Why are doctors so hard to educate?

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Education after residency has been difficult. There is no clear curriculum to follow, and physicians need to generate their own schedules over long reporting periods. In the past, we had limited resources to affect postgraduate training. Continued medical competency training mandates have theoretically raised the bar by trying to ensure further education. More resources were needed to ensure that this happened — with a proliferation of courses and education sources that were accredited by medical societies. The resources that were needed to do that have slowly come up to speed. What once was limited exposure in-person education at a general conference and perhaps a subspecialty meeting has now evolved. We have a plentitude of in-person and live online physician education as well as tailored written information. So, we should see a heightened level of adaption and general increase in quality among our professional cadre. Setting aside the difficulty of measuring these outcomes, are we really aware that education of licensed physicians is effective? What does it take to change practice patterns? Have we even adopted proposed new clinical guidelines as the prospective randomized controlled trials have started to proliferate?

Is there any real control over the level of education after medical school? Is there a way to ensure high-value care practices are taught? All good questions with no firm answers.

We know it takes a long time to translate research into clinical practice. Taking more than a decade to bring research into a clinical care scenario is arguably too long with the amount of money and time that is needed to generate good research. The National Health Service does a good job of ensuring new technology and processes are fully vetted, economically feasible for the disease process and then mandated into care maps with indoctrination of purchasing power and usage implementation. That process may take about a decade but is usually based on good evidence. Education still lacks that needed rigour but arguably could have a bigger effect on patients’ outcomes. The best delivery method for affecting graduated physicians is still being debated. Individual conferences and webinars do address some gaps in knowledge — if the individual physician picks the correct event. More structure is probably needed. Some commercial efforts are trying to tackle some of the evidence delivery assuming physicians will internalize that information and change how they practise. A group at McMaster University in the field of orthopedics has developed an interesting online service (we have no economic interest in the product) that is trying to distill concepts to evidence-based decisions. Theoretically, this is easy-to-digest best evidence that should change surgeons’ practice. Unfortunately, there is no way to know if it does. Attention spans seem to be shortening, with commercial messages delivered in 6-second movie clips being the best way to reach the next generation. Is medicine headed this way as well? We are not configured as a professional body to enact that process or measure its reach. It seems we have made great progress in all fields of surgery. New techniques and devices are delivered constantly, but practice is still grounded in what the doctor learned in residency. Unfortunately, we remain unsure how to change practice patterns and how to measure whether we have.

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