Pakistan Medical and Dental Council – strategic imperatives

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PMDC's strategic imperatives

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Recent controversies around the Pakistan Medical and Dental Council (PMDC), the efforts underway to break the resulting stalemate and more topically offered solutions now favouring a major overhaul highlight an opportunity to flag some fundamental questions about the role of this institution.

Mandated with a regulatory role within the ambit of the medical profession, the PMDC is a statutory autonomous organization. The PMDC Ordinance of 1962 and the subsequent amendments introduced in 1967 and 1973 provide a policy framework enabling it to set standards of medical education, register practitioners and accredit academic medical establishments. Should the PMDC's role be broader, since this is the only body that regulates the medical profession? If considerations of protecting, promoting and maintaining the health and safety of the patients are brought to bear — as they should, because they are the cornerstones the PMDC's code of ethics.

These bring to the forefront many other issues such as assessment of performance and accountability, credentialing of doctors through a peer review processes, continuing medical education as a prereq-uisite to maintaining a PMDC licence, accreditation and quality assurance mechanisms for private health facility infrastructure and effective adjudication of complaints. The proposed health reforms make a strong case for creating appropriate institutional mechanisms for this purpose. For example, the recently released Gateway Paper of Pakistan's Health Policy Forum, makes a case for the creation of a National Council for Health Care Quality, Peer Review Boards, and an institutional mechanism for Continuing Medical Education to support the reforms it proposes. Within this context it needs to be determined whether the PMDC can perform these roles or is there a need for configuring independent institutional mechanisms for this purpose. In the case of the latter, what relationships will these have with the PMDC?

Expanding the scope of the regulation — within or outside the PMDC's domain and presumably through autonomous institutes — raises the question of who gives autonomous institutions a regulatory mandate. Who enforces the mandate and makes institutions accountable, and in what manner? Granting autonomy to a regulatory institution such as the PMDC is quite unlike granting autonomy to service delivery institutions such as hospitals, where appropriate policy and operational frameworks and mainstreaming of the market mechanism can serve the debatable core purpose of making them efficient and sustainable. However, that is not the case with an institution whose core functions are normative and regulatory. Regulation and standard setting are the functions of the State per se. This is even more critical in a medical education context, which is not — and cannot be — a private-sector forte. However, this does not imply that an institution to regulate the medical profession cannot be autonomous. A certain level of autonomy in terms of ensuring that the voice of all stakeholders is expressed in decision-making and management may actually be necessary to ensure that regulation does not become coercive, that standard setting is reflective of an appropriate expression of all perspectives and that the enforcement of these standards and norms is being overseen by a participatory process. However, autonomous institutions in the truest sense work most efficiently and transparently in institutional and societal cultures that have fully matured to the realties of self-governance. In settings where there are gaps at this level, professionally led regulatory institutions should be configured in a public sector-professional partnership and must not be separated from State oversight,

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the limitations of the latter, notwithstanding.

Given these considerations, four areas of reforms are proposed within the PMDC and PMDC allied-regulation context:

The first area of reform relates to the PMDC's governance functions and operations. In this area, there is a need to clearly separate the governance functions of the Council and its functions which relate to case work and adjudication of complaints with appropriate safeguards — not just byelaws but also their implementing mechanisms — to ensure the upholding of evidence in decision-making and protection against interference from vested-interest groups. In this area of reform, the terms of engagement of this autonomous institution, the level of State oversight and its mechanisms and the accountability paradigms need to be articulated with clarity and due representation of stakeholders ensured. There is also the need to bring greater clarity in the means of conflict resolution. This links in with some overarching questions about the mandates of the Senate and Parliamentary Standing Committees on Health and how these relate to the operational scope of health policy implementation within Pakistan.

The second area of reform relates to revisiting its existing mandate. Here the feasibility of introducing conditionalities for retaining the PMDC licence should be assessed. This can either be through the introduction of revalidation — or demonstration by doctors that they meet the standards required for continued registration — or through incorporating a Continuing Medical Education program as a prerequisite for maintaining a PMDC licence. Ideally it should be a combination of both. There is also the need to assess the feasibility of revising the examination procedures and creating a national examination board.

In the third place it is critical to mainstream its role in the evidence and the policy cycle. By virtue of its core role to register medical practitioners, the PMDC holds the largest dynamic database of healthcare providers in the country. There is a need to synthesise this "information" into "evidence" for policy-level decision-making with respect to human resource quantitatively from the supply and demand perspective, qualitatively, and with respect to their effective deployment. The PMDC owned data can potentially yield evidence in several areas. These may be relevant to personnel management reforms which should ideally go beyond "personnel actions"; pragmatic human resource solutions for public-sector doctors with relevance to dual job holding and coercive bans on private practice; dealing with quackery, the effect of privatisation of medicine on the quality of education and an analysis of the demand for these institutions vis-ŧ-vis self-financing schemes for existing public medical institutions.

And in the fourth place, drawing an analogy with the UK's General Medical Council and connecting with the overall context of the PMDC's ethical principles and standards which determine its responsibilities, serious thought must be given to the scope and scale of the PMDC's role within the context of broader considerations relating to regulating the medical profession. If the purpose is to protect, promote maintain the health and safety of the public, then there is a need to expand the scope of regulation — within the PMDCs ambit or outside of it — to encompass considerations of performance assessment, credentialing of doctors, continuing medical education, licensing and accreditation of service delivery facilities, quality assurance mechanisms and the monitoring of errors. These considerations underpin the viability of the reforms being introduced in the health sector — at the level of delivery of services through basic health care facilities or hospitals or the financing of health care. Whether the PMDC can be restructured for this role or whether other institutional mechanisms need to be configured must be the subject of strategic deliberations.

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Recent controversies around the Pakistan Medical and Dental Council (PMDC), the efforts presently underway to break the resulting stalemate and more topically offered solutions now favoring a major overhaul highlight an opportunity to flag some fundamental questions about the role of this institution. Mandated with a normative and regulatory role within the ambit of the medical profession, PMDC is a statutory autonomous organization. The PMDC Ordinance of 1962 and the subsequent amendments introduced in 1967 and 73 provide a policy framework enabling it to set standards of medical education, register practitioners and accredit academic medical establishments. But is this all that needs to be within the PMDCs remit? Or should its role be broader given that this is the only body that regulates the medical profession? If considerations of protecting, promoting and maintaining the health and safety of the patients are brought to bear – as they should given that they are the cornerstones PMDC's code of ethics – perhaps there is a need for revisiting its scope. These bring to the forefront many other issues such as assessment of performance and accountability, credentialing of doctors through peer review processes, continuing medical education as a prerequisite to maintaining a PMDC license, accreditation and quality assurance mechanisms for private health facility infrastructure and effective adjudication of complaints. Currently proposed health reforms make a strong case for creating appropriate institutional mechanisms for this purpose; for example, the recently released Gateway Paper of Pakistan's Health Policy Forum, makes a case for the creation of a National Council for Health Care Quality, Peer Review Boards, and institutional mechanism for Continuing Medical Education to support the reforms it proposes. Within this context it needs to be determined whether PMDC can perform these roles or is there a need for configuring independent institutional mechanisms for this purpose and in the case of the latter what relationships will these have to the PMDC given the cross-cutting mandates.

Expanding the scope of regulation – within or outside of PMDCs domain and presumably through autonomous institutes – raises the question of who gives autonomous institutions a regulatory mandate. Who enforces it and makes them accountable and in what manner? Granting autonomy to a regulatory institution such as the PMDC is quite unlike granting autonomy to service delivery institutions such as hospitals where appropriate policy and operational framework and mainstreaming of the market mechanism can serve the debatable core purpose of making them efficient and sustainable. However that is not the case with an institution whose core functions are normative and regulatory. Regulation and standard setting are the functions of the State per se. This is even more critical in a medical education context, which is not – and cannot be – a private sector forte. However this does not imply that an institution to regulate the medical profession cannot be autonomous. A certain level of autonomy in terms of ensuring that the voice of all stakeholders is expressed in decision making and management may actually be necessary to ensure that regulation does not become coercive, that standard setting is reflective of an appropriate expression of all perspectives and that the enforcement of these standards and norms is being

overseen by a participatory process. However autonomous institutions in the truest sense work most efficiently and transparently in institutional and societal cultures that have fully matured to the realties of self governance. In settings where there are gaps at this level, professionally led regulatory institutions should be configured in a public sector-professional partnership and must not be separated from State oversight, the limitations of the latter, notwithstanding.
Given these considerations, four areas of reforms are proposed within the PMDC and PMDC allied-regulation context:

The first area of reform relates to PMDC's **governance functions and operations.** In this area, there is a need to clearly separate the governance functions of the Council and its functions which relate to case work and adjudication of complaints with appropriate safeguards – not just byelaws but also their implementing mechanisms – to ensure the upholding of evidence in decision making and protection against interference from vested interest groups. In this area of reform, the terms of engagement of this autonomous institution, the level of State oversight and its mechanisms and the accountability paradigms need to be articulated with clarity and due representation of stakeholders ensured. There is also the need to bring greater clarity in the means of conflict resolution. This links in with some overarching questions about the mandates of the Senate and Parliamentary Standing Committees on health and how these relate to the operational scope of health policy implementation within Pakistan.

The second area of reform relates to **revisiting its existing mandate.** Here the feasibility of introducing conditionalities for retaining the PMDC license should be assessed. This can either be through the introduction of revalidation – or demonstration by doctors that they meet the standards required for continued registration – or through incorporating a Continuing Medical Education program as a prerequisite for maintaining a PMDC license. Ideally it should be a combination of both. There is also the need to assess the feasibility of revising the examination procedures and creating a national examination board.

In the third place it is critical to **mainstream its role in the evidence and the policy cycle**. By virtue of its core role to register medical practitioners, PMDC holds the largest dynamic database of healthcare providers in the country. There is a need to synthesize this 'information' into 'evidence' for policy-level decision-making with respect to human resource quantitatively from the supply and demand perspective, qualitatively, and with respect to their effective deployment. PMDC owned-data can potentially yield evidence in several areas. These may be relevant to personnel management reforms which should ideally go beyond 'personnel actions'; pragmatic human resource solutions for public sector doctors with relevance to dual job holding and coercive bans on private practice; dealing with quackery, the effect of privatization of medicine on the quality of education and an analysis of the demand for these institutions vis-à-vis self financing schemes for existing public medical institutions.

And in the **fourth** place, drawing an analogy with the UK's General Medical Council and connecting with the overall context of PMDC's ethical principles and standards which determine its responsibilities, a serious thought must be given to the scope and scale of PMDC role within the context of broader considerations relating to regulating the medical profession. If the purpose is to protect, promote maintain the health and safety of the public, then there is a need to expand the scope of regulation – within PMDCs ambit or outside of it – to encompass considerations of performance assessment, credentialing of doctors, continuing medical education, licensing and accreditation of service delivery facilities, quality assurance mechanisms and the monitoring of errors. These considerations underpin the viability of the reforms being introduced in the health sector – at the level of delivery of services through basic health care facilities or hospitals or the financing of health care. Whether the PMDC can be restructured for this role or whether other institutional mechanisms need to be configured must be the subject of strategic deliberations.

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