KEYNOTE ADDRESS FORUM

"TRAINING FUTURE DOCTORS: HAVE WE GOT IT RIGHT?

BY

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Thank you Mr. / Madam Chairman

Tan Sri-Tan Sri and Puan Sri-Puan Sri, Dato'-Dato' and Datin-Datin,

Honoured and distinguished speakers at this Forum,

Invited guests,

Ladies and Gentlemen,

A very Good Morning and Greetings,

I would like to first of all thank the Organising Committee for inviting me with to deliver the keynote address in this "Forum on Medical Education' with the theme **"Training Future Doctors: Have We Got It Right?"** Indeed this is a subject close to my heart.

This forum is indeed timely and apt in view of the on-going concerns for the quality and safety of health care and our present and future doctors. This is of course not just a Malaysian problem. It is also a global problem. Be that

as it may, Malaysia has its own peculiar intricacies and challenges that may not be so evident in other countries and it is my hope that we can discuss all these issues in a transparent, cordial and constructive manner to remedy the situation because if we do not do this today or now, the opportunity for us to offer possible solutions will pass us by. And if that happens, we will not forgive ourselves for not acting when we could and should.

I am therefore very pleased when Dato Hamid approached me to give this talk in this forum. This forum has brought together some of the top minds in the field of medical education in Malaysia, including other significant stakeholders, whose contributions are also critical to the success of the medical profession.

L & G, you and I will agree that we have talked enough about the varying quality of our doctors, albeit in informal discussions and talks. The time has come for us to act. ***"The great aim of education is not knowledge, but action"*** said Herbert Spencer, the great 19th century English philosopher. In addition, Thomas Henry Huxley, the English biologist and writer, once said that ***"Perhaps the most valuable result of all education is the ability to make yourself do the thing you have to do, when it ought to be done, whether you like it or not; it is the first lesson that ought to***

be learned; and however early a man's training begins, it is probably the last lesson that he learns thoroughly".

In the field of medical education, we need action that is thoroughly discussed and one that is based on evidence to ensure that the education, training and acculturation of future entrants to the medical profession will produce doctors who can respond to "real world" needs of society, which has entrusted us with this crucial mandate.

We have always been a nation that prizes the attainment of knowledge and skills and it is not surprising that the Malaysian Government is actively providing opportunities for our students to pursue their education, including medical education, locally as well as overseas. To cater for the demand for more good doctors to provide high quality health care to an ever demanding, discerning & well informed public, the government has allowed for an increase in the number of both public and private medical institutions.

Between the year 2000 and the present, the number of public medical faculties in Malaysia has increased from 6 to 9 and the number of private medical faculties has increased from 4 to 12 and we are still counting. We continue to receive requests to establish more medical faculties! Often the

MOH and MMC are blamed for the deluge of medical schools in this country. Not many know that we are also at the receiving end as I will highlight in my talk later.

The medical doctor to population ratio has improved from 1:8,229 in 1957 to 1:1,145 in 2007. This is indeed a tremendous achievement for a small developing country, with a modest expenditure on health, like ours, compared with developed nations. Still, there is wide disparity between the ratios in different parts of the country. We cannot deny that the growth of medical schools in the country has greatly contributed to the increase in numbers of our medical graduates. Up to September 2008, we have already registered more than 2,000 new graduates to commence their housemanship training and by December 2008, the number of medical graduates registered to undergo housemanship training is expected to reach 2,300. They not only come from our local medical faculties (public and private), but also from foreign medical schools. These numbers are expected to grow every year due to the increasing number of government scholars and private students managing to secure places in local medical faculties and overseas. In 2013, the doctor-population ratio in Malaysia is expected to be 1:600 which, on paper, will further improve equity and access to health care but I am not so sure whether we will, looking at the shortage of doctors & other healthcare providers, facilities and other

amenities especially in Sabah & Sarawak. A very important issue we need to address is the technical quality & soft skills of these doctors & other HCPs. Today we will deliberate on whether we have got our formula right in shaping the future of healthcare in this country and especially, whether we are doing things right in the training of our future doctors.

Ladies and Gentlemen,

The medical profession continues to be rightfully regarded as the "noble profession" and Society has bestowed upon us the mandate and trust to act as advocates for our patients in their pursuit for better health, whilst protecting their dignity and rights. The medical profession has the responsibility to ensure that the health care that is provided is of the highest quality i.e. consistent with the best available evidence, so that our patients can achieve the desired health outcomes. To achieve this, we all have a duty to ensure that the doctors we produce possess the capability to become "competent and ethical carers", who are able to meet the real-world challenge of providing healthcare that is safe, effective, appropriate, efficient and patient-centred. One of the key elements in our quest to provide high quality health care is medical education, which is a continuing endeavour as Medicine is a life long course. Getting the requisite qualifications is just the first step in a long, long journey to accumulate sufficient knowledge, skills and experiences to manage an ill patient

competently, appropriately and confidently and independently. In this respect, it does not really matter where our doctors graduate from. What is important is whether they have the ability to grasp and retain new knowledge and skills and the resilience to go through some arduous tasks and challenging moments in their lives, henceforth, to be transformed into a competent carer, someone who is trusted with making decisions that will determine whether a patient lives or die.

Perhaps we can start by understanding what medical professionalism (MP) is. According to a report "Understanding Doctors" by RCP London, MP refers to " A set of values, behaviors & relationships that underpins the trust the public has in doctors" . The report went on to state that "Medicine is a vocation in which doctors' knowledge, clinical skills and judgment are put in the service of protecting and restoring human well being". This purpose is realized through a partnership between patient and doctor, one based on mutual respect, individual responsibility and appropriate accountability. In their day to day practice, doctors are committed to: integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider health care team.

In an attempt to focus on relevant issues that can contribute to the discussion, I have decided to focus on 5 areas of contention:

1. Student
2. School
3. Policy
4. Changes In the Health Care Environment: locally/ globally
5. Society

1. Student

How do we identify future medical students who are most likely to become effective and respected doctors? Presently we go by their marks and not so much their inclination. There was an attempt to expose them to the healthcare environment in the hospital settings. I'm not sure how useful & effective this is. There are other medically–related disciplines they can pursue, like medical biotechnology and molecular biology.

There are of course 2 types of students: those who get scholarships, sponsorships or loans and those who are funded by their parents and I can tell you their behaviour and attitude can be quite different!.

Let us talk about the first group.

Do we need to interview them? Can an interview give us the advantage of choosing one student over the other? Are the students driven by their ambition, their altruism or those of their parents? Are they prepared to study hard, work long hours, sacrifice some of their pleasures in life and

strive for excellence? Do they have the resilience to not only go through medical school but be able to trudge along the long and risky road to achieve excellence in their vocation? Are they able to withstand the stress of medical education and the intense competition they will face as students and doctors? I mention this with some concern because of late, we have seen many students and house officers who have to be referred to the medical review panel of the MMC for mental problems.

Prospective students should be thoroughly screened to weed out those with mental problems. I am not so sure whether we can pick up those with attitude problems during an interview unless such problems are so obvious. Of course, we may be seen as being biased and prejudiced and in conflict with the Human Rights Commission but we have to be realistic and fair to these students. Otherwise, they will end up being non-functioning or non-registrable doctors even though they have completed their medical education. As President of the MMC, it is quite disheartening for me to refer not less than 5 mental cases to the Medical Review Panel at almost every MMC monthly meeting. Medical schools must therefore screen and select their students carefully and meticulously. Bringing in students just on grades alone may no longer be sufficient.

The other requirement, in my opinion, is the proficiency of the English language. This is crucial & necessary if students and future doctors wish to keep themselves constantly updated on current developments in the ever evolving medical literature and basic scientific research and be able to interact freely with the best brains and experts in the relevant fields of medicine all over the world. Also, they can afford to dazzle and mesmerize the global scientific community whenever they wish to impart new knowledge based on their original research findings.

2. School

There is a diversity of medical institutions with different philosophies and training methods with regards to medical education. To some extent, this will influence the quality of medical graduates. MOH has come up with a structured format to evaluate new graduates.

We have 21 medical schools in this small country of ours. There are approximately 400 recognized medical schools overseas. Different medical schools around the world will have different selection criteria for its medical students. The undergraduate medical curriculum in the universities where our Malaysian students are trained will undoubtedly be based on that particular country's development plans and its social and health needs, which may be different from the needs of our own country. Many have

what are called Foundation Courses. While these courses may be useful for those preparing to enter the 1st year of medical education, this is also one way for weak or even unqualified students to gain entry. All they need is a no objection letter from MOHE. While this is usually done properly, there have been infringes. In Malaysia, we have agents who act as mediators between the student and the universities. While we appreciate the role of these agents, we have had our fair share of problems with them, some of whom consider themselves very influential and will do whether is necessary to get their students in. Some give false information to parents about the status of registration of the medical schools and when these students are asked to sit for the MQE, parents will cry foul and blame the MMC for being unfair. Some institutions send student to universities not recognized by MMC, perhaps confident that these schools will be recognized by MMC by default. Some agents impose a significant levy on the institution in Malaysia on each student forcing the JPA to stop sending our students to these universities. If we need to have agents as go-betweens, then it is time we have SOPs and a set of rules they have to abide by so that everything is above board. Otherwise the students and their families will be at their mercy.

Enough of these agents and irregularities.

There have been many changes in both the undergraduate and postgraduate medical education in most universities. Key changes, such

as that promulgated by the General Medical Council of the UK, include early patient contact from the beginning of the undergraduate course; more emphasis on patient-centred communication skills; an increased focus on ethics, culture, and ethnicity; and more training in the community.

Students and doctors must be taught about good medical practice. Patients must be able to trust doctors with their lives and health. So it is important for doctors to do the following and I borrow this from the GMC:

1. Make the care of their patient their first concern.
2. Provide a good standard of practice and care
3. Treat patients as individuals and respect their dignity
4. Work in partnership with patients
5. Be honest and open and act with integrity

Systematic procedures are necessary to apply these principles to the practice of medical education. The MMC has produced several guidelines, in consultation with members of the profession and the community, to ensure ethical practice. Universities must take the cue from these guidelines and principles in order to make medical education more relevant and reflective of current developments in the medical profession.

Undergraduate and postgraduate curriculum reforms over the past 20 years have resulted in major changes in the way our students and postgraduates are being taught and quite often, this has been done on the basis of nothing more than pragmatism, fashion, and whim. Not all of these have been good for medical education or for the doctors that it produces. We have witnessed unwieldy student numbers and poorly-developed web-based learning introduced as a substitute for direct personal contacts. I think too much compromise has been made in the teaching of clinical and practical skills. To ensure that future changes will be beneficial, there is a need for evidence-based medical research as well as evaluation to guide decision-making on what the best curriculum and teaching methods are.

Another issue that influences the choice of medical schools, especially for private students, is the costs. This is part of the reason that we have students in Indonesia, Russia, Ukraine and others. Decisions made by the Joint Accreditation technical Committee are at times unpalatable to some and get delayed. There have been some unhealthy developments whenever decisions are made to limit the number of students or schools.

Then there are the local private medical schools who wish to send their students for clinical training in our hospitals. When we say there are no more hospitals, they exert their political influence and even go to the extent

to say that we are not co-operative. When we say we just do not have the clinical space, they will then use another term "clinical observers". It would be better for these schools to outsource their clinical training to reputable and recognized universities overseas or have proper twinning programmes. One or two have done so and as long as there is mutual endorsement and recognition by both our authorities and the foreign universities concerned, we are willing to support. This is far better than crowding our hospitals with students who cannot learn and teachers who cannot teach.

Many of the local schools want more and more students every year and if we say no, because we are concerned about the staff : student ration, they get all riled up and start hurling accusations.

L & G,

There is also the issue of the format of examinations. Some of the formats used are questionable and may give rise to all kinds of speculation. Some schools do not have exit examinations. Passing or failing is based on cumulative assessment by just one individual lecturer. With this format, there have been instances whereby students graduate earlier than others (express graduation) after getting fast track approval from the supervisor. So you have a scenario where students enter the medical schools at the

same time but graduate at different times even if they have not failed any of their subjects.

We are now living in the era of evidence-based clinical practice and not surprisingly, there have been calls for medical education to become more evidence-based. I know of many journals and books just on medical education and training of doctors. For good decision making based on evidence, we must have good medical education research. Sad to say, in this country, there is a dearth of medical education research.

A relatively recent review of the medical literature on medical education research by the British Medical Journal in August 2007 has revealed, alarmingly, that research into medical education has not developed much over the past 10 years, in terms of funding and methods. Topics should cover topics such as examinations, student selection, predictors of academic success and professional trajectories in medicine.

3. Policy

The Malaysian Medical Council (MMC) is empowered to recognize medical schools for the purpose of licensing medical graduates for practice in Malaysia. Implicit is its role in setting standards and certifying the achievement of standards of medical degree programmes awarded by all medical schools within and outside Malaysia.

In June 1996, the Government established the National Accreditation Board (LAN) under the LAN Act (which is now renamed Malaysian Qualifications Agency or MQA in short) with the aim of assuring the quality of educational programmes in private institutions of higher education.

To avoid unnecessary duplication, the Director General of Health, as the President of the Malaysian Medical Council, directed for a Joint MMC-LAN-Ministry of Higher Education workshop to be conducted in 1998 with the aim of establishing common guidelines for standards and procedures in accreditation and to recommend a practical working relationship that will be adopted by all three agencies.

Following this, a Joint Technical Committee responsible for the accreditation process and course approval in both private and public medical schools local and abroad was set up in 1999. The Joint Technical Committee comprises 5 agencies namely MMC, MOH, JPA, MOHE and MQA. The Technical Committee, chaired by the President of the MMC, is responsible for constituting the evaluation panel, studying the report of the accrediting team and submitting the recommendations for ratification by relevant accrediting authorities. The Technical Committee is also responsible for reviewing the validity of the standards and procedures from time to time and to submit proposals for changes to the respective accrediting authorities.

Briefly, the accreditation process entails the following steps:

a) Medical school's submission documents

c) The Accreditation Survey Visit

d) The Accreditation Draft Report

e) Recommendation by the Joint Technical Committee to the MMC

f) Recommendation by the MMC to YB Health Minister

g) Final decision by the YB Health Minister

Once the YB Health Minister agrees to the recommendation by the MMC, the Second Schedule will be amended accordingly and JPA will be informed. JPA will then inform the YB MOHE Minister who is the Chairman to the Jawatankuasa Tetap Pengiktirafan (a committee determined by the Cabinet) to recognise the degree for the purpose of employment or recruitment doctors into public services by the Public Services Department (PSD).

Accreditation may be granted for a maximum period of five years subject to certain conditions being addressed within specified periods. Accreditation may be refused if the Joint Technical Committee considers that the deficiencies are so serious as to warrant remedial actions.

Those institutions which do not achieve recognition or accreditation status will not be placed in the Second Schedule and their graduates need to sit and pass the medical qualifying examination before they are eligible for registration.

The concern is the prior approval given to the setting up of new medical schools without prior feedback from MMC. We are only involved in accreditation of the school after it has taken in stidnets. We have already indicated this to MOHE and we hope this anomaly will be given serious attention.

There are some issues with the no objection letters (NOL). While we can see the benefit of these letters, some years ago, we discovered to how horror that even those with objectionable results manage to get their no objection letters form MOHE. We have written to MOHE and am awaiting for their response. I am particularly concerned about the issuing of NOL fro foundation or pre-medical courses run by the affordable universities overseas.

There is also the issue of a common licensing examination. Do we need a common licensing examination for all doctors who graduate from foreign medical schools?

As for the policy on training of doctors, we know that there are several types of training given to the doctor upon graduation and these include the "housemanship" training, general clinical training as a medical officer, specialist training and this include training in public health, subspecialty training, and others. The doctors themselves must engage in continuing professional development activities to keep themselves up to date and relevant..

In Malaysia, we have the 2 years of housemanship and 3 years of compulsory service

The 2-year housemanship encompasses six disciplines namely general medicine, paediatrics, surgery, orthopedics, O&G and emergency medicine. The purpose of this change is to improve the capacity and capability of our trainee doctors. Recently, the Malaysian Medical Council (MMC) embarked on an assessment programme for the first 4 months of housemanship to determine the performance of medical graduates from each university as part of its efforts to evaluate the quality of undergraduates from the various medical schools in a more objective manner. In enhancing quality, all qualified housemen are required to obtain full registration from the Malaysian Medical Council before being allowed to

practice medicine. In addition, specialists will soon be required to be registered with the National Specialist Registry.

Opportunities to undertake specialist training for our doctors have also been increased. Starting from 2008, the intake for post-graduates in local universities has been increased from 450 to 600 doctors. Still, we will face challenges in providing specialist care to all. We need to have a nice mix of specialists, including those in general medicine or surgery, oncology, nuclear medicine, geriatric medicine and infectious diseases and we need specialists who will not throw tantrums when they are sent to district hospitals or rural areas, to serve. We also need to strengthen the capabilities of our public health specialists in disease prevention and managing health crises and doctors trained in health care planning, health economics and hospital and health services management.

The MOH is recommending some form of bonding for our specialists who are given opportunities for subspecialty training so that we do not lose them from the public health care system after having trained them for 3 years,.

Postgraduate training: Local vs overseas

4. Changes in the Health Care Environment

L &G

We are witnessing marked changes in our health environment resulting from the marked improvement in the health status of the Malaysian population as indicated by the longer life expectancies at birth as well as the low infant and maternal mortality rates. Our disease burden has changed from a predominantly infectious disease focus to life-style related chronic diseases such as cancer, heart disease and diabetes. Extensive urban development due to rapid modernization has brought, along with it, issues related to personal behavior and psychosocial problems. Medical professionals must be well-prepared to manage complex, widespread disasters that can occur as more sophisticated high rise buildings, mass transportation modes as well as increased industrialization are being made possible. They also should be prepared to handle changes in disease patterns and emergence of new health problem related to food and environmental issues including the health threat of new pathogens such as SARS that can cause substantial harm not only to the public but also to the health care provider and the country's economy.

Both undergraduate and postgraduate medical training should keep pace with the changes in the health care environment. This training should be more dynamic and be subjected to constant review to allow modifications

to keep up with the changes in the profession as well as the needs of the community and the nation. We are caught in the inexorable tide of globalization and liberalization of the economy, whereby the doctor must not only be able to tackle clinical issues but also issues that affect health such as health economics and financing, patient safety, occupational safety and health, medico-legal issues as well as public health medicine and medical management. All these will have a bearing on his or her ability to provide good health care. The medical graduate also should be able to adapt to new environments and keep up to date with new knowledge from progress in science and technology, be innovative and constantly upgrade his or her skills. There is a fear of globalization and the impact it may have on our doctors. We cannot stem the tide of globalization nor prevent it. It is up to our doctors to upgrade their skills and knowledge and maintain their competitive edge. Do not expect the government to always protect you because globalization and liberalization are beyond our control. All we can do is ensure that we are no less competent than whoever comes along to offer their services to our rakyat.

Today's doctors are required to be life-long learners in order to maintain their competency and effectiveness and allow them to continue to adapt to changes in the medical environment.

5. Society

The public is becoming more demanding and certainly more knowledgeable now, through media coverage and the use of ICT, whereby they can gain access to knowledge at their finger tips (such as personal digital assistants (PDA) and internet), they have begun to question the appropriateness and effectiveness of the treatment given to them. There is now greater demand for newer and presumably better, high technology treatment modalities and often the costs are very steep.

What about our doctors? Too much reliance on sophisticated equipment to make a diagnosis has blunted their clinical acumen and skills. Besides, these developments will increase the costs of health care and may impede their ability to provide good health care to everyone equitably. With increased expectations and complexity of illnesses, medicine has become highly specialized, resulting in the development of more sub-specialties. To respond to this, MOH has set aside RM 300 MYR in the 9th MP to increase training opportunities for our doctors. About three decades ago, there were only 265 clinical specialists in MOH hospitals. As of June 2008, the number of specialists in MOH hospitals stands at 2,519.

L & G, our society wants the best treatment, delivered in a fast and cordial manner by pleasant, smiling, competent and efficient healthcare providers, doctors especially. They do not want to wait long; they would rather not

pay for treatment and hope the government can provide them with whatever they need. This is the scenario in Malaysia as we do not yet have a NHCF mechanism and the government is subsiding 97% of health care. The MOH is feeling the brunt of all these expectations. Our clinics and hospitals are crowded and our doctors are exhausted. Obviously under such circumstances, some are bound to have lapses in clinical judgement along the way. I am not providing excuses for incompetence and negligence. I just want to remind all of us that things may go wrong because of sheer exhaustion on the part of our young doctors who are ill prepared for what is in store for them when they jumped with joy on learning that they have been accepted to do Medicine.

For our doctors to be the darlings of society, they must have knowledge and skills. They must have patience, resilience and a warm personality. Where do we get these doctors, L & G? Can we train them to be what society expects them to be? Some things are within our control and some things are not. We can ensure they get the best medical education and provide them with the best training by insisting on the adherence to guidelines and policies by our medical schools. That we can do and that is what we can achieve together if we can get some good recommendations at this forum.

But the rest of it, the humility, the compassion and the tolerance are better taught by mentors, supervisors, experienced grey-haired clinicians who call themselves heads of department or disciplines or simply, bosses. Does this group of clinicians provide enough time to teach young doctors? Do they walk the extra mile or go out of their way to teach and train the young doctors? Have they got the ability to motivate and encourage the young doctors to be exemplary health care providers? Are they always available in times of need and crises? Do they get annoyed being called at 3am for an opinion? Do they come for ward rounds at night or during weekends and public holidays, just to inspire confidence and provide some comfort to the young doctors who are on call? Do they take time to display and teach the desired values expected of a doctor in our society?

So, L & G, we may get the training of doctors right in medical schools, but our job is not done yet until we also get the training right when these young doctors are thrown into our hospitals and clinics and in the various institutions they work in. We ourselves may be part of the problem not just the young doctors.

Ladies and Gentlemen,

By attending this forum, we have demonstrated our commitment to share our views and experiences on the strategies to employ in order for us to produce doctors who can serve our society today and in the future. Let us also study how we ourselves can influence the system to help raise the standards and quality of healthcare in this country. We know the issues, we are aware of the challenges; we have had our share of disappointments and frustrations. Now is the time for us to act.

I close with 2 quotations:

1. A quotation from Douglas Adams on learning from the mistakes of others: ***"Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so"***

2. ***The greater danger for most of us lies not in setting our aim too high and falling short, but in setting our aim too low and achieving our mark*** ***Michelangelo***

I wish all of you a fruitful endeavour. Thank you.