Medical Education in Pakistan

Abdul Majid Rajput
Head, Department of Community Medicine, Islamabad Medical and Dental College, Islamabad (Bahria University)

In Pakistan, medical education at national level is facing multidimensional issues best described by the situation where the public is asking for more and better doctors, young doctors demanding better facilities & training opportunities, older graduates and specialists wanting robust continuing medical education CME programs, both students and teachers in medical colleges dissatisfied with present conditions and regulatory mechanisms. Above all, the relevant stakeholders such as; the medical organizations (PMA, PMDC, CPSP, etc), the policy makers and civil society organizations, are not responsive to the situation and show least interest to reform the scenario.

Pakistan is not the only country where such problems exist in the field of medical education. These problems appear to be universal and all concerned stake holders are striving to explore ways of solving the crises. Medical education at national level should not be seen in isolation; a system approach with holistic and integrated imperatives is the way forward to avert the deepening crisis.

The health system (all activities relating to care of the people) has three components: medical education, the centre piece (health human resource development), service delivery (care facilities) and research (culture of evidence and use of information). The effectiveness and efficiency of health system is judged by the level of social responsibility being fulfilled by the respective component. At the time of inception only two medical colleges existed, and, over the years, 61 medical and 25 new dental colleges have emerged. It is also said that the actual number of medical & dental colleges are 98 and 39, respectively, with a total of 137 instead of 86 medical and dental colleges as most of them are in the pipe line and carry some sort of recognition by PMDC. Presently, the College of Physicians and Surgeons, Pakistan alone is offering 85 post graduate programs. The annual output of doctors is more than 6000.

The impact of medical education at national level can be analyzed in the light of burden of disease (BOD); and in Pakistan both communicable and non communicable diseases (NCD) exist almost in equal proportions while in West NCD are prevalent.

The double BOD pose major challenge requiring different teaching strategies, provision of care services and research imperatives; sustainable and substantial resources are needed to overcome both communicable and NCD. Pakistan is not likely to achieve MDGs in 2015, and may touch the targets in 2020 and beyond.

Social Responsibility:
The study by Mullan and colleagues describes three domains of social responsibilities of medical schools, namely, percentage of their graduates practicing: primary care, underserved areas and representing minority doctors.

In fact, PMDC subscribes to similar attributes: Prepare a caring, general purpose, community oriented doctor, competent to deal with common health problems of people, significantly sound and cost effective manner and using appropriate technology and a holistic approach. Similarly, the relevance of the curricula is in the right direction as far as vision is concerned, but actually there is disconnection between the theory and the practice. In order to have relevant curriculum following steps are needed: shift from medical care to health care; better understanding of causes of diseases, as majority of diseases can be prevented or reduced with existing knowledge; medical educationists to understand the shift and change of training settings.

In Pakistan, there has been rapid growth of medical colleges; in Punjab the number of medical colleges has risen from 19 (10 public, 9 private) in 2001 to 37 (14 public, 23 private) in 2011- an increase by 95%. In addition to training doctors, are these colleges meeting social expectation of equitable supply of health care in the rural areas (400 vacancies of doctors in Punjab). Loss of large female medical force is another dimension. Colleges have a role in promoting acceptable pathways for female graduates, e.g. teaching posts in basic sciences and flexible working hours in hospitals. The concept of accountable standards should be taught in undergraduate courses to implant the principle of responsibility to the society in the minds of the students to overcome problem of workforce. Following measures are proposed to ensure a healthy change in the medical education system:

- Utilizing benefits of knowledge to reduce BOD
- Environment change, Life style related conditions, population control, safe drinking water, safe disposal, EPI
- Shift from relief of symptoms to prevention and reducing adverse effects
- Obligation of Institutions to train physicians and health work force, conduct research, advance technology, provide health care services within own resources, ensuring accessibility and equity.
- Relicensing or recertification
In view of the IT explosion, there is exponential growth in medical field and new information is doubling after every 03 year. It is impossible to know everything; hence, it may not be possible to teach everything. The short shelf life of text books/lecture notes, new drugs & their adverse effects pose different challenges. The best way is to produce lifelong learners and self learners.6

Way forward
There is obvious disconnect between our medical education, service delivery and research components of the health system with the result that desired outcomes such as BOD and attrition rate of medical force are apparent despite comparable resources are allocated to the health sector when regional countries are considered. Duplication of efforts and resources, abounding and virtual non regulation of private health sector; and under utilization of private public partnership potential are contributing to the present situation. The culture of evidence and use of information (research), shift of curriculum to health than medical paradigm (education system along with learning methodologies and CME) to be based on holistic and integrated framework built on accountable standards (social responsibility) would accrue the desired outcomes. The suggested way forward is to have the following perspectives:

• Integration of academic and service delivery research components would yield effective & efficient health system to tackle the BOD
• Correcting imbalances in health workforce and urban rural facilities would ensure accessible and equitable care.

• Focus of academics on common health problems using appropriate technology with a holistic approach held in the community settings; and in a cost– effective manner.
• Regular update of curriculum in the context of BOD and evidence based scientific research; and establishing medical education departments.
• Service providers to be lifelong self learners; mandatory relicensing and recertification

How to do it !
A standing commission of stakeholders comprising policy makers, planners, regulators, managers, teachers, students, community organizations should be established to undertake the task.

References