Dear editor,

We read the descriptive article on accreditation systems in India [1] and duly acknowledge the sincere endeavours made by the responsible bodies for accrediting the Continuing Medical Education (CME) programmes and thereby contributing to the growth of healthcare professionals. We, on behalf of the participants in CME, would like to share our concerns around certain loopholes in the existing system.

First, India harbours a huge and diverse health sector encompassing various educational needs. In the absence of clear demarcation between the definitions of CME and continuing professional development (CPD) by accreditation agencies, often, it becomes a daunting task to decide what type of educational activity would be effective for a particular context or target audience. Upon performing a gap analysis and needs assessment, providers may be faced with a dilemma. They may choose a lucrative topic which may or may not attract participants or alternatively go for a "time-tested" and faded topic, placing them in a safer zone. We request that the accreditation agencies define multiple needs-based CME/CPD protocol roadmaps for Indian doctors belonging to various disciplines. The terminology "CME", in its true sense, should be reserved for the sessions whose objective is to sensitise the audience to an innovation in that particular discipline. Our practical experience suggests that it is the lack of awareness among the providers, which results in some accredited CME turning out to be nothing less than a series of decontextualised lectures delivered in auditoria.

Second, at present, the choice of attending a CME activity is purely on a voluntary basis and it is enough if a registered medical practitioner accrues 30 h of CME over the period of 5 years. This has positive repercussions in a way, in that it seldom restricts a medical practitioner to his/her discipline-specific domains. But, some, if not many participants try to register for CME activities held at nearby places, which fall out of their scope for mere accreditation points. This defeats the basic purpose of accreditation as the content developed for the particular CME is not going to contribute to the professional development of the healthcare professionals.

Third, as the authors pointed out, organising and delivering large-scale CME activities without receiving industrial funding is difficult in Indian settings. This would exorbitantly raise a delegate’s participation fees, who has to make an “out of the pocket” expenditure for all his expenses including travel and accommodation. Also, an ordinary medical practitioner needs to balance between education, research and clinical service. In “physician-crunch” countries like India, compromising on organisational responsibilities for attending an educational activity might result in negative repercussions in one way or another.

Fourth, the measures for evaluating the effectiveness of CME are not well developed in India. Accreditation agencies monitor only the level-1 of Moore’s framework (participation) [2] and we feel that, at the least, level-3 (self-reporting of knowledge gain) should be documented, to ensure effective CPD is taking place. Personalised web tools such as “Tiatoni platforms”, which document the formal and informal learning activities of physicians [3] and portfolio development, are feasible alternatives to measure higher level outcomes. Health professionals should be recommended to frame their personal development plans based on three sequential questions [4]: “What will I learn?” derived from identifying the learning gaps; “How will I learn?” which promotes choosing the appropriate educational activity; and “How well have I learned?” which drives incorporation of learned things into practice.

Finally, in India, even though the Medical Council of India prescribes weightage to departmental/institutional activities such as journal club and mortality meetings, there is no streamlined criteria-based rubric for providing accreditation. These activities, could in fact, act as hubs for disseminating knowledge at institute level and catalysts for inter-professional education. Rather than receiving at first hand, information from pharmaceutical industry-sponsored programmes, indigenous critical appraisal sessions would promote lifelong collaborative learning among peers.

We would like to suggest a few recommendations for fortifying the existing accreditation system. First, to
consider moving beyond attendance-based credit system and measure the higher level outcomes, appropriate to the prescribed needs of a particular practitioner. Second, to identify and standardise the competencies required for health professionals of various sectors with the help of specialist societies and give credit points only for CME addressing those competencies. Third, to focus on indigenous inter-professional continuing education activities and developing a credit system for that. Fourth, to promote and fund more biomedical and educational activities, which lack funding from any companies and eventually fail to meet the necessary expenditure. Finally, to develop a clear and pragmatic approach to assess individual learning by managing portfolios and monitoring the documented changes at practice and community level. We know that, implementation of a common programme is a Herculean task in a diversified country like India. Nevertheless, small steps towards the zenith would enable us to reach international standards in the near future.

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