

SPECIALIST TRAINING IN PAKISTAN: TIME TO STOP DEFENDING THE SYSTEM AND START FIXING IT

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This article may be cited as: Khan SJ. Specialist Training In Pakistan: Time To Stop Defending The System And Start Fixing It. J Med Sci 2026 July - September;34(3):63-65

Postgraduate medical education in Pakistan is not working as it should, and the evidence for that judgment comes from those inside it. Residents report programs that go unreviewed, research they cannot conduct, and hours for which they are not paid. A province and the national college are now openly at odds over who controls specialist training, months before an induction cycle. Abroad, our own fellows were placed in arrangements that paid them less than the doctors working beside them. None of this is rumor. All of it is documented in peer-reviewed studies, official notifications, and independent reporting, and every claim below is cited so it can be checked.

The College of Physicians and Surgeons of Pakistan built this system. Founded in 1962, it made the FCPS the qualification most Pakistani specialists hold, and it did so for decades with limited support and less money.¹ That history earns the College a serious hearing. It does not earn it an exemption from the evidence. The College describes itself as entering a phase of transformation, citing simulation-based assessment, artificial intelligence in evaluation, restructured workshops and research capacity-building. Each of these is worth having. None of them addresses what the trainees are actually reporting.

WHAT THE TRAINEES ACTUALLY REPORT

In the largest national survey of Pakistani residents to date, satisfaction with research provision stood at twenty-one per cent and with personal growth and development at twenty-four per cent. Eighty-seven per cent of respondents strongly denied being paid for extra working hours. Forty-one per cent strongly denied that any monitoring or evaluation of their residency program existed at all. Forty-seven per cent strongly denied that training programs were comparable across the country. Between twenty-nine and thirty-four per cent reported workplace harassment affecting themselves or a colleague, and fewer than a quarter of institutions had any disciplinary committee to deal with it.²

These are not the figures of a system needing marginal adjustments. A training program that two in five residents believe is not being evaluated is not accredited in any meaningful sense; it is merely registered. It is worth noting what trainees rated well: the role of their supervisors was the single most favorably assessed facet of their training. The consultants are doing their part. The failure lies above them, in the structures that fund, monitor, and certify.

A separate study of candidates who failed the FCPS exit examination found, to their credit, that most blamed themselves, citing preparation and effort. Half nevertheless described examiners as harsh or inattentive, and some described an examination they did not experience as uniformly fair.³ Perceptions of this kind attach to high-stakes clinical examinations everywhere and prove nothing on their own. That is precisely why they should be answered with data. Anybody confident in the reliability of its assessment would publish its examiner-variance and reliability statistics as a matter of routine. Publishing them would settle the question; declining to does not.

THE DISPUTE OVER WHO OWNS SPECIALIST TRAINING

This argument is no longer academic. By notification dated 9 July 2026, the Punjab Specialized Healthcare and Medical Education Department directed that, from the January 2027 induction, second-fellowship training, formerly Level-IV, under Central Induction shall be offered only against university MD and MS degree programs, with seats in public-sector teaching hospitals allocated equally between MD/MS-qualified and FCPS-qualified candidates.⁴ This followed an earlier revision of induction criteria already contested by graduates of public-sector institutions.⁵ The College has objected. In a video message, its President has set out the structure at issue: FCPS in a major specialty is a Level-III qualification, subspecialty training is the higher Level-IV tier, and a hospital accredited by the College to deliver that training gives a binding undertaking

to maintain the posts. On that basis the College argues the provincial instrument cannot stand against the existing accreditation framework.⁶

Both positions carry force. What has no defense is the manner of the dispute. Two public authorities are setting the architecture of specialist training through notification and rebuttal, in public, as an induction cycle approaches and candidates cannot say which qualification will admit them. The legal question belongs to the regulator and the courts. The failure of coordination belongs to everyone involved, and the cost of it falls entirely on doctors who had no part in creating it.

The underlying premise deserves scrutiny too. The claim that one qualification alone constitutes real specialist training does not survive comparison. In India, specialists qualify both through university MD and MS degrees and through the Diplomate of National Board awarded by the National Board of Examinations in Medical Sciences, with the national regulator determining equivalence.⁷ That equivalence is conditional rather than automatic: under the faculty regulations notified in 2025, a DNB from a hospital of five hundred or more beds counts as equivalent for academic appointment, while one from a smaller institution requires an additional year of senior residency. The lesson is not that standards were relaxed to permit plurality. It is that the regulator, rather than any single college, defines the benchmark and applies it to every route. Pakistan's insistence that only one qualification can be the genuine one is a local position, not an international standard, and the university MD and MS degrees it disputes are themselves structured, examination-based qualifications recognized by the regulator.⁸

CERTIFICATION WITHOUT RESPONSIBILITY

There is an asymmetry at the center of this system that is rarely stated plainly. A college that examines, certifies, and accredits derives both its authority and a continuing income from its fellows. It carries no corresponding duty toward their pay, hours, or job security. That arrangement is tenable while such a body confines itself to setting standards. It becomes considerably harder to justify when the same body also seeks to determine who may be trained and appointed.

The point was tested in the open in 2024, when the British Medical Journal reported that, under arrangements between CPSP and several English NHS trusts, senior Pakistani fellows at the registrar level and above were paid a stipend below the salaries of trust-employed doctors performing the same work, with no guaranteed payment for overtime or on-call hours. The College subsequently indicated it would review and revise the relevant guidelines, which was the correct response.⁹ It should not have required a British medical journal to establish that Pakistani

doctors abroad were being underpaid under a Pakistani institutional banner. At home, the College has supported statutory protection of trainee stipends.¹⁰ That support is welcome, and it is also a concession: posts accredited for training routinely fail to pay the people training in them.

POLITICS, AND THE VACUUM THAT PERCEPTION FILLS

The influence of politics on this sector is not an allegation; it is documented in published scholarship. Baig and colleagues describe informal guilds, groupings of senior professionals who hold positions across regulatory and accrediting bodies, whose shared interests, in the authors' words, are not necessarily educational, and whose decisions carry consequences for graduates and population health that are not thought through. The authors further note that because accreditation criteria are not in the public domain, the perception arises that such decisions are politically driven.¹¹ That observation identifies both the disease and its treatment. The remedy is unglamorous and entirely achievable: publish the accreditation criteria, publish the inspection findings, and publish the examination statistics. An institution that declines to open its processes should not be surprised when perception fills the space where evidence ought to be.

The external clock is running. Since 2024, graduates from countries whose accrediting bodies lack recognition from the World Federation for Medical Education have faced restrictions in international licensing pathways. A third of medical students in a recent survey intend to emigrate, citing pay and working conditions.¹² Doctors are voting with their feet on this system, and the verdict is not ambiguous.

WHAT SHOULD HAPPEN NOW?

Four things, none of them novel. The equivalence between FCPS and accredited university MD and MS degrees should be determined by the national regulator against published standards, not asserted by any institution on its own authority. Examination reliability and examiner-variance data should be published annually. Accreditation criteria and inspection findings should be placed in the public domain. And anyone who certifies doctors and collects fees from them should accept a defined obligation to their pay and conditions, or else confine itself strictly to standard-setting and relinquish its influence over appointments.

The College built something that mattered, and it remains the institution best positioned to lead this correction. But it is presiding over a system in which two in five trainees say no one evaluates their program, nearly nine in ten say they are not paid for the hours they work, and a province has begun legislating around it. Simulation laboratories and artificial intelligence will not address any of

that. The reforms that would be are duller, harder, and entirely within the College's power to begin. If it will not begin them, the provinces have already demonstrated that they intend to proceed regardless.

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