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THE DILEMMA OF A UNIVERSITY SURGEON IN TODAY'S NIGERIA

by Michael A. Banko

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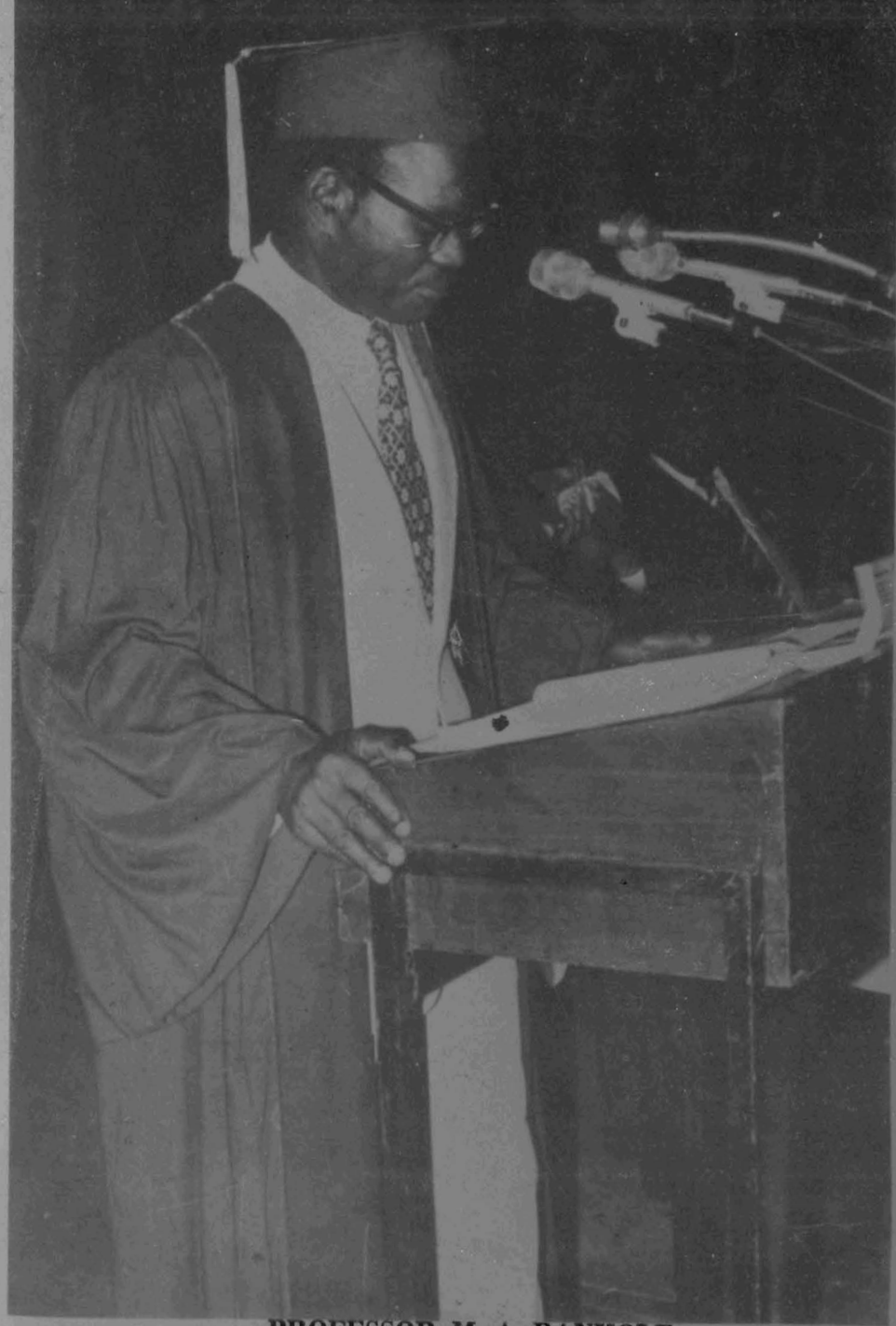

PROFESSOR M. A. BANKOLE

THE DILEMMA OF A UNIVERSITY SURGEON IN TODAY'S NIGERIA

by

MICHAEL A. BANKOLE,
M.B., B.S. (Hons.) *(Lon.)*, F.A.C.S., F.A.A.P.,
F.I.C.S., F.M.C.S. *(Nig.)*, F.W.A.C.S.
Professor of Surgery

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Mr. Vice-Chancellor, Dean, Faculty of Health Sciences, Officers of the University, Deans of Faculties, Learned Colleagues and fellow students all, I understand that traditionally, an inaugural lecture is one of the first responsibilities of a newly appointed University Professor. In it he exercises a privilege to formally address the University community on some scholarly topic that has occupied his mind and time, giving vent in the process to some of his conclusions to date, as well as some of his hopes and expectations for the future. It is traditionally understood that his appointment as a professor would afford him the opportunity and wherewithal to pursue the concepts enunciated and eventually realise his hopes.

In the circumstances of here and now, you must therefore understand that it is with a sense of uncertainty, if not utter confusion that I exercise this traditional privilege this evening, some ten years, almost to the day, after my appointment as Professor of Surgery to this University. I would like to think that some of the uncertainty derives from the maturity that the intervening years have imposed on me. As Kenneth Johnson says "Education is a process of man's going forward from cocksure ignorance to thoughtful uncertainty", and I would like to think that I have been educated over the years. However, I cannot deny the possibility that I may have merely been a hapless victim of my circumstances and environment. Hence the title of my lecture: "The dilemma of a University Surgeon in today's Nigeria".

I started out in Ife ten years ago with definite ideas of the place of surgery and a surgeon in a new concept of medical education and health-care service organisation. Today I am not so sure about those or any other ideas. A respected older colleague has expressed the opinion that the Ife philosophy was a collection of ideas born before their time into an environment devoid of the will and wherewithal to receive and nurture premature births even of ideas!! The concept of medical education that brought me here has reverted, albeit by concensus, to traditional form; and as for health-care service organisation, what we have now is a monstrous mutation of what was originally conceived. I shall say more on that later, but first, to ensure that we are communicating on the same wavelength, it is essential for me to briefly provide the interpretation which I intend to apply to some keywords in the title I have chosen. Since I believe that the absence of such initial agreement, or at least, concensus on basic ideas and definitions is responsible for some of the problems we are about to discuss.

First the word DILEMMA. The dictionary definition of the word dilemma is a situation in which one is faced with two alternative choices, neither of which is a satisfactory or desirable solution to the problem in hand. In this presentation, I will perchance include situations in which the difficulty is not so much one of being faced with competing alternatives but rather one of being presented with circumstances that make the obvious course of action impossible, leaving one with an inevitable, even if unsatisfactory alternative like watching a salvagable newborn baby die because the incubators are not working, or the last cyclinder of oxygen in the hospital has run dry, or because intravenous alimentation fluids are not available, or because he was referred too late.

Now the word SURGEON. There are of course many definiof a surgeon, some of them more humorous than illuminating, but in order to establish the widest possible scope for this

presentation, I shall adopt the definition that portrays the surgeon as a "a doctor, that is, a teacher or counsellor on health matters, who also possesses the competence to intervene by surgical operation in the process of maintaining or restoring health, or at least controlling disease". I hope you do note the true meaning of the word "doctor" as used in this definition - a teacher or counsellor. It essence rests on the belief that health is a matter of man behaving in a manner that enables him to live in optimal ecological balance with his physical, biological and emotional environment, while controlling that environment appropriately. The most important role of the doctor in the process is thus to teach and give advice on healthful behaviour, only intervening to restore optimal pattern when the teaching/learning process and manifest terminal behaviour run into difficulty.

In respect of the word UNIVERSITY, with the same objective in mind (that is, to broaden the cope of the presentation), I shall adopt a definition that defies confinement within a physical institution as preferred by the author of a book which I once read, *"Zen and the art of motor-cycle maintenance,"* a book that contains very little about Zen and less about motor-cycles, but this much about the University "The real University is a state of mind. It is a great heritage of rational thought that has been brought down to us through centuries and does not exist in any specific location .... The real University is nothing less than the continuing body of Reason itself."

My university surgeon therefore is a doctor anywhere who can also competently carry out a surgical intervention when necessary, and whose mind is committed to the great Heritage of Rational Thought; the commitment being such that he acknowledges the body of rational thought inherited from the past, accepts the responsibility to assimilate it unto his daily professional thought and activity, and in the pro-

.cess, replicate and alter it by adding to it, and finally pass it on to future generations in order to ensure its continuity. It is an inescapable fact that in order to effectively live up to this commitment, the university surgeon does seek a physical location, a setting in which conditions have been or can be made favourable for the attainment of his objective: that is, a physical University or University Hospital. It is nevertheless essential for us to retain a distinction between the enabling physical setting on the one hand, and the essence of the university on the other. For such a distinction makes it possible for the idea and the ideal of a university to survive no matter what shape or form the physical setting takes.

TODAY'S NIGERIA: For this audience, I do not need to define the Nigeria of today with its inherent contraditions: poverty in the midst of affluence, squalor hand in hand with immaculate pretensions, power without conscience and bureaucracy without a purpose!! However, a brief look at some aspects that bear on the peculiar problems of surgeon as defined is in order, that is, the nation's health and medical services. I have had cause to comment in detail on these services on the occasion of the passing out of the first set of doctors and graduate nurses from this University in 1978. I offer no apology for repeating myself as indicated because much of what I said then is still pertinent today.

The Unprofessional Health Professions

A profession is a body of persons who carry on their work in accordance with rules designed by themselves to enforce certain standards both for the better protection of its members (against unreasonable demands from the public) and for better service to the public (Delp, 1964). In essence, a profession assumes certain responsibilities for the compe-

tence of its members and the quality of the service they render. However, the individual and group activities of Nigerian health professionals – doctors, nurses and others, -- have largely been geared towards securing favourable conditions for themselves to continue in practice almost to the exclusion of any responsibility for ensuring the quality of their service. Those in private self-employment have cut corners on quality in order to maximise profit. Those in the public service have fought relentlessly for personal advancement and better conditions of service for themselves while allowing the quality of the service they render to slip away to nothingness, and blaming someone called "Government" for it. The gap between what we know and should do and what we actually do has continued to widen, not only among academic professionals who function near the frontiers of knowledge but also among beginners within the professions.

On the face of it there are many plausible excuses for this state of affairs: infrastructural facilities are lacking, patients are not health conscious enough to seek help early, government health budget has been consistently hopelessly inadequate, health administrators have formulated inappropriate policies without consulting health professionals, etc. etc. The excuses can be multiplied tenfold, but the honest truth is that as a group, we health professionals -- doctors nurses and the rest do not care about the quality of the health care we provide. There is not even a concensus among us as to what constitutes "quality". If we did care and could find such a concensus, I am convinced that we possess the collective strength not only to arrest the declining quality of our service, but also to build it up to heights that would be the pride of any nation. Instead we all succumbed to the pressures of the volume of work and allowed ourselves to be held down by hanging on to the traditional anchors of medical practice.

We maintain for instance:

(a) that only doctors can diagnose illness and prescribe treatment. Does anyone see an ostrich with its head in the sand here?

(b) that a doctor is answerable only to his conscience in respect of his professional decisions and conduct provided that these are within the bounds of the criminal code.

On our terms therefore, the patient's interests are only safeguarded by the criminal code, which unfortunately offers no protection against lack of human concern, lack of a reasonable level of knowledge, lack of patience and lack of the ability or the will to communicate effectively. Even when the law is clearly infringed we have good reasons to rally to the protection of the offending professional.

The rest of the world, particularly the Western world from whom we inherited them have begun to abandon these protectionist "articles of faith". America is coming to rely more and more on medics, physician's assistants, nurse practitioners, and emergency medical technicians to diagnose and treat many ailments as primary care givers. The concept of peer-review has gained considerable acceptance, even in conservative Britain, while Patient Care Audit Committees and their various ancestors and off-shoots have long been adopted as custodians of quality in American medicine where various voluntary accreditation schemes have replaced the doctrine of infallibility of the doctor.

But in Nigeria, what do we have? The Basic Health Service Scheme or Primary Care Scheme is tottering on the brink of collapse for lack of support. The use of middle-level manpower to diagnose and treat is frowned upon. Even nurses are denied the privilege of using the stethoscope. The Nigerian Medical Association has never been persuaded to take on assignments that would necessitate taking its own members to task. Its recent threats of industrial action in support of demands for improvement in health care facilities is a step in the right direction but it falls short of demanding creditable performance of its own members. Other professional associations have been content to remain largely theoretical and academic, limiting their activities to annual scientific conferences, the highest merit of which lies in the fact that they offer opportunities for social contact among academics and professionals. Even the statutory licensing bodies -- the Nigeria Medical Council and the Joint Nursing and Midwifery Council have avoided the responsibility for setting and monitoring standards of professional practice.

Apart from dealing with criminal offences by temporary or permanent withdrawal of the license to practise, the Nigeria Medical Council concerns itself mostly with the inspection and recognition of health institutions for undergraduate and pre-registration education of doctors and dentists. It also does a pretty inaccurate job of maintaining a register of medical and dental practitioners. When pressed on the issue of quality care, the Nigeria Medical Council shifts the responsibility to the Ministries of Health and Social Welfare. These ministries do register private health care facilities largely for statistical and taxation purposes, but do not appear to have any intention of nor organisation for setting standards or monitoring the quality of health care in these registered premises, let alone in the government-owned facilities.

In the circumstances of such a void across the board, one would have hoped that the academic leaders of the health professionals would naturally remain our bastion of hope. Unfortunately the current situation does not justify that hope:

(a) In the absence of a clinical peer-review system, the academic professionals are assessed by the university peer-

review system (The "publish or perish" system) with its emphasis on publications rather than clinical excellence, hence many medical academics now choose a dedication to their desks and/or laboratories rather than their patients' bedside.

(b) The emergence of trade unionism among the professionals has increased the right of the professionals to free time and more pat at the expense of the patients right to dedicated care. Gone are the days when doctors, nurses and technologists worked round the clock providing health care as and when needed, not as dictated by the union.

(c) The emergence of a powerful group of Teaching Hospital administrators who see themselves more as authority figures to be reckoned with and function more as constraints rather than as facilitators, has helped to increased the frustration of professional staff.

(d) The whole situation has more recently been compounded by the systematic cutback in funding and the simultaneous multiplication of medical colleges all drawing on the severely limited manpower pool.

In the face of all these, it is simply impossible for the medical colleges to develop into real centres of excellence in respect of the quality of health care they provide. I have a very strong suspicion that improved funding alone will not change that situation, rather it may lead to wastage since the trouble is with the whole system and the current concept of managing it.

Another issue covered in the previous address is that of the government's responsibility for health service; or shall we say the government's lack of responsibility for health care. The governments of this nation run health services, but not one of them has ever accepted its responsibility for the health of the people. Hence the health service has remained an end in itself.

In the beginning the Nigerian health service was a privilege of the British Army resident in Nigeria. Later, the privilege was extended to the Civil Service. More recently the health service has become a commodity, a gift to barter for political patronage. Since it is accepted that you do not look a gift horse in the mouth, such a policy orientation guarantees that no questions are asked as to the efficiency or even the usefulness of the service so provided. At the management level, a policy orientation that sees the provision of health care institutions as an end in itself creates a health management hierarchy entirely for the maintenance of these institutions. In these circumstances, health management activities are limited to: (i) staff welfare and discipline to prevent trade union and other types of staff agitation. (ii) the maintenance of an impeccable balance sheet in the name of public accountability. Since no functional objectives are known or set, no questions to effectiveness, efficiency or even relevance are asked of management or by management itself of its employees. Public expectations are easily satisfied once everyone can point to the institution, a reward for their political activities and the leaders of thought as well as top mamangement persons can receive preferential treatment and also obtain jobs and contracts for their relations and protégés.

It is interesting to reflect that even though the Nigerian Medical Association made the case in the sixties for the establisment of the Health Management Board system, with a view to : (i) bringing the management decision-making machinery nearer to the health care institutions in the field, and (ii) getting the health professionals (especially doctors) more involved with the decision-making process, all that have in fact happened are that:-

a. The bureaucratic organisation has been enlarged.

Major management decisions involving data manipulation, planning and execution in fact now take longer with the "bamboo curtain" separation between the Ministry of Health and the Health Management Board in many States -- Ondo State for one, on the Board of which I once served

b. An enlarging, powerful hierarchy of administrators has emerged displacing the professionals further away from the management decision-making process, with resulting increased inefficiency. As for effectiveness, it was never in view anyway.

In recent years, as a result of government's newly acquired consciousness of the nation's total population, there has developed an exaggerated obsession with the numbers game in an attempt to spread the health care institutions not health care, over the population. This has created a never-ending call for more and more hospitals, more doctors, more nurses, and more medical schools. In the process, thoughts about quality, effectiveness, or even appropriateness have become eclipsed even further. The proposed pilot project of Basic Health Units designed to test out the feasibility and effectiveness of the Basic Health Services Scheme fell through in most states under the spell of the numbers game. In that project, a Basic Health Unit comprised of 4 Primary Health Centres, each receiving referrals from 5 Health Clinics, each of which provided direct Primary (Basic) Health Care to a population of 10,000. In turn, the 4 Primary Health Centres referred their problems to the Comprehensive Health Centres referred their problems the coordinating nerve-centre for the Unit. Beside their coordinating and referral functions, each of the Primary Health Centres and the Comprehensive Health Centre was also to provide direct Basic (primary) care to its own target population of 10,000. That way, a Basic Health Unit was expected to provide comprehensive basic primary care to a

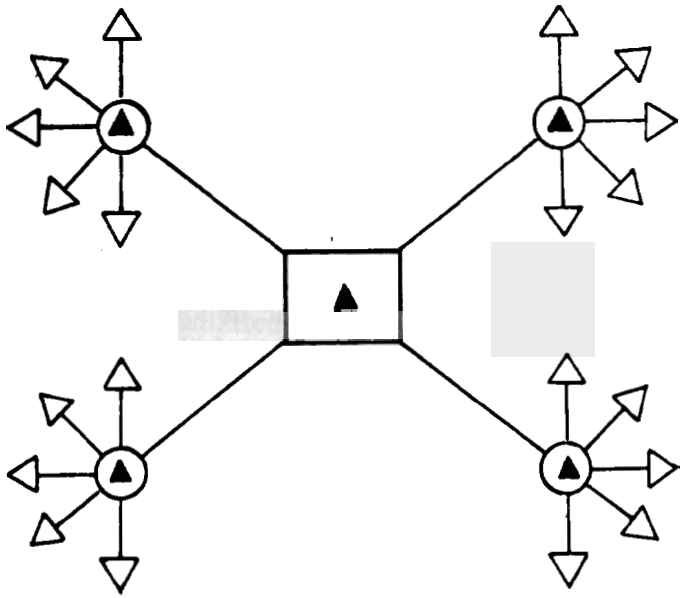
population of 250,000 in contiguous location. (Fig. 1). In practice, most states lost sight of the functional relationship of the 25 component institutions making up the Basic Health Unit of the Pilot Project and simply scattered them throughout the state in response to political considerations. Little wonder that any evaluation of the functional effectiveness of the Pilot Project was impossible. And so the Basic Health Service Scheme was abandoned.

Currently, free health service is the name of the game, a game that makes nonsense of any consideration of functional effectiveness. In a country that imports all medical equipment as well as most drugs and supplies, the development and equipment of hospitals to provide acceptable standards of effective care at no direct cost to, but within easy access to, all users is an economic impossibility even for a wealthy country with an efficient administration. In any case such a network of well equipped hopsital facilities would end up being underutilised, because only a small proportion of any given population would need the services of a sophisticated hospital over any given period of time! The free National Health Service of the United Kingdom is based on a foundation of primary care given by General Practitioners. The Nigerian situation can be compared with a builder who builds the walls and the roof of a house without giving a thought to the foundation.

The Surgeon's Dilemm

The preceding description of the Nigerian Health Service scene must be all too familiar. In the last few weeks, the national news media have been particularly active in focusing attention on the inadequacies of equipment, drugs and supplies as highlighted by threats of industrial action by groups of doctors here and there. The stage is set for some "quick solution" based on the usual crisis management tac-

A BASIC HEALTH UNIT
A model for regional development



KEY

- □ – Comprehensive Health Centre.
- ○ – Primary Health Centre.
- △ – Health Clinic providing primary care for a target population of 10,000 people.
- ▲ – Represents the 10,000 target population receiving primary care from the Health Centre(primary or comprehensive)

tics which is fast becoming the hallmark of public service administration in Nigeria. I suspect that apart from a little bulk money being made available, we are likely to be treated to the creation of some new organisation for the importation and distribution of drugs and hospital supplies, a new bureaucracy, theoretically plausible but in effect achieving little beside providing job opportunities and avenue of political patronage- another N.N.S.C.

Be that as it may, I wish to examine with you this evening the viewpoints of a University Surgeon in respect of some of these problems. As indicated by my title I do not believe that I have solutions, but I have given the issues some thought in nearly 15 years of trying to practice and teach Paediatric Surgery in Nigeria.

MEDICAL EDUCATION

Perhaps the first issue which I should examine is that of medical educator. For one thing I have been more of a medical educator than a practising surgeon in the last 10 years. In any case, I believe that the long term solution to the problems we now face lie in a reorientation of the policy and programme of both undergraduate and post-graduate medical education in this country.

The Teaching/Learning Environment

First of all, inspite of what may well be seen as the failure exemplified by Ife, I believe that the idea of a functionally-isolated special hospital institution designed only for teaching and insulated from the abounding mediocrity it as well as the routine problems of health care delivery in the country is not in the best interest of either the medical school or the country. For one thing, such an insulation is never complete as long as major policies and funding for all health institutions emanate from the same general source.

Such a policy orientation merely leads to, and undeservedly justifies, an attitude of indifference on the part of management to the plight of patients. It also removes a vast area of the very real problems of health care delivery from the consciousness of the medical school staff and students. Thus impoverished, the medical school staff are unable to give meaningful advice or leadership in the nation's effort to plan and implement an effective health care programme, and students when they graduate are unable to function effectively in the health service of the nation even when they are willing.

The efforts of this University to redress this situation sadly misfired because the basic issues were misunderstood from the onset. The government saw Ife's proposal as a way to have their cake and eat it: have a medical school without a teaching hospital. Even the foundation faculty were not clear in their minds as to the immense functional significance and far reaching implications of the task they very lightly undertook. So what we had did not include even the limited advantages of the old system, neither did it attain the challenging objectives of the new!! In short, we got the dregs of both worlds, being neither with one nor with the other. The fundamental issues are:

a. that medical education in Africa, certainly in Nigeria, cannot be considered in dignified isolation as in the developed Western world, nor can medical schools be regarded as mere manpower factories and minor research institutes. Rather, medical education must be planned and executed in the context of the day to day health problems and the logistics of effective health care delivery for the nation.

b. Nigerian medical school curriculum must therefore centre, not on some indefinable international standard of acceptability, but on the acquisition of requisite

knowledge, skill and attitude sufficient to enable the graduate to function effectively in the national scheme of things. To this effect, each medical school must have total health care delivery responsibility for a defined population of urban and rural settlements, making up its immediate catchment area.

Health care responsibility, be it of government or of a medical school, must be seen not merely as responsibility for the management of a number of health care institutions, but as responsibility for the health of a population. Management objectives then would be defined, not in terms of the expansion of physical facilities or increase in staff establishment, but in terms of measurable changes in the health parameters of the target population.

For instance, we should propose, not that by the end of the 1980-85 quinquennium, the Faculty of Health Sciences shall have become a College with so much increase in staff so many buildings and so much increase in student population, but that over that period, the infant mortality rate in this area shall have dropped by, for instance, 1%; maternal mortality rate by 2%; incidence of post operative surgical complications down by 2%; and the incidence of early diagnosis of cancer of the breast increased by 0.5%. The diverse enabling objectives which would make these targets possible then become the subject of intensive consultation and planning among numerous departments, professionals and professions. The success or failure of the resulting activities would be easy to measure!!! Then the concept of team work in the arena of health care delivery becomes practicalised in our thoughts and our actions, rather than remain as cliches to be bandied around at Faculty Board and Senate meetings by erudite-sounding dons who do not, and may be cannot, even apply the concept in their day to day work.

The various "units" of functional interaction among the various professional groups working towards these objectives then form the basis of practical learning experiences for the various professional students. This is the only rational interpretation of my faculty's proposal to "train different profesional cadres together in a setting conducive to their acquiring the habit of working together"--merely making them sit side by side in class for a fraction of their didactic lectures and practicals does not achieve this objective.

THE MEDICAL CURRICULUM

When we consider the wide vistas of medical science and practice generated by the knowledge explosion of the last 3 decades it becomes clear that no undergraduate educational programme can hope to cover everything possible and still remain of reasonable duration. In any case, the political pressure is for a shortening of the duration of formal education. It is obvious therefore that a deliberate choice must be made by medical educators as to what is included and what is excluded. I submit that as university people, committed to the ideals of the real university, the only rational way for us to make that choice is to analyse the tasks which our graduate doctors perform in the course of making effective contribution to the nations' health care objectives, and then design a curriculum that prepares him for these tasks. I suspect that such a curriculum would contain more of basic and applied social sciences--sociology, demography and social statistics, management, communication skills, educational methods and psychology--than our current curriculum. Such a curriculum stands a greater chance of producing more of "doctors" i.e. "teachers and counsellors" than the "medical technocrats" that we currently produce as a result of the Western curricula we have imported and modified to a greater or lesser extent in the name of international acceptability.

Curriculum Administration

Whereas, as stated above, the content of the medical curriculum needs to be tailored to the medical geography of the nation, the administration of the curriculum needs must take cognizance of the universal body of knowledge in educational pedagogy. In this respect, it is my considered opinion that our Faculties of Education have been shirking their responsibility for teaching university teachers how to teach. Furthermore, it is accepted that heath care is a collaboration of different people: professionals and non-professionals, leaders and followers, in such a way as to identify and solve problems that relate to man's ability to live in harmony with his biological, and physical environment. For leaders of such team effort to be effective, their education and training must be based on problem-solving team work. The integrated, problem-oriented curriculum is to be preferred to the traditional teacher-subject oriented curriculum. In any case educational psychologists tell us that in general, student learning is facilitated when the material to be learnt is presented and perceived in the context of problems associated with the expected functions of the graduate. Even though many of us recognise this and talk and write about it, I suspect that our inability to make a practical show of our conviction is due to the fact that our own education and training had been based on the Osler-Flexner tradition of individual excellence rooted in a deep understanding of each of the basic medical sciences. Such a tradition was well suited to the Western world of the first half of this century where the medical problems had been "purified" by non-medical developments in social and environmental organisation during the 19th century. The peculiar medical geography of Africa (certainly Nigeria) today poses a different set of problems, and requires a different set of approaches, calling for a different orientation in training of the leaders of the task force. The challenge of African, cer-

tainly Nigerian medical educators today is to rise above the limitation of our own training and give the world Nigeria's, and Africa's brand of medical education as predicted by Monekosso in his Convocation Lecture to this community in 1977.

Health Care Delivery

It is obvious from the on-going public outcry that Nigeria does not yet have an effective health care delivery system. It is also obvious that a policy of trial and error, experiments at political level on various imported models is expensive and soul destroying, to wit, the National Basic Health Services Scheme that failed. The answer is for the medical school to be given and to accept the challenge to design and test out various models of health care delivery systems in realistic fashion, using various sections of their own target population. And I don't mean more of Igboora, Malumfashi and Imesi-Ile examples where university lecturers attempt to provide necessarily expensive primary care, but comprehensive programmes including middle and low level manpower training, demographic survey, data collection and evaluation. With some degree of cooperation among 13 medical schools, some 3 or 4 models can be designed and tested simultaneously. And what a wealth of information would be available to the nation's health planners by such a scheme!! The adoption of any one system on a national or even regional scale would be on the basis of locally collected data and also of considerable pre-implementation experience and expertise--that would be a far cry from the void of both data and experience that characterised the launching of the Basic Health Service Scheme during the 3rd National Development Plan. Even those inevitable groups of medical schools who find their own scheme unworkable shall in the process have acquired considerable data as well as experience in planning, implementation and evaluation of a health care delivery system. In the event of such a development, discussions at national task forces and planning workshops would no longer be dominated by foreign experts nor by opinionated local demagogues full of stuff lifted from textbooks written for other environments than our own.

Though there are many questions for which we do not have answers. and for which the approach outlined above need to operate for many years before definite answers begin to emerge, yet a few facts have emerged from the gropings of the last three decades which we can no longer afford to ignore except at our own national peril:

1. Hospitals are not ideal settings for the primary health care of our population, be they rural, or urban. Hospitals are too expensive to be provided in large enough numbers, and too alienating in design to encourage regular spontaneous utilization by majority of our people. Therefore the recent trend towards the development of 60 bed district general hospitals all over the place is a step in the wrong direction. Cheaper and more accesible health centres and health clinics would be more ideal, provided they are appopriately and adequately equipped as well as staffed.
2. At the end of 6 or 7 years of the current medical curriculum (including internship) in the Nigerian Medical Schools, the average doctor is already over-trained in many respects for the level of function possible in the many district Hospitals and Heath Centres that abound, and in which they are currently required to serve at least during the Youth Sercice Corps assignment. Many are therefore underutilised and frustrated during this year and can't wait to get out; thus defeating one of the objectives of the assignment i.e. a hope that many, after the assignment would elect a career in community health care delivery.

Yet there are many aspects of community health care

that could be stimulating and challenging to these young doctors or any doctor for that matter, but the current medical curriculum in the Nigerian Medical Schools (including Ife in spite of its promise) does not prepare these doctors to even recognise these aspects let alone respond to the challenges they represent in terms of community mobilisation, health care planning, implementation, management and evaluation at the grassroots. Many who possess the innate ability to recognise and respond to such challenges are frequently handicapped by existing bureaucracy.

Nigeria cannot afford primary care institutions routinely manned by university professors and lecturers, not even newly qualified doctors, except in as much as these people are expected to train and supervise the middle-level professional and sub-professional manpower required for these services.

At the other end of the spectrum, it is equally wasteful of scarce human resources and the time and money expended on their training to expect highly trained medical personnel--surgical, medical specialists--to languish away in ill-equipped and inadequately staffed institutions unable to function at a more than half their acquired capability.

Therefore there is no denying the need for a hierarchical organisation of a network of health institutions designed, equipped and staffed to increasing degrees of complexity and sophistication according to the level of health care function each is required to provide for a given regional population of both rural and urban settlements. The following hierarchy has been suggested.

A. For primary care:
   - Health Clinics/Dispensaries
   - Health Centres/Maternity Centres
   - Comprehensive Health Centres/Health Offices (Urban and Rural).

B. For Secondary care:
   - District Hospitals
   - General Hospitals
   - State Hospitals.

C. Tertiary care:
   - Specialist Hospitals -
     - Orthopaedic
     - Children's
     - Psychiatric
   - Federal Medical Centres.
   - University Teaching Hospitals

About this much there need be little argument. What remains uncertain is the pattern of distribution, the mix of the various cadres in the hierarchy and the functional relation of one to the other and the mode of national or state coordination in order to make them work towards the achievement of the national objectives. These are the aspects that experimentation at the level of the medical schools as suggested above would help to unravel. The concept of hierarchical organisation for regional or zonal planning and development has been accepted in Administration and Political Science. It has been applied in respect certain aspects of health care delivery in the Western world, to wit: cardiac surgery, neonatal care, neuro-surgery, organ transplant, to mention but a few. With our large population, and limited resources, such a concept of regional development would have been tailor-made for us. But somehow the Basic Health Service Scheme conceived that way foundered. The Ife University Teaching Hospitals Complex

was also conceived as such a hierarchical organisation of institutions, a model for zonal or regional health care delivery. It too has failed. It remains to see whether other medical schools would be allowed, even if they would volunteer, to choose the model in spite of Ife's failure.

The Specific Case of the Care of Infants and Neomates:-

This is as close s I intend to get to my own particular area of interest in this presentation, since facilities for effective neonatal care, medical or surgical,are virtually non-existent in our Teaching Hospitals Complex. The situation is only slightly better in the older medical schools and infinitely worse in the non-teaching hospitals throughout the country. Yet it is an adage, old and true that "the hand that rocks the cradle rules the world", which translated, means that *the wealth and welfare of a nation tomorrow depends on the care of its infants and neonates today*. The unacceptably high perinatal and infant mortality in most parts of the country is sadly obvious enough. What is not so obvious but of equal concern is the fact that thousands survive with avoidable sublethal brain damage due to inadequate care and poor nutrition during this period of life when the brain cells are developing most rapidly and hence are maximally susceptible to injurious effects of deficiencies of oxygen and various nutrients.

Clinically obvious brain damage syndromes are a challenge enough, considering our limited resources; but no one will ever know to what extent preventible sub-clinical brain damage due to such causes contributes to the all pervading incidence of immaturity and illogical thinking within our national body politic; even in university communities.

With our young population, demographically speaking, it would cost the earth to provide hospital facilities sufficiently well staffed and well-equipped to cater to the needs of the sector of women and children at risk. Fortunately David

Morley, working in Imesi-Ile and the Wesley Guild Hospital two decades ago, showed that with minimal facilities, the simple expedience of health education and a lot of "caring", considerable improvement in the health status of women and children, a reduction in the risks attending child birth and child-rearing and a drop in prenatal and neonatal morbidity and mortality can be achieved. The irony of course is that David Morley obtained an M.D. of London, a chair of Tropical Paediatrics in the London Institute of Child Health, and world fame from his various reports of this work. Countries as far away as Tanzania and Zambia have since adopted his methods and appear to be obtaining results, but no, not Nigeria!! Twenty years after Morley, Ife University Faculty of Health Sciences and Teaching Hospitals Complex inherited the facilities which he used. We insisted on using university professors and doctors to do what nurses and midwives in training did for Morley. The results have been predictably negative.

The Federal government proposes to provide 5 Specialist Children's Hospitals in different parts of the country. This is indeed a welcome proposal, after so many years of national neglect of the health needs of our large population of children. However, considering our very large population, and against the background of David Morley's work, one cannot help feeling that the cart has gone before the horse. No one denies the need for a few centres of excellence in paediatric care (People like me can only function optimally in such a setting). However with due regard to the great heritage of national thought to which we, as University men and women, are all committed, it would seem such a development should be preceded by or at least clearly accompanied by the development of a network of simple, Morley-type Maternal Child Health Care clinics throughout the country integrated with the Basic Health Service Scheme or primary care, and grouped in regional/zonal pattern with the children's depart-

ments of general or state hospitals providing secondary care for infants and children. The logical development of tertiary care in specialist children's hospitals would become obvious from such a setting and their physical location would be dictated not by political expediency, but by the pattern of needs identified from the records of the clinics and hospitals. It would however fall in line with the concept o regional development to which we alluded above.

In conclusion therefore, I submit that there is a great deal for which the medical profession in Nigeria, and especially the medical academics can justly be proud of in the heritage of the Osler-Flexner tradition - - a tradition of excellence in the one to one practice of medicine, rooted in a sound knowledge of Human Biology and Pathology, aided in an inestimable way by the more recent development in medical science and technology. There is a justifiable tendency for us therefore to continue in this great tradition. I submit further however that given our nation's vast and varied population and patently limited resources, there appears to be an inherent immorality in the pursuit of the Osler-Flexner tradition of clinical excellence, and we do so at the risk of its becoming for us a mirage; for ever in sight but never within reach.

It is with a strong conviction, born out of participating in the medical arena of this country over the past 15 years, seeing more doctors trained, more Ph.D. produced, more lecturers and professors made, and yet sadly seeing the standard of health professional practice decline and the health status of the country make no appreciable progress. It is with a strong conviction born out of this experience that I submit that the task before the medical profession in this nation today is how to bring the results of our professional expertise to bear on the health of our nation by improving not only the quality, but especially the relevance of our professional service. We have access to a

large enough body of knowledge and skill, what we must seek is *how* to use these to effectively improve the health status of our people. It is perhaps here more than anywhere else that we have a chance of contributing to the body of universal knowledge in the art and science of medicine. The phenomenon of a vast, varied and ever increasing population needing health care in the face of limited and potentially diminishing resources poses a challenge too important and too all-pervasive to be left to politicians, certainly not to health administrators, nor to those of our number in the outdated practice of Public Health even when they misname it Community Health. It calls for a total mobilisation, in fact of the entire population, certainly of the entire medical profession. And who else must lead this mobilisation but the large clusters of us in University Medical Schools.

The battle-line is drawn in the interface of medicine and the social sciences: in psychology, medical sociology, medical demography and medical economics; no longer in pathology and human biology, not even in medicine and surgery *per se*. The soldiers with a chance of victory are not those, in the words of Monekosso:

> "with simple minds equipped with electron microscopes and scintilating countries but those with electronic minds equipped with simple microscopes and paper and pencil."

No doubt, a few skirmishes remain, and the fight must continue in the area of clinical excellence backed by laboratory research, but I am convinced that for us in Nigeria, the victories in these areas can only become significant and relevant when the larger issue of basic health care delivery to the population has been fought and won. Then the possibility of early diagnosis and prompt treatment of most ailments including cancer, congenital malformation, even infection, and the

existence of facilities and organisation for post-hospital follow-up and rehabilitation would combine to make the pursuit of clinical excellence in tertiary hospitals a satisfying and worthwhile life endeavour, not a dilemma, for those of us who have, and will continue to choose careers in that trip of the ice-berg known as clinical medicine, surgery or, we may add, neonatal paediatric surgery.

I thank you Mr. Vice-Chancellor.

May God help us.

Reference

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