

The Attitude of Physicians towards Continuing Medical Education in Greece

Ziroyanis P.N¹, Katostaras Th², Mousiama T²,

¹Department of Nephrology, State General Hospital of Athens "G. Genimatas"

²Department of Nursing, University of Athens

The aim of this study was the estimation of the attitude of Greek physicians on the issue of Continuing Medical Education (CME). Four hundred – fifteen physicians (professors, private office practitioners, consultants/senior registrars, registrars and others) participating in a medical congress answered a questionnaire of five points: a) the kind of scientific educational activity preferred, b) the selection criteria of scientific subjects, c) who must undertake the expenses, d) the ways that CME can be more effective and e) the extend to which printed and electronic press is being used as a means of CME. The answer in question a was discussions with experts (>82%), clinical tutorials (> 81%) and lectures (> 81%). The answer in b was the health needs of popu-

The need of the population for health care provision is increasing day by day. The demand is nevertheless not accompanied by a proportional increase in health care resources.¹ Hence, the provision of medical care through "modern" health care systems, even in developed countries, is judged as inadequate with regard to meeting the needs of society.

The last decade a new link has been added in the chain of problems arising from the process of health care provision. The state, the society, the medical community and the other health agencies recognise now that Continuing Medical Education (CME) does not follow the rate by which the medical problems of society are growing, so that the health needs of the population are not being fully met^{2,3}. The problems associated with medical education and the adequate coverage of contemporary medical needs have been pin-pointed since many years and several efforts have been made towards their solution⁴⁻⁶. On the other hand, the potentials of research have accelerated

lution (>92%) and the educational needs of the doctors (> 92%). The answer in c was scientific societies (> 87%) and public health services (> 73%). The answer in d was the establishment of obligatory attendance (> 82%), more CME events in district areas (> 80%) and more educational CME events (> 73%). In conclusion Greek physicians believe that the discussion with experts is crucial for their education, subject selection must be based primarily on the health needs of the population and the educational needs of the doctors, and the attendance must be obligatory at least for a minimum number of scientific events. Also there is a preference for CME activities in district areas.

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progress in health care technology, at the same time expanding their applications⁷, many of which have direct bearing on clinical practice⁸.

The subsequent reduction in the lapse of time between the introduction of a new technology and its clinical applications makes the issue of CME more imperative than ever before. The physician is responding to the challenges posed by the contemporary trends and requirements through the process of CME^{9,10}.

In keeping with these developments, governmental legislative regulations are being instituted, an example of which is the recognition of the patient's rights; these interventions have instilled into patients the perception that they can and, after all, they should expect always more from the health care system of their country.

In recent years, CME has been a topic of considerable debate in our country¹¹. Several proposals that have been sent in from time to time, have not been accepted for a number of reasons. Some suggest a

standardised CME based primarily on attendance, while CME calls for the active participation of the physician. Others recognise CME as a commitment of the physician to his profession, while the principal of CME is ruled by ethical issues in the context of the voluntary provision of medical services¹². Another point that also makes the implementation of the proposals concerning CME difficult is that their objectives do not square with the demands and the needs of society. The citizens demand that the physicians show human behaviour, efficiency and competence in covering their medical needs. The implication of these controversies is that there is no central planning of CME in our country and that the demands and needs of our society as regards health care provision are not worked out in the process of CME.

In the face of the inactivity or the debate among those who are responsible for the activities of CME, the individual Greek physician and patient, who will profit by the process of CME, may feel unable to do anything but watch.

This study attempts to compare the preferences of physicians with different practice backgrounds as regards the kind of CME, the way by which it will be provided and relevant cost issues.

Material and Methods

The examination of the attitude, as well as the position of Greek physicians on the major issue of CME was based on the completed questionnaires which had been distributed to 2500 physicians attending a multispecialty Conference held in Athens. The study population consisted of the following practice groups: *university professors, private office practitioners, consultants* and *senior registrars* in public and private hospitals and *registrars*. The distribution and collection of the questionnaires was assigned to a team of four student nurses from the Nursing Faculty of the University of Athens. The questionnaires were handed over to physicians entering certain sessions of the Conference, and the completed ones were collected on exit. The selection of the sessions for the distribution of the questionnaires was based on their expected attendances. The rationale for the selection was to achieve as representative a sample of the medical community as possible.

The questionnaires were completed by physicians coming from different fields of practice. All four days of the Conference the distribution of the questionnaires continued; physicians were therefore asked to complete only one questionnaire each. Questionnaires were completed by 552 practitioners.

The structure of the questionnaire aimed to re-

veal the attitude or the preferences of the physicians in relation to five essential CME topics.

The first topic concerns the **kind of scientific educational activity** that would satisfy them most (as a part of the organisational structure of a conference or a congress), the second topic examines how the **selection of the subjects** for presentation/discussion should be made, the third topic treats the issue of the **undertaking of the costs**, the fourth explores **how can CME become more effective** and the fifth records the **extend to which printed and electronic press is being used as a means of CME**.

1. As regards the kind of scientific educational activity of their liking (lectures, clinical tutorials, symposia, round tables, discussions with experts), the intensity of their preference among these kinds was rather evaluated than what their choice would be if they were to attend only one kind of such a scientific activity. This seemed most appropriate as it is common that most, if not all, of the above mentioned activities constitute integral parts of a conference or a congress.

2. In relation to the way the subjects covered in these activities should be selected, the study sought to determine the position of the physicians on the following question: The selection of subjects should be based on: a) the health needs of the population, b) the educational preferences of health professionals or c) the putative interest of the public agencies of health care?

3. The allocation of CME expenses is now starting to puzzle the governments and the community, since they shoulder this burden. The financial burden of CME deems disproportionate to the knowledge it provides. It has been estimated that the costs of conferences held world-wide exceeds US\$ 140 billion in a year¹³. The physicians attending the conference were asked who they thought should undertake the CME costs arising from the conference organisation, the participation and the transportation of those who will attend the CME event, among the following alternatives: scientific societies, private or state agencies, or the participants themselves.

4. The effectiveness and the efficiency of CME should be assessed in the context of the regulation of its organisational structure, regardless of whether it is statutory established or not. For the purposes of the consideration of the relevant parameters, the attendees were asked their opinions as regards: a) the creation of a co-ordinating committee for the CME process, b) the institution of more educational events, c) whether participation should be obligatory or not, d) the rating of the CME activities.

5. The physicians were asked to indicate their relative use of printed and electronic press to the purpose of CME.

In the groups of questions regarding the preferred kind of CME activities, the way of subject selection, the improvement of the effectiveness of CME and the undertaking of the costs, the answers of the physicians should reflect their preference in a four level scale: not preferred, partly preferred, much preferred, very much preferred. Those with at least a partly preference constituted the first group, while those with objection constituted the second group. As regards the extend of their use of printed and electronic press, the ranks of the scale were as follows: not at all, occasionally, a lot, very much. Those using at least occasionally a kind of press entered the first group and those who were not using the press at all entered the second group.

The computer software SPSS 10.0 was used for the statistical analysis, which included chi square test comparisons (Pearson or Fischer exact test).

Results

From a total of 552 physicians, 41(7.4%) were university professors, 114 (20.7%) private office practitioners, 160 (29%) consultants or senior registrars in hospitals and 100 (18,7%) registrars. The remaining 131 (24,1%) subjects were excluded from the study either because they occupied executive positions (hence, they were not actively practising medicine) (100 subjects) or because they did not state their practice mode (31 subjects) (Table 1).

The positions of CME acceptance in the 5 practice groups are as follows (Tables 2, 3):

1. Preferred kinds of scientific activities

As regards the preferred kinds of scientific activities, 74% of the attendees expressed at least positive preference for lectures, 76% for symposia, 81% for clinical tutorials, 78% for round tables, 82% for discussions with experts, and 5% for "other activities".

2. Way of subjects selection

In relation to the way by which the selection of the CME subjects should be made, 92% of the attendees expressed an at least positive preference for a selection process based on the health needs of the population, 92% for a selection based on the educational needs of the physicians, 82% for a selection based on the interests of competent agencies and 7% for "other ways".

3. Undertaking of the costs of the activities

The minimum percentage of physicians who accept the undertaking of the costs by scientific societies is 87%, by public agencies 82%, by private agencies 78% and by the participants themselves 37%.

4. Improvement of the effectiveness of CME

Percentages of minimum positive preference as regards means that could lead to the improvement of the effectiveness of the CME were 81% for the creation of a co-ordinating committee, 73% for the institution of more educational events, 80% for the organisation of CME events in district areas, 82% for the establishment of obligatory attendance of a minimum number of scientific events, 81% for rating the CME activities, 71% for the financial aid for the trainees, and 4% for "other means".

5. Use of printed and electronic press

At least 93% of the physicians had a positive preference for journals, 90% for books, 92% for CME events, 62% for visual learning aids, while at least 46% access Internet for CME purposes.

6. Comparisons of preferences for kinds of CME activities among different practice groups

Table 2 demonstrates that, compared to private office practitioners, professors show a slightly higher preference percentage for round tables ($p=0.080$, NS) and for a process of subject selection based on the assessment of health needs ($p=0.080$, NS). In this group, however, appears the higher percentage of "other ways of selection" ($p=0.049$), as well as the higher percentage of Internet use ($p=0.001$).

Table 1. Practice groups, percentages responding to the study and percentages of participation in the analysis.

Practice group	Number responding to the study	Percentage responding to the study (%)	Percentage of participation in the analysis (%)
Professors	41	7.4	9.8
Private office practitioners	114	20.7	27.3
Consultants/Senior registrars	106	29.0	38.3
Registrars	100	18.7	24.6
Others	131	24.1	-

Table 2. Percentages of at least acceptance of professors (P), private office, practitioners (POP), consultants/senior registrars (C/S) and Registrars (R).

Kind of scientific activity	P (%)	POP (%)	C/S (%)	R (%)
Lectures	78	80	74	82
Symposia	81	80	76	79
Clinical tutorials	85	83	81	86
Round tables	90	79	82	78
Discussions with experts	83	82	83	86
Other activities	22	13	7	5
Way of subjects selection				
Based on health needs	100	93	92	95
Based on educational needs	95	92	95	98
Based on suggestions of public agencies	88	86	82	94
Based on other criteria	27	14	14	7
Undertaking of the costs of the activities				
Scientific societies	95	87	90	91
Public agencies	93	82	92	94
Private agencies	78	83	83	92
Participants	56	53	56	37
Improvement of the effectiveness of CME				
Financial aid for the trainees	71	74	73	83
More CME events	73	84	74	89
Obligatory attendance	85	84	86	82
CME activities in district areas	85	84	80	89
Other ways	10	11	7	4
Creation of a co-ordinating committee	81	86	91	81
Rating of the CME activities	85	81	84	84
Use of printed and electronic press				
Journals	97	94	96	93
Books	90	92	92	95
CME events	93	95	92	92
Visual learning aids	73	66	62	68
Internet	80	52	46	53

As shown in Table 3, professors, in comparison with consultants and senior registrars, have a higher percentage of preference for other CME activities ($p=0.012$). They prefer, with higher percentages, the selection of the subjects to be based on the assessment of health needs ($p=0.046$) or on other criteria ($p=0.042$), and they maintain that the creation of a co-ordinating committee would improve the effectiveness of CME ($p=0.048$). Finally, they have higher percentages of Internet use ($p=0.000$).

Professors, compared to registrars, show a slightly higher preference percentage for round tables ($p=0.061$) and other CME activities ($p=0.004$). Furthermore, they show a higher pref-

erence percentage for "other criteria for subject selection" ($p=0.002$). In this group, the preference percentage for the undertaking of the costs by private agencies is lower ($p=0.021$), while a higher preference percentage for the undertaking of the costs by the participants themselves is noted ($p=0.028$). A lower percentage suggests that more CME events should take place ($p=0.017$). The percentage of Internet use is higher in this group ($p=0.002$).

Private office practitioners compared to consultants and senior registrars, show a lower preference percentage for the undertaking of the costs by public agencies ($p=0.010$), and a higher percentage of pref-

Table 3. Significant levels of two by two differences in percentages of at least acceptance of professors (P) private office practitioners (POP), consultants/senior registrars (C/S) and registrars (R).

Kind of scientific activity	C/S and POP	P and C/S	P and POP	P and R	R and POP	R and C/S
	P	P	P	P	P	P
Lectures	0.183	0.396	0.485	0.395	0.441	0.114
Symposia	0.252	0.333	0.563	0.500	0.481	0.341
Clinical tutorials	0.413	0.327	0.437	0.530	0.271	0.147
Round tables	0.279	0.166	0.080	0.061	0.474	0.209
Discussions with experts	0.505	0.568	0.578	0.383	0.273	0.296
Other activities	0.090	0.012	0.140	0.004	0.029	0.280
Way of subjects selection						
Based on health needs	0.461	0.046	0.080	0.182	0.352	0.222
Based on educational needs	0.233	0.667	0.405	0.321	0.043	0.176
Based on suggestions of public agencies	0.275	0.288	0.501	0.169	0.036	0.004
Based on other criteria	0.541	0.042	0.049	0.002	0.064	0.057
Undertaking of the costs of the activities						
Scientific societies	0.323	0.210	0.119	0.345	0.209	0.391
Public agencies	0.010	0.635	0.088	0.499	0.006	0.398
Private agencies	0.549	0.292	0.297	0.021	0.037	0.024
Participants	0.357	0.550	0.422	0.028	0.014	0.002
Improvement of the effectiveness of CME						
Financial aid for the trainees	0.516	0.449	0.431	0.070	0.056	0.034
More CME events	0.027	0.542	0.095	0.017	0.183	0.001
Obligatory attendance	0.437	0.568	0.541	0.390	0.367	0.238
CME activities in district areas	0.233	0.295	0.541	0.343	0.183	0.032
Other ways	0.185	0.418	0.515	0.161	0.033	0.176
Creation of a co-ordinating committee	0.157	0.048	0.275	0.579	0.189	0.016
Rating of the CME activities	0.310	0.508	0.342	0.500	0.361	0.546
Use of printed and electronic press						
Journals	0.262	0.564	0.325	0.279	0.530	0.204
Books	0.539	0.418	0.466	0.230	0.265	0.280
CME events	0.252	0.582	0.441	0.539	0.230	0.515
Visual learning aids	0.334	0.137	0.253	0.344	0.423	0.220
Internet	0.190	0.000	0.001	0.002	0.458	0.135

erence for more CME events ($p=0.027$).

In comparison with registrars, private office practitioners show a lower preference percentage for the undertaking of the costs by private or public agencies ($p=0.006$) and a higher preference percentage for the undertaking of the costs by the participants themselves ($p=0.014$). Private office practitioners preferred in higher percentage, compared to registrars, other CME activities ($p=0.029$), while their preference percentage for subject selection based on suggestions of public agencies was lower

($p=0.036$). They demonstrate greater preference for seeking other ways for improving the effectiveness of CME ($p=0.033$), as well as for other criteria for subject selection ($p=0.064$).

Consultants and senior registrars show a lower percentage of preference for subject selection based on suggestions of public agencies ($p=0.004$) and a higher percentage of preference for using other selection criteria ($p=0.057$), compared to registrars. Lower expense rates should be allocated to private agencies ($p=0.024$) and higher expense rates should

burden the participants ($p=0.002$). In the group of consultants and senior registrars, the percentages of preference for improving the effectiveness of CME through financial aids for the trainees, through more CME events or through holding CME events in district areas were lower ($p=0.034$, $p=0.001$ and $p=0.032$, respectively), while preference for the creation of a co-ordinating committee was higher ($p=0.016$).

Discussion

The contribution of the Greek physician in the modulation of "contemporary medicine" has been slack. It has been claimed that the condition which would trigger and activate his participation in the evolution of his science is the up-grade of CME.

In spite of the desperate appeals of the medical community, no political will to activate the procedures of CME has been manifested during the past years. As a consequence, the diffusion of new medical knowledge, that would allow the physician to keep himself up-to-date in relation to their potential applications, follows a rather disorganised pattern. In contrast with the international situation, the way CME is realised in our country at present, does not cover all needs of a "modern health care system". This is partly due to a lack of central planning, which in combination with the absence of the necessary orientation hinder the process of adapting CME to clinical practice and, hence, improving health care provision.

The answers of the participants in the conference with regard to subject selection are of particular importance, as they can serve as a useful guide for a medical organising agency. Ninety two percent of the physicians support that the selection of the subjects should be based on the health needs of the population, and the same percentage backs subject selection on the basis of the educational needs of the trainees. Public agencies (e.g. district authorities) have a place of significant priority (percentage 82%) in this selection process. At present scientific medical societies are tasked with selecting CME subjects and, with the help provided by pharmaceutical companies, make strenuous efforts to cover the range of the scientific and economic requirements of CME.

The reasons usually given for this inactivity as regards the activation of the institution of CME as already legislated, are the following two: first, the costs arising from the creation of the organising committee and, second, the possibility that the medical community will react to the efforts of an organised

approach and planned diffusion of new medical knowledge.

The first parameter cannot be used to justify the delay in the organised implementation of CME, when the amounts traded for CME activities are big and are disposed without any kind of control; consequently, they could be allocated in a way that would take into account the needs and the demands of society in the modern world for better health care provision. It has already been mentioned the financial burden of CME activities deems disproportionate to the knowledge it provides. It has been estimated that the costs of conferences held world-wide exceeds US\$ 140 billion in a year¹³. Eighty two percent of the attendees expressed at least positive preference for the undertaking of the costs by public agencies, while 87% preferred that scientific societies would undertake the costs.

The possibility that the medical community will react unfavourably has been put forward as a major inhibitory factor in the decision making for the activation of CME processes, that would lead to its effective contribution in contemporary medical developments, many times.

Eighty two percent of the participants request the establishment of obligatory attendance of CME events. The finding of such a high percentage of positive answers in this topic has raised a great deal of concern. This position comes as a result of the transition from the negative side of the myth to a side which raises troubling questions. A few years ago, no one would consider suggesting the establishment of obligatory attendance of CME events. This finding gives us the opportunity to pinpoint that the concept of CME does not provide for such procedures. CME should be based on ethical principals and come as result of the internal need of a doctor to voluntarily provide medical services. In this context, CME is a moral commitment that should be acknowledged by every single doctor. It is noteworthy that all doctors have the right to participate in CME activities and therefore the appropriate facilitating conditions should be provided to them.

In Europe, participation in CME activities is voluntary. Furthermore, the European Union of Specialist Doctors and the Standing Committee of European Doctors have adopted a chart of principles, according to which a doctor has the ethical commitment and duty to keep himself continuously and life-long updated^{14,15}. The European Association of General Practitioners pinpoints that ethical commitment is not adequate by itself, although it motivates the participation of the doctors in the CME process¹⁶.

Undoubtedly, the most significant parameter of CME activities is the quality of the educational programs, regardless of whether they are voluntary or obligatory^{17,18}. For these reasons, the position of the conference attendees on the issue should really set the community thinking, as it conveys an intangible message of anxiety and concern, which have possessed practitioners. A recent Israel's supreme court decision upholding the condemnatory judgement of the court of the first instance against doctors with the accusation of malpractice due to ignorance of recent literature data contrasts with fixed and universally accepted positions about the autonomy of a doctor in the provision of medical care¹⁹.

The need for reviewing the principles of CME is imperative. This need is also underpinned by studies evaluating the effectiveness of CME recently published²⁰. Several investigators have come to contradictory results as regards the implementation of CME, which are summarized as follows:

- a) CME promotes a doctor's skills in performing key procedures,
- b) CME has little effect on clinical practice and
- c) CME has little effect on health outcomes of the provided care²¹⁻²³.

The effect of the time invested in the attendance of educational activities on the quality of the clinical practice of medicine has been questioned¹⁸, while it has been claimed that the traditional procedures of CME may constrain the development of new, more effective forms of education, which would promote continuous learning²⁴. A study indicated that time of attendance of educational activities was not associated with an increase in the ability of performing medical procedures²⁵. In this context, the benefit of establishing a fixed time licence for practising medicine is double: first, doctors will be prompted to keep up with the evolution of medical knowledge and, second, it provides a means to differentiate between practitioners who fulfil the necessary conditions to continue practising medicine and those who do not²⁶.

The results of the present study have put on complementary study procedures aiming to detect the position of a wider range of specialist doctors, both in numerical scale and in terms of practice group, which are in the analysis stage at present.

The condition presented so far has led to some seemingly odd effects in health care provision by contemporary health care systems, the most important of which are the following three:

Many of the developments in medicine, especially in laboratory medicine, have direct implications in clinical practice. It seems as medicine had never

before so much to offer to mankind as it has at present day. However, never before have doctors been subjected to such strenuous criticism. It has recently been claimed that nowadays few people trust doctors, the provided health services and the medical profession in general²⁷.

Never before have so many resources been spent for health care provision, at least in the developed countries, while these resources seem more insufficient to cover basic health needs than ever.

In developed countries, the increase in life expectancy is accompanied by an increase in the prevalence of chronic disease and disability.

The changes in modern health care systems are also associated with the following issues of concern: a) the delay in updating medical professionals in underdeveloped and developing countries with regard to new kinds of disease, and b) the emergence of new diseases as a result of the increase in life expectancy, in particular in developed Western countries, which has also led to an increase in chronic diseases, as well as the demand for the rehabilitation of such patients. These shortcomings are transformed to medical needs, which have been added to the already existing socio-medical problems health services have to solve.

The dilemmas and the concerns arising from the recent changes in the practice of medicine should sensitize the competent agencies to the need not only to re-examine CME programs, but also to adopt a more humanistic approach to the doctor-patient relationship in undergraduate curricula and CME programs.

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ΠΕΡΙΛΗΨΗ

Π.Ν. Ζηρογιάννης, Θ. Κατοστάρας, Τερέζα Μουσιαμά. Η θέση των γιατρών για τη συνεχιζόμενη ιατρική εκπαίδευση στην Ελλάδα. Ιπποκράτεια 7 (2): 84-92

Σκοπός της μελέτης είναι η εκτίμηση της θέσης του Έλληνα γιατρού απέναντι στο μείζον θέμα της ΣΙΕ. Η ΣΙΕ είναι ηθική υποχρέωση την οποία πρέπει να αναγνωρίζει κάθε γιατρός, ο οποίος έχει δικαίωμα και καθήκον να αξιοποιεί κάθε ευκαιρία και μέσο για αυτό το σκοπό, καθώς η ταχύτατη εξέλιξη των γνώσεων έχει κατα-

στήσει σήμερα τη ΣΙΕ περισσότερο επιτακτική από ποτέ άλλοτε.

Για τις ανάγκες της μελέτης συντάχθηκε ερωτηματολόγιο που διανεμήθηκε σε γιατρούς που παρακολούθησαν ή/και συμμετείχαν σε Ιατρικό Συνέδριο. Σκοπός του ερωτηματολογίου ήταν η αξιολόγηση της ΣΙΕ όπως την αντιλαμβάνονται διάφορες κατηγορίες Ελλήνων γιατρών (καθηγητές, ελεύθεροι επαγγελματίες, διευθυντές και επιμελητές δημοσίων και ιδιωτικών νοσοκομείων, ειδικευόμενοι) και η προβολή της θέσης τους. Εξετάστηκαν οι απόψεις των γιατρών όσον αφορά πέντε παραμέτρους της ΣΙΕ: το είδος της επιστημονικής εκδήλωσης που προτιμούν, τα κριτήρια με τα οποία πρέπει να γίνεται η επιλογή των θεμάτων που καλύπτονται στις εκδηλώσεις ΣΙΕ, το φορέα που καλύπτει το κόστος των εκδηλώσεων ΣΙΕ, τους τρόπους με τους οποίους μπορεί να βελτιωθεί η αποτελεσματικότητα της ΣΙΕ, και την έκταση στην οποία ο έντυπος και ηλεκτρονικός τύπος χρησιμοποιείται ως μέσο ΣΙΕ.

Τα έγκυρα ερωτηματολόγια που συμπεριλήφθηκαν στις αναλύσεις της μελέτης ήταν 415. Όσον αφορά τις προτιμήσεις του συνόλου των γιατρών για το είδος της επιστημονικής εκδήλωσης, σημειώθηκαν τα ακόλουθα ποσοστά: (α) διαλέξεις: >74%, (β) συμπόσια: >76%, (γ) κλινικά φροντιστήρια: >81%, (δ) στοργυλές τράπεζες: >79%, και (ε) συζητήσεις με ειδικούς: >82%. Σχετικά με τα κριτήρια με τα οποία πρέπει να γίνεται η επιλογή των θεμάτων που καλύπτονται στις εκδηλώσεις ΣΙΕ: (α) >92% υποστηρίζουν ότι κριτήριο πρέπει να είναι οι ανάγκες φροντίδας υγείας, (β) >92% υποδεικνύουν ως κριτήριο τις εκπαιδευτικές ανάγκες των γιατρών, (γ) >82% προτείνουν ως κριτήριο το πιθανό ενδιαφέρον των δημοσίων φορέων υγείας. Ποσοστό >73% εξέφρασε θετική προτίμηση για την οργάνωση περισσότερων εκπαιδευτικών εκδηλώσεων, >80% είχε θετική προτίμηση για τη διοργάνωση εκδηλώσεων στην περιφέρεια, και >82% είχε θετική προτίμηση για την καθιέρωση της υποχρεωτικής παρακολούθησης ενός ελάχιστου αριθμού εκδηλώσεων ΣΙΕ από κάθε γιατρό. Διαπιστώθηκαν, ωστόσο, σημαντικές διαφορές στις προτιμήσεις μεταξύ διαφορετικών επαγγελματικών κατηγοριών.

Τα αποτελέσματα της μελέτης υποδεικνύουν σημαντικές διαφορές στις προτιμήσεις των γιατρών μεταξύ των διαφορετικών εκδηλώσεων ΣΙΕ. Ιδιαίτερο ενδιαφέρον εκφράστηκε για τις συζητήσεις με τους ειδικούς. Η επιλογή των θεμάτων πρέπει να γίνεται αξιολογώντας, κυρίως, τις ανάγκες φροντίδας υγείας και τις εκπαιδευτικές ανάγκες των γιατρών. Ενδιαφέρον έχει η λεπτομερής μελέτη των διαφορών στις απαντήσεις που δίνουν οι διαφορε-

τικές επαγγελματικές κατηγορίες. Αξιοσημείωτο είναι, επίσης, το υψηλό ποσοστό (74%) που υποστηρίζει την καθιέρωση της υποχρεωτικής παρακολούθησης ενός ελάχιστου αριθμού εκδηλώσεων από κάθε γιατρό, τη στιγμή που η ΣΙΕ θεωρείται ηθική υποχρέωση σύμφυτη με το ιατρικό λειτούργημα.

ΒΙΒΛΙΟΓΡΑΦΙΑ

1. Chantler C. The role and education of doctors in the delivery of health care. *Lancet* 1999; 353:1178-1181
2. Garcia-Barbero. Medical education in the light of the World Health Organization. Health for all Strategy and the European union. *Med Educ* 1995; 29: 3-12
3. Parsell GJ, Bligh J. The changing context of undergraduate medical education. *Postgrad Med J* 1995; 71: 397-403
4. Parry KM. Medical education worldwide. *Med Educ* 1985; 19: 487-502
5. Walton HJ. Medical education worldwide: a global strategy for medical education: partners in reform. *Ann Community-Oriented Educ.* 1993; 6: 327-332
6. Marston RQ, Jones RM, eds. Medical education in transition. Commission on medical education: the sciences of medical practice. Princeton, New Jersey: The Robert Wood Johnson Foundation, 1992
7. Wyatt JC. Clinical data systems: Components and techniques. *Lancet* 1994; 344: 1 609-614
8. Irving D. The performance of doctors: the new professionalism. *Lancet* 1999; 353: 1174-1177
9. Walton HJ. Continuing medical education in Europe: a survey. *Med Educ.* 1994; 28: 333-342
10. United Nations Development Programme: implications for medical education. *Med Educ* 1993; 27: 1-2
11. Ziroyanis P.N. Evaluation system of Continuing Medical Education activity. *Continuing Medical Education bulletin* issue 36. October-November 1995
12. Hayes TM. Continuing medical education. A personal view. *B Med G* 1995; 310: 994-996
13. Rivlin G. Guide to organizing an international scientific conference. Basel, Tokyo, Karger, 1995
14. European Union of Specialist Doctors (UEMS). Chapter on continuing medical education of medical specialist in the European Union. Brussels: UEMS; 1994
15. Standing Committee of European Doctors. Declaration of Dublin on continuing medical education. Brussels : Standing Committee of European Doctors, 1993
16. Europe Union of General Practitioners (UEMO). Declaration on Continuing Medical Education. In: European Union of General Practitioners reference book 1995/96. London: Kensington Publications, 1996
17. Ziroyanis NP Welcome address 22nd Annual

- Panhellenic Medical Conference, Athens, 7-11th May 1996
18. Holm HA. Quality issues in continuing medical education. *Br Meds* 1998; 316: 621-624
 19. Fishman RHB. Israel's doctor obliged to read journals. *Lancet* 1998; 352: 1765
 20. Ziroyanis PN. Continuing Medical Education and its role in contemporary Health Care System. *Iatriki* 1998; 74:409-415
 21. Lloyd JS, Abrahamson S. Effectiveness of continuing medical education, a review of the evidence. *Eval Health Professions* 1979; 2: 51-280
 22. Bertram DA, Brooks-Bertram PA. The evaluation of continuing medical education: a literature review. *Health Educ Monogr* 1977; 5: 330-362
 23. Haynes RB, Davis DA, Mckibbin A, Tugwell P. A critical appraisal of the efficacy of continuing medical education *JAMA* 1984; 251: 61-64
 24. Manning PR, Petit DW. The past, present and future of continuing medical education, *JAMA* 1987; 258 : 3542-3546
 25. Gaulford PG, Lamb SB, Kaigas TB, Hanna E, Norman GR, Davis DA. Physician incompetence: specific problems and predictors. *Acad Med* 1993;270 (suppl): 16-18
 26. Bashook P, Parboosingh J. Rectification *Br Med J* 1998; 316: 545-548
 27. Portet Rgg. The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London: Harper Collins, 1997

Corresponding author:

Ziroyanis P.N
Department of Nephrology,
General Hospital of Athens "G. Genimatas"

Αλληλογραφία:

Π.Ν Ζηρογιάννης
Νεφρολογικό Τμήμα
Γενικό Νοσοκομείο Αθηνών "Γ. Γεννηματάς"