Meeting challenges through professional development

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(This article is based on the presidential address delivered at the induction of the 32nd president of the Sri Lanka College of Obstetricians and Gynaecologists on the 07th of January 2018)

Introduction

The Ceylon Obstetrics and Gynaecology Association, the forerunner of the SLCOG was founded in 1953. Subsequently the Association of Obstetrics and Gynaecology of Ceylon which was formed in 1967 was raised to the status of a College in May 1970. When Sri Lanka became a republic in 1972, the College was renamed as the Sri Lanka College of Obstetricians and Gynaecologists. The College was incorporated as a company limited by guarantee on the 8th of June 1983[1,2,3].

Accordingly, the College is entering its 51st year of existence in 2018 and it is an opportune moment to reflect on the challenges ahead and identify means of meeting them, such as professional development.

Sri Lanka enjoys good health indices when compared to other low middle income countries and the College is proud that it has contributed to achieve and maintain these indices for a long time. This is evident in areas like maternal mortality ratio, ratio of births attended by skilled health personnel, perinatal death rate, and child mortality rate[4,5].

The landscape is changing: However, the population pyramid of Sri Lanka, as in many developing countries, is changing[6]. The proportion of older people is gradually increasing and the trend is expected to continue in to the future.

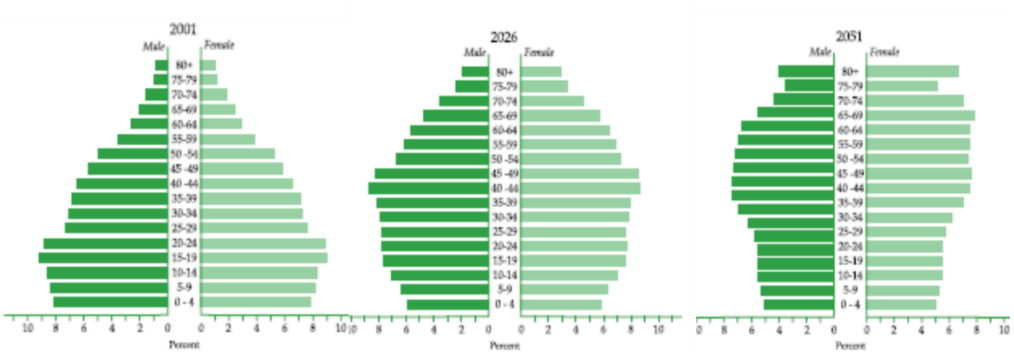

Figure 1 Changing population pyramid in Sri Lanka

This change in the demographic landscape will have significant implications on women's health and disease. Average age of all mothers and the average age at the birth of first child is increasing.

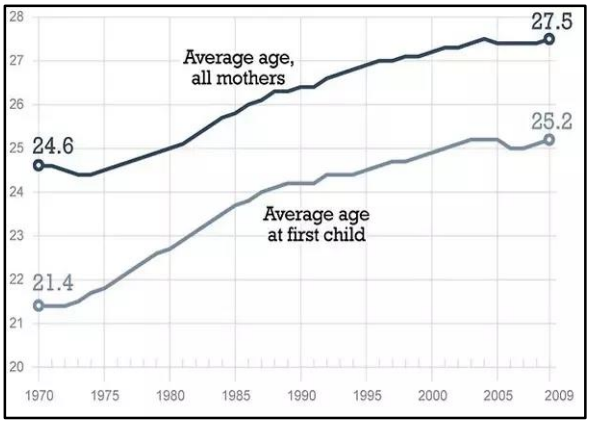

Figure 2: The average age of mothers at first childbirth and average of all mothers in USA (from CDC, 2012).

This will lead to a higher demand for infertility treatment, as seen worldwide, as well as a higher rate of chromosomal abnormalities thus needing fetal medicine input. Women aged 36 and above contributed to 27.7% of all maternal deaths in Sri Lanka in the year 2016 (Unpublished data from the maternal mortality reviews of the Family health bureau). The incidence of gynaecological malignancies, depicted by number of new cases, continues to rise among our population[7]. With the average age of the population increasing, this trend is expected to continue.

Socio economic factors: The media is advancing at a rapid pace. Information reaches the masses very effectively. This results in increase public awareness on many issues including

health related issues. This will change the treatment seeking behavior of our clients. Furthermore, their expectations are increasing and they will demand for more novel treatment modalities. Litigation probably will also be knocking at our door.

During the last 50 years there has been a paradigm shift in the practice of Obstetrics and Gynaecology in Sri Lanka. The lifesaving interventions which were the priority of the yesteryear have given way to life giving interventions that improve the quality of life. Furthermore, cost effectiveness of health services is gaining importance. There is need to meet the challenges ahead of us and find solutions through professional development to address the demands of our clients.

It is pertinent to ask the question "have we been basically plucking the low hanging fruits?" If so it is the right time to achieve more by meeting these new challenges ahead.

The Challenges

Given the changing demographic landscape and associated with socio-economic factors, the challenges the profession will face in the coming years will be many fold.

Introduction of clinical governance: Firstly, there is a need to bring in clinical governance in a more robust manner. This will include clinical effectiveness, clinical audit, research and development, accountability, risk management, as well as education and training. To quote the great surgeon Hugh Brendon Devlin, The founding director of the surgical epidemiology and Audit Unit, Royal College of Surgeons of England, **"**surgery without audit is like playing cricket without keeping the score". This is how the practice of medicine should be in the present day. Clinical governance is an integral part of day to day clinical practice and hence is an important aspect in postgraduate training.

Addressing severe acute maternal morbidity: Sudden deaths rarely contribute to maternal deaths. In many instances of maternal deaths, development of severe acute maternal morbidity (SAMM) is the final common pathway. Say *et al* defined SAMM as "A very ill pregnant or recently delivered woman who would have died had it not been that luck and good care was on her side"[8]. This condenses the need to pay adequate attention to this area since neither luck nor good care will be available at all times.

Such severe acute maternal morbidity may result from disease itself, obstetrics or non-obstetrics, or owing to lapses in the care due to factors related to the patient or the health care provider. If SAMM is an iceberg with mortality as the tip of the iceberg that is easily visible, we represent the environment. As caregivers we should be able to change the atmosphere, thereby making the iceberg smaller or may be make the water less dense so that the tip will be

smaller. It has not been possible to bring about the desired changes at the correct time and address the issues at hand in bringing down the maternal morbidity and mortality.

Keeping up with world trends: With Sri Lanka's economic progress there is a need to keep up with the world trends. In the field of obstetrics, we have still not been able to address the issue of high caesarean section rates adequately. Similarly, in the field of gynaecology, the number of hysterectomies performed for benign gynaecological conditions have declined over the years in developed countries. This is after realizing that a significant proportion of women underwent major surgery and lost their womb due to benign gynecological conditions some 25-30 years ago. Therefore, alternatives such as hormonal methods, intrauterine hormone delivery systems, and endometrial ablation techniques were introduced in the management of these conditions. As a result women do not have to undergo major surgery for a problem that is largely functional. However, this country has failed to see a similar change over the years. Therefore, it is pertinent to ask the question; "Are we practicing evidence based medicine?"

Disease prevention: Cervical screening is regarded as a success story of disease prevention by mass screening. In countries such as United Kingdom, a sharp decline in the incidence of cervical cancer was noted with the introduction and popularization of the cervical screening [9]. Unfortunately, we have not been able to achieve a similar trend and our women continue to suffer and die of cervical cancer, in spite of a cervical screening programme for over 20 years provided through well woman clinics conducted countrywide. Yet, cervical cancer remains the second leading cancer among females, second only to breast cancer[7]

Cancer Site	2001	2002	2003	2004	2005	2006	2007	2008	2009
Breast	1,548	1,580	1,580	1,746	1,859	2,101	1,914	2,220	2,293
Cervix uteri	744	753	753	816	881	936	732	858	879
Ovary	466	539	539	627	596	671	529	637	698
Thyroid	337	451	451	555	592	683	656	815	816
Oesophagus	498	490	490	554	524	610	534	617	608
Lip, oral cavity & pharynx	369	364	364	414	377	390	398	477	520
Colon & rectum	245	258	258	310	353	372	405	508	517
Leukaemia	218	241	241	265	257	267	275	285	310
Lymphoma	223	144	144	230	243	257	257	288	252
Uterus	168	177	177	201	237	251	263	397	397
Total number of cases	5,901	6,351	6,445	7,009	7,314	7,875	7,279	8,816	9,030

Table 1: Number of new cases detected in the Top 10 cancers among females, 2001-2009

Unmet need of contraception: At every maternal mortality review meeting discussions take place about unmet meet of contraception while the country records a fairly high contraceptive prevalence rate of more than 65%. There are two main challenges here. Firstly, there is a high

discontinuation rate among the clients. As shown in the latest demographic health survey report nearly 20% of women discontinue their contraceptive methods. Secondly, women who deserve contraception most, are the ones who are not availing them thus contributing to the unmet need. The problem is with the care giver. We as a specialty has delegated the provision of contraception to the public health teams, and the public health midwife has become the primary care provider. She has instructions to select the healthy women, without any co-morbidities, in providing contraceptive services whereas the ones with such co-morbidities are to be referred to specialist clinics for a proper evaluation. However, due to many reasons they fail to do so. As a result, we see women with medical disorders going through unplanned pregnancies while the medically fit women practice contraception. Time has come for the specialist to take an active part in providing contraceptive services.

Multidisciplinary team approach: Looking at the causes of maternal deaths in the year 2016 the picture looks very familiar. Major obstetric hemorrhage is standing out the leading single cause of maternal deaths (Figure 3). However, when one look closer a different picture can be seen. It is the fact that 49 out of the 112 deaths resulted due to medical disorders complicating pregnancy. To reduce the burden of maternal morbidity and mortality due to medical disorders complicating pregnancy, emphasis should be given to provide targeted care for these women through a well-coordinated multidisciplinary team.

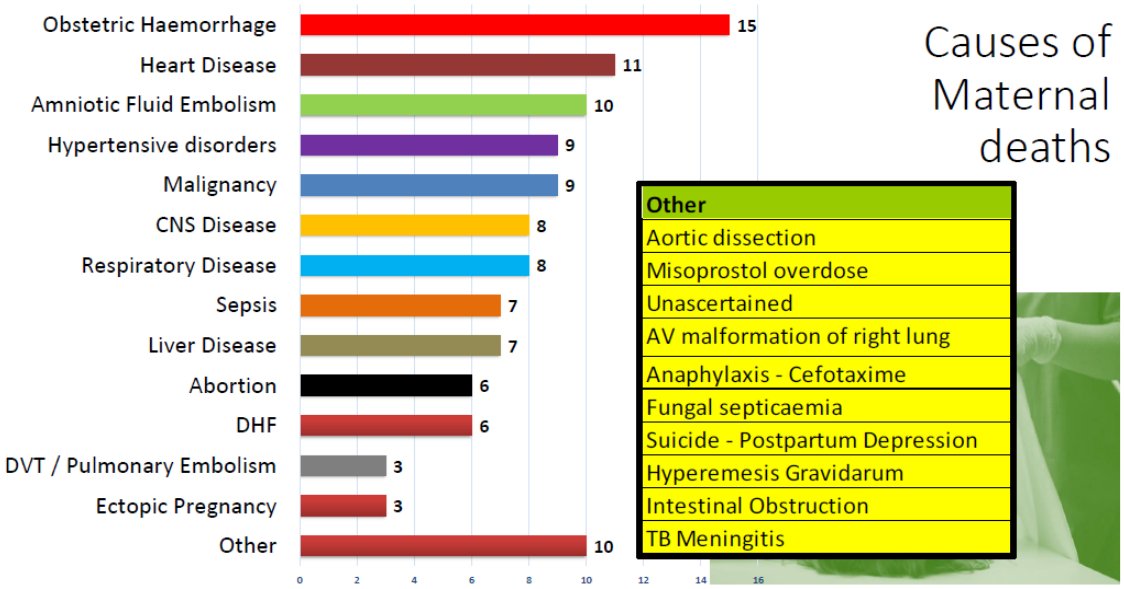

Figure 3. Causes of maternal deaths in the year 2016 (Unpublished data from the National Maternal Mortality Reviews 2016 from the Family Health Bureau)

Improving perinatal outcome: The perinatal mortality rate in Sri Lanka, though reasonably placed among other low and middle income countries, seems to remain static over the last few years. If this is to improve further addressing the main causes of perinatal deaths, congenital

abnormalities, prematurity and birth asphyxia will be important. It is time to pay more emphasis in reducing perinatal mortality due to birth defects and improving neonatal intensive care facilities.

Treatment of pelvic floor dysfunction. With the changes in socio demographic landscape as well as the living standards of the population, more women will demand effective treatment for pelvic floor dysfunction in the coming years. Such treatment should not only include the anatomical correction but also functional improvement of symptoms such as urinary symptoms, sexual dysfunction and overall quality of life. The health care provider should be equipped with the resources, both physical infrastructure as well as manpower to provide the care they deserve.

Cost effectiveness: Last but not least the next big challenge we will have to meet head on is making the services cost-effective for the provider as well as the consumer. Cost-effectiveness is like the '*elephant in the room*' for low and middle income countries (LMICs), no one addresses it, possibly due to our misconception of '*free health*'. It is vital that LMICs such as Sri Lanka enquire in to cost to ensure that maximum value for money is obtained with the limited resources at hand[10]. Health care costs can be looked at from many angles and are often inter-related[11]. In a similar vein, parallels can be drawn between issues in in our field and others; static maternal mortality, high production costs in tea industry and revenue generation in tourism industry etc. All these problems may be the different sides of a dice, the problems of a middle income country. The way to overcome this challenge, '*middle income trap*' is through innovation and improved efficiency which translates to research and development[12]. One cannot depend on evidence from the west forever and there is a need to generate our own evidence in order to improve clinical effectiveness and efficiency in the healthcare model.

Professional development

The above raises the question; "How do we meet all these challenges?" While acknowledging the many possible approaches that have to be undertaken, one effective approach would be professional development within the specialty and allied fields.

Professional development should not only deal with knowledge and skills; aspects such as attitudes, values, professionalism, vision for life, mind set and the paradigm need to be addressed. There is no doubt that such global professional development is required though it is likely that not enough emphasis is laid on these aspects at present. It should also be remembered that such professional development is necessary not only for the doctors but all members of the health care team; from the public health midwife right up to the policy maker.

Training and continuing professional development: We have a fairly robust system for training and continuing professional development for both medical as well as allied health professionals. While the medical schools contribute in training of medical and allied health sciences graduates, the nursing schools and other training centers operating under the ministry of health produce trained technical staff. The postgraduate institute of medicine provide post qualification training for medical officers up to the level of board certification as specialists. The professional colleges including the SLCOG contribute through CPD activities that facilitates skills training among specialists and middle grade medical officers. The SLCOG also contribute in training of allied health professionals such as midwives and nurses in essential skills.

The time is right to introduce novel training modalities to supplement these in order to meet the demands and challenges of the present times. Such training requirements include mandatory training sessions for all grades of staff including skills and drills sessions that will improve the management of emergencies as well as strengthen teamwork. Also there is a need for more advanced post board certification training in areas such as advanced ultrasound scanning, advanced labour room practices and minimal invasive surgery that specialists may need to acquire. The professional Colleges have a major role in encouraging such undertakings and facilitating them.

Improving the service provision: In the current service provision model of our health system the policy making is at the top where the bulk of the responsibility lies with the policy makers. Maldistribution and shortage of staff leading to inability to provide 24/7 comprehensive obstetric care, and improving infra-structure and supplies are areas for the policy makers to handle. Lack of accountability, delegation beyond the capabilities of the juniors, and limited involvement of the seniors in demanding situations are areas of concern. During service provision the work is delegated from top to bottom, through the hospital based curative and public health arms, thus much of the service provision is at the grass root level. It is becoming clear that the health care workers in the lower levels are becoming dissatisfied with their respective jobs, due to a variety of reasons, hence leading to many trade union actions as well as lack of commitment to daily work. The ministry of health seems to be struggling to recruit new public health midwives to its cadres, apparently due to the general public not considering midwifery as a desired vocation.

We may need to modify this service provision model in order to meet the demands and new challenges. More involvement of the senior grades of staff in service provision should be encouraged. All grades of the service providers should be made to feel important and proud of their respective roles in delivery of services. Such changes are needed not only in the field of obstetrics & gynaecology but also in other supportive specialties such as transfusion medicine,

anesthesiology and laboratory services. Since obstetrics is a specialty that should be functional round the clock, our aim should be to strengthen these services without any change in quality whilst providing 24/7 care.

Summary

The aim should be strengthening clinical governance activities so that there will be more accountability and self-reflection. More emphasis should be placed on development and implementation of user friendly and relevant clinical guidelines to help in day to day practice. We should pay adequate attention to the preventive aspects of medicine. All team members of the health care delivery team should be empowered, may it be in providing family planning services or demanding curative services, to deliver round the clock services, with more job satisfaction. Last but not least we should aim to make the service provision cost effective for both the provider as well as the client in order to maximize the output from limited resources at hand.

In conclusion, following two quotations are worth repeating in order to motivate ourselves to meet the challenges through professional development. Firstly, a quotation from the victory speech by Justine Trudeau, the prime minister of Canada; “We beat fear with hope; we beat cynicism with hard work”. Secondly, a famous quote from Martin Luther King Jr: “If you can’t fly, then run. If you can’t run, then walk. If you can’t walk, then crawl. But whatever you do, you have to keep moving forward”.

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