Presidential Address - 1993

Kaizen

C Selvie Perera

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The Ceylon College of Physicians is, first and foremost, academic in outlook, meaning that it helps in the education of the country's future physicians and caters to the intellectual needs of those who have chosen this particular discipline. The College was founded in 1967 by a group of dedicated physicians with the objective -

1. Of Advancing Knowledge,
2. Of Promoting Research, and
3. Promoting postgraduate education in medicine.

For the record, the College does not award postgraduate degrees. However, the College is well represented on the Board of Study of Medicine of the Postgraduate Institute, which is affiliated to the University of Colombo. The College conducts teaching sessions and courses for post-graduates preparing for higher studies.

As one of my predecessors in office, Prof. W.A.S. de Silva, noted in his Presidential Address in 1985. "We have established a firm framework for further development of Postgraduate Medical Education and indeed made headway in this field. We have established a tradition and authority".

I have up to now, in a sense, been looking back. As we turn our gaze to the future, we must ask ourselves, where do we go from here? Medical Education proceeds along three basic phases -

1. Undergraduate education resulting in certification.
2. Postgraduate education leading to a specialised degree which is a certificate of professional competence, and third,
3. C.M.E. — the longest stage of learning, one that never really ends, is the period of continuing medical education.

The College has promoted some programmes for C.M.E. from its inception in the form of guest lectures, seminars, updates and of course, the annual scientific sessions, like this one we are inaugurating today.

It is my firm belief that the time has now come for us to tailor the concept of continuing medical education with structured programmes of study so that the result will ensure *continuing professional competence*, for one cannot consider a certificate to practice medicine as being no different to, say, our driving licence which, I regret to say, is generally considered, in this country at least, to confer on the holder competence for life.

The 21st century will experience a series of changes so rapid that professionals will not be able to cope with the quantum of knowledge which proved adequate when the human race entered the 20th century. Scientific knowledge has been known to double every ten years, and medical knowledge has a short half-life. It is thus with a different spirit and vision that doctors, and indeed *all* professionals (I see in this audience Engineers, Accountants, Lawyers) — should enter the 21st century.

Education must prepare professionals to face these challenges. A Physician who qualified in the 1920's remarked when he retired — I quote from the B M J Vol: 306 May 1993 "When I was a house physician, I had only half a dozen effective drugs at my disposal, now I have several *hundred.* Nothing in my medical training prepared me for this explosion in clinical pharmacology".

Consultants retiring in 1993 look back on many more developments during their graduate careers, most of which they were quite unprepared for. These range from such scientific milestones as cracking the gentic code, the birth of molecular biology and modern genetics, the beginnings of the H L A system and spectacular organ transplantation, to everyday medicine, such as coronary care, thrombolysis, angioplasty and by-pass surgery, to mention a few".

The moral to be drawn and which is truly self-evident is that medical and scientific education must continue unabated throughout a consultant's life for him to maintain professional competence.

What, then, is philosophy and the goals for the maintenance of professional competence?

They are:-

1. To improve the quality of patient care.

2. To set standards of clinical competence for the practice of medicine.

3. To foster continuing scholarship required for professional excellence over a lifetime of practice.

4. Mediate the relationship between the often conflicting worlds of work and that of learning.

5. Respond to the needs of the day. The requisites for population care are changing dramatically, and doctors need to play a greater role for instance in:-

    a. Chronic long-term care and genetic care.

    b. Team-work with other professionals — Colleagues like the Neurologist or the Cardiologist and with the Nursing Staff of the Physiotherapist.

    c. Counselling of patients and their relatives.

    d. Policy making — we must contribute to the formulation of policy, being closest to the patients and not leave it entirely in the hands of colleagues in administration.

    e. Cost containment, which is so important today with expensive modalities of investigation and treatment.

    f. Preventive medicine.

We must be able to relate more effectively than ever before to patients, to colleagues and to communities. Preserving patient autonomy while striving to act in a patient's best interest often leads one in to the complicated ethical and legal realms of medical practice. Bewildering changes in equipment and technology, medication as well as treatment procedures necessarily demand of the medical practioner so daunting an ability to adapt at speed, that often leave many opting out in sheer exasperation. Sometimes it is, quite genuinely, a crisis of confidence.

How can C M E adapt its approach to meet these challenges? Whatever the methods, they must take account of the C M E participant.

1. Firstly, that they are adult learners — so that learning should be specific and the content determined by practice. We should have faith in the academic ability and dedication of the participants.

2. Second, that they are busy practitioners — so that learning activities are best practice-linked. e.g. Grand Ward Rounds, Teaching Rounds, Local Clinical Meetings, Journal Clubs.

3. The learning may require distant learning methods — A doctor at Bintenne who understandably, cannot attend sessions in Colombo has yet to be catered for. The professional Colleges have up to now organised less structured programmes. But the world over, be it in the U.S., U.K., Canada or Australia, there is now an increasing emphasis on structured programmes.

Let us first consider the less structured programmes.

1. Reading Journals & Books — A recent random survey of physicians in U K showed that a physician contributed to an average of four journals (range from 1 - 16) and it was common practice to buy text books individually or for their departments from 'slush' funds.

   We in Sri Lanka cannot afford to buy journals individually and the Sri Lanka Medical Library is fighting merely to stay alive. Almost no hospital has a library with even the basic journals.

2. Journal Clubs are self-explanatory.

3. Audio & Video casettes and teleconferrencing which may be of importance for distant education but these media have not become popular.

4. Clinical Meetings & International Meetings.

5. Grand Ward Rounds.

6. Teaching postgraduates which keeps us on our toes and upgrades our knowledge.

7. Lecturing, whether local or international, requires in-depth reading on the subject.

8. Research — but here C M E activity is more likely to be directed by the dictates of research programmes than by the needs of patients.

9. Visits from pharmaceutical firms — This type of free choice C M E — like reading journals and attending clinical meetings, though useful, has been shown by research to have no effect on upgrading patient care. A recent study showed that where, instead of studying by oneself, physicians met together and interacted — that is, shared knowledge on various topics, got to know the experts on a topic what, in public health

circles in known as networking proved more useful than journal reading. So that from the educational point of view it is important to provide a social strucutre in which independent learning can take place. Groups of doctors coming together to learn significantly improves learning. Conferences and Courses received higher ratings than reading journals among docters in the U.K.

Strucutred Programmes — these are many and varied, and so I will confine myself to four models.

Self-Evaluation Process (S.E.P.)

Self selected, home administrated, self placed assessment process called S.E.P. It is planned as a series of questions arranged in a modular open book format. The module will be selected by a panel of clinicians. Each module has about 60 questions and will emphasise synthesis and judgement rather than pure recall knowledge as well as stress on recent advances in clinical science. MKSAP Medical Knowledge Self Assess Programme of the American College of Physicians. ACSAP are two such programmes. They provide syllabus, testing and feed back.

Medical Audit

The WHO has set a target in "Appropriate Health Care and Technology Programme" to have by 1990 a built-in, effective mechanism for ensuring the quality of patient care by Medical Audit in all its member states. Medical Audit is a systematic and critical analysis of the quality of medical care including -

a. Procedures used in diagnosis and treatment.

b. Use of resources.

c. The result from the patient's point of view.

The medical firms in the General Hospital under the direction of Prof. Rezvi Sheriff are already carrying out a pilot Medical Audit Project. But, as we know only too well, we physicians and surgeons are not exactly used to being criticised. Professional good faith has come to be regarded as a implied, implicit, even unquestionable characteristic of our calling. In that context, Medical Audit is discomforting because of its almost heretical potential, in that it presumes to think, or even worse suspect, the unthinkable. It was Mathew Arnold who defined 'Criticism' as a disinterested endeavour to learn and propagate the best that is known and thought in the World. In Medical Audit the intent is a sharing by a group of peers information gained from personal experience through perusal of the medical records, mortality studies, methods of treatment of a particular disease etc., so as to assess patient care and improve their own knowledge. In other words, the rationale behind medical audit is educative rather than punitive.

Recertification

The once-and-for-all license to practice medicine does not provide for the patient an assurance that the conferment of this life-long privilege guarantees that every physician will continue to acquire the needed updating of knowledge and skill in his discipline to abide faithfully by the Hippocrate oath. We need urgently to break out of our self-induced complacency on this, a vital aspect of our professional life.

Qualified and experienced airline pilots require re-certification at regular intervals — because their competence while up in the air has a direct bearing on the safety of the passengers in their aircraft. The comparison here is the same whether up in the air at 30,000 feet, or rooted firmly on terra firma the bottom line is identical — the safety of human beings, be they passengers or patients.

It is time that Medical Educationists and Colleges set up a task force from *within* to examine the need for re-certification before this requirement is thrust upon us from without by licensing authorities or health authorities, in response to a public demand. Learning does not end with the M D or M S — it has to go on throughout life. Various strategies can be employed for recertification, not only examinations as in undergraduate and postgraduate certification.

Some of them are:-

1. Continuing Medical Experience.

2. Participation in professional development activity eg — M.O.Ps which I will describe in detail later.

3. Assessment of competence by examinations.

4. Assessment of performance by peer review.

5. Assessment of outcome.

6. Patient satisfaction which will assume increasing importance. i.e. Accountability to your client.

Again the process of re-certification is meant to be educative, not punitive. If deficiencies are identified, appropriate remedial education is made available — not

cancellation of the medical license. The evaluation is done by his peers, and the physician is dealing in his own speciality on practice rather than esoteric concepts, so the result must necessarily be educative all round. As I said earlier, the recertification need not necessarily be by examination as in the American Boards.

The Australian M O P's (Maintenance of professional standards programme is another modality that has been phased out over a period of 5 years and requires its Fellows engage in -

1. C.M.E. - (1) Reading (2) Attending Scientific Session, (3) Teaching and Research (4) Grand Ward Rounds (5) Jounal Clubs each of which carries points.

2. Quality Assurance — Medical Audit.

3. Physician Associated Assessment.

The basic mechanism involves an annual self report of activities by which each fellow gains credit points. A minimum of 500 credit points 5 year cycle entitles one for re-credentialling.

The Australian College says it is vitally concerned with the standard of practise of its Fellows and the M O P's Programme is a simple strategy to promote continual improvement. It is part of the internal accountability of the College.

Who Provides C M E?

1. Medical Schools.

2. Professional Medical Societies & Colleges.

3. Hospitals — The Health Dept. does not stress the importance, of study leave or give it generously. It is time they also thought of re-inbursing fees paid for courses etc., Up to now this has been totally alien concept with the department.

4. Local Medical Associations — SLMA.

5. Health related industries eg. Pharmaceutical manufacturers.

A word of caution here — in all these processes we are not — I repeat, not looking for 'Bad Apples'. The rigid adoption of the bad apples theory seriously affected American industrial output for decades. It took some visionary theorists to discover that relying on inspection to improve quality is, at best inefficient, and, at worst, a formula for failure. The Japanese leamt quite early that there are better ways of improving quality, and the cumulative result of that approach has become part of current interntional economic history. What Japan discovered was primarily a new, more cogent, and universally acceptable way to focus on quality. Call it the Theory of Continuous Improvement — 'Kaizen'. Quality improvement is more readily achieved when all people involved are presumed to be genuinely doing their best not accused of indifference. The disciplinary approach poisons the atmosphere and leads to a loss of the chance to learn.

The modem quality improvement experts care more about learning and co-operating with the average worker. The Japanese call it 'Kaizen' — the continuous search for opportunities to do things and execute all processes better than before. Therefore, whether it is C M E Activity, MOPs, Re-certification or Medical Audit, they should all be voluntary. To make meaningful headway, we should desist from indulging in value-judgements on the state of our health care services, for only then can the co-operative spirit be encouraged in what is, essentially, a complex web of human relationships. Put simply, the absence of an *offensive* approach clearly obviates the need for any *defensive* response. We are not a trade where minimal standards are acceptable; we are professionals who aim at excellence. Physicians who apply 'Kaizen' or the principles of continuous improvement, daily through C M E activities will probably achieve:-

1. Better efficiency.

2. Greater effectiveness.

3. The Gratitude and loyality of satisfied patients.

I would like to end by quoting Prof. Alex Cohen PRCAP's message to us at our Silver Jubilee last year. Talking of the College he said "throughout the period (25 years) a dedication to the dual ideals of academic excellence and professional standards have kept our vision clear".

Our vision, as the 21st century looms into view over the horizon, must be to achieve greater excellence — for excellence is very much a relative term.