

COMMENT

To grade a clinician

ANUSHEEL MUNSHI¹, NAVIN KHATTRY²

¹Department of radiation oncology, ²Department of medical oncology, Tata Memorial Hospital, Parel, Mumbai INDIA email: anusheel8@hotmail.com

For ages medicine has been practised as an art of healing. Over the last century, however, it has undergone a revolution, augured by parallel advances in science and technology, and the definition and concept of “grading” a physician has evolved accordingly. In earlier times the yardstick for assessing a physician’s ability was simple, albeit relatively abstract. It involved appraising his art and skill to consistently diagnose the source of illness in patients based on their signs and symptoms, and then to cure them or provide relief to symptoms, using available resources. From these humble beginnings, clinicians now talk in terms of “translational medicine,” phased trials, randomisation and analyses, all under the umbrella of rational and scientific medicine. There is an increasing tendency to judge a physician’s credibility and stature only by his contribution to scientific medicine, and the value of good clinical sense and approach to patients has taken a relative backseat.

In most parts of the world, a physician’s contribution to science is measured by the number of publications in indexed journals. This method of grading is tempting by virtue of its simplicity and is supposed to reflect the doctor’s intellectual ability. However, occasionally it falls short of its objective. “Complimentary” authorship is offered, “friends” are accommodated whenever possible, and occasionally a deserving junior may be left out. There may be disagreement about the criteria for authorship and the sequence of authors in the final publication. Finally, editors have often been accused of favouring a particular region or country when accepting articles for their journal. Clearly, this system has some lacunae.

Another related tool for assessing a clinician’s contribution to science is to count the protocols that he or she is running. Being principal investigator in a trial confers a certain status to the physician. However, there have been several reports that all is not well with clinical trials (1). Pharmaceutical companies have flooded the research market, and most trials are industry-funded and -operated, rather than investigator-initiated. Drug companies that conduct the trials are reluctant to share their data and many industry trials are never published (2). Conflicts of interest are apparent.

We need a grading system that looks at more than how much one has published in the medical literature, that looks at how sound one is as a physician, clinically and beyond.

A frequently ignored parameter of ability is the doctor’s clinical aptitude and skill. Most clinicians are attracted to the mission of healing. Over time, however, the clinical mind dwells on other issues, partly because pure clinical work is not rewarded.

While it may be difficult to make an objective determination of clinical skills and their change over time, we need novel strategies to give credit for daily clinical work.

It may be even more difficult to evaluate the teaching skills of the oncologist. Medicine and oncology cannot move on till pupils are taught the theory and practice of a sound clinical approach so that they can carry forward the baton of clinical medicine and research. Since appreciation for this is hard to obtain, the contemporary physician will dedicate more energy and time to “profitable” areas.

In one way or the other, at some point in their careers, doctors need to take on administrative roles, even in the context of clinical pursuits. Their communication, ability to work as a team, and leadership skills also need to be tested and graded. Finally, there are other, more abstract-as well as straightforward-areas that need to be accounted for in the assessment. Punctuality, in work and in out-patient departments, and interaction with patients, hospital staff and nurses are some examples of these.

Finally, assessment of the modern-day physician should include other parameters such as the opinions of patients, peers, medical students and nursing and administrative staff of the hospital in a structured format. Such a score, which takes into account the opinion of all those with whom a physician interacts, would be a more robust indicator of a physician’s success and could be assessed on a yearly basis. This score could be demanded in the resumes of doctors.

It must be admitted, however, that it is easier to objectively quantify one’s scientific contribution, but far more difficult to quantify a subjective variable such as the definition of a “good physician”. The tools for the latter are more abstract and less defined, and suffer from ambiguity and biases.

To summarise, the leaps of science in medicine need to be lauded. However, the art and the skills of the physician need to be preserved, propagated, respected and, finally, incorporated in an assessment system. We propose making such a system for assessing clinicians and welcome provocative responses in this regard.

References

1. Chan AW, Hrobjartsson A, Haahr MT, Gotzsche PC, Altman DG. Empirical evidence for selective reporting of outcomes in randomized trials: Comparison of protocols to published articles. *JAMA* 2004 May 26; 291: 2457-65.
2. Chalmers I. Underreporting research is scientific misconduct. *JAMA* 1990 Mar 9; 263: 1405-8.