SURGICAL TRAINING IN NIGERIA – THE NEED FOR PUBLIC/PRIVATE PARTNERSHIP

by

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Mr President, my teachers here present, members of the executive and the local organizing committee, distinguished colleagues. Let me start by expressing my sincere gratitude to the Nigeria section of the International College of Surgeons for another opportunity to come to this citadel of knowledge, pragmatism and hope for the art and science of surgery in our nation.

The last time I performed a function like this on this campus was on 26th May 2005 when I delivered the lecture, SURGICAL TRAINING IN NIGERIA - A REAPPRAISAL, at the clinical conference in the Department of Surgery of the College of Health Sciences. Today, I have come to highlight the need for public/private partnership in sustaining the standard of the surgical profession and extending the availability of modern surgery to the majority of our compatriots who live in rural settings.

I bring you the compliments of the Eleruwa of Eruwa and the community of Eruwa where I have been practicing for almost 30 years.

This university could boast of the first successful separation of Siamese twins and the first all-Nigerian renal transplantation team in Nigeria.[1] These pioneering surgeons were trained in Nigeria. The chief medical director of this teaching hospital, Prof 'Sanya Adejuyigbe, the paediatric surgeon, and I were classmates at the University of Ibadan from 1970 to 1975. I wanted to train as a paediatric surgeon but, when I realized the non-surgical demands could not be met in the rural setting I had set my eyes on, I opted for **surgery in general**.

In August last year, he and other faculty members considered it fit that my younger son, Ayodele, should be called our colleague. For this, I am very grateful to them all. In 2007, his elder brother, Oluyombo, graduated from this university in the department of electrical and electronics engineering . (Figure 1)

Fig 1
AYO AND YOMBO 2012

Permit me to break protocol by making this aspect of the conference an interactive session. By so doing, we should be able to provide some pragmatic solutions to the challenges bedeviling our nation in the health sector and work out ways the private sector could be co-opted into the training of our junior colleagues who will eventually take over from us. This is in accordance with the Yoruba proverb, (apologies to senior citizens here present) that literally says: "when the fire dies out, it is covered with ash, while, though the banana is forever fertile, it leaves many offspring when its lifespan is spent".

My spring board for setting the pace is the revelation of Prof S K Gyoh, a foremost academic surgeon, medical educationist, researcher and administrator who was the penultimate chairman of the Medical and Dental Council of Nigeria, MDCN. The last chairman was no other than the inimitable Prof R O A Makanjuola, also of this university.

At the first conference of the Association of Rural Surgical Practitioners of Nigeria, ARSPON, that took place at Layo Model Hospital, Ikire, 30km from here, Prof Gyoh, the first president of the Association, said:

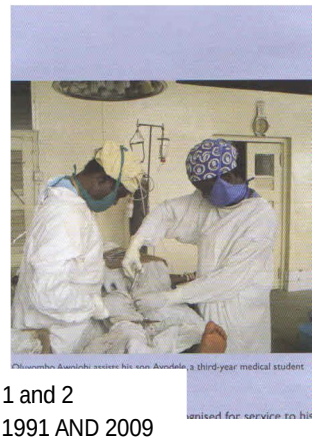
"The surgeon is the most frequently sued specialist in the health profession. Records at the Medical and Dental Practitioners' Disciplinary Tribunal show that over 95% of the cases were for operations that went wrong, though many of the procedures were not necessarily performed by doctors with formal surgical qualifications. The outcomes of operations are more manifest and less arguable than those in internal medicine."[2]

In other words, as soon as we solve the surgical challenges of our junior colleagues, 80 per cent of the health problems of Nigerians would have been resolved. This we have achieved in rural Ibarapa district of Oyo State where I have been practicing since August 1983.[3 - 6] Table 1 This district has the best health care delivery system in the country as there are two rural surgeons, twenty generalist medical officers, several capable of offering primary care surgery including extraction of cataracts, one radiographer, Mrs Tinu Awojobi, two pharmacists, many nurses, midwives, community health extension workers and a few laboratory technicians resident in the district. Of course, the private institutions perform much better than the public hospitals.

The questions I wish to pose for this interactive session are:

1. Why should most medical students graduate without assisting at surgery or taking normal deliveries? That is why they are called 'baby doctors' by their patients and professionals allied to medicine want to head the health team.

2. Why would the senior colleagues not mentor and train junior colleagues so much so that SURGICAL TURF PROTECTION has been entrenched?[7] Yet, eminent Nigerian surgeons (Emeritus Prof A Adeloye and Dr Hannah Faal) would train non-doctors to perform surgery effectively outside Nigeria.[8,9] That was what I did to my son, Ayodele.[10] Sanya and I were trained like that at the University College Hospital, UCH, Ibadan. However, Ayo and I went further because he showed that extra ability I did not have in keeping with the wish of the Yoruba who prays that his offspring would be greater than him. (figures 2 and 3)



Figs 1 and 2
AYODELE IN 1991 AND 2009

Fig 3
ILE-IFE TEAM AT ISOTUN
MAY 2013

One of his teachers, seeing how he held the stitch scissors while assisting him, informed me his colleagues called him 'congenital doctor'. This teacher noted that some surgical residents were not that good at holding instruments.

Some years ago, this teaching hospital sent three surgical registrars to Awojobi Clinic Eruwa, ACE on two monthly rotations. When I made the seemingly innocuous statement "once a stricture always a stricture", the first of them countered and informed me that Dr Ayodele Salako, a urologist, in this hospital did not believe that. To cut the story short, I made a trip to see Ayo in Ile-Ife. On a return visit to Eruwa with his senior registrar, I was taught Quartey's urethroplasty. A couple of months later, we published a collaborative study on the use of Quartey's urethroplasty in curing stricture.[11] That was a form of private/public partnership exemplifying the

Chinese proverb “Give someone some fish and you feed him once. But, teach someone how to fish and you feed him forever”. I say thanks to Dr Salako.

Recently, this collaboration is being extended to the primary health centre at Isotun, 25km from here. The oba of the town, Prof A A Owosekun, has equipped the centre with the equipment we use at ACE and I have led a team of medical officers to repair inguinal hernias on five occasions. I want to congratulate the department of surgery of this university that on 14th May 2013, a team comprising Drs W Afolabi (leader), A O Mosanya and A W Aderounmu conducted a successful hernia mission at the centre with me in attendance. (Figure 3) I hope this effort will be sustained for the benefit of humanity.

3. Why should the government fix an arbitrary monthly salary of N170 000.00 for house officers which cannot be sustained by non-governmental organizations without government subsidy knowing that all new medical graduates could not be absorbed by accredited government hospitals? Ayodele is undertaking his internship at Sacred Heart Hospital, Abeokuta on a monthly salary of N65 000.00 the hospital could afford. He is having a wonderful training not obtainable in any of the teaching hospitals.

4. As a honorary consultant in UCH, Ibadan, why should I be paid a monthly honorarium of N200 000.00 (two hundred thousand naira) monthly since 2007 and no medical students or surgical residents are sent to me? I have continued to accept this money because I offered the services without pay between 1984 and 2005 when the last surgical resident was sent. During this period, my teachers were in charge of the hospital and the department of surgery.

   Residents who came, picked up surgical skills quickly and some published papers on common conditions we have managed.[12 - 21] The story of the twinning phenomenon in Ibarapa is worth relating.

   In the 60’s, Emeritus Prof P P S Nylander, obstetrician and gynaecologist and my teacher conducted a series of research into the phenomenon of twinning in Ibarapa district. He found that the Yoruba of Ibarapa had the highest twinning rate in the world (40 per 1000 live births) and the twins were of the fraternal (dizygotic) type. This meant that the women were having multiple ovulations in their menstrual cycles and could be triggered by environmental factors. He suggested these factors were in the local yam.[22]

   In 2005, at ACE, I was conducting a morning ward round with some Ibadan medical students and on the maternity ward were a Yoruba, an Igbo and a Fulani woman with twins. This triggered a review of our deliveries from 1986 to 2004 epitomizing Pasteur’s aphorism that: ***‘Dans le champs de l’observation la chance ne favorise que l’intelligence prepare’*** *(‘In the field of observation (research), chance favours only the mind which is prepared’)*

   Since the 60’s, there has been a steady influx of other Nigerian nationalities into Ibarapa but very few, if any, intermarriages. We found that these other nationalities had the same propensity to have twins like us, Yoruba. This result was published in the Nigerian Postgraduate Medical Journal.[21] The paper generated some interest on the internet.

   The next stage in the research was to find out the factors in the environment responsible for the multiple ovulations in the women. I turned to an egg head at the U C H. He was talking ‘above my head’ and making the case more complex. Then, I remembered that in all my years of fabrication and invention, whenever my designs and solutions were becoming complex, I knew I had ‘missed the road’ like ‘Fela sang many years ago. I would put on my thinking cap, return to basics and recollect the words of my teacher and mentor, Prof O O Ajayi:

"While the unavailability of modern technology has limited the scope of research, it is still possible to conduct appropriate, "low-tech," and relevant research that is subject to excellent study design, proper controls, and scientifically valid interpretations"[23]

And, as a matter of fact, over the last 50 years many more major advances have been made in medicine by simple observation than by all the current molecular techniques put together.[24]

In 2007, I turned eastwards to my niece, a food nutritionist, in the Department of Biochemistry of the University of Calabar.

In the following four years, she made several trips to Eruwa collecting the local yam and the popular edible vegetable, *ilasa,* to feed the experimental rats in her laboratory. The outcome was the PhD she obtained in 2011.[25] She confirmed that these food items caused the rats to produce more litters than the control group.

She has got two papers[26, 27] already from the project and like most basic researches, there are several spin-offs like the professor of agriculture in the university thinking of using the yam and *ilasa* to improve reproduction in cattle and other animals and thereby ensure food security for the nation.

5. Why should my proposal to the Faculty of Surgery of the West African College of Surgeons in July 2011 be thrown into the dust bin without discussing it?[28] This proposal aims at correcting the surgical challenges of ordinary Nigerians in rural and semi-urban settings by recommending that the residency be staged into diploma, membership and fellowship. Is that the way a senior colleague should be treated? This was not the first time senior colleagues were openly insulted and it explained why most of them had kept a low profile and would want to be left alone.

6. Why should the National Postgraduate Medical College of Nigeria, NPMCN, insist that she would NOT award membership because that would dissuade governments from employing fellows as if her mandate was to produce fellows only and not solve the health challenges of the nation especially in the face of the facts at the disposal of the MDCN referred to above?[11] Please, let us remember that the NMA and the NPMCN are members of the MDCN.

7. Why should the faculty of ophthalmology of the WACS cancel the diploma programme when holders are successfully extracting cataracts – the most common visual problem in Nigeria while ordinary citizens are still couching the eyes?

8. Why should I be made to pay any renewal fee when professionals allied to medicine and ordinary Nigerians are practicing medicine and surgery? There is a bone setter close to me patronized by all cadres of Nigerians including members of the law enforcement agency.

9. Why should there be a differential in the examination fees paid at part I whereby the resident in pathology pays N80 000.00 while others pay N60 000.00 bearing in mind that pathology is the basis of orthodox medicine and which distinguishes us from the traditional healers? Shouldn't training in such specialties like human anatomy, physiology, pathology, anaesthesia and radiation oncology be made ABSOLUTELY free until we have the quantum to sustain the colleges of medicine and the practice of medicine and surgery in Nigeria?

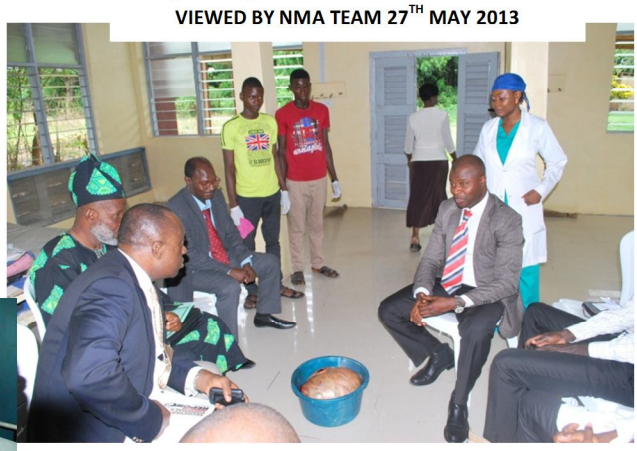
10. How does the MDCN believe that all her continuing professional development programmes including those of the ARSPON would impart the much needed surgical skills to medical officers just concluding their national service?

11. Why should junior colleagues who have passed the primary exams have difficulty proceeding on the residency training for almost five years when there are credible non-governmental

hospitals like Awojobi Clinic Eruwa, ACE, that could be accredited as training institutions? And, this is an institution where 140 major surgeries (like mandibulectomy Figure 4) are performed monthly, 80 per cent of which by five medical officers. These operations performed by the residents include repair of groin hernia, laparotomy for appendicectomy, ruptured ectopic pregnancy, closure of intestinal perforation, Caesarean section, myomectomy, (Figure 5) hysterectomy, bowel resection and anastomosis for strangulated bowel or tumors; prostatectomy, mastectomy, skin grafting, urethroplasty and major amputations.

Fig 4 **RIGHT MANDIBULECTOMY MAY**

Fig 5 **15kg FIBROID EXCISED BY RESIDENTS VIEWED BY NMA TEAM 27TH MAY 2013**



12. At this stage of our development, why should the postgraduate training institutions be so money conscious they make things so difficult for the trainees, the prospective institutions and ultimately the patients?

13. In 2006, ACE paid N30 000.00 to be accredited for the three month tutelage programme of the faculty of family medicine of the NPMCN. Three years later, the fee was hiked to N100 000.00. Of course, ACE dropped out.

14. After almost thirty years, why shouldn't the appropriate technology developed at ACE not replicated in other primary and secondary health institutions of our country and some it even in the teaching hospitals? For example, harvesting rain water. This technology has stimulated Bells University of Technology, Ota and the University of Ilorin to start undergraduate course in biomedical engineering. I am an associate senior lecturer at Bells.

Fig 6. KEKE ERUWA (AUTONOV 3) PERSONNEL CARRIER

Fig 7. KEKE ERUWA (AUTONOV 3) VILLAGE AMBULANCE

I hope this interactive session will provide answers to these and many more questions and stimulate the Nigerian chapter of the International College of Surgeons in supporting the International Collaboration for Essential Surgery, ICES, that aims to award a certificate for training in essential surgery that is based in non-governmental hospitals in developing countries like Nigeria. I am a member of the executive board of ICES and Prof O O Ajayi is an advisor who had identified that ***'the ability to make virtue out of necessity is the greatest and immediate challenge of all'.***[23]

I thank you for your attention and look forward to a stimulating brain storming.

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SURGICAL OPERATIONS IN ERUWA 1983 – 2010.

OPERATION		**NUMBER**	**PER CENT**
External hernia repair		6355	39.4%
Excision of lumps		2144	13.3%
Hydrocelectomy		960	5.9%
Laparotomy	infection	940	5.8%
	gynaecologic	850	5.3%
	intestinal obstruction	345	2.1%
	trauma	50	0.3%
Caesarean section		920	5.7%
Prostatectomy		852	5.3%
Thyroidectomy		352	2.2%
Sequestrectomy		202	1.2%
Orchidopexy		180	1.1%
Vagotomy and drainage		165	1.0%
Mastectomy		133	0.8%
Major open fracture		120	0.7%
Chest tube insertion		100	0.6%
Vesico vaginal fistula repair		100	0.6%
Vaginal hysterectomy		74	0.5%
Splenectomy		38	0.2%
Major amputations		30	0.2%
Nephrectomy		30	0.2%
Mandibulectomy/maxillectomy		25	0.1%
A-P Resection of rectum		2	
Others		1200	7.4%
TOTAL		**16167**	