

Medical education and healthcare needs

Educators in the sphere of medicine face a number of complex challenges in the provision of a learning environment suited to ensuring students acquire essential core competencies as well as additional skills and expertise targeted to their area of practice. This needs to be done against a series of standards in medical curricula for quality assurance purposes. Furthermore, in medicine, the concept of life long learning is essential to the further honing of available skills and the acquisition of new expertise relevant to the ever-changing and increasing demands on medical practitioners. Mobility of graduates and doctors has highlighted this, as moving to a different geographical area invariably causes a change in the working environment, the medical problems encountered and the resources available to deal with these issues.

The World Health Organisation has data showing that the equity of distribution of medical staff is related to patient outcomes, for example to maternal and fetal/neonatal mortality (www.who.int/whr/2006). This poses the question as to whether medical schools in developing countries should develop curricula linked to healthcare delivery in a highly technological environment or in primary care or rural areas for example. The ethics of promoting access to specific knowledge pertinent to eventual practice can be debated but could possibly be one way of preventing the brain drain from the developing countries to the developed ones.

The World Federation of Medical Educators is aware of this dilemma and has established core competencies that are essential for medical practitioners worldwide and that need to be imparted in the undergraduate courses (www.wfme.org). In its recommendations, quality assurance with regards to these competencies is highlighted but medical schools are encouraged to build in the flexibility and adaptability necessary to ensure optimal healthcare provision specific to individual countries or societies. In certain areas this mandates deviation from high technology medicine as the majority of graduates will not, in fact, work in such environments, particularly in resource strapped countries.

This is in contrast perhaps to the process of harmonisation of European education that is the fundamental principle in the Bologna Process (www.bologna-process.org) where the main aim is to promote mobility of graduates and professionals by standardising education across the board through the establishment of two cycle degree structures around the award of a Bachelor's and Masters's degree as opposed to one cycle

courses as has been the custom in areas such as Medicine. An emphasis on research is made in addition to the need to ensure core competencies acquisition. This can however result in an additional financial burden imposed on medical schools and the possibility that time spent on research will detract from time available to acquire essential skills useful to eventual medical practice and healthcare provision. One way to deal with this would be to remove time limits on the duration of courses and introduce flexibility. This would lead to an increasing financial and administrative burden however on the bodies providing training.

In Malta, similar concerns exist amongst medical educators and healthcare service providers. Our medical curriculum is geared to the provision of an excellent undergraduate education that prepares our students for their pre-registration 2 year housemanship and subsequent specialisation. Following registration, career options include moving into primary healthcare or opting to stay in hospital medicine. In the latter instance, following rotations through the necessary subspecialties and acquisition of the membership or fellowship of the relevant bodies or institutions, our young doctors opt to continue their further education overseas with the consequence that the majority subsequently do not return to our shores. One of our most valuable exports in fact is our graduates. Financial remuneration is cited as the crucial factor in this decision but a number of surveys world wide indicate that lack of career development programmes and career progression as well as poor working conditions are what tip the scales in a very significant proportion (www.who.int/whr/2006).

With regards to primary health care, a number of fine graduates are keen to specialise in Family Medicine with the aim of working in the private sector or in the National Health Service. Regrettably they encounter a number of obstacles that have actively discouraged them from pursuing this career path. These doctors still await the launching of the first structured training programme in Family Medicine. Meanwhile they can opt to work in the primary healthcare centres, centres that need a complete overhaul regarding infrastructure, organisational policies and service provision. Alternatively, they can compete for training posts in various specialities at the University Hospital. The number of available posts that are never sufficient to meet the needs of the hospital itself anyway let alone to accommodate those interested in community medicine needs to be re-considered as is the processing procedure for these posts. One further major

concern is that without an established, functional and organised community medical programme, the new hospital is doomed as the patient load remains massive. This in particular as the prevalence of chronic non-communicable disease continues to escalate.

These problems have been passively contemplated for far too long. It is high time that both the Ministries of Education and Health provide the Faculty of Medicine and Surgery and the Medical School with adequate funding to continue its task of producing excellent graduates who will contribute to education, research and healthcare provision in this country and on a global level. Academic autonomy with regards to the structuring of the relevant curricula is to be safeguarded. The work of the College of Family Doctors and the specialist associations should be facilitated by due attention to the infrastructural needs of these institutions as well as to the working conditions of those educators and physicians without whose services and expertise, healthcare eventually founders. Innovation in the development of alternative career paths, in introducing flexibility into the working environment would promote job satisfaction, enable

expansion of the workforce whilst recruiting additional expertise which might otherwise be lost as a result of financial or personal considerations such as family responsibilities etc. This however necessitates that resource and service allocation be determined after appropriate consultation with the relevant stakeholders, keeping our trainees and our patients in mind. The principal of self regulation both within the primary health care service and at MaterDei is core to this process. WHO and WFME provide us with an excellent basis to develop and expand medical education and services. Should such measures be deemed unachievable within the public service domain, then an autonomous institution needs to be established where undergraduate and postgraduate curricula develop core competances and target areas of knowledge and expertise related to the needs of the patient and the country. In such an instance, our new hospital becomes **the** milieu to deliver optimal medical training and healthcare.

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