even national cultures such as those found in places like Bhutan, China, Iran, and Saudi Arabia are at risk.^{5,6} A number of these vulnerable national cultures have adopted official—or de facto—policies of limiting the entry of outsiders to protect their cultural identity.

Provision of continuing medical education is further complicated by the fact that many nations, while dedicated to maintaining their indigenous cultures, also seek to adopt modern Western medicine to improve the health of the population. This presents a quandary. Since all cultures have their own healing traditions, the introduction of pharmaceuticals, technology, and clinicians represent potential competition with the old ways. A thorough discussion of each of these topics is beyond the scope of this paper; my focus is one aspect of the latter, to wit, the continuing medical education (CME) of medical professionals in sensitive cultures.

How can CME best be provided in endangered cultures? Various existing models all have their drawbacks. Outside consultant educators brought in to present short courses and seminars, who are unfamiliar with the culture, may inadvertently or intentionally “contaminate” or offend the local sensibilities. Sending local physicians abroad for regular updates also risks cultural compromise upon their return or may result in a “brain drain” if they do not. Both CME strategies run the risk of introducing irrelevant or inappropriate technology or methodologies. These issues are relevant to both rich and poor nations with sensitive cultures.

The Model

It was into such a combination of physician shortage and sensitive culture that a novel approach to CME was born. While meeting with the Minister of Health in a nonindustrialized nation regarding a proposal for a visit by a reconstructive surgery brigade, the representative of the non-governmental organization (NGO) sponsoring the brigade was told, “What we really need is a means of updating the knowledge and skills of our District Medical Officers (DMO).” Though initially well trained, these physicians are posted to remote regions of the nation where they serve in relative isolation. Over time, their knowledge base becomes outdated, and their confidence wanes. The result is a tendency to refer inappropriate cases to the regional referral hospitals, which both consumes health care resources and creates significant hardships for the families who must make the strenuous trip of several days to the hospital. Much of the rural population is engaged in subsistence agriculture, so time away from their fields presents a special hardship.

The Minister of Health outlined a model in which an experienced physician-educator would work alongside the DMO in a mentoring relationship for a defined period of time. He explicitly stated that it is vital for the personnel involved in this mentoring relationship to have a scope of practice that is not limited by age, gender, or affected organ system of the patients, ie, a family doctor. This preceptor would maintain a low profile, exercising sensitivity to the local culture and emphasizing a peer relationship rather than an expert consultant attitude, to ensure that there is no loss of face to the DMO in the interactions. The goal was to use the mix of patients encountered in both the hospital and outpatient setting to update the knowledge and skills of the DMO.

Although resource intensive due to the 1:1 instructor-learner ratio, such a model is cost-effective in this nation, which has a low outward migration rate of professionals. It was anticipated that this would be a temporary measure until a critical mass of physicians was achieved. With more than one physician posted to each district hospital, more centralized and cost-

efficient means of providing CME could be undertaken without leaving the district without physicians.

The details of the model were further developed, and a pilot project of 1 month’s duration was successfully undertaken. To evaluate the effectiveness of the pilot program, an open dialog between Ministry of Health representatives, the local clinical staff, and the expatriate physician-educator was maintained throughout the duration, and a formal written evaluation was completed by each of these parties upon completion.

In debriefing from the pilot project, one of the most significant observations was of the need for the mentoring arrangement to be longer. In primary care, 1 month does not provide an adequate time to encounter a representative mix of the pathologies present in the community. This is quite distinct from programs focused on disciplines like orthopedic or reconstructive surgery, in which patients may be scheduled in advance to arrive at the time the educator is present. It was felt that 3 months would be the minimum time required at each site. Additionally, it was suggested that nonphysician clinical staff of the district hospitals be included in some form of formal training. During the pilot project, they appreciated the benefit to the local physician but expressed a desire for instructions geared toward them, too.

The lessons learned in the pilot phase were used to further refine the program, and an implementation phase was instituted in an individual district hospital. In addition to a longer duration and formal inclusion of ancillary staff, the expatriate physician-educator was accompanied during the stay by his family. The longer term of the project made the feasibility of an option to bring family along worth exploring. Means to evaluate the implementation phase were similar to that of the pilot project.

The implementation phase, too, was well received and effective; plans are underway for a continuation phase that will encompass several district hospitals each year. Several physician-educators will arrive in the country simultaneously, each stationed at a separate district hospital for 3 months. This will be repeated each year for 3 years, at which time the need for a renewal of the program for additional years will be reevaluated. More objective measurements of effectiveness, such as changes in referral rates, mortality rates, etc, will be used in the continuation phase.

Opportunities and Challenges

This model, though tailored to the specific needs of one nation, has features that suggest it might have broader applicability. Its low-profile aspect represents a minimally invasive educational intervention, important to all sensitive cultures. The length of time in situ allows the observant physician-educator to become integrated, at least superficially, into the local culture and allows

the instruction to be expressed in locally relevant terms to a much greater extent than a brief visiting lecturer could. The in-house training serves as an excellent reminder of exactly what technologies and methodologies are available locally. Experience practicing within the constraints of local realities enhances the relevance of the instruction given. Additionally, some things are better “caught than taught,” and the opportunity for the physician-educator to personally model family medicine in practice is most effective.

A key challenge to this model is funding, and such resource-intensive interventions may be beyond the financial means of many developing economies. In the case presented here, funding for the initial phases was provided by a combination of host government funding and a private philanthropic group; more extensive foundation or donor government support will be required for the full implementation. In wealthier nations with sensitive cultures, funding may not be a significant challenge.

Another challenge is recruitment of qualified personnel. While many qualified individuals are available for short-term participation (weeks), longer terms (months) are more difficult to arrange. The continuity of a single individual at each site for the full duration would be ideal, but may not be feasible. A tag-team approach may be workable but greatly diminishes the possibility of integration with the local culture and of establishing solid rapport with the local physician,

potentially negating the advantage of the approach in vulnerable cultures.

Conclusions

Medical professional shortages are likely to be with us for a long time to come. Hopefully, too, will the vulnerable cultures. Sacrificing the latter to allay the former is an avoidable situation. Meeting both medical and cultural needs ought to be a priority. The model presented here, and others that have been or will be developed, can help to preserve both the health and heritage of those in sensitive cultures.

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