

### **Safe medical practice in Pakistan: are we prepared to adopt a path?**

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While there are many discussions about improvements in medical education in Pakistan, reports, personal communications and print media write ups are not concurring with these anecdotal hearsays. Ironically, medical education in public sector medical colleges with large hospitals attached, are not fulfilling the training and teaching needs of the prospective medical graduates. There are a number of factors for this including a lack of motivation among teachers, bad regulatory control and subtle politics. With the upsurge of a number of private sector medical colleges, it was assumed that this situation would improve in view of effective quality control, incentives for teachers and some sort of accountability. The problem with private institutions is the inadequate number of patient turnovers in ill equipped hospitals. There is more teaching with less patient exposure and hands-on training. Medical students in the public sector made their personal efforts in learning through their patients under the umbrella of larger hospitals with huge patient turn out. At the end of the day, it transpired that a number of medical graduates from the private sector did well in their Professional and Linguistic Assessment Board (PLAB) and United States Medical Licensure Examination (USMLE) exam, some scoring up to 99% of marks in USMLE exams. So which is better? We cannot compare one over the other, as both have inherent disadvantages. However, it is important to look at the end product: which is the 'Medical Doctor.' A large number of medical graduates commence and complete their

postgraduate training (specialization) in Pakistan and start their career. Some after completing their internship would immediately go into general practice. The dilemma remains about safe practice of a doctor. In the current era, there are no formal assessments, observations, or periodic reviews of practice or revalidation of certification. There is a big change in how the western world is making medical practice safer and, once it is in full bloom, there will be an expectation from medical practitioners aspiring to work in the western world to have undergone this exercise, on a periodic basis. There are some reports where bad practices in medicine have reflected dangerously on a number of patients. It is therefore pertinent to initiate such a system in Pakistan. For this country, designing and implementing new policy has always been a nightmare. However, it is necessary to look at some models designed by the western world and find a way where a suitable system can be developed in Pakistan. The Irish Medical Council initiated discussions on Competence Assurance Structures (CAS) in 1997 and intends to fully implement the policy for performance assessment in practice.<sup>1</sup> The salient features of this plan include participation of all doctors in a Continuing Quality Assurance (CQA) programme for 50 hours per year. These doctors must also align themselves with a postgraduate training body where there is a requirement to submit evidence of participation, involvement in clinical audit and peer review activities as part of ongoing education. The structured peer review assessment is carried

out by two trained peer assessors and one lay assessor. The chief medical officer of the National Health Service in Britain in his report<sup>2</sup> places the regulation of doctors within the wider set of systems. For improving and ensuring quality assurance in modern practice, his emphasis is on assuring the availability of the 'good doctor'. A common standard of entry to the profession would be through a new standardized national examination for all doctors applying for registration with the General Medical Council (GMC) for the first time, irrespective of their place of primary qualification. For established doctors, continuing competence to practice will be assured through revalidation, embracing re-licensure and recertification. Though there is no universally agreed definition of 'good doctor' those who are technically competent, are capable of forming and maintaining good relationships with patients and colleagues and are honest may fall into this category.<sup>3</sup> GMC, in collaboration with the Royal Colleges will undertake this huge task in the United Kingdom. The issue of revalidation has been a recent development primarily as a result of the Harold Shipman Legacy.<sup>4</sup> The process of revalidation is defined simply as "to be valid again." The main focus of revalidation is to improve the quality of patient care, while its fundamentals elements will revolve around the following three questions; Are you up to date? Are you fit to practice? Are you safe with the patients? This process is divided into two components: re-licensure and recertification. The former is related to fitness to practice as a doctor and the latter relates to fitness to be certified as a specialist. The former is the first stage in the process of revalidation and this entails doctors' registration with the local medical council. After this the practitioners would be required to complete the re-licensing procedure at least once every five years, indicating that they meet standards of medical practice set by the local medical council (GMC in the UK).<sup>5</sup> The evidence required to re-license a practitioner would depend on the following: partaking in a system of annual appraisal where the performance of the doctor is appraised against a minimum set standard, providing an independent 360 degree feedback that includes filling out questionnaires like the Mini-Peer Assessment Tool (Mini-PAT) by a variety of people e.g. consultants, peers, nurses, secretaries, and patients and confirmation that any professional conduct issues have been resolved. The process of recertification will rest with the respective specialist institutions (Royal Colleges in case of UK) that will set down standards and criteria. While these can vary slightly within each speciality, the majority will conform to the minimum set of generic standards agreed upon by all. The mainstay of the process of recertification should include the practitioner's professional standing in the form of a valid and current licence, learning and self assessment, involvement in interactive educational

activities and evaluation of performance in practice. In February 2007, a White Paper<sup>6</sup> was published which delineates about seven areas from which verification for recertification can be taken: appraisal, clinical audit, simulator tests, knowledge tests, patient feedback, Continuing Professional Development (CPD), and observation of practice. One important aspect is the peer appraisal which is a structured process of facilitated self reflection. It allows individuals to review their professional activities comprehensively and to identify areas of real strength as well as the need for development.<sup>7</sup> It involves a one-on-one meeting with a colleague of the similar status to avoid situated authority. As well, a dedicated time and place must be allocated for this activity. All the prescribed forms and suggested documents are recommended to be prepared before the meeting. The prime aim of the peer appraisal is to improve the patient care by providing a vibrant educational process contributing towards a personal plan. The appraisal process provides an environment where peer appraisal can be conducted and evaluated on a yearly basis. The record is kept so the administrators of the organization can be rest assured that the hospital consultants are maintaining the professional standard set out by the authorities. The process of an annual peer appraisal provides an opportunity to a fully trained doctor to set aside a time to review one's own practice of the past year, present all achievements and potential shortcomings (if any) to a colleague and to make a realistic plan for educational and professional growth for another year. As well it will help the doctor achieve the goals set for the year. To discuss matters with a peer allows a clear vision of one's own practice and behaviour. Multi Source Feedback is a very useful and well validated type of appraisal.<sup>8</sup>

In conducting a one-on-one meeting, there arises a question about the probing of a colleague. If a person does not want to disclose the adverse events it will be very difficult for the appraiser to identify those areas. Not providing enough documentary evidence of good medical practice and CPD will very clearly be picked up as some deficiency in the practice or development process. Providing a feedback to a poorly performing colleague at peer appraisal is a very difficult task which requires appropriate training for the appraisers. The UK system has not only addressed the undergraduate medical education but also governing the postgraduate education for which the Postgraduate Medical Education and Training Board (PMETB) is the statutory body for monitoring, approving and regulating the postgraduate education in Britain. There is also documented emphasis on the specialists "being judgement-safe and competent in their specialist practice. They must be able to demonstrate the qualities and capabilities to manage a clinical unit or team, ensuring high

standards of professional care and effective relationship with colleagues across professional disciplines. They may take a leadership role within teams and organizations and will have the vision and foresight to develop new ways of working and the commitment to see projects and teams through to the end. New specialists will need to demonstrate the personal capacity and qualities to respond positively to feedback from colleagues and patients, to take and accept responsibility for clinical decisions, and to manage and respond to complaints from families of patients and fellow professionals in a professional manner. They will have the potential to teach and to support training programmes for trainees, departments and staff under their supervision".<sup>9</sup>

The Canadian model focuses on CanMEDS<sup>10</sup> which is an innovative framework of essential physician competencies and has been adopted by the Royal College of Physicians and Surgeons of Canada since 1996. This model looks at a doctor as a Medical Expert, Communicator, Manager, Health Advocate, Collaborator, Scholar and Professional. These qualities are assessed through written tests, oral exams, direct observation, OSCEs, 360° and peer evaluations, portfolios and logbooks as well as general observations. In the Canadian system, there is a provision for periodic peer review and essential requirements for Continuing Medical Education (CME). A certain number of hours (400) per five-year cycle have to be completed as credit points and submitted to the Professional Development division of the Royal College of Physicians and Surgeons of Canada (RCPS).<sup>10</sup>

In Pakistan at the present moment no such procedure is available and the regulatory body, Pakistan Medical and Dental Council (PMDC) is not considering any such plan in order to ensure safe practice. There are many problems within and outside the PMDC, mostly political, which have remained a great cause of concern for the smooth regulation and monitoring of general medical education in the country. Furthermore, if such models are to be adopted, there will be a need for strong motivation among the PMDC council members. There is every possibility of resistance by many

doctors who may feel threatened by such a process, especially the fair conduct of peer review assessment. Under these circumstances, should we abandon this idea and leave the patient at the mercy of few doctors who would do more harm with no consequent accountability? If we do not deal with this issue then it will just be a violation of basic human rights as our patients need what they deserve in terms of better health care.<sup>11</sup> We also believe that this will not be fair to the already fragile health care system in Pakistan. A modest beginning can be made as a PMDC initiative. This initiative would require mandatory credit maintenance via CME which should be monitored by the College of Physicians and Surgeons of Pakistan (CPSP). We can also have periodic peer review with the help of Pakistan Medical Association (PMA) along with the regular auditing, which can be done through the concerned departments and organizations. Can this process be started now?

## References

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