PROPOSED SIMPLIFIED PROMOTION SCHEME FOR CLINICAL DEPARTMENTS

MINISTRY OF HEALTH – KUWAIT

Nadeem Al-Duaij, MD

BACKGROUND

The hierarchical structure in place for medical doctors in Kuwait is based on an obsolete and highly administrative British system which has now, for obvious reasons, fallen out of favor. There currently exist seven administrative levels within which any given medical doctor fits into. Starting at the bottom, the *intern* is the medical school graduate who is completing his or her internship year at the MOH (tadreeb). Next is the *assistant registrar* who has completed the internship and has entered a given specialty prior to or in the early stages of engaging in graduate medical education (i.e. specialty training). *Registrars* are medical doctors with additional years of experience but who have not completed specialty training. *Senior registrars* are usually trained and have completed the requirements, including certification, of a specialty board. Finally, we have the *consultant* whose title, for administrative purposes, has been fragmented into *specialist*, *senior specialist* and consultant. The reason behind this is mainly to allow for a stepwise salary raise.

Although this appears to be a well-structured scheme, there are some major drawbacks to consider. In any given system, when one adds steps to the administrative process, you inevitably slow the entire machinery. Responsibility is diluted within a very complex system; employees lose their focus and become too dependent on their superiors. Furthermore, this cumbersome system restricts innovation and focuses competition within a given unit instead of allowing for “healthy” competition between units and, subsequently, between hospitals. The consultant (i.e. head of a unit) distances him or herself from the day to day clinical work by delegating responsibilities to their senior registrars. The title of consultant is attributed to trained physicians with years of experience, numerous scientific publications or political influence. So, if you do not fulfill one of those requirements, you will remain limited in your decision-making and will not have the “freedom” of contributing significantly to the progress of your department.

In more advanced systems, such as the North American model, a simple distinction is made between the physician-in-training and the trained physician. During specialty training, you are either a *resident* or a *fellow* depending on whether you are enrolled in specialty (e.g. internal medicine, general surgery, psychiatry, etc.) or subspecialty (e.g. cardiology, nephrology, transplant surgery, etc) training. Upon graduating, you are given the title of *attending physician* (or staff physician) regardless of your years of experience and/or academic affiliation. As a staff physician (i.e. the residency-trained physician), you are a specialist in your area of expertise and have the equal opportunity to contribute to change as any other more experienced colleagues. The only obvious distinction made within a given department is that of the chairperson and vice-chairperson positions. Other roles may then be attributed to staff physicians depending on their personal interests more than their clinical experience. These include, among other things, directing quality improvement, medical education, or research activities within the unit. By reducing the number of steps needed to reach this “freedom”, physicians may be able to add to the advancement of their department at an earlier stage in their careers. By hiring larger numbers of trained physicians within a unit, you allow these “consultants” to share the responsibility of patient care, guarantee daily supervision of untrained staff, provide 24-hour on call specialist coverage, increase the quality and quantity of medical education, and create internal competition between units.

PROPOSED SIMPLIFIED PROMOTION SCHEME FOR CLINICAL DEPARTMENTS

MINISTRY OF HEALTH – KUWAIT

Nadeem Al-Duaij, MD

The reason why I disagree, to some extent, with the importance of experience in one's career is because promotions cannot be solely based on the number of years of practice or scientific publications, as it is currently the case, but must involve a comprehensive evaluation process which takes into account multiple aspects of the clinician's role which we attempt to detail below. To give you an example, one may carry a respectable number of years of experience and be looked upon as the most knowledgeable physician in a given group but may be practicing an outdated medicine or have certain unethical practices not picked up by a thorough evaluation process. He or she may be responsible for countless medical errors which, again, will not be flagged by an absent quality assurance program.

The changes we encourage are indeed not simple ones. We recognize the difficulties faced by any policy maker who attempts to undertake such radical improvements. The system is old, its faults are engrained in people's lives and attempting to reeducate and retrain our workforce will be a daunting task. However, they are necessary as the negative effects of this unproductive and dangerous system are felt by each and every practitioner in his or her daily practice. Our families, friends and colleagues suffer the consequences through the repercussions on the quality of care.

Following are objectives set forth by our team followed by an exhaustive list of potential regulations that will aid in reversing the negative effects of our current administration.

OBJECTIVES

1. To standardize rank and promotions for physicians within clinical departments of Kuwait's Ministry of Health.
2. To speed professional achievements and encourage academic development.
3. To avoid conflicts of interest and differences between board certified physicians.
4. To make a formal distinction between physicians-in-training (i.e. residents and fellows) and staff physicians (i.e. board certified specialists and subspecialists).
5. To distinguish between the clinician and the academic.
6. To encourage training in all areas of medicine, particularly deficient specialties.
7. To simplify the administrative process and reduce its burden on clinicians.
8. To encourage a comprehensive approach to promotions.
9. To enforce compliance with continuing medical education programs.
10. To promote employment of multiple board-certified physicians within a department or unit.
11. To enforce increased responsibilities for board-certified physicians.
12. To encourage the creation of hospitalist roles within medical centers.
13. To increase the number of specialists in the community (i.e. clinics and offices).
14. To enforce the creation and staffing of new departments and divisions within a medical center or clinic.
15. To maintain an appropriate level of competency predetermined by the respective Boards of Medicine.

PROPOSED SIMPLIFIED PROMOTION SCHEME FOR CLINICAL DEPARTMENTS

MINISTRY OF HEALTH – KUWAIT

Nadeem Al-Duaij, MD

REGULATIONS

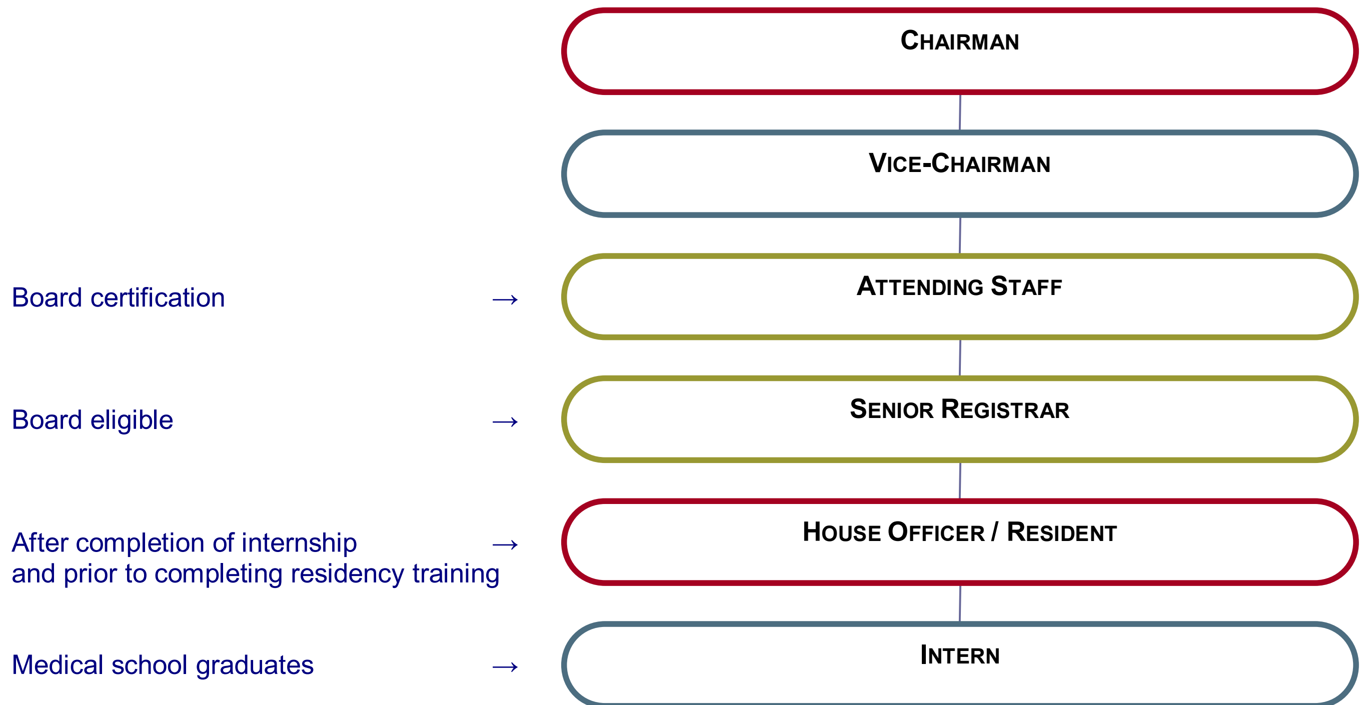
1. All North American (and other recognized boards) residents and fellows are equal.
2. Hierarchical levels should be kept to a strict minimum.*
   a. Postgraduate year 1 → Intern
   b. Postgraduate years 2 – X (in training) → Resident / Fellow
   c. Postgraduate years 2 – X (not in training) → House Officer
   d. Board eligible (i.e. residency or fellowship trained) → Senior Registrar
   e. Board certified → Attending
3. Promotion to staff physician (i.e. attending physician or consultant) must be made after obtaining board certification. ‡
4. Board certified physicians are responsible for:
   a. Overseeing the care of patients on a daily basis
   b. Taking call per a well-defined and evenly distributed call schedule
   c. Rounding and writing daily progress notes on hospitalized patients
   d. Seeing patients in their outpatient clinics
   e. Assuming the legal responsibility of their patients (i.e. medical errors, complaints, etc.)
   f. Enforcing and participating in CME
5. A board certified physician may opt for a community, hospitalist and/or academic employment.
   a. Kuwait University employees will carry their academic titles (i.e. instructor, assistant professor, associate professor, etc.), as regulated by the MOHE, in addition to their MOH designation mentioned under article 2.
   b. Community and hospital employed staff will carry the above-mentioned MOH designations.
6. Promotions of clinicians within the MOH will follow well-defined, comprehensive, and standardized guidelines. Assessment of individual physicians will include but will not be limited to the following:
   a. Certification status
   b. Years of experience beyond GME training (i.e. after completion of residency and/or fellowship training)
   c. Achievements within one's department (e.g. involvement in CME activities, quality improvement committees, scheduling, operations, etc.)
   d. Involvement with medical student and graduate education
   e. Academic productivity (e.g. clinical research, publications)
   f. Additional non-clinical degrees (e.g. MPH, MEd, MS, etc.)
   g. Scheduled evaluations (peers, employers, house staff, medical students, nursing staff, etc.)
7. Board certified providers are responsible for maintaining their competencies throughout their careers and for abiding by the CME regulations set by the Kuwait Institute for Medical Specialization (KIMS) and, preferably, their respective training Boards (e.g. MoC by the RCPSC, ABMS, etc.).

PROPOSED SIMPLIFIED PROMOTION SCHEME FOR CLINICAL DEPARTMENTS

MINISTRY OF HEALTH – KUWAIT

Nadeem Al-Duaij, MD

PROPOSED DEPARTMENTAL HIERARCHY:



* Promotions and rank should be irrespective of the number of years of training. It is recognized and agreed upon that different specialties take a varying number of years to be taught (i.e. in the United States, general surgery requires five years of postgraduate training whereas internal medicine, pediatrics or emergency medicine will take on average three years). To be inline with international standards, each and every newly certified attending physician, regardless of clinical specialty, must be at the same rank and have access to equal promotion opportunities.

‡ Avoidance of additional hierarchical levels after board certification will provide a more flexible environment for the professional development of the clinician and the advancement of the health care system as a whole. The classic, outdated and academically-oriented concept of "consultant" must be abandoned for more current and practical leadership roles in view of accelerating much-needed progress.