

Editorial

Best Evidence in Medical Education (BEME)

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In 1998, I wrote an editorial in the Kuwait Medical Journal on Evidence Based Medicine (EBM)^[1]. Over the last three years, interest and practice of EBM by the medical profession in the Arabian Gulf region has rapidly increased. In this issue I am introducing to the readers, from the field of Health Professions Education, the younger sister of EBM, "BEME" Best Evidence Medical Education.

In 1999, a number of sessions at the Association for Medical Education in Europe (AMEE) Conference in Sweden were devoted to discussing the use of evidence in medical education. The BEME definition was refined and adopted by the BEME Steering Group in December 1999 and stated that it is "the implementation, by teachers in their practice, of methods and approaches to education based on the best evidence available"^[2].

BEME encourages the use of trustable research findings to replace personal opinions as a basis for decision-making in education for health professionals. The need for scrutiny in education is the same as in clinical practice^[3]. BEME operates at two levels:

1. to utilize existing evidence from worldwide research and literature on education and associated subjects.
2. to establish sound evidence where existing evidence is lacking or of a questionable, uncertain or weak nature^[4].

Several organizations are involved in developing evidence-based education. The Campbell Collaboration, an offshoot from the Cochrane Collaboration, follows the Cochrane's principle of mainly considering controlled trials. The BEME Collaboration is an international collaboration to evaluate the effectiveness of different strategies in medical education using systematic reviews. Such reviews are time and resource intensive and methodologically challenging. A BEME Steering Committee

including internationally-known educationalists is active in developing this initiative.

Concerns about BEME have been raised. Having the evidence of the effectiveness or non-effectiveness of a teaching or assessment method is not sufficient to make a positive significant change in the educational process or outcome. The reason for that important educational decision usually takes place at the level of the teacher and in the classroom and training sites; "micro decisions"^[5].

In order for BEME to have a significant impact on the education and training of health professionals, teachers should be educated, and trained and their teaching capabilities developed. Teacher training has to take place hand in hand with the methodological and organizational development of the BEME movement.

Improving the methodology of BEME has still a long way off. From how to develop a researchable question in education with frequently difficult to measure educational outcomes to where to look for the evidence and the searching strategies, critical appraisal skill of educational research has also to be refined and instructed faculty should be trained on how to evaluate the available evidence. The first International Workshop on BEME took place at the College of Medicine and Medical Sciences, at the Arabian Gulf University during the Network Community Partnerships for Health through Innovative Education, Service and Research Conference in Bahrain in October 2000 and the second one will take place in Londrina, Brazil in October 2001.

Many lessons have been learned over the years from teaching and practicing evidence-based medicine that may be helpful in building evidence-based medical education.

Two lessons are important to emphasize. The first is that translating the evidence into practice can be more difficult than generating evidence. The second is that secondary or even tertiary databases

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may be more efficient and useful than primary data bases for accessing good quality evidence in real time^{6]}. These two lessons will definitely influence the direction of developing and using BEME.

I hope that academic institutions in the Arabian Gulf region responsible for health professions education will support this new paradigm.

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