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Delivering effective medical education in Iraq: Transition from outcome-based learning to future trust-based learning

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Abstract

Health professionals in Iraq include physicians, dentists, pharmacists, nurse lab technicians, etc. The present reports have contended that the health system is still oriented toward the curative side and inpatient care. Iraq has 3650 health centers, but according to the previous report, less than half are without a professional. For now, there are 33 colleges of medicine in Iraq.

There is an immediate demand to restructure our higher health professional education based on global standards, which are converging evolutionarily into unity as agreed standards. The WFME initiates these standards for basic medical education in many countries in the world. The rules are in nine parts with 36 subparts usually.

We believe that the three outcome-based core components of effective medical education in today's world should be: A curriculum suited to the 21st century, including new challenges of highly competent academic teachers for this curriculum, having state-of-the-art facilities and infrastructure and enough resources for imparting the outcome-based training doctors that orient them to meet the challenge and ensure a transition from outcome based education through competency-based up to trust-based education. High-performing medical and health institutions in the Western world are massively investing in the first three components above, advancing competency-based education and a trust-based education approach.

Introduction

University, syllabus review of all medical and health professional schools needs to be an integral part of the curriculum analysis in such assessment setting the first step on identifying deficiencies and problems; [1, 2], hence the justification for a wider process to plan development for new syllabus addressing health needs and priorities envisaged not as a definitive response but as guidelines in identifying common graduate learning outcomes.

Iraq now has a total of 33 colleges of medicine referring to basic medical education, these standards have already been established by WFME in several countries around the world.[3,4]

The optional change in the curriculum was being viewed as a flash point for teachers' professional learning by engaging the content, reading and watching, and talking about it[5,6]

It defines how we propose that Research Development and Diffusion RD&D are important for developing metrics that would serve as proxies of progress in training new graduate competent graduates in a competency and toward trust-based one [7, 8].

Methodology

Teachers and experts tend to teach requirements; these are the things people need to learn & where those approaches should be used. The emphasis dimensions include a primary interprofessional collaboration, interprofessional education (IPE) emphasis, and less on IPE as a secondary issue, reflecting an extensive curricular analysis.

Curriculum Theories Understanding Theory as Strategy for Effective Teaching & Learning Engaging the Active Curriculum Learner in a Complex, Changing Environment Theorizing from Practice and Practicing with Theory.

Theoretical on the other hand provides the philosophical & conceptual foundations essential for effective teaching and learning strategies, curriculum designs, methods of assessments, and overall organization of medical education programs. One of the review studies about the educational curricula of 33 medical colleges in Iraq, tries to assess and analyze these curricula mainly concerning whether they use subject-based curricula or Competency-based curricula. It aimed to evaluate the extent of reforms in transitioning from a traditional, subject-based, clerk doctrine-focused undergraduate medical curriculum to a competency-based and community-oriented medical education model at these institutions.

Selection of Medical Colleges: All 33 medical colleges in the country were included in the study sample. A diversity of institutions were selected to provide a range of accreditation, geography, and curriculum specifics.
Data Collection: A serious search was made by collecting publicly available institutional documents and government database(s), and direct requests to some medical colleges to search the curricula of selected medical colleges. These materials included curriculum objectives, course outlines, and program descriptions.
Curricula Falls into an Organized System– Presented in the approach of education where it falls under a Subjects-Based Curriculum. Subject-based colleges were those orientated to perform in the traditional model of discrete subjects of study (anatomy, physiology, pharmacology) within medical schools.
CBME was defined as teaching that focused on specified achievements of competencies (e.g., clinical skills, communication, critical thinking) or learning outcomes in the curricula at colleges.
Methods: The rubric that we developed was based on essential educational principles designated by the World Federation for Medical Education (WFME) and the Accreditation Council of Graduate Medical Education (ACGME), to measure course curricula. It incorporated the following elements into a rubric: Integration of theoretical knowledge and practical skills, Focus on clinical competence/patient-centered care Individualized Learning paths and assessment methods Continuous service-based learning (Application) throughout practicing lifetime.
Statistical Analysis: A descriptive analysis of data was done on the percentage of colleges following subject-based curriculum Vs competency curriculum. Adjusted results were mapped by regionality (northern, central, and southern Iraq) to explore if the findings ascertained in curriculum development varied across regions.
Limitations: Not all institutions studied may have provided thorough documentation of their curriculum; also, competency-based educational models might be carved out in more ways than one across different colleges.

Results

A survey of curriculums in Iraq's 33 medical colleges would probably reveal a variety of educational models, many of which are likely to have conventional and subject-based curricula. Wind the clock forward a few years, and it appears that you get some initial indications that perhaps there is some movement on competency-based medical education (CBME) in these colleges at the same time as that regional/local thing still holds within a smaller number of institutions.
While colleges in other regions may be more aligned to existing CBME systems than the ones the focus will need to be on making changes or updating implementation processes rather than creating entirely new ones as is currently under consideration. Together, the results may indicate an approach to change in medical education within Iraq that is fragmented and defined by its lack of full national integration. The best way to understand this confusion between the contents (conception) and the methods (presentation) of the medical subjects is to provide an example of a learned concept-by-example, from Iraqi Medical Curricula.
It is clear from the diverse presentation modes used to teach every strand across the course (pictorial, diagrammatic, etc) that an all-inclusive relevance exists for students to interact with images and models as more than just theoretical models or representations.
In the enacted curriculum, however, teachers are seen considering being part of effecting change and addressing different successes on a local level when a shift from individualization to collaboration takes place within the curriculum.

Discussions

An account of the concerns and barriers towards wide adoption of CBME in Iraq including teacher readiness, limited resources, and resistance to change in institutions. Looks deeper into how local context can shape the design of curriculum reform efforts, including specific issues related to regional disparities, political uncertainty, and health system needs. Likewise, building on the potential for a type of more flexible and patient-centered doctor may well be another intrinsic

promise of this model. Benchmarking Iraq against the milestones set by such international stakeholders (e.g. World Federation for Medical Education WFME) with undergraduate medical education will provide us tangible guidance as to how we could accelerate this transition and be more aligned with current global benchmarks.[9,10,11]

Conclusions

Different teaching materials have been employed to supply the latest knowledge about the topic to improve what should be for students, contain demos supported by simulations, and provide you with gradual learning. The curriculum aligns with the career growth of watching, reading, and speaking.

That is the thought on Competency-based learning and if a part of the equation (CBE) teaches students; here are metrics from a cause in RD&D that have altered your future graduating competencies, then another approach with trust can be standardized and scaled to infinity. Learner-meta-cognition: Feelings, novelty→ knowledge →skills-- a) values & beliefs; b) learn→ Transfer of academic learning for applications

This is dramatically at odds with the view of teachers as professionals taking system-wide actions to change adaptation in response to local needs. The refreshment in the curriculum will rest on a change in the profession for teachers, with more reading, viewing, and discussing ideas professionally

It then intends to clarify the concept of RD&D as a kind of measurement tool for assessment on its influence towards graduand competencies in the coming future, changed from an OBE-based into a CBEL and eventually in this way offers trust-based learning. Educational Change in Iraqi Medical Education Measuring and managing the impact of these changes is critical as mentioned previously if no improvements have been made there won't be any future enhancement.

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