Editorial

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The Big Business of Undergraduate Medical Training

The primary purpose of a healthcare system in a country is to ensure the health and wellbeing of its population is well taken care of. The factors that contribute to this may vary in importance depending on the person that you speak to but when the issue is seen within the context of the needs of the country as a whole, the view is usually more comprehensive. One such attempt to rank a country's effort to improve the health of its own people using five different performance indicators is the survey done by WHO in 2000 involving 191 countries.[1] The top spot went to France followed by Italy and the country that spent the most for health as a percentage of GDP, the US, could only be 37th, outranking Cuba by only 2 positions. The best performer in Asia was Singapore at number 6, even better than Japan, and we were 49th. Two observations made from the report to account for the noticeable deficiencies or obvious failings of many health systems were poor regulation and integration between the private and public health sectors, and the other being the lack of enforcement of rules and regulations, how uncannily accurate one might say.

One obvious difference between these countries in the ranking list is the number of doctors, if measured by the ratio of doctors to population, ours overall is around 1:950, compared to 1:400 in the developed countries in Europe or North America.[2] This number is not the absolute criteria as seen above but is quite essential to ensure adequate provision of overall health services.

This is one rationale embraced by the Ministry of Health as one of many prerequisites to improve health care and consequently drives efforts to increase the number of doctors in this country. Done by opening up more medical schools in Malaysia, from a total number of less than 10 not so long ago to more than 30 now and is still increasing, and within them many more variety of medical programs conducted in this country or outside or both. This exponential increase in the number of medical schools churns a frightening number of medical graduates every year and this number keeps rising by medical graduates returning for housemanship from unscheduled or scheduled universities abroad. It has been estimated that the ratio of 1:600 or perhaps 1:400 is achievable within the next 5 years, and in fact we have very few reasons to doubt this.[3] From another perspective, the drive to see Malaysia as a global education hub results in a massive growth of private higher learning institutions including private medical schools which now stands at a ratio of more than 2 private to one public medical school. In the long term, the Ministry of Higher Education envisages a growth of more than 200,000 foreign students into the local higher learning institutions, a growth by 3 folds to the current intake.[4] Both reasons above quite clearly provide enough pressure driving the number of medical graduates to increase at breakneck speed. This is made more difficult as the internationalization of medical training did not quite happen as expected as almost all places are taken up by local students, self or publicly sponsored, and leads to the influx of housemen in our country. It is therefore not unexpected that we hear clamor for moratorium from anxious quarters or even the announcement of one from the authority, only to be broken again and again by the announcement of establishment of another medical school.

While it may not necessarily be a bad thing but in Malaysia training in undergraduate medicine is as a lucrative commercial venture. Well run private medical schools make a huge profit every year and this is such a big incentive for business. As a result, new medical schools are still being established said to be approved before the moratorium, the existing ones look for opportunities to increase intake and even some public medical schools introduce new innovative private medical programs, our students are spoilt for choice. It is very hard to imagine another reason behind this initiative except that a medical graduate either paid for by the government or privately funded, provide handsome monetary return to the medical school. Granted, some medical schools do genuinely respond to the call to increase the number of doctors but there is an added advantage in the monetary return to be reaped. Perhaps to mitigate this argument, at least for the public medical schools, this is an expected reaction to the calls by MOHE for universities to be financially independent by 30%, or they are merely responding to make Malaysia an education hub. The fact that undergraduate medical training is a lucrative business if properly conducted is an added incentive.

Is quality compromised?

With the explosion in the number of medical graduates, this is a very fair and pertinent question to ask but it is not that easy to answer. To judge you need a standard, and perhaps this is the easiest to set out, and in some ways rely on what the profession and the society expects of this noble profession. The Guidebook for House Officers by the Malaysian Medical Council is one such standard manual and accounts primarily checklists on some essential competencies and a brief mention on ethics, including the statutory dictates often used in our style of advocacy. A similar in purpose book

from the General medical Council in the UK goes further to spell out steps to help achieve the required overall standards and maybe another option to consider. Once you have the standard, quality is measured by assessing how far our medical graduates fall short of these standards. Thus far, there is none published in public domain despite many surveys and assessments being conducted.

At least at the point of graduation, new medical graduates from local medical schools that are regularly accredited by MQA/MMC have achieved the core outcomes that are generally accepted and espoused by all accredited medical schools. While MQA/MMC vet through curriculum, staff, infrastructure, governance and strategies in teaching and learning among others, the practice of external assessors by selected external examiners in final or other professional examinations ensures the final vetting process to be robust and comprehensive. Anyone who has ever been invited as an external examiner to participate in one such examination would vouch to the strict attention to quality and standard during examination of our medical students before graduation. Therefore we should concur that the quality of our local medical graduates from both public and private medical schools is excellent, and the simple proof is the acceptance of our graduates from UKM and UM to such a demanding health system like Singapore. Does this mean that the quality of the two medical schools significantly surpass the others? Surely this is not the case. We all know from our own long clinical experience and also some data from well conducted survey (as yet unpublished) among local medical schools that there is no significant difference in major domains among our local medical graduates. Perhaps the upcoming DSETARA rating by MOHE will shed some light on this issue but sadly the rating only deals with domains in teaching and learning. The rationale for Singapore to accept from just the two medical schools is unrelated to quality or standard. It is therefore true to say that despite the explosion in the number, the quality of our medical graduates is not compromised.

But remember this, medical graduates are only temporarily registered and they have to complete the mandatory 2 year housemanship before full registration with MMC. This is another half of the equation and lies almost exclusively under the purview of the MOH apart from a few teaching hospitals in the country. This is actually where all the complaints about the quality of our medical graduates have come from and perhaps it is because what is taught at medicals schools are being tested in the real clinical settings, and what are superficially acquired and understood may have faltered somewhat under real strain.

The issues that are said to be related to quality during housemanship are very important and must be meticulously dissected or we shall never understand the nature and extent of the problems and their root cause. To do this in theory should be quite easy because all the hospitals are under MOH, almost all the supervising consultants are working for MOH, and all the housemen are employed by MOH. Once a problem with our housemen is identified for example, it is imperative to understand the nature, the extent, the trend, and factors that may contribute or exacerbate it. If there is a trend, it is even necessary to know the source medical school. There should also be scrutiny of the circumstances in the working team too to find out whether there has been oversight by the supervising consultants or seniors and if undue demands are placed on the housemen.

What can be the future?

The overall ratio of doctors to the population will undoubtedly be favorable at perhaps 1:400 or even less but the perennial issue of doctor distribution geographically will likely remain, and this is one that is not easy to be overcome as big city conurbation will still be the magnet. Whether or not the exponential increase in doctor number is met similarly with the health resources and budget that should follow or the Public Services Department is quick enough to react with the rise in doctor post is another matter, and it is doubtful that both resources and posts could cope with sudden increase in demand in the short term. There have been predictions but the scenario of unemployed doctors with healthy job competition in public employment will be an accepted reality and the picture in the private sector will get readjusted too.

We need doctors of all grades, notably specialists at the consultant level to supervise the provision of health care and our numbers in many specialties are still very low. As it is, the path to be a general specialist is long and difficult and unfortunately it is even more challenging to become a subspecialist to complete a training to be a consultant unless one chooses to be a general consultant in a specialty. While the path for training to be a general specialist in all fields has remained the same over the years, the trusted 4 year MMED pathway, but the subspecialty training is often riddled with feebleness as it is mainly a human interaction which can go wrong in quiet a few ways.

One very reasonable thing to do is to combine the specialist MMED program and subspecialty training into one program like the one in UK or US to reduce the total period and allow more humane and seamless training period but this is going to be difficult as the MMED is with the universities and subspecialty training is done in the hospitals with MOH.

The future will also see the introduction of 1 care following a nationwide consultation and the amended Medical Act into practice among others. Rationalization of public ministries will also see many wastes and overlaps trimmed and removed, with

improved supervision and leadership we shall see as a result an equitable and more diffuse allocation of health resources to all parts of Malaysia to allow for greater good to all the citizens.

Professor Dr Mohammed Fauzi Abdul Rani
Dean, Kulliyyah of Medicine,
International Islamic University Malaysia

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