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## Impact of Part-Time Private Practice on Medical Education in Kenya – A Personal Opinion

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**Traditional medical schools the world over are facing major challenges in educating physicians capable of responding to the continuously increasing health care needs of populations they serve<sup>1</sup>. The Kenyan situation is no different and the challenges are bigger considering the rampant poverty and the decline in what had been achieved in the health sector. In this country, effective healthcare, both promotive and curative, lies in the cooperation between a well-managed district hospital and health centers<sup>2</sup>. The district hospital, as the leader, plays a central role in promoting healthcare delivery. The failure of a district hospital will therefore lead to an unacceptable lowering of health standards and the collapse of preventive programs.**

Doctors are the pillars at the district hospital upon which the desired, effective and efficient health care is built. By necessity, a doctor is expected to have acquired the five competencies involving skills traditionally valued in medical practice: diagnosis and treatment; effective communication with patients; problem solving; life-long learning and counseling on medical ethics<sup>3</sup>. With these, a **FIVE STAR** doctor (*a learner and researcher, a teacher, a service provider, a manager and a leader*) is expected to emerge from the medical school and preside over health care provision at the district level. These competencies make a doctor an effective care giver, adequately treating a wide spectrum of medical and surgical conditions, being aware of his/her limits and therefore referring as is appropriate, be a decision maker, be an effective communicator disseminating knowledge and information on health promotion, offer leadership in community and a manager reaping greatest benefit from minimal inputs in health at the same time distributing resources to effect good health for all.

Every year, top-performing students in national examinations proclaim that medicine is their desired destination and it is the “A” student who lands a position in the Kenyan medical schools. This, then, is a profession of the Kenyan academic giants. Medical training, therefore, falls in very fertile minds and therefore the graduates should be above reproach.

To be a five-star doctor, one requires sound medical training, be well grounded in ethics and be a disciple of the Hippocratic Oath. A doctor must also value the importance of life long self-education, exhibit the abilities of critical reasoning, be flexible and be an effective team player. The doctor with good attitude, appropriate and competent skills and one who inculcates a

value system that reflects the tenets of professionalism in medicine (4), should be the desired product of the Kenyan medical schools.

However, it is known that the products of the medical schools’ training are below the expectations here and elsewhere<sup>5,6</sup>. Several factors come into play: Emphasis on research and promotion of teachers in medical schools based on publications has been identified as one of the reasons for falling standards<sup>5,6</sup>. Teachers have abdicated their responsibilities of teaching and proper patient care to concentrate on research leading to atrophy of the vocation of clinical teaching.

I wish to consider part-time private medical practice by clinical teachers in Kenya as one other major factor contributing to the dismal performance by their graduates. Senior medical practitioners are allowed to offer their services to patients outside their official premises during their free time – lunch hour 1pm – 2pm, and from 5pm - when they are not engaged in public service. They therefore have private clinics/medical centers in cities/towns. Some own hospitals.

Clinical teachers are expected to balance time spent in part time private practice and in public service without infringing on the expectations of the employer. This, however, has been difficult, and in some situations, the privilege has been out rightly abused. This, in my opinion, has taken the toll on clinical teaching by taking away quality time senior doctors spend at their work-stations. It is anybody’s guess as to what happens when the clinician with a large following walks into his/her clinic at 1pm and finds the office overflowing with patients anxious to be served and pay handsomely. It is unlikely and will be unethical

to walk out at 2pm before the last patient has been seen, after all, service to patients comes first wherever they are found. Private practice time hence extends into official working times and may merge with the 5pm free time.

There have been instances where junior students have confused some of their teachers who religiously turned up for examinations, but not for teaching, for external examiners. These teachers have had to go through the uncomfortable routine of being introduced to their students by the “*true*” external examiners. Some who make technical appearances on ward rounds (*baptized “business rounds”*) go about it with the speed and fury of a hurricane. Damage to learning along their paths during these appearances is certainly significant. Tantrums, negative feedback and criticisms are generously exhibited, attributes that do not foster the learning of clinical skills. By religiously turning up for examinations effectively to intimidate students they shunned to teach and lament about falling standards because student are unable to demonstrate/remember skills written in the standard textbooks of medicine, they have totally misunderstood the functions of a clinical teacher. At no time should end of year examinations be given undue prominence in the evaluation of a future doctor.

In continuing the above argument, I will take cognizance of the survey done at the Moi Teaching and Referral Hospital by Hospital Administration. Though the survey does not conform to the standards of a scientific survey, there was shocking revelation of non-performance and non-appearance by some senior doctors in the institution for clinical service and teaching. Is Moi University Medical School in danger of falling to the same low standards of clinical mentorship we are experiencing in the region, and in students who come from some parts of the world? The initial graduants of Moi University were acclaimed as being superior and as good ambassadors silenced the critics of the innovative teaching methodology adopted by this University.

With free access to patients in our teaching hospitals<sup>5</sup>, our students have a golden opportunity of sharpening their clinical skills. The presence of teachers to keep the learning process on course, but allowing progressive independence in clinical training<sup>7</sup>, is important. Feedback on their performance needs to be continuous. This can only be done when students are allowed to show what they have acquired. Where else can this best be done other than on *Teaching Ward Rounds* and *bed-side clinical* sessions where the teachers

are patient enough to allow students run the show of presenting clinical history of patients and demonstrate the physical examination skills? For residents in surgery, wards, clinics and theatres are their learning stations. How will the teacher know that appropriate surgical skills have been acquired other than by being assistants for their residents once in a while in major operations?

Clinical skills competence is easier demonstrated than described and like ballet is best performed in front of a mirror<sup>8</sup>. Clinical teachers are “*wall size mirrors*” for medical students and junior doctors. In teaching hospitals, residents play a pivotal role in the education of medical students and house officers, but are rarely provided with the tools to help them teach effectively<sup>5,9</sup>. They are “*small mirrors*” in need of training and feedback on their performance.

Expertise is the product of individual experiences<sup>6</sup> not gained from books. Teachers (with vast experiences) should not relegate their responsibilities to the books but should supplement the written word by observing and guiding its application. These experiences should also enrich clinical teaching and help unravel bizarre presentations as diseases do not always present in the classical textbook descriptions, the clinical teachers hope their students have read and mastered. A teacher’s vast experiences should rub off onto his/her students. This requires close interaction to happen. In one study, residents placed a higher premium on a teacher’s ability to answer questions clearly and explain difficult topics and felt more strongly that it was important for quality clinicians to be readily available and be able to provide a safe, non-judgmental, non-threatening learning environment<sup>10</sup>.

There is need, therefore, for a revolution in the running of medical schools in this country to enable them produce the five-star doctor. Mentorship from clinical teachers should not be assumed, but should be seen to be taking place.

*The roles of Deans of medical schools should be enhanced above other Deans’ roles to give them supervisory roles over the tripartite mission of a medical school – teaching, research and clinical care.*

Recruitment and promotion should consider clinical service provision and hence ability of one to provide clinical mentorship. A survey in Makerere University has shown that whereas it is desirable for the academic staff to acquire a PhD, it should not be a mandatory requirement<sup>11</sup>.

The debate and emphasis on PhD and promotions based on research publications as is emphasized in Moi University disregard the role clinical mentorship plays in moulding a five-star doctor. Down-grading the clinical role has led to frustration and therefore contributed to the flight of clinical teachers into private practice. A clinical-based promotion, a conducive and supportive environment is important in the retention of teachers.

Appeasing clinical teachers by offering them part-time private practice missed the point, and like the proverbial ostrich with the head in the sand, it was hoped that the problem would dissipate. The product of this is doctors whose performance is below expectations! Appropriate rewards should be dangled and the clinical teacher who accepts should clearly be informed in appointment about the mandatory need for clinical service provision.

By regarding students as being central in clinical teaching and remaining true to the calling of the medical profession, clinical teaching will stay on course in the production of the five-star doctor, the **HEALER** the public once assumed doctors were, the doctor that all of us would comfortably entrust with our lives<sup>5</sup>.

***Let ALL doctors in Kenya and in the East and Central African region as a whole, collectively tell the policy makers to improve terms of service so that the clinical teacher can come back to the wards and not sit in a shop on a street corner hoping that the sound of feet is carrying potential customers and income.***

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### References

1. Des Marcals J.F. Medical Education at the Dawn of the 21<sup>st</sup> Century: A Challenge for the French Units of Education and Investigation: *Ann Med. Interne (Paris)* 1999; 150 (6): 469 – 75.
2. James C. Debate on the Methods to Improve Health Care. *Tropical Doctor*; 1995; 25 (suppl. 1); 9 – 12.
3. Finocchiro L.J., Bailiff P.J., Grant R.W., O’Neil E.H. Professional Competencies in the Changing Health Care System: Physician’s Views on the Importance and Adequacy of Formal Training in Medical School.
4. Boelen C. The Five-Star Doctor. *Acad. Medicine* 1992; 67 (11); 745 – 749.
5. Kakande I. Our Medical Colleges; A Reflection on the Past, Present and Future. *ECAJs* 2004; 9(2): v – vii (editorial).
6. Kigonya E. Medical Education in Uganda – A Critique *ECAJS* 2004; 9(2);1– 4.
7. Kennedy T.J., Regehr G, Baker G.R., Lingard L.A. Progressive Independence in Clinical Training: A Tradition Worth Defending? *Acad Med.* 2005 Act; 80 (10 Suppl): 5106 – 11.
8. Ende J. “Feedback in Clinical Medical Education”. *JAMA* 1983; 250 (6); 777 – 81.
9. Bensinger L.D., Meah Y.S., Smit L.G. Resident as Teacher; The Mount Sinai Experience and a Review of the Literature. *Mt. Sinai J. Med.* 2005; 72(5): 307 – 11
10. Buchel T.L., Edwards F.D., Characteristics of Effective Clinical Teachers. *Farm Med.* 2005; 37(1): 30 – 5.
11. Galukande M. et al. Should a PhD be a Requirement for a Lecturer in a Medical School? *East and Central African Journal of Surgery.* 2004; 9(2): 96 - 102