

## SPECIAL ARTICLES

### PRIORITIES OF PROFESSIONAL POSTGRADUATE SPECIALIST TRAINING

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#### Introduction

I must thank the Chairperson of Council and the Council for the honour and privilege of inviting me here this morning to reminisce on our collective experiences over the past ten years, in the exercise of our basic right to determine the modalities of training and admission into our profession in this country. I sincerely hope that my emphasis strikes the right accord, i.e. less on the facts of history and more on how these events help to direct our efforts towards more effective strategies in training in the ensuing years. This is the reasoning for focusing our attention in this address on the Priorities of Professional Postgraduate Specialist Training.

The ideal health personnel for any population or community is one who is closely attuned to and therefore, most readily responsive to the health needs of the population. This is a universal truth which finds expression in the experiences of health services of many developing countries, and is echoed repeatedly in the exhortations of the World Health Organisation in its educational policies. The implication is that excellence is and should be defined by relevance. This has certainly been the Ghanaian experience in the training of all cadres of health personnel, but particularly of doctors from their basic training through vocational to postgraduate specialist training and education. The crucial issue is the mechanisms that set the priorities of these health needs. What then becomes of global excellence or the "Five star doctor or specialist?" There is no contradiction so long as the criteria of excellence are relevant to the local context.

The answers to these questions can be sourced from the genesis of the undergraduate schools and the preparatory stake holders consultations involving the Universities, Ministry of Health, the Ghana Medical Association and the general public. There were six priorities that emerged at the beginning of the Ghana Medical School; the subsequent schools that followed independently developed variations on the same theme, *viz:*

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- Primarily to produce generalist (multi-purpose) doctors.
- Curriculum to reflect local health problems emphasising preventive, social medicine and emergencies
- Acquisition of experience in medical, surgical and obstetric emergencies
- Exposure to practice in district hospital and health centres.
- Encouragement of continuing self-education and lifelong learning.
- Assuming the role of an integrator of medical and social services.

The first two items were seen as preceding all priorities, but an issue that later gained prominence was the timing of continuing professional education and development. On the premise that postgraduate education has the capacity to strengthen undergraduate programmes, there was an almost unanimous feeling firming into a decision that specialist training should commence at the earliest opportunity, notwithstanding the implications for the work load of the few hard pressed teachers at post; this in retrospect was a wise and crucial decision.

So it was that early in 1972, i.e. three years after the graduation of the premier class of the University of Ghana Medical School the first batch of residents was admitted into a postgraduate programme which was a collaborative effort between the Ministry of Health and the Medical School. The priorities and objectives were a further elaboration of the priorities that guided the undergraduate training, namely:

1. Broad based specialization
2. Relevant Curriculum
3. Appropriate competencies
4. Exposure to community challenges
5. Encouragement of continuing self education

Under this special arrangement young doctors were tutored in Ghana to meet the standards to pass the Part I or Primary Fellowship and Membership Examinations of the Royal Colleges in the UK.

They then proceeded to the UK for further training to pass the Final Sections of these particular examinations. Some of these on completion returned to serve in Ghana, but the vast majority succumbed to the torrent of the brain drain.

It was this continued loss of human resource that gave the impetus to the clamour to train Ghanaian

medical postgraduates locally<sup>1</sup>. Meanwhile throughout English-speaking West Africa there was a ground swell movement towards collaboration in postgraduate medical training to ensure maximum utilization of scarce human and material resources.

The upshot of this was the creation in 1973 of the West African Postgraduate Medical College (WAPMC) an agency of the West African Health Community, as an administrative organ advising various governments on prosecution of medical postgraduate training.

Out of this emerged the transformation of the West African Associations of Surgeons and Physicians into the West African College of Surgeons (WACS) in 1975 and West African College of Physicians in (WACP) 1976<sup>2</sup>. The WAPMC phase of postgraduate training thus started in the mid 1970's and by 1979 examinations had started in earnest. These were however difficult times in Ghana, for the brain drain was at its height, and funds were in short supply to ensure provision of adequate equipment and materials needed for the sustenance of job satisfaction for the trainees.

By mid 1980's misgivings were being expressed by the hierarchy of the Ministry of Health in Ghana in relation to the output, cost and even the morale of all the training processes in the system. In particular the projections in respect of specialist coverage of Regional and District hospitals were not being met. These sentiments found expression in open debates in the profession; the Ghana Medical Association officially weighed in on the exchanges, clearly supporting the notion of a national postgraduate medical college for Ghana.

A number of study groups including Task Forces were commissioned subjecting the priorities and objectives of postgraduate training *vis-a-vis* service provision to searching analysis. The curriculum for training which had grown out of the undergraduate system of education was never in doubt and there was a ground swell agreement that it should be competency based. So what were the controversial issues that emerged?

### **Duration of the Programme**

The West African programmes in general were expected to take four years. For most candidates in practice the programme was more like 5 to 6 years; and of course there were those who were in the system for much longer creating a hold up in flow of trainees. If in mid 1985, some ten years after the inception of training the impact of specialists was not being felt at the periphery in the District, let alone the Regional Hospitals, there really was a problem of output in terms of numbers.

### **Recognizable Intermediary Stage of Training – The Membership**

In most fields the lion's share of the specialist's time is given to solution of common routine problems, which can be imparted in the first half of the training period and recognized as an intermediary attainment. This was the genesis of the concept of the "membership" section of training. In retrospect many postgraduate medical institutions have come to accept this proposal including the Royal Colleges in the U.K; the WACP has already implemented it, and WACS is in process of adopting the innovation.

### **The Need to Extend the Venue of Training**

The manpower projections of the Ghana Health Service and the Ministry of Health envisage adequate specialist coverage of all Regional and District hospitals in all clinical fields and health management facilities. Clearly, with the output of training a decade ago, this objective could not be realized for many years. The innovation proposed then was to extend the training sites to selected and specially accredited Regional and if possible District Hospitals. Efforts were indeed made in this direction but regrettably the vast majority of trainees still congregate at the two leading Teaching Hospitals.

### **The Need for Structured Programmes in all Fields of Postgraduate Education**

A recurrent complaint frequently lodged by trainees was the lack of structured schedules of activity with set targets that must perforce be attained. This gave to all concerned an impression of open-endedness resulting in trainees spending unusually long periods with some exiting virtually empty handed in terms of career attainment.

### **Absence of a Functional Mentoring Process**

With all its modern trappings, professional education and training in the health sciences is still an apprenticeship even at the postgraduate level. Trainees/residents definitely need role models to look up to, and draw inspiration from. This calls for a level of commitment on the part of trainers and trainees alike, a process much in need of reinforcement. Against the swelling tide for change, there were some pressing concerns:

#### **1. The Maintenance of Standards**

Ghanaian medical education has always been sensitive to the issue of standards, as far back as the beginnings of undergraduate training. Under the then existing postgraduate training system particular efforts had been made, against some severe constraints to maintain acceptable international standards. How would the surging demand for higher output, cope with

the maintenance of standards? Would standards be sacrificed for numbers?

## 2. *Provision of Infrastructure*

Clearly from the change in output being demanded, and also the alteration in strategy of training being considered, more dramatic changes in infrastructure would be required than was available at the time. Change without matching infrastructure in terms of resources, would be meaningless.

## 3. *Continued Sustenance of Innovations*

It is one thing to initiate change, but perhaps an even more arduous task to maintain the momentum and ensure against reversion to the *status quo ante*. This would require not only flow of resources but also sustained dialogue on all fronts – trainers, trainees and responsible authority. This intense debate would have raged for much longer but for two factors that weighed in: first Ghana's democratic transition was fast taking roots.

The year 2000 was an election year; the debate for a national postgraduate medical college was captured in the manifesto of the New Patriotic Party which went on to win the election and formed the Government in 2001. Operationalisation of the Medical College idea became a serious issue for the new Minister of Health himself a distinguished practitioner convinced about the merits of the proposal. Secondly opportunities for migration of the young products of African Medical Schools to Europe and America, even for further training, had been, as a matter of policy in these countries severely curtailed, effectively halting the brain drain of health personnel from Ghana.

These were the factors that significantly turned the scales in favour of a national college, at the famous crucial consensus meeting in Kumasi in January 2002. After two days both sides in the debate had had their say. The consensus – Ghana should have its own postgraduate medical college. For me the important signal was the very strong backing from the Government of the day which has found expression in these magnificent buildings in which the College operates today.

I have resisted the temptation to single out personalities to attribute this change to, because so many have contributed, but naturally some names will go down in the annals of this College as the material agents of change. Permit me to mention but a few candidates: the first rector, Prof. Paul Nyame, the first president Prof Samuel Ofori Ammah and the Minister of Health under whose watch these developments took place, the Honourable Dr Richard Anane.

The College did come into existence in December 2003 with its priorities and objects captured in Law 635 now updated to Law 833. These objects in the

Law addressed the contentious issues raised by the stakeholders, but outstanding was object (d).

## **GHANA COLLEGE OF PHYSICIANS AND SURGEONS SPECIALIST TRAINING ACT. 635 TO ACT. 833**

### **OBJECTS**

- a. Provide specialist education in medicine, surgery and related disciplines.
- b. Promote continuous professional development in medicine, surgery and related disciplines.
- c. Provide and coordinate education and research in medicine, surgery and related disciplines.
- d. Contribute to the formulation of policies on sound health and public health generally.

For the first time a training institution is being tasked to participate in formulation of health policies, and in particular public health policies. I wonder if as fellows we have spent enough time to take in the full import of this provision in the Act. I feel certain however, that in the ensuing years College will rise up increasingly to this challenge.

The difference in approach to training is the close correlation of training with needs of practice in the health service – the arrival of “generalist specialist training” – the Membership, followed later by the Fellowship (for emerging teachers); appearance of structured and competency based programmes and their evaluation.

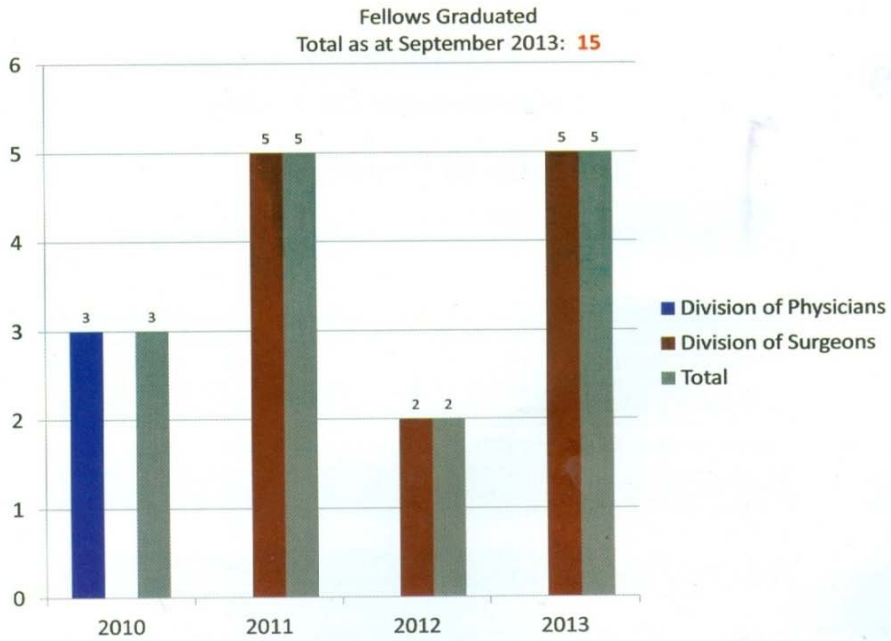
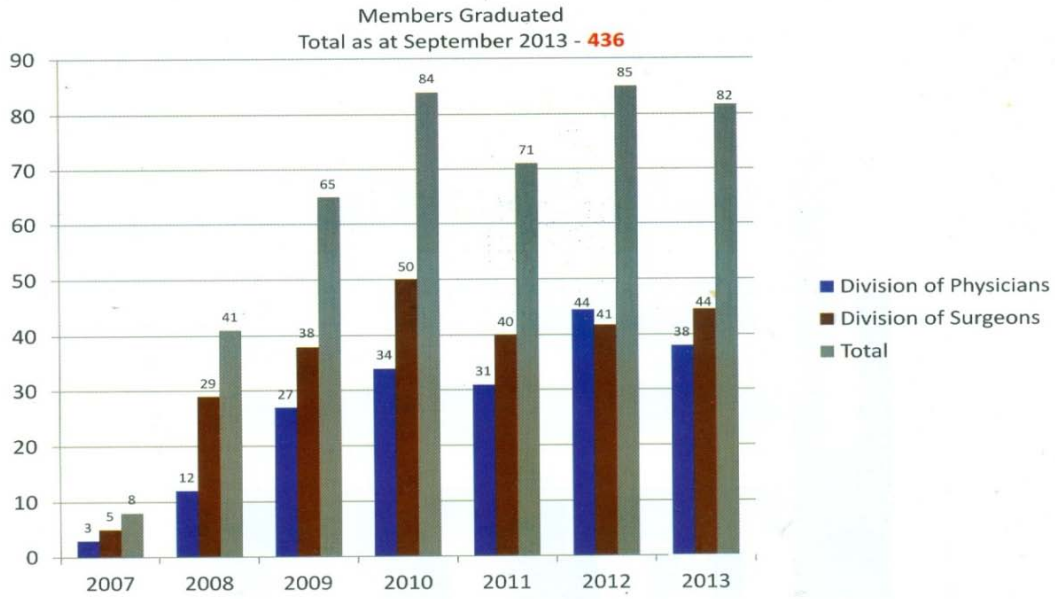
### **The Outcome of Training**

The College has been fully operational since 2004. Since first graduation in 2007 it has at the last count in September 2013 graduated 436 membership holders who are all practising throughout the country. (Fig 1)

The numbers are clearly building up; in terms of pairs of hands at the workplace there is no doubt that the MOH/GHS in these past 7 years have received a veritable shot in the arm. Training has continued at the senior resident or fellowship level since 2008 and to date a total of 15 Fellows have been produced by the College. These indeed have the trappings of teachers and trainers. (Fig 2)

The numbers of specialists are building up impressively, but what about the quality? This is where the College has been remarkably proactive in response to current best practice. Each faculty has a quality assurance unit, monitoring College wide performance criteria. With regard to this there has already been one review of curriculum in the decade of the College's existence, which means that curriculum review in response to population dynamics and health needs is very much an active ongoing process. Furthermore as reported in an article carried by the

# STATISTICS



College's Journal, College itself has undertaken an internal in-depth evaluation of the assessment of the exit professional competencies in the membership residency programmes<sup>3</sup>.

In a study of Focus Group Discussions sampling the views representing a wide range of residents and newly qualified specialists, as well as administrators and Clinical Coordinators of institutions participating in training, the investigators found strong leanings towards indicators of Good Practice in Higher Education, namely:

- i. Regular assessment of the assessor, but with a felt need for College rules to protect resident's anonymity and the supervisor's rights.
- ii. Openness to peer assessment, notwithstanding the risks entailed.
- iii. Higher weighting of continuous assessment in the final analysis, but with a preference for the establishment of an "Independent monitoring Authority" for the avoidance of bias.
- iv. Competency based assessment with a willingness to explore modern modalities of achieving this.
- v. Verification of standards with the implication that the College documents stake holders opinion about the quality of residents exit professional competence. The stake holders here include clients as well as Co-professionals –Pharmacists, Nurses and Paramedics.
- vi. Extrapolation of these priorities must perforce therefore, lead us into our next decade.

The issue of general acceptance by the Ghanaian public of the home grown specialists produced by this College is of central importance to the entire process of training. It requires detailed and sophisticated data collection through an independent broad based survey, and yet not entirely devoid of the impression and compassion of alumni such as ourselves. It is a verdict we need to know comprehensively whichever way it turns out to be, so an appropriate response by the College can be mounted, for these specialists bear the imprint of the College. It is a project, which I am sure is of primary importance to Council as we enter our second decade of existence.

If the College is to lead in the development of specialist manpower that is most responsive to the health needs of the population, then the College must participate more actively in the genesis of the National Strategic Plan for training of specialists as Law 635 now L 833 demands. This can be achieved through transparent collaborative deliberations with Policy decision makers in the Ministry of Health (MOH) and Ghana Health Service (GHS).

What have we learnt about conditions at the training sites preparing candidates for the College in the country? As the number of undergraduate training schools and colleges increases so will the output. Soon the private Universities will be adding their quota to

the annual output of doctors in the country. A conservative estimate puts this currently at about 500. If only 50% of these opt for specialist training this would more than double the current intake of 140 residents.

The College had at its beginning envisaged training at suitably equipped regional and district hospitals, besides the two main teaching hospitals; this has unfortunately not materialized and there is a feeling of overcrowding at the training centres. The need for decentralization is evident and College in collaboration with MOH/GHS needs to press for upgrading and accreditation of targeted hospitals and ensure circulation of residents through these hospitals in the country at large. Active collaboration with the main regulatory body in medical education in the country i.e. the Ghana Medical and Dental Council is crucial. Although there has been extensive discourse on the establishment and maintenance of a specialist register, the reality is that this statutory provision is still not in place. As the principal professional training agency of specialization in Ghana, College has a crucial role in setting the criteria and format for registration; College must also fully exploit the opportunities for continued medical education and continued Professional Development, and contribute to the ongoing debate on maintenance and re-validation of registration.

Finally some comments in the global context. We in the Developing World benefited from the first set of global reforms, the Flexner Reforms of 1910 in medical education, which integrated modern science into the curriculum of schools that led to the doubling of life span during the 20th century. These dramatic health advances have not been equitably shared, both within and between countries, and laudable attempts to address these deficiencies have mostly floundered because of so-called tribalism of the professions i.e. tendency to act in isolation or even in competition with each other. A second generation of reforms was introduced around mid 20th century in the form of problem based instructional innovations. That the inequities continue and widening is not in doubt. A third generation of reforms has been proposed over the past decade by an independent think tank of distinguished teachers and practitioners suggesting education by mobilization of knowledge worldwide to engage in critical reasoning and ethical conduct, so that practitioners are competent to participate in patient and population centred health systems as members of locally responsive and globally connected teams.

This vision emphasizes Transformative learning and interdependence in education (Table 1 and Fig 3). There are three successive levels: Informative to Formative learning is about acquiring knowledge and skills to produce experts. Formative leaning is about socializing learners around values and its purpose is to produce professionals.



**Figure 3.** Priorities of Postgraduate Specialist Training

Transformative learning, the peak, is about developing leadership attributes, and its purpose is to produce enlightened change agents. Inter dependence is a key element in team work – the creative adaptation of resources to focus on identified priorities.

**Table 1.** Levels of Learning

<u>Level</u>	<u>Objectives</u>	<u>Outcome</u>
Informative	Information, Skills	Experts
Formative	Socialisation, Values	Professionals
Trans Formative	Leadership Attributes	Charge Agents

I am aware that our College in engaging in so much interaction with corresponding regional bodies in the area of harmonization of curricula, programmes and even talking of harmonization of examinations is on its path to this highly productive and innovative transformative form of education. It however has to be extended to co-professions first within country, because

charity begins at home, and subsequently internationally and regionally. In the 21st Century this would be the global context in which our national College of Physicians and Surgeons has to grow and flourish.

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