Letter to the Editor

Dear Editor,

We read with great interest the article ***"Physician's Burnout Rate at King Edward Medical University: A Cross Sectional Survey"*** by Aftab et al in your Oct-Dec 2016 issue. Doctors' burnout is an issue even in developed countries. And from what we have seen, read and experienced, there is no other solution to this vexing problem than better planning of and increased spending on healthcare. Most of the times, doctors and other health care providers end up spending more time than they would like to in the hospital simply because the work load is unplanned and irrational.

Work load rationalisation is the need of the hour.The number of patients that a doctor can see in a day needs to be capped e.g., a doctor on an average takes 10 minutes per patient for a detailed history and physical examination, then that doctor must be allowed to see only 6 patients in an hour. If the OPD is for 8 hours a day, then the doctor must be allowed to see only 48 patients, no more. This would be essential for maintaining the quality of treatment too. If the doctor is a surgeon, then there should be a cap on the maximum number of surgeries too, with this calculation being done with the type of surgeries and time taken for the different kinds of surgeries kept in mind. What this would mean is that hospitals would need to hire more doctors and nurses. This can be implemented only through legislation. The government must implement this first in government set ups, including all primary health centres, community health centres, district hospitals and teaching hospitals.

A culture of work load based manpower planning must become ingrained in all policy makers and hospital and health administrators. This will also require that the government upgrade its own healthcare infrastructure and then bring the private hospitals in line. This is of utmost importance because we strongly believe that patient care is being seriously compromised by overburdening of doctors. We need to generate literature on the quantum of morbidity and mortality ensuing from poor medical care and medical errors due to overworked doctors and nurses in south Asian countries like Pakistan and India. The obvious hurdles to a move like this will be a lack of trained doctors, lack of healthcare infrastructure and a lack of funding. But this is the only real solution to this problem. All other measures will be stop gap or cosmetic measures.

In India, we see that accreditation is nudging hospitals towards better practices. Concepts like patient safety are gaining traction because of the quality initiatives. The Indian government is also, in phases, making it mandatory now for its health centres and hospitals to comply with accreditation requirements with the National Accreditation Board for Hospitals and Healthcare providers (NABH) bringing out a set of standards especially for the government health set-ups.A process of continuous iterative manpower planning must be made one of the requirements for accreditation. This can be the first step. After some time, when a critical mass of policy makers and industry experts become familiar with this concept, it can be brought in through the legislative route.

It goes without saying that a step as resource intensive as this would be possible only with strong political and bureaucratic will. Political will is generated when people demand something. It is time that the people of Pakistan and India demand from their politicians that they be given a better deal in healthcare with quality time from their doctors resulting in unhurried clinical decision making and fewer medical errors from doctor fatigue.

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