PUBLIC HEALTH PHYSICIANS: PREVENTIVE MEDICINE SPECIALISTS PERPETUALLY CONFINED TO MANAGEMENT AND ADMINISTRATION

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Summary

A medical specialty constitutes a branch of medical practice, in furtherance of medical education focused on groups of patients, diseases, skills, or philosophy acquired after a multiple-year residency, pursued after completion of medical school education[1]. Specialist training in Ghana, typically state-sponsored, is aimed to ensure availability of highly skilled doctors to boost a currently sparse population of medical specialists who typically function in new professional capacities after post graduate training as specialists or consultants; this attracts higher remuneration. Public Health specialists, unlike clinical specialists, face a career, (refutably though) defined by an unclear *professional* job description coupled with ambiguous professional expectations. A reliable escape from this conundrum remains that of application for public health advertised jobs that are inextricably linked to management that will be competed for with other staff of varied backgrounds. This, by deduction, implies that Public Health specialists in the Ghana Health Service have no *technical/professional job descriptions* aside that of *management* which largely otherwise continues to define them. *Management* is inherently not entirely professional/technical as it essentially constitutes a responsibility that other cadre of varied professional backgrounds with recognized organizational and coordination skills can perform. The possible risk of inadvertent human resource underutilization should be averted through development of *specific professional job descriptions* for all public health practitioners of varying backgrounds in the health service.

Key Words: *Postgraduate, medicine, training, doctors, specialization, public health.*

Introduction

A medical specialty constitutes a branch of medical practice, in furtherance of education focused on groups of patients, diseases, skills, or philosophy acquired after a multiple-year residency, pursued after completion of medical school education[1, 2]. The concept of medical specialization has characterized the practice of medicine for a long time as Galen indicates it was common among Roman physicians[3]. Modern medical Specialization evolved gradually through the 19th century while the informal social recognition of medical specialization developed before the formal legal system[3]. Considered largely arbitrary, the particular subdivision of medicine into specialties varies by country[4]. Specialization throughout history has largely been characterized by division into *surgical* (i.e. with an important part of diagnosis and treatment achieved through major surgical techniques) and *internal medicine* (i.e. with the main diagnosis and treatment never being major surgery)[3].

Anesthesiology is classified as a surgical discipline in some countries as it remains vital to the surgical process[3]. The European Union publishes its recognized list of specialties within the territory of the Union and European Economic Area[4]. Medical specialties in Ghana, North America and other areas are largely organized into *surgical* (i.e. specialties that focus on manually operative and instrumental techniques of treatment) and *medical* (i.e. specialties that focus on the diagnosis and non-surgical treatments) of disease[4]. Ghana and the West African Sub Region organize the two-tier medical and surgical specialization system.

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Public health physician specialists – postgraduate training

Specialist training in Ghana, (started in 1973 prior to which postgraduate medical and surgical training abroad, particularly in the United Kingdom)[4] provides key state-sponsored career progression opportunities for medical doctors after a stipulated period of continued service in state-owned public health establishments/facilities; a practicing medical doctor is typically therefore due for the pursuance of postgraduate studies after three years of continued practice.[6] Doctors in the private sector may also pursue postgraduate medical qualifications with self-sourced funding.[5] Prior to the founding of the Ghana College of Physicians and Surgeons, *GCPS*, in 2003, facilities in Ghana to train specialist doctors were not available.[7] Prior to this, postgraduate ambitions were pursued through the West African College of Physicians and Surgeons, head quartered in Nigeria.[7] Others sought training in other areas e.g. South Africa, USA, United Kingdom etc.[7]

Postgraduate training areas include all specialties of the medical profession and various commensurate sub specialty areas organized by the West African and Ghana College of physicians and Surgeons; new areas for specialization have been added to the currently existent programs.[6] Specialist training is aimed to ensure the availability of human resource, highly skilled to offer services that are deemed subjectively and/or objectively beyond the capacity of a currently available comparatively less skilled workforce; it additionally aims to boost a currently sparse population of highly skilled personnel with the addition of specialists and consultants.[5] Medical specialists, i.e. products of the above mentioned medical postgraduate colleges, therefore typically function in new capacities following completion of post graduate training programs.

Specialization (i.e. acquisition of additional qualifications) for doctors engaged with the public sector, is inextricably further therefore linked with significant financial implications for the state (both during the training period and after completion) as assumption of duty after completion also bears implications for an upward adjustment of monthly or annual remunerations of such highly skilled medical doctors.[9, 10] The *judicious* use and most equitable distribution of such a highly skilled medical workforce (who also attract comparatively higher remunerations after qualification) remains of essence from the human resource management perspective. The Ghana and West African Colleges of Physicians and Surgeons, among predominantly clinical specialties, have public (or community) health faculties that responsibly organize Public Health residency programs training doctors towards the award of qualifications, membership and fellowship in the tier of physicians.[6, 11] Graduates of *clinical specialties* organized by these postgraduate colleges, after completion of training, serve in capacities with well-defined professional (clinical) job descriptions. Medical doctors who specialize in the non-clinical specialty of public health from the postgraduate college's tier of physicians however, upon completion, contrarily have a professional course of specialist practice characterized by an unclear job description and unclear well-defined professional expectations.

Professional job description versus managerial position

Technical or *default professional* portfolios for the public health (physician) specialists in the current Ministry of Health (MOH) and Ghana Health Service (GHS) structure remain unclear. Clinical specialists, after residency training, perform specific and well defined clinical tasks deemed a default professional function commensurate with their newly acquired specialist qualification characterized by clear professional job descriptions; this responsibility is discharged within the context of well-defined organizational units and purpose-designed infrastructure. Jobs or professional responsibilities of these clinical specialists are not applied for nor competed for as they are deemed a smooth continuum of the individual's professional obligations. Public health specialists, trained by the physicians' tier of the same postgraduate colleges, after completion, contrarily typically only get a job through application and attendance of interviews with persons of varied professional backgrounds together with whom they keenly have to contest for various *management positions*; these jobs largely comprise *management positions* and should therefore not be defined as default *professional positions*; they essentially comprise executive positions. The image of the public health physician in the health service delivery system therefore, virtually, invariably, remains synonymous with one who typically occupying a *management position* or *aspires to one*. *Management* in this regard, may therefore not be technically consistent with a default *professional* job of a public health (physician) specialist or any other person with public health skills as it otherwise comprises only one competence from a spectrum of concepts that public health specialists are exposed to during postgraduate training.

The image of the public health worker who performs a specific routine technical/professional assignment (*while not necessarily being a manager or institutional or departmental head*) is currently probably only a feature in disease prevention and control documentaries and/or only known to exist in other public health establishments e.g. at the Centers for Disease Control, *CDC*, Atlanta; clinical specialists, by virtue of the availability of *specific professional job descriptions*, contrarily may therefore perform *professional* functions without necessarily being in *management positions*. An example may include the fact that clinical specialists at hospitals may choose to work as a *specialist doctors* with a clear *professional job description* (that is different from the *management job description*) without necessarily being the medical superintendent nor clinical coordinator of the hospital; though not *mutually exclusive*, the two capacities are *different*. While clinical specialists assume *professional work* soon after completion of postgraduate training at a specific designated and amply available work posts (following postings), public health (physician) specialists, contrarily but ordinarily have to apply for a job which is typically *managerial* and not *professional in nature*, attend interviews and compete for the particular *management portfolios* with cadre of varied backgrounds.

Implications therefore hold, in view of the above, that public health specialists, trained by the same postgraduate medical colleges have no *technical/professional job description aside that of management* which otherwise continues to define such specialists. Management is *inherently* not entirely professional or technical and therefore remains open to other cadre of varied professional backgrounds with recognized organizational and coordination skills

coupled with a relevant academic management background. *Management* therefore essentially, but not invariably boarders on individual abilities, capabilities or skills to lead an institution towards attainment of very specific objectives, not necessarily being directly representative of the *manager's background*; examples may include the fact that an engineering firm may have a CEO who is a lawyer with *excellent organizational skills to lead staff and enhance productivity. It also further, in this vein, remains a political fact that ministers of health are not always medical doctors*.

What would then, hypothetically, be the job description or duties of the public health specialist who is not keen on assuming a managerial capacity but actually only wants to work in a strict technical or professional public health portfolio? This, likely unnoticed, unavailability of any professional job description implies that the highly skilled workforce of public health physicians may be *inadvertently rendered redundant*.

Further *avoidable* implications of the current virtually inextricable association between management/administration and public health work for public health (physician) specialists is the *hypothetical* scenario in which vacancies for *management positions* may all be occupied at some point; what then would *professionally* define the job of the next generation of public health physicians from the postgraduate college in this hypothetical scenario? The unavailability of a *professional* job description may further also raise concerns on the objective basis on which remuneration is premised; the practice of public health physicians, and indeed all other public health workers is characterized by wide heterogeneity in designation together with staff of varied professional backgrounds mostly largely performing the same or similar duties yet not all being on the same remuneration scale.

Vacancies advertised at the Ghana Health Service and Ministry of Health all essentially comprise management portfolios and, further still, do not uniformly apply throughout the Regions and districts of the country.[12, 13]

Human resource management implications in the public sector

Newly qualified senior specialists are observably, *though not in accordance with any established conventions*, posted to teaching hospitals and regional hospitals while specialist i.e. doctors awarded 'membership of the postgraduate college' are observably posted to both Regional and district hospitals. Public health physicians are on the contrary, posted back to their regions/districts to fill in the *same capacity they occupied* prior to leaving for postgraduate training; the logical assumption of a new role or performance of measurably *additional* duties, commensurate with the newly acquired specialist skills, remains unreal in this regard. Despite the *unavailability* of a clear technical/professional job description for the public health physician specialist, *an upward review of remuneration (common to all other specialists) applies to the public health (physician) specialist as well.* The profitability to the state of an upward review of remuneration for cadre without *clear job description*s who only *arbitrarily* choose their own magnitude of work mainly per individual *discretion and conscience* remains questionable.

Despite an upward review of remunerations of public health physicians (soon after completion of their postgraduate training), the specific set of professional tasks that they should expectedly perform differently from the other public health practitioners in the service (e.g. disease control/surveillance officers, public health nurses, nutrition officers, health promotion officers, etc. who may also be in identical managerial capacities) remains inconspicuous. The public health physician specialist is therefore remunerated varyingly for performing assignments/jobs almost identical to that of other public health practitioners/cadres of varied backgrounds; District Directors of Health Services, a heterogeneous group of public health practitioners for example, perform the same *managerial* duties as public health physicians in the same position.

Is the public health physician specialist therefore remunerated on a specialist scale by virtue of having attended and completed a recognized postgraduate medical college or by virtue of ascension to a new capacity defined by clear higher professional responsibilities, expectations, increased physical demands etc.? This therefore calls for dispassionate policy debates to ensure any risk for silent *human resource wastage* is averted timeously. Leaving any particular human resource to *arbitrarily* manage itself in accordance with human discretion and conscience while placed on a specialist remuneration scale calls for policy review and clear policy directives with regards to specific *professional* job descriptions defined and characterized by clear, (and if possible, uniform) performance objectives.

Recommendations

Development of *specific professional job descriptions* for all public health practitioners of varying backgrounds in the health service is imperative to avert any possibility of underutilization of a highly skilled workforce. Hospital public health units should be strengthened to accommodate public health physician specialists who may not aspire to mainstream health management positions or administrative positions. Such public health specialists may therefore be tasked to be actively involved in the use of institutional data to extensively conduct research, a competence that is otherwise very silent in the public sector, i.e. outside academia. This may help strengthen collaborations between public health physicians and clinical specialists and help erase all existent dichotomy between public health and clinical medicine.

Management positions in Ghana are *fixed term positions* i.e. after four years, performance is reviewed and after eight years, a tenure expires subject to reapplication. Public health physicians whose *management* tenure eventually expires would only be left with the option of looking for another related *management* position as they would have no professional public health job to return to in this hypothetical scenario. Creation of a default professional portfolio remains therefore imperative.

Posting directives for public heath physicians, inextricably linked to a specific *professional* public health job description should be prioritized to help eliminate ambiguity of duty or purpose after completion of postgraduate training. Assumption of a specific specialist portfolio should not be linked to a prior conduct of interviews that public health physician must attend together with all other public health practitioners/cadres.

Training of public health physicians, at both membership and fellowship levels should be regulated till a technical/professional job description is developed to ensure a streamlined scope of standardized, near homogeneous practice for such highly skilled public health practitioners who also have comprehensive clinical backgrounds as they are medical doctors as well.

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