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Research Article

**STUDY TO KNOW THE CORE SKILLS, CURRENT
POLICIES AND KNOWLEDGE OF PUBLIC HEALTH
PHYSICIANS****Dr Robina Naheed¹, Dr Raima Asif², Dr Shariq Ali khan³**¹ Asst Prof. Community Medicine, Women Medical College, Abbottabad² Foundation University Medical College Islamabad³ M. Phil Public Health, Punjab University, Lahore**Abstract:**

Objective: The purpose of this analysis was to determine the assessment of public health physicians' knowledge of various areas of study and basic daily skills in general, and to encourage learning through an educational clinical supervision.

Study design: An Analytical Study.

Place and Duration: In the Institute of Public Health, Lahore for one year duration from February 2018 to January 2019.

Methods: A group of experts in different aspects of public health were requested to participate in multiple choice questions. With the help of a computer; the questionnaire was marked. The questionnaire was distributed to registered professors and registered experts for Continuing Professional Development (CPD), but participation was optional. The specialists marked their answers according to an evaluation program compared to the agreed model answers.

Results: 499 total public health doctors returned the response forms. There was no "passing grade" because it was a knowledge workout, not an exam. However, although the negative rating system meant that the possible rating range was between -100 and 100 percent, negative marking was not done. 44 out of 80 was the median of the uncorrected answers. Questions about critical evaluation and infectious diseases had the maximum scores. While the contributors believed that the most exciting questions were evidence-based medicine and epidemiology, they were the pilot programs of the most popular Personal Health Services. Most of the comments were positive for the approach, but many said that the whole workout was very general and expertise said there were irrelevant questions.

Conclusion: The general public health doctors who participated in this review seemed to be essentially capable in their basic skills knowledge and were able to keep up with the problems of existing health policies. However, the audit leads to controversy about what "basic" knowledge is necessary in the post-training period. This will receive further support due to the need to revise and determine existing CPD activities in public health medicine.

Key words: Clinical supervision, basic skills, continuous professional development.

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INTRODUCTION:

In 1998, the School of Public Health Continuing Medical Professional Development (CPD) Program introduced a new inventiveness for clinical comparative control through a survey questionnaire¹⁻³. The first training was aimed at public health doctors involved in the control of infectious diseases during the assignment and have series of scenarios for various infectious diseases⁴⁻⁵. The questions consisted of combination of free-text answers and multiple-choice. Although all participants appreciated the audit, this exercise response was not good and only 200 returned questionnaire⁶. However, it turned out that the marking was unsuitable for an individual, and it was decided that a MCQ questionnaire could be used that could be electronically marked if a similar application would be made in the future⁷.

This document describes the development and analysis of a second audit practice for all faculty members and specialist specialists registered with the CPD in 2017⁸. The purpose of the audit was to disseminate a general review by linking questions about basic public health competences developed by the Faculty, as assessed in communicable diseases. He was mainly trained and had a goal to assess the knowledge of his daily work fields⁹.

MATERIALS AND METHODS:

This analytical Study was held in the Institute of Public Health, Lahore for one year duration from February 2018 to January 2019. Several groups of experts in the relevant field were requested to submit questions about specific public health problems in MCQS format. In practice, everyone chose the right or wrong method with questions divided into 5 main segments. The questions concern infectious diseases, epidemiology, primary and policy issues,

as well as health care evaluation and critical evaluation. The aim of the wide range of products was to create a complete survey where all contributors could find some problems with their employment status and some could find general interests in lesser-known parts. 2 different questions of fundamental attention have similar answers. In a booklet form Questions were given and circulated to all affiliates listed with a cover letter, an evaluation form, special MCQ response form and complete directions. Expert registered members were also participated. If they are encouraged to learn more about the questions they find incomplete, participants can normally refer to work resources. For the exercise, no time limit was assigned but a deadline was set to send all answer pages back so that a single dial run can be configured. They assured the participants that the audit results will be added and that the answers will be kept confidential. Participants will receive sample responses, an anonymous performance and individual scores. The system performed performance analysis according to individual candidates, questions and thematic area. It was not possible to analyze the performance in relative to the participants' positions.

RESULTS:

A total of 1424 questionnaires were sent to CPD registered members and specialist registrars. 517 total answers (a 36 percent response rate), but 499 only of these questions contained the full questions and answer page were selected. The questionnaire was written by 3 respondents and for evaluation form sent to 15 respondents. 492 answers were marked and analysed by computers. One is manually marked. These include 98 expert registrars and 10 anonymous extraditions. This means a general rate of return of 35% with the participation of 40% of full members and 25% of participating registrants.

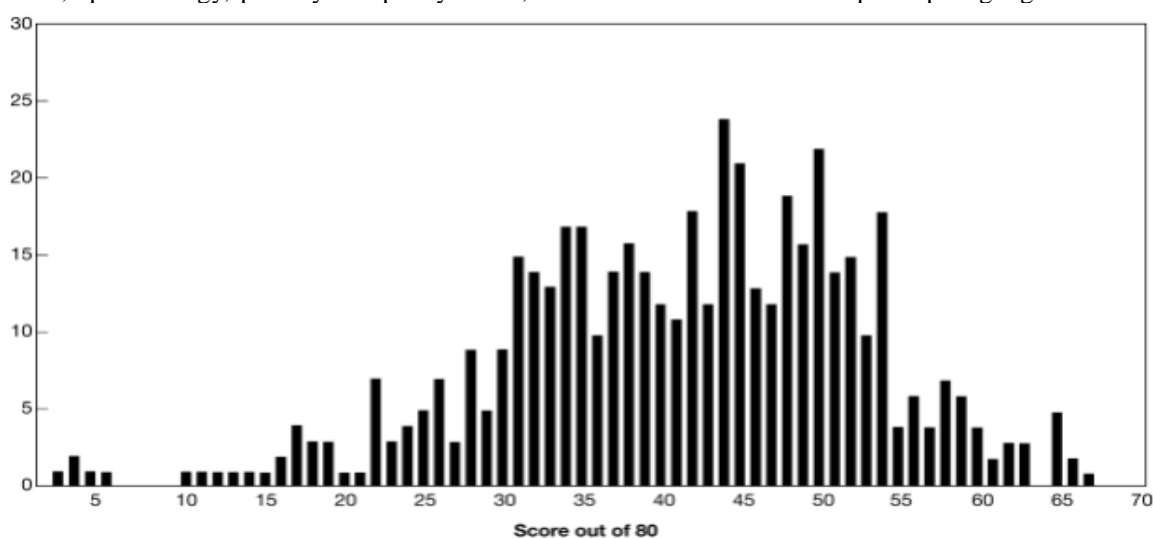


Figure 1 Frequency distribution of overall raw scores from comparative audit questionnaire (n = 491).

A large number of participants had difficulty in the response form. Ten answers were unidentified and one page was completely closed. Given negative scores, candidates were counselled not to mark their answers when not sure about the answers, and most of them followed this guidance and most did not answer twenty questions (range 0-69). To avoid a negative marking; the candidates were advised to mark the answers by lead pencils. Eight participants changed more than 20 responses in this way. Nobody received a negative rating. The corrected scores of the participants ranged from 2.6 to 84.05 percent with an average of 50.94 percent (SD 14.7). 80/44 was the median of the uncorrected result. The frequency distribution was given in Figure 1. The analysis of signs according to questions is shown in Table 1 and Table 2.

Table 1 Analysis of comparative audit results by question (*n* = 491)

Question number	Range	Number with negative score	Median score	Number scoring		
				median	Mean	SD
1	-3 to +5	24	+3	211	3.04	1.68
2	-4 to +5	65	+3	129	1.77	1.89
3	-3 to +5	18	+3	202	3.00	1.68
4	-2 to +5	1	+5	313	4.31	1.15
5	-3 to +5	15	+5	197	3.30	1.87
6	-5 to +5	93	0 and +1	106	1.08	1.87
7	-3 to +5	22	+3	112	1.89	1.69
8	-4 to +5	54	+3	134	1.65	1.74
9	-3 to +5	23	+3	97	2.58	1.80
10	-3 to +5	34	+3	141	1.93	1.67
11	-3 to +5	6	+5	366	4.33	1.38
12	-5 to +5	18	+5	186	3.28	1.82
13	-1 to +5	2	+3	183	3.36	1.34
14	-5 to +5	70	+1	121	1.58	1.80
15	-3 to +5	51	+3	94	1.90	1.89
16	-2 to +5	19	+3	140	2.28	1.47
Total					41.11	11.74

The mean scores for individual questions were 1.08 - 4.33 [mean 2.57, 95 percent confidence interval (CI) 1.13-4.01]. The most successful questions were the least successful in the 11th question of communicable diseases, critical evaluation and trust in primary care. The health assessment question, which provides data on the restructuring of A & E services, also received a surprisingly weak score.

Table 2 Analysis of results by question topic (*n* = 491)

Topic	Questions	Mean score per question
Epidemiology	1-3	2.60
Communicable disease	4	4.31
Primary care	5-7	2.09
National policies	8-10	2.05
Critical appraisal	11-13	3.66
Health service evaluation	14	1.58
Evidence-based medicine	15	1.90
Environmental health	16	2.28

469 total evaluation forms were given back. Many people appreciated the exercise, accepted it reasonable and demanding, and was ready to repeat it next year. The most motivating questions were evidence-based medicine and epidemiology. The minimum interesting and most popular question was the question of Personal Medical Services, which was considered very elegant and was not included in the work of most people. In fact, many people stated that the all workout is very general and that such questions are irrelevant. Questions about policies and primary care were involved because keeping public health doctors importance and to keep them

up-to-date and the numerous deviations made recently.

DISCUSSION:

If the participants had a real training period to investigate the questions raised, the audit practice had significant educational potential¹⁰. Doctors looking for CPD seem to favour various learning methods, such as peer education and group work. They were stimulated to learn in multidisciplinary teams to face the issues of modern medical care. Recently, there have been some entries on distance learning. Current developments in this area focus on

facts such as public health epidemiology and statistics. This strengthens the exam-oriented aspects and knowledge-based of the non-popular experience among larger members¹¹.

Providing wrong answers over and over again, the Faculty poses a challenge as follows. The audit was carried out on a budget at a given time using a project manager, volunteer researchers and computerized brands¹². Within the MCQ limits, it was appreciated and successful by most of the participants. In PAKISTAN, the leading agency for clinical supervision, made it clear that government should support its evolving agenda, and re-validation has made significant demands for the development of systems that show significant¹³. Although efficient, it is unlikely to re-recommend a centralized audit initiative that enables public health learning due to the response rate. There will be a significant reflection of what kind of initiative is desired in PAKISTAN or how much initiative should be taken in relation to the future CPD in the field of public health. Before continuing these approaches, the question is: what or should be a national, regional or local approach to a CPD initiative in PAKISTAN? Are regional or national differences in CPD significant? With the growing importance of clinical governance and the need for the next re-validation, the Faculty should address this problem in the near future¹⁴. The MCQ format simplified the marking and analysis process and was very profitable. It is not practical to have 500 laps individually marked¹⁵.

CONCLUSION:

The organizers felt it was appropriate to have departments on primary care and the latest policy issues. Unfortunately, even with the help of CPD coordinators, this was very difficult to accomplish because there were a wide range of policies and practices. For the participants, the two basic questions of the first step did not completely solve the problem and even made things worse. Apart from exercising separately, there is no easy solution to this problem, but funding must be tried to complete the audit.

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