

**Setting standards in medical practice – the role of the consultant physician****Jagath Wijesekera\****Journal of the Ceylon College of Physicians, 2000, 33, 5-10*

All those who are responsible for providing a satisfactory health service in this country, have one common objective and that is, to provide a better service to our patients. Many individuals are involved in achieving this objective. The authorities i.e the officials of the Ministry of Health are mainly involved in laying down the rules and objectives.

Then there are those who are actually responsible for providing this service.

- Consultants
- Junior doctors
- Nursing staff
- Paramedical personnel

Today in this Induction Address, which I have titled 'Setting Standards In Medical Practice – The Role of the Consultant Physician' I will be, as the President of the Ceylon College of Physicians, looking at the role the Consultant Physician has to play to achieve this ultimate goal – Providing a better service to our patients.

During this address I would like to highlight some of the problems that physicians face and suggest recommendations to improve existing services.

Consultant physicians working for the ministry of health face many problems and stresses. As a result many feel that their ability to provide good standards for their patients is being compromised.

In the past few years' consultant physicians have come under considerable stress as a result of changes in their workload, coupled with lack of resources and rising public expectations. A large increase in hospital admissions without a parallel increase in the available beds and back-up service accompanied by an increasing awareness and expectations by the public who now demand constant consultant involvement in their care, have led to this situation. The relatively small

increase in the number of consultant appointments has certainly been insufficient to enable them to cope with these increasing pressures. This factor is compounded by the additional demands for consultants to participate in undergraduate and postgraduate teaching programs, continuing medical education and training of junior doctors.

The ability of the health services of this country to provide good standards of medical care for its patients has always depended upon the dedicated hard work of the professional working in it. Consultant physicians for their part have not stinted in the time and effort they have given to provide the highest possible standards for their patients. However the ever increasing multiple pressures on Consultant Physicians pose a threat to these high standards achieved so far and could well reduce the quality of care.

Sri Lanka is seriously under doctored, a fact further aggravating the major difficulties in providing a safe medical service. In this address I would like to warn that if working conditions are unsatisfactory for physicians then the standards of care is likely to fall. There is perception among many Consultant Physicians that standards are already falling.

I sent out a questionnaire to consultant physicians working in general hospitals (Teaching and non Teaching) and base hospitals to gather their views on the subject of medical care and workload.

The Questionnaire consisted of 7 questions. They were,

1. What is the average number of patients seen on a ward round?
2. Is it possible to see all patients in the ward every-day?
3. Average number of patients per clinic?
4. Is there enough time for teaching and training?
5. Is there enough time for reading journals and books?
6. Do you think the standard of care is rising or falling?
7. Do you still like the work you do but feel there is too much of it?

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\* Consultant Neurologist, Institute of Neurology, National Hospital of Sri Lanka, Colombo.

## Results

A summary of the results of this survey is given below

Q. Is there enough time for teaching and training  
Responses:

No – 68%  
Yes – 32%

Q. Is there enough time for reading journals and books?  
Responses:

No – 88%  
Yes – 12%

Q. Is the standard of care is rising or falling?  
Responses:

Falling – 48%  
Rising – 32%  
Static – 16%  
Don't know – 4%

Q. Do you like the work but think there is too much of it?

Too much – 80%  
Not too much – 16%  
Don't know – 4%

The results of this survey thus showed that the consensus among the Consultant Physicians in this country was that Physicians in general were burdened with a work load which was well in excess of the optimal. In their response it was also evident that a majority of Physicians felt that more emphasis should be laid on team effort and that methods of distributing this work load should be found.

### The principle reasons for increased stress and pressures on consultant physicians

There are many reasons for the increased stress and pressures on the work of the consultant physicians at the present time. Principle among these is the expanding workload, but other factors are also salient.

### Public expectations

The public expects standards in medicine to be high and understandably complain when they are judged not to be so.

On the one hand, patients and their families demand higher standards at existing costs, which is inadequate to meet these demands. On the other hand, there is pressure from the government to reduce costs as far as possible.

There is also a perception that every misadventure must be 'someone's fault' and this has led to an increase not only in complaints but also in the pursuit of medico-legal actions, thus adding still further to the pressures on the consultant.

### Bed numbers

There has been no increase in bed strength to keep pace with increase in admissions especially in the number of beds available for acute medicine.

In most medical wards of General and Base Hospitals there are at times an equal number of 'floor patients' as there are patients occupying beds. The physician in charge has a difficult job of trying to decide.

- (a) which patient is well enough to give up his bed to a more critically ill patients
- (b) is this patient well enough to be actually treated on the floor

One has to have total disregard as to the comforts of a sick individual and the physicians has to compromise on adequate and proper investigations, as, his priority becomes, 'clearing' the ward to make room for new admissions.

### Junior doctors

Most physicians working in General and Base hospitals have only two post intern housemen manning their wards with no Senior House Officers or registrars, the situation being marginally better in the Teaching Hospitals. On the other hand, when one considers the Intern House Officers, disruption of the undergraduate medical programme in the universities over the past years has resulted in an increase in the number of intern medical officers being crowded into a single unit. Before this disruption of university education, interns were regularly posted into units and there were not more than two to three interns per unit at any given time. This ensured a good training to these interns whereas now there are six to seven of them in most units, even in base hospitals, resulting in these doctors not obtaining an adequate training.

### Nursing staff

There is also a severe shortage of nursing staff in the state sector due to an inadequate number of nurses passing out each year from the training schools. This is compounded by the fact that a significant number of trained nurses are leaving the country to work abroad for higher salaries.

### **Availability of laboratory and radiological services**

In the majority of hospitals where consultant physicians work, even the basic biochemical and haematological investigations are at times difficult to obtain or is being rationed. Radiological facilities are limited and even basic investigations like a chest X-ray is sometimes not available.

Even at the National Hospital, which is the final referral center for medical care in Sri Lanka, investigations are not freely available to the physician. For example at the Institute of Neurology the limited number of CT scan facilities have made it necessary for the Consultant Neurologists to actually decide which patient need CT scan investigation most and sometime patients who actually require CT scans cannot be scanned due to the limited quota available.

### **Deciding priorities**

There are ethical considerations relating to performing sophisticated and expensive investigations for some very ill and extremely elderly patients in situations where there is little hope of successful therapeutic outcome. Decision making in these circumstances is very stressful for the physician concerned and can take much time in discussion with patient's relatives and other staff.

As Consultant Neurophysician in charge of the intensive care at the Institute of Neurology I often have to face such situations especially since our is a six bedded unit and patients are referred to this unit from all parts of the country.

One has to decide on issues such as

- Which patient needs intensive care?
- How long can he stay in intensive care?
- At what point of his critical illness could he safely leave intensive care to make room for another patient who needs such facility?
- At what point does one withhold life support therapy for irreversible neurological disease? (such as severe encephalitis, cerebral haemorrhage, advanced motor neurone disease and muscular dystrophy in the terminal stages)

### **Other ethical considerations**

The consultant physician has to decide on various other ethical issues. Among these are

- 1) The role of the patient and his relatives in decision making

The autonomy of the patient in the central ethical principle in medical practice. Thus the wish of the patient is the main determinant of the physicians actions.

### **2) Ethical aspects of cost-benefit relationship**

The general consensus is the prevention of futile treatment. Thus appropriate use of life sustaining therapies and 'Do-Not-Resuscitate' (DNR) decisions have become important ethical issues. The discussions on foregoing therapy and DNR decisions are usually led primarily by the opinion of the patient or his relatives. However at times, these decisions have to be taken unilaterally by the consultant in the best interest of the patient.

### **3) Ethics in the Transportation of the critically ill**

Studies indicate that necessary intensive care intervention should not be denied due to the fear of transport related complications. Therefore patients requiring intensive care should be sent to hospitals with the available facilities provided they are transported under optimal conditions.

The physician is also involved in important issues such as ethics in research, issues pertaining to brain death and ethics in organ procurement, which I believe, will become a major issue in this country in the near future with the introduction of the cadaveric organ transplant programme.

### **Recommendations**

Having briefly outlined some of the problems and stresses Consultant Physicians have to face, now, I would like to discuss recommendations for the betterment of effective hospital practice, looking primarily from a Physicians perspective. These are:

#### **1. Team work**

The Consultant can no longer work in isolation and now need to work in teams, often as the team leader. In many specialties teamwork has become the central feature for the provision of care to patients and it is incumbent on all physicians to adapt to this style of work. Any lingering prejudice regarding teamwork must be rejected.

In this context I am pleased that we were able to start the first stroke unit in Sri Lanka at the Institute of

Neurology in July this year. The success of this stroke unit depends on the team involved. This team includes the Consultant Neurologist (team leader), Consultant in Rheumatology and Rehabilitation, junior medical staff, nurses. Speech Pathologist, Physiotherapists and occupational therapists.

Consultants must collaborate with and understand the skills of the other professionals involved in the team. I am happy to say that we are already seeing some positive results where stroke care is concerned at our stroke unit, in the six months since it's inception.

## 2. Adequate consultant cover

It is impossible for consultant to single handedly provide a 24 hour cover while working in acute medicine. This is also true for the finer medical specialties such as Cardiology, Neurology, etc where it is no longer acceptable for a consultant to work alone.

I would like to emphasize that whenever new units are opened outside Colombo, especially in the finer specialties, at least two Consultants or one Consultant and a Resident in that specialty should be appointed, if one were to provide a satisfactory service.

## 3. Man power

In Sri Lanka the figures for each specialty are as follows

### 1. Number of Consultant Physicians (State sector)

	Cadre status as at 1998	Projected cadre for 2006
General Medicine	60 (41)	110
Cardiology	16 (13)	19
Neurology	08 (07)	14
Chest Medicine	08 (03)	14
Rheumatology	11 (02)	17
Dermatology	13 (06)	67

**NB.** The numbers in brackets indicate the number undergoing training at the moment.

## 2. Consultant: Population ratio

	1998	2006
General Medicine	1:300,000	1:165,000
Cardiology	1:1,500,000	1:195,000
Neurology	1:2,250,000	1:1,300,000
Chest Medicine	1:3,000,000	1:1,300,000
Rheumatology	1:3,000,000	1:1,100,000
Dermatology	1:1,800,000	1:300,000

These figures speak for themselves and need to be improved urgently. It is interesting to note that e.g: The recommended European guidelines is one Consultant per 80,000 population with at least two Consultant per specialty in a hospital.

Therefore our Consultant cadre requirements have to be reviewed and the relevant authorities namely the Ministry of Health and the Post Graduate Institute of Medicine will have to evaluate the ground situation and calculate a reasonable number of new posts that will be necessary to achieve the optimum ratio Consultant per population for both acute medicine and the finer specialties for a developing country like ours. It is indeed encouraging to note that both the Health Ministry and Postgraduate Institute of Medicine have recognised the need for new specialties such as Nephrology, Endocrinology, Neuro Physiology and Cardiac Electro Physiology and that postgraduates are already being trained in some of these fields.

## 4. Basic requirements when opening new units

When new units are opened both in acute medicine and the finer specialties, the Health Ministry should ensure that a reasonable number of beds, adequate staff and investigatory facilities are provided before Consultants are posted to these new units. It is regrettable to note, for instance in the past, Neurologists have been appointed to new units set up at General Hospitals at Kurunagala and Ratnapura without even an Electroencephalogram been provided to these units. Non availability of these basic facilities lead to frustration and disappointment in those young physicians who are posted to these newly opened units.

#### **5. Adequate junior medical and nursing staff**

A Consultant Physician will need an optimum minimum number of junior medical officers and nursing staff in his unit, to provide a satisfactory service for his patients.

#### **6. Availability and access to a full range of investigative facilities**

Basic investigatory facilities such as Haematology, Biochemistry and Radiology should be available and accessible in all institutions where Consultant Physicians work.

More specialized investigations such as Ultra sound, CT and MRI scanning and other imaging techniques should be available when appropriate.

The benefits of modern imaging technology are becoming apparent but it is clear that only hospitals of a certain size will be able to provide such equipment.

#### **7. Referral for a second opinion**

There must be immediate access to other medical opinions particularly acute surgical opinion.

#### **8. Secretarial support**

The Ministry of Health should address this as an urgent priority. The lack of secretarial support results in the poor coordination of the work of the Consultant Physicians. I would consider this as one of the major problems facing all Consultants, especially for those in the State sector.

#### **9. Time for communication**

Consultants must have adequate time to assess patients and to explain the diagnosis and treatment to them and their families. This has become increasingly difficult in the face of a heavy workload and often leads to a perception of lack of communication or 'off handedness' with a greater likelihood of complaint.

#### **10. Audit**

Physicians should be encouraged to do regular audits of their own units. Audit involves the systematic critical analysis of the quality of medical care including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome.

I would like to briefly mention an audit we did at the Institute of Neurology last year, the findings of which were presented at the last SLMA annual sessions. Stroke care in Sri Lanka has not been previously evaluated. We used an audit package designed by the Royal College of Physicians and the UK stroke audit group.

The study highlighted deficiencies in certain aspects of stroke care at our institute. Relative strengths and weaknesses have been identified, and based on these, intervention to improve care has been designed and implemented already.

In Sri Lanka at the moment, efficient audit is often severely impaired, if not impossible because of the non-availability of records and when available, the very poor quality of these. More adequate provision of record keeping and Information Technology is an urgent need in our hospitals.

#### **11. Continuing Medical Education**

The requirements for Continuing Medical Education (CME) should be considered mandatory to allow the provision of an up-to-date clinically safe service. The Consultant is an employee of the ministry of health. Encouraging and finding the funds when possible for CME are a duty of the employer. The Post Graduate Institute of Medicine also, obviously, has a major role to play here.

#### **12. Research**

Research is not a mandatory part of every Consultant's life, but it is essential if medicine is to advance and it can enhance job satisfaction. Onerous work loads make research impracticable in busy non-Teaching Hospitals and, even in Teaching Hospitals, they are increasingly a hindrance. Whenever possible reasonable opportunity should be provided for research and adequate time and facilities should be made available.

In Teaching Hospitals, good relations with the affiliated university is important to encourage collaboration with other scientists and help each party understand the working arrangements of the other. For example changes in the undergraduate curriculum and its consequences should be discussed by the University staff with Consultants of the Ministry of Health and a consensus arrived at, all stages of its implementation.

**Role of the Ceylon College of Physicians In assisting consultants**

The prime role of the Ceylon College of Physicians which is an umbrella association of the Sri Lanka Medical Association, has always been to ensure high standards of care for patients. Judging the conduct of doctors, of course, is the responsibility of the Sri Lanka Medical Council.

Physicians are encouraged to approach the College whenever they face difficulties at work. Such help has been sought in the past and will probably be sought increasingly in the future. A visit to a hospital by a team of physicians selected by the College, (Peer Reviewing ) may be a helpful way to identify problems and suggest possible solutions. The implementation of these, would then be the responsibility of the local doctors. Such an approach, will typify the desire of the College to be supportive to Physicians in maintaining standards. It is my belief that the College should strive to implement such a programme in the near future.

**Concluding comments**

Some of the thoughts I have shared with you this

evening have been discussed at the council meetings of the Ceylon College of Physicians and some are in function already. It will be my endeavor to ensure that these ideals are further strengthened during my tenure of office. The provision of high quality medicine by Consultants is a dual responsibility. The Health Authorities must employ sufficient staff and provide appropriate facilities for the work of the Consultant and his team. The Consultants either individual or as a body in the hospital, must make firm and if necessary, vociferous requests for the staff and other facilities they need, adopt satisfactory working patterns and practices and educate themselves to monitor their own performance, and possibly, even partake to monitor the performance of colleagues.

Considerable pressure from all of us will be necessary to bring working conditions into line, as discussed in this induction address. Success will help to safeguard the quality of care given to our patients. This in turn, will help set higher standards in medical practice. The Consultant Physicians and the College of Physicians, which is the official body of the Physicians in this country, have an important role to play to achieve this goal.