

Original Article

Postgraduate Educational Program for Primary Care Physicians in Remote Areas in Lebanon

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Abstract

Introduction: Continuing medical education (CME) is a requirement in many developed countries. Lebanon lacks such a rule; hence, the dictum “once a doctor always a doctor” holds. This article describes a pioneering postgraduate educational program for primary care physicians in remote areas of Lebanon.

Method: The Lebanese Society of Family Medicine introduced a 2-year structured CME program to four remote Lebanese areas. Thirteen family physicians provided 33 activities to 1,073 primary care physicians tackling 22 subjects chosen from a list of 53 common clinical problems approved by community medical leaders. Each attendee was requested to complete an evaluation form at the end of each session.

Results: The activities were attended by 1,073 physicians, 914 of whom filled out the evaluation forms (85.2% response rate). The analysis of the response of the attendees revealed that 65% of the attendees completely agreed that they benefited from the activities, 68% completely agreed that the presentations were clear, 86% thought that the methods used were adequate, 57% agreed completely that the presenters were prepared, and 69% replied that enough time was available for interaction.

Discussion: The CME programs were conducted with minimal costs. They were well received by attendees. It is recommended that the Lebanese health authorities make CME a requirement to promote the knowledge and behavior of primary care physicians and improve health.

Key Words: Continuing medical education (CME), education policy, family medicine, primary care

Introduction

Lifelong continuing medical education (CME) is widely accepted as a form of keeping current with the rapid advances in medical sciences. This process is usually organized and monitored by academicians and official authorities.¹ Pertinent and varied needs of each community dictate the content and the standard of the activities,¹ but the programs themselves often are not well developed.² To be effective,

CME must use effective methods, be truly continuing, and not be sporadic or opportunistic.^{3,4}

In Lebanon, there are approximately 10,000 physicians, of whom 30% are general practitioners (GPs [Lebanese Order of Physicians, 2002]). In this country, there is no requirement for any form of CME after graduation from the medical school; hence, the dictum “once a doctor always a doctor” holds. No budget has ever been assigned by the Lebanese Order of Physicians (LOP) or the Lebanese government for CME. Only a few private universities and hospitals run periodic CME sessions, which are attended mainly by academicians. The activities consist of grand rounds and didactic lectures, which usually do not have an impact on improving health outcomes.^{3,4} The LOP recently has been involved in formulating a CME program. However, the nature and the essence of

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Table 1 List of Common Clinical Problems from which Continuing Medical Education Subjects Were Chosen for the Activities

Dermatology: acne, common skin infections, psoriasis, hair loss
Ophthalmology: red eye, visual disturbances
Otorhinolaryngology: painful ear, dizziness, hearing loss, neck mass
Neurology: headache, cerebrovascular accident
Cardiology: coronary artery disease, congestive heart failure, hypertension, heart murmurs
Respiratory: upper respiratory infection, lower respiratory infection, chronic obstructive pulmonary disease, asthma
Gastroenterology: diarrhea, dyspepsia, upper gastrointestinal bleeding, rectal bleeding, irritable colon
Endocrinology: diabetes mellitus, hyperlipidemia, osteoporosis
Nephrology: urinary tract infection, renal colic, hematuria, enuresis
Family medicine: health maintenance, exercise prescription, nutrition, interviewing skills, immunization, adolescent medicine, smoking cessation
Psychiatry: anxiety, depression, mental examination, alcoholism, schizophrenia, drug abuse
Rheumatology: osteoarthritis, low back pain, the swollen joint
Obstetrics-gynecology: infertility, vaginal discharge, contraception, antenatal checkup, vaginal bleeding

such a program have not yet crystallized; hence, there has been no field action as yet.

In 1995, the Lebanese Society of Family Medicine (LSFM), a scientific organization that functions under the umbrella of the LOP, initiated a self-motivated 5-year CME program for primary care physicians (PCPs) in rural areas of Lebanon. The present report describes the program and its impact on targeted physicians.

Objectives of the Program

The objectives of the program were as follows:

1. To determine if a pilot nationwide CME program is feasible. In this study, CME was defined as provision of sound medical information using evidence-based guidelines, when available, in an interactive format.
2. To promote medical knowledge among PCPs in remote areas in Lebanon.
3. To promote the image and principles of family medicine as a specialty and of the LSFM as an active society among other scientific societies in the LOP.

Materials and Method

Fifty-three topics of common medical problems in the community were identified (Table 1). The

list of topics identified was based on data from a health maintenance organization (HMO). This HMO offers comprehensive and continuous primary care to 10,000 persons from both genders and all age groups originating from all regions of the country, with approximately 25,000 visits per year. Five registered nurses, 1 laboratory technician, 2 research assistants, 4 clerks, 16 family physicians, 2 pediatricians, 1 specialist in community and occupational medicine, and 1 dermatologist operate this HMO.

Members of the LSFM were contacted and asked to contribute to the CME activity. The process and rationale of conducting the program were evaluated and discussed first with the LSFM members who agreed to participate. The project was then presented to medical community leaders from the targeted remote areas, who are knowledgeable about the needs of their areas. The input of the community leaders regarding the topics was then taken into account.

The last group to approach was the pharmaceutical companies, which were contacted to provide financial and logistical support (provide transportation to the physicians and a simple cocktail to the audience, invite PCPs whose practice is within a radius of 10 kilometers from the activity center). The companies were not allowed to interfere in selection of the topics or developing contents of the presentations. The topics could not even be related to the company's products. The com-

panies were allowed, however, to place a stand outside the activity hall with some promotion material. They were also acknowledged for their support at the end of the activity.

The speakers were all family physicians who were members of the LSFM. They all participated on a voluntary basis. Material on effective presentation was distributed to the speakers at the initiation of the program. The importance of the interaction with the audience and the clarity of the audiovisual material were stressed. Speakers were encouraged to present evidence-based information whenever possible. Ample time for discussion was requested as a priority. There were one to three speakers in each session. Two to three topics were discussed in each session, which lasted 2 to 3 hours. Each topic took 20 to 30 minutes, with almost equal time allocated for discussion.

Physicians who attended the activities were requested to complete an attendance form. They also were asked to fill in an anonymous evaluation form in which five items were included: benefit from the presentation, clarity of the presentation, adequacy of the methods used, adequacy of speaker's preparation, and availability of enough time for interaction. The evaluation was rated as 1 = complete agreement, 2 = partial agreement, 3 = no agreement, and 4 = no response. The forms were collected at the end of the program and analyzed. The physicians who attended two-thirds of the activities were awarded a certificate of attendance signed by the presidents of the LSFM and the LOP. A representative of the Lebanese Ministry of Health handed out the certificates during a banquet.

Results

Over 2 years, 1996 and 1997, 33 sessions were held by 13 family physicians in 4 remote areas (Halba in North Lebanon, Ain W Zain in the Chouf district, Nabatiyyeh in South Lebanon, and 3 locations in the Biqaa Valley). The activities covered 22 topics. Fourteen sessions were not held (unforeseen holidays, weather difficulties, and poor attendance). Two sessions were held without being sponsored by pharmaceutical companies. All of the carried activities were attended by 1,073 physicians

(average 34/activity; range 14–91); this includes the multiple attendances of some physicians to more than one activity. They completed 914 evaluations (85.2% response rate). Less than 1% of the attendants who filled out the evaluation form reported no benefit from the activity they attended. Four percent of the attendants complained that the speaker was not clear. Almost all of the attendees (86% fully and 13% partially) praised the methods used in the presentations. Eight percent felt that there was not enough time for interaction between the speaker and the audience. The feedback on all of the activities is detailed in Table 2.

Discussion

Feasibility

Around 70% of the scheduled activities took place as planned, with limited expense. Almost all attendees benefited from the program presented. The activities were well attended. The above facts indicate that the pilot program was feasible and should encourage health authorities to build on this experience to promote medical knowledge and improve health behaviors and possibly health outcomes.

Image Improvement

Several gnawing pains have accompanied the maturation of family practice in Lebanon. Other specialties and medical students believe that family physicians are second-class doctors who know a little bit of everything. This may have been related to the anticipated low income of the family physician and to the difficulty in comprehending how one physician can face successfully the multitude of medical problems covering many aspects of other specialties. Though the income of family physicians in other parts of the world rose during the 1990s, this was not the case in Lebanon.⁵ Unlike the German population, Lebanese and Tunisians, in general, prefer subspecialists to GPs.^{6,7}

Cameron stressed the importance of training and innovative ideas as means to promote the image of family physicians.⁸ Lebanon lacks any type of structured or outreach CME for PCPs.

Table 2 Results of 914 Feedback Evaluations on Topics Presented

	Completely Agree n (%)	Partially Agree n (%)	Do Not Agree n (%)	No Response n (%)
Benefited from presentation	590 (65)	312 (34)	4 (< 1)	8 (< 1)
Presenter was clear	621 (68)	240 (26)	40 (4)	13 (1)
Methods used were adequate	788 (86)	121 (13)	3 (< 1)	2 (< 1)
Presenter was prepared	524 (57)	310 (34)	73 (8)	7 (< 1)
Enough time for interaction	631 (69)	184 (20)	70 (8)	29 (3)

Our program was the first attempt of its kind whereby educational activities were introduced to remote areas. Eighty-six percent of learners commented positively on the methods used by the presenters in teaching. The fact that family physicians presented the topics, from which the majority of attendees benefited, contributed favorably to the image of family practice and the LSFM.

Benefit from Program

Physicians practicing in remote areas in Lebanon are at a disadvantage. Internet services are not as popular and accessible as in developed countries.⁹ Subscription to medical journals is not the routine, and the availability of structured CME activities is scarce. Although approximately one-third of the medical body in Lebanon work in general practice, there is no journal for PCPs per se. In general, PCPs in outreach areas rely mostly on their own experience and information provided by pharmaceutical companies either through drug representatives or sporadic teaching activities organized by the drug industry.

Benefits acquired from CME activities may be attributed to several factors. The subjects presented were chosen from a list of 53 topics commonly faced by PCPs in a national HMO. Community medical leaders had a say in selecting the subjects. This made the subjects presented relevant to the learners' needs.

The interactive method and leaving sufficient time for discussion enabled even closer determination of individual needs. Presenting updated information that is supported by evidence may have exposed the audience to new material.

There is a debate as to whether CME programs result in changed health outcomes.¹⁰⁻¹² Whereas one study detected no relationship

between global quality of care scores and either the type or quantity of the physicians' CME activities,¹⁰ another study detected statistically significant improvement in patients' quality of life despite the absence of statistically significant changes in patients' knowledge, behavior, and health service use.¹¹ Davis reported that formal CME conferences without enabling or practice-reinforcing strategies had relatively little impact when compared with academic detailing, reminders, and patient-mediated strategies.¹² GPs' experience of CME events was also investigated in one study and showed that GPs perceived the events as beneficial, raising their confidence and thus indirectly benefiting patients, provided that the subjects were relevant to general practice and the educational format was appropriate.¹³

Although the majority of physicians who attended the LSFM activities reported to have benefited, we did not evaluate the impact of the CME activities on physicians' performance and quality of care as there was no follow-up evaluation and this was not the objective of this study. However, using the methods of outreach visits and interactive discussions in relatively small groups (average 34 physicians per session) and presenting relevant material after undergoing an assessment need could theoretically be effective in improving the quality of medical care in remote areas.

Our educational activities attracted acceptable numbers of GPs. The education was received with enthusiasm many times and was disregarded on rare occasions. The causes of enthusiasm may have been biased by several factors: some doctors were somehow "obliged" to attend by their directors; others who attended one activity in which they benefited knowledge-wise were encouraged to attend other activities. Physicians may have disregarded the CME because

Lessons for Practice

- A continuing medical education (CME) program to primary care physicians in remote areas in Lebanon is feasible.
- Primary care physicians in Lebanon benefit from relevant material presented in an interactive format.
- The Lebanese Society of Family Medicine can play a key role in CME in remote areas in Lebanon.

it was not suitable to some doctors (clinic time, rest time, weekend). Lack of time and loss of income are generally known to be great barriers to participation in CME.¹⁴ In Lebanon, it is generally understood that sociopolitical problems may also influence participation; an activity supported by one political group may be “boycotted” by supporters of another.

Conclusion

The CME program presented was the first of its kind in Lebanon. PCPs reported increased knowledge from participating in educational activities with locally selected topics, scientific evidence to address the needs, and interactive teaching techniques. These facts and the ability to maintain the program over 2 years resulted in raising the image of family medicine as a specialty and family physicians as promoters of medical knowledge. Theoretically, the knowledge benefit is most likely to affect physicians’ behavior and improve health outcomes; however, further work is needed to see if this is true.

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