

Editorial

The Status of Postgraduate training in Obstetrics and Gynaecology in Pakistan

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Till recently, most of the teaching Faculty and Consultant Obstetricians and Gynaecologists in Pakistan were trained in UK or USA. Now fewer and fewer foreign trained Obstetricians and Gynaecologists return to Pakistan, and even upon their return find it difficult to find appropriate job opportunities where they might pass on their recently acquired skills to local trainees. Most are lured to more lucrative job offers in the middle east where female Obstetricians and Gynaecologists are in great demand, and hence potential new trainers with experience of working in UK and USA will not be able to our trainees.

The problem is compounded by the fact that opportunities for training abroad are drying up with the formation of the European Union (EU) resulting in decreased posts in the UK for non-EU doctors. The post 9/11 scenario has made it increasingly difficult for Pakistani doctors to obtain working visas for USA, as well as most other developed countries where they might have sought training. As these alternative avenues are drying up, attention needs to be paid to opportunities at home, and developing them

In a recently published comprehensive health reform agenda for Pakistan, the author states that postgraduate academia has performed better than the undergraduate academia, both in qualitative and quantitative terms. The author cites the increasing number of graduates of the CPSP as an indicator.¹ However merely an increasing number does not reflect on the quality of the Fellows of CPSP. We must develop some criteria to evaluate the performance of those who have passed the Fellowship examination

Theoretical knowledge of the subject is not enough justification for qualification to practice as a consultant. Unfortunately, clinical skills are inadequately tested in most postgraduate examinations. There is misconception regarding training, eligibility and clearing postgraduate examinations. Structured training with continuous assessment is the answer. Only trainees who are performing adequately should be allowed to proceed to the next stage. A Faculty which is interested in teaching should be allowed to be supervisors. In the personal experience of this author there is great resistance by faculty to be evaluated even though it is anonymous and confidential

Trainees in most teaching hospitals, express

dissatisfaction with their training. There is virtually no guidance from their supervisors, who leave them unsupervised. They are underpaid or not paid at all, and utilized as workhorses to run the department without proper "reward" in the form of supervised teaching of surgical skills during elective surgery. However, when dealing with acute emergencies out of hours, they virtually teach themselves. They complete their requisite number of years of training without being competent to perform major gynaecological surgery independently. In addition their diagnostic and communication skills are mostly lacking. This is an alarming trend as they are virtually being certified to work as independent consultants.

Another disturbing factor is that freshly qualified consultants are shy of seeking help and guidance from seniors. This is particularly important while performing surgery. Instead, they seek the help of theatre technicians. The reason for this needs to be addressed and rectified. Why they do not, or cannot seek the help of their seniors...? Do the training years make them so materialistic and sceptical about their supervisors, that they ignore patient safety and proceed with procedures which they are incompetent to perform? Are they perhaps lacking in role models?

Most of the career gynaecologists in Pakistan are female. The majority of students in government as well as private medical colleges are also female. It seems to be taken for granted that female graduates will pursue Gynaecology and Obstetrics. In developed western countries female doctors do enjoy job security, maternity benefits etc, despite this, there is dissatisfaction regarding their career progress.²

In Pakistan very few employers would employ pregnant doctors, preference being given to single doctors. Marriage or pregnancy have been reasons for non-selection and even job terminations. This is very unkind coming from mostly women Consultants who are involved in decision making. Some extremely good doctors drop out for this reason. Let us not forget the personal life of a female doctor. On average she is 24 or 25 yrs old when she graduates; if she gets married she has to divert attention and time to house, husband, in-laws etc; she realizes that childbirth is safest in her twenties. Once pregnant, very few employers are considerate about her condition, while her family pressurizes her to quit her training which has sometimes

inhuman number of working hours (one in two rosters are still operational in some institutions), without much monetary gain. A flexible career plan is needed for married trainees and junior consultants, under which they can leave for five or so years and rejoin when the children are of school going age.

Another sad fact is that some senior consultants do not let their trainees do major surgery.. One consultant refused to teach abdominal hysterectomy to a 4th year resident who was in the last week of her training, the reason given being that she would start doing this operation once she graduates from the training program!. Consultants with such attitudes should never be allowed to become supervisors if they are not willing to teach. Admittedly it is easier and quicker to perform an operation, rather than teach it. After the Calman Reform of specialist training in UK, trainees in all grades reported greater satisfaction with their current posts. This was the result of extra training time and effort from their consultants.³

Another neglected aspect of training is understanding of scientific research and the ability to critically read the current inflow of information. This is the domain of scientifically inclined, meritorious professionals. Unfortunately most appointments in government teaching hospitals are based on quota not merit; and promotions are based on seniority not performance.. The trainees get very little guidance from their seniors in such a scenario. Dissertations are long winded, rather than limited to relevant points, . A lot of time and money is wasted on

submitting and sometimes resubmitting repeatedly, several copies of the dissertation. These requirements need to be reviewed by the CPSP. The Royal College of Obstetricians and Gynaecologists UK, in comparison has abolished dissertation as a prerequisite for Membership.

The answer to improvement lies in a structured training programme, with regular trainee and faculty evaluation under a designated Tutor/ Programme Director. Candidates should only be allowed to proceed to their final Membership/ Fellowship examination unless they have been certified by their supervisors and found fit to take the examination. Eligibility to appear in the final examinations should not be based just on the number of years they have spent in training. Clinical and operative skills, as well as their interpersonal interactive skills should be assessed by the supervisors. Employers need to be more lenient with working hours, providing job-share / part time employment facilities for pregnant / breast feeding women doctors. Maternity leave and benefits should be included in their contracts. In addition Creche facilities should be developed in hospital premises, to decrease the attrition rate from training.

References

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