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Coordinating Between Medical Professions’ Tasks to Optimize Sub-Saharan Health Systems: A Response to Recent Commentaries

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We are grateful that our perspective1 received commentary from leading experts on African human resources for health. All endorse and several quote our central suggestion that the “development in non-physician clinician” deployment should unfold in parallel with strategic rethinking of the role of physicians and with critical innovations in physicians’ education and in-service training.

Given the respondents’ expertise and number, this symposium can perhaps be seen as an informal consensus statement in support of greater coordination between different medical professions’ role definitions and training benchmarks. In sub-Saharan Africa, non-physician clinicians (NPCs) have existed for many years,2,4 and they and other non-traditional professionals are increasingly assuming the bulk of clinical tasks. Now is the time both to streamline their roles as providers of clinical services and to integrate them with the rest of the health system. That affects physicians as well. System-level coordination, necessary for physicians in primary care roles with other physicians,3 is a broader necessity—for everyone, in all roles, including for physicians vis-à-vis NPCs. Commentators also agree on sub-Saharan Africa’s pressing need for task delegation to NPCs and other associate health workers, for additional rural externships and rurally-focused curricula, and for higher budgets towards incentivizing physicians’ and NPCs’ rural deployment. The present response focuses on four potential areas of disagreement.

What is a Non-physician Clinician?

Some respondents4,5 criticize our definition of NPCs, originally by Mullan and Frehywot, according to which NPCs are “health workers who have fewer clinical skills than physicians but more than nurses.”6 On any definition by clinical skill, inter-individual skill variance may count as variance in professional—affiliation. To prevent that quirk, one might try to define the skill level as the mean level among practitioners in the relevant country. But that would make the definition country-relative, because mean skill levels vary between countries (eg, because the allowed scope of service by professional regulatory bodies varies). A problem with any definition in terms of skill level is that it compels us to pronounce on which profession has the highest overall “level”—although each has some unique skills. We concur, therefore, that a different definition, perhaps based on the different skill levels traditionally ascribed to each profession, or on their tasks and responsibilities instead of their skills, may be better.

Should Practitioners’ Independence and Scope of Work Be Fixed Individually, by Their Profession, or Otherwise?

Dovlo et al discuss the “delineation of tasks between physicians and NPCs… at the same service delivery point.”4 They recommend that “scopes and the relative independence of practice of both NPCs and physicians shall depend on the circumstances and experience of each cadre type. An NPC practicing in a remote inaccessible area that has significant experience… may need less oversight than newly qualified physicians….”4 At the other extreme, Gottlieb Monekosso re-affirms the World Health Organization (WHO) earlier definition of scopes as uniform across professions.2 Should tasks be delineated per individual practitioner and her individual skills, or per profession?

The attraction of individualized task delineation is nuance, as well as more equal opportunities, unbound by professional affiliation. But, there is something to be said for profession-wide standardization as well. Standardization facilitates coordination, harmonizes performance evaluation, and, by setting uniform expectations, may preempt personal offense and tension. Moreover, coupling standard training for NPCs with special fit for resource-poor settings may have helped limit NPCs’ attrition to the private sector and foreign countries. An intriguing intermediate measure is proposed by Sidat: adjusting the scope of work to the likely first job after school, for either physicians or NPCs. His intriguing proposal defines role definitions differently for areas where the first job is likely to be in primary care than for ones where the first job is likely to be at district hospitals.8

Finding the correct answer to these questions may require health system studies that compare different approaches empirically.9

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Should Managerial and/or Educational Roles Be Reserved to Physicians Only?

Some writers warn against assuming that physicians should occupy all managerial roles, or all educational ones. They suggest that NPCs or non-medical staff could also fill those roles.

Systems thinking about role definitions for different professions remains open to this thought. What we said applies only to those areas where, despite attempts to shift managerial and/or educational tasks, physicians and their longer training or professional aura have been shown to remain irreplaceable. A physician managing a small team may turn out on rigorous examination to bring authority and smooth coordination that other professionals could not. A physician may turn out to prove essential in specialist roles. But there may be individual exceptions. In Uganda for example, senior NPCs are also assigned managerial, educational, and supervisory roles in the lower tiers of the health system. Again, empirical studies could be a good way to move forward.

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