A Reform Agenda Outline for Medical Education in Pakistan

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Provision of quality healthcare is a multi-dimensional and multi-disciplinary function – each profession and discipline committed and geared towards carrying out this function with maximum competence and dedication.1 Some are directly involved to carry out the technical aspects of healthcare such as front line patient care, while the other groups indirectly help in building an effective, efficient and equitable system of healthcare. The first group has to work in complete harmony and unison with team spirit and symbiotic relationship to optimize the quality of the healthcare provided.2 Although medical personnel usually serve as the leader of a healthcare team, the role of other members of the team is equally essential for achieving the goals. Each member varies in education, qualifications, training and experience depending upon the level of healthcare facility. But the most important single determinant of quality of healthcare is the competence of the medical doctor heading the team, particularly, with reference to the level of the facility. If it is a primary care facility, the doctor should be well-versed with the common diseases found in that area and competent to manage and disseminate the education to prevent these. If the facility is of secondary care level such as district headquarter hospital, the postgraduate doctors working there should be able to independently manage ailments requiring specialist care. Finally, at tertiary care hospitals, the consultants should be competent to diagnose, manage and carry out sophisticated procedures to treat complex health problems.

Provision of competent doctors, graduates or postgraduates is the responsibility of medical institutions and bodies regulating and overseeing the standards of education and training. The mechanism of certifying the competence at each level should be rigorous conforming to match the healthcare needs of the population. In order to ensure training of competent doctors, the practice of competency-based medical education has gained popularity across the globe. Competency-based medical education, which is a departure from traditional apprenticeship, process-based and time-bound models, entails defining of the competencies to be achieved at the outset, and careful selection of appropriate methods of instructions and assessment for ensuring their acquisition.3 The College of Physicians and Surgeons Pakistan (CPSP) is already following this model in its fellowship, membership and diploma courses. But in order to produce competent graduates and postgraduates and to make sure that they continue to remain so throughout their professional career, competency-based model needs to be introduced in every phase of the medical education. This will require delineation of core competencies for undergraduate medical education, postgraduate medical education including internship period and continuing medical education as has been done by the General Medical Council and the Department of Health of the UK.4,5 The quality assurance mechanisms employed by the CPSP in its examinations ensure that only those candidates who manifest attainment of prescribed competencies pass these examinations, particularly for the award of fellowships.6 The low pass percentage in these examinations can and should be attributed more to the inadequacies of the system of undergraduate medical education, which to say the least neither prepares them for the general practice nor for the postgraduate medical education. Moreover, the internship training does not have any structure and mechanism for evaluation. At some places, it has become a mere formality, particularly, in the wake of huge number of interns in each clinical unit. As a matter of fact, this critical foundation period, ideal for acquiring basic clinical skills and to develop informed choices for future professional career, is wasted.

A myth quite commonly held in Pakistan, like some other developing countries, is the notion that graduation is sufficient to prepare for general or family practice and hence no need for specialization in this field. Contrary to this belief, family physicians constitute the backbone of health delivery system7 by serving not only as the first contact physician but also as the physicians responsible for continued, holistic and integrated care, require rotational training in all essential clinical disciplines culminating into specialization in general practice in order to perform their role effectively and efficiently.
Reforms in the structure of medical education, so as to provide better healthcare to the masses, can not be brought about by either individuals or individual sections of the society. All stakeholders, whether concerned directly or indirectly with the provision of healthcare, have to make concerted efforts for this purpose. The State, provincial and local governments can contribute by making budgetary enhancements for health so as to improve physical conditions and patient care equipment and educational capacities of the institutions; political leaders by exhibiting the will for reform agenda; Higher Education Commission of Pakistan and PMDC by arranging brainstorming sessions for identifying competencies for all phases of medical and dental education including house job and then by facilitating the development of competency-based curricula; PMDC by introducing mechanisms for implementation of its regulations and approved curricula for undergraduate and postgraduate courses; CPSP by devising effective tools for monitoring the training for its fellowship and membership programs; medical institutions including teaching hospitals by adhering with the PMDC and CPSP requirements and regulations regarding undergraduate and postgraduate training and providing for contributing professional development and vistas for medical education so as to pursue a reform agenda through faculty development activities.

REFERENCES