SURGERY IN POVERTY: PRAGMATIC OPTIONS FOR TRAINING AND ACCREDITATION IN NIGERIA

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Appreciations

For over four decades in the medical profession, for almost 36 years in surgical practice, in research, in the teaching of medical undergraduates, in the training of postgraduate surgical residents and in health service administration, the fear of an imminent end to a chequered career gathers strength by the day. But, I have realized that, it is a misguided fear. An invitation such as this, to give a lecture to the Faculty Board of Surgery of the National Postgraduate Medical College of Nigeria, is an occasion for celebration. To me, it signifies a 'curtain-call', not the dimming of the stage lights, an acknowledgement of a 'life well-spent', not an informal interview for a new beginning. It is an opportunity to share the experience of the past and together seek any possible amendments for the present and for the future. I, therefore, thank the college, particularly the chairman of the Faculty Board of Surgery, Professor Adebayo Adeyemo, a most respected colleague, friend and compatriot. He is a model for the study of the human values that matter, a good man, an erudite scholar, a great and compassionate surgeon who is generous in his words and deeds. I also thank other members of the Board, more especially Drs L I D Kufeji and Wole Atoyebi for the tireless energy in coordinating the arrangements for this lecture. I am grateful to my Faculty for yet another honour so generously bestowed.

Introduction

I have for many decades denied the existence of rural surgery by insisting that the principles of surgery cannot be altered by the circumstances or environment of practice except by new evidence or experience which must always be subject to scientific evaluation. **If anything else, surgery in a rural setting may be more demanding of better judgement, higher cognate skills and satiate experience than surgery in more salubrious settings.** Yet, the glory of surgery resides in pragmatism since to fold hands and do nothing is an anathema to the dynamism of surgical care. It is in the same sense that I have chosen the practice of surgery in the milieu of the crippling poverty of the individual, his society and his country. Whether we are really poor or just guilty of mismanagement of resources is not the issue of the moment. The issue is the deprivation of the individual and the access to a reasonable level of healthcare. We are here to address the problems of a new urban reality in which expediency threatens the principles of surgery, in which the indications for surgery have shifted from what is best for the patient to what is readily available for use, in which the instruments of care are pre-selected by the circumstances of practice, in which the recent advances in surgery are interesting to read but the benefits of progress are frustrating to achieve, plainly denied, or just inaccessible to our patients.

The Measures of Poverty

The impoverished state did not arise overnight. The analyses of macroeconomic indices such as Gross National Product (GNP), inflation rates, export and import ratios, balance of payments, national savings and investments are not reliable guides to the poverty of the masses. The shift to the human-centred indicators tells a better story if not the whole truth because it helps us to focus on the practical factors in human development and in the quality of life[1]. The paradigm shift from macroeconomic aggregates challenges us to a more pragmatic critical self-appraisal of what we have been doing and what we ought to be doing. While Human Development Indices (HDI) measure the basic achievements in human development, this faculty lecture invites us to take stock of the effects of the deprivations in our human development (otherwise known as the Human Poverty Index, HPI) on the art and science of surgery.

When the 1989 World Bank Report observed that Africans were almost as poor as they were 30 years earlier[2] we reacted negatively to the truth as the imperialist plot to rubbish the benefits of our newly won political independence. It has taken us almost half a century later to accept that it was not so. The

measurable deprivations include the per centage of people who are not expected to survive beyond the age of 40 years, the adult illiteracy rate, the per centage of children who do not survive to the age of 5 years, the per centage of people without access to safe water and health services[3].

But, what are the facts? Nigeria has an estimated population of about 120 million. This translates to 20% of the population in Sub-Saharan Africa and 2% of a world population of 5.975 billion people. According to 1991 census, there were 96 persons per square kilometer (including Bakassi), the median age of the population was 17.41 years, 39% of the people were aged between 5-24 years, 93.2% were dependent on households for incomes, consumption, maintenance, social welfare and adjustments, child rearing and socialization. While there has been an improvement in the per centage of the population with access to adequate sanitation, access to safe water, infant mortality, under-5 mortality rate have remained about the same in the last 2 decades. Apart from the dip in the 1980s, maternal mortality has remained the same in 40 years.[1] What is more of a bad news to the surgical specialty is that 25% of the population had no access to health facilities in 1980, the percentage had risen to 40% by the year 2000. The magic year of Health for All was the year life expectancy at birth declined since 1960. I shudder at the figures for the year 2010 against the background of global concerns for HIV/AIDS. Tables I & II give the details.

TABLE I: Trends in Nigeria's Three Mortalities

	1960	**1970**	**1980**	**1990**	**2000**
Infant Mortality Rate (per 1000 live births)	189	120	116	116	112
Under-5 Mortality Rate (per 1000 live births)	207	201	196	191	187
Maternal Mortality Rate (per 100,000 live births)	1000	1000	750	1000	1000
Life expectancy at Birth	42.7	43.5	47	52	50.1

Source: UNDP Human Development Report (Nigeria 2000/2001 Millennium Edition)

TABLE II: Access to water and public health

	1980	**1990**	**2000**
Lack of access to safe water (as % of total population)	48	51	43
Lack of access to adequate sanitation (as % of population)	75	60	37
Lack of access to public health services	25	33	40

Source: Federal Office of Statistics/UNDP Human Development Report (Nigeria 2000/2001 Millennium Edition)

Surgery in its current setting

Surgical practice in Nigeria is characterized by late presentation of cases and therefore more demanding in resuscitative and supportive care. The predominance of trauma and infections, elective and emergency abdominal surgery, obstetric and gynaecological emergencies dictate the need of broad- based training for surgeons working in underserved areas.[4] To these, must be added, in the words of Olikoye Ransome-Kuti, **"the growing menace of non-communicable diseases in Nigeria"** with many becoming **"the victims of this emerging third-world 'pandemic'"**"[5.] The effect of all of these is the expanding frontiers of surgical practice with attendant new knowledge and sophisticated technology necessary for their management.

Poverty and the decay in infrastructure may have denied many more of the old skills and technology and the recent advances in basic knowledge. Electrolyte estimation, blood grouping and compatibility tests may now be subject to the availability of reagents, electricity and water. The decision to give blood, unscreened for HIV/AIDS virus is a daily tussle between good conscience, good medicine and manslaughter. Testing for bacteria sensitivity for the appropriate choice of anti-bacterial chemotherapy has become a thing of the past in many centres. The management of an appendix mass is now impossible to many surgeons without ultrasonography and CT- scan which are neither affordable nor in good working order when available. Sclerotherapy for bleeding esophageal varices? – No esophagoscope, no sclerosants. Transurethral prostatectomy in the Teaching Hospitals? You have a better chance of getting it done in a home garage for a fee which only a few can afford anyway.

These are neither speculations nor exaggerations. They are the effect of poverty in surgery. In a recent study[6] of the effect of user fee charges in Kano, Nigeria 27% of clinical decisions were not implemented in the teaching hospital. 39% of unimplemented clinical decisions were due to the inability of the patients to pay for them while 16% of patients abandoned treatment for that reason alone. Of those who continued with treatment, 62% were able to do so with the assistance of friends, loans and the disposal of personal effects like wristwatches, earrings, clothings, and other decorative ornaments. The 93% family dependency ratio recorded in the 1991 census has trickled to 38% in the support of family members in need of hospital care in a teaching hospital in Kano. Many of us here know that the Kano studies can be replicated anywhere in Nigeria.

The introduction of user-fee charges in teaching and specialist hospitals has not only altered practice patterns and the indication for surgical interventions at critical phases of illness, but has also changed bed occupancy ratios and the number and frequency of clinical cases suitable to undergraduate instructions and on hand acquisitions of skills for postgraduate residents. The large number of undergraduate and postgraduate residents that have to be trained has not been helped by the recent directive of the Medical and Dental Council of Nigeria which increased the number of house officers that could be taken as house men thereby further diluting the quality of cognate skills and experience which can be transferred to house officers within the stipulated duration of the pre-registrations period.

I had the privilege of being the only house officer in a 50 bed surgical unit at Crowdon General Hospital, Surrey, England in 1962 and to have run a 40-bed unit as surgical registrar and Senior Registrar at the University College Hospital Ibadan from August 1967- November 1969. They were the days of underdeveloped specialties. From boreholes to maxillectomies, from thyroidectomies to esophagectomies, from total gastrectomies to abdomino-perineal resections, prostatectomies to amputations, mastoplasties to urethroplasties- you name the time and place, and the house staff was there and the supportive services were ready. How did we get to where we are? Don't ask me. Ask the historians and the political scientists. Our task here is to fashion out how the enthusiasm and the zeal of the past will return.

Finding New Ways

This nostalgic era has given way to frustrations which Monekosso[7] once described as an "African Health Crisis", a period of pervading near despondency, which may not pass quickly. We must, therefore, seriously consider the challenges in facing and setting new pragmatic options for training and accreditation. In doing this, we must not tire of repeating *ad nausea*m that a TEACHING HOSPITAL IS DIFFERENT FROM A TERTIARY HOSPITAL. While a teaching hospital is a tertiary hospital, a tertiary hospital need not be a teaching hospital. Teaching hospitals are not consumer outfits subject to the principles and tactics of the marketplace. Manpower development, through appropriate training, is beyond a product conception which like a non-teaching tertiary hospital can be marketed through the process of planning and executing the conception, pricing, promotion and distribution of ideas, goods and services to create exchanges that satisfy individual and organizational goals.[8] Of course, we can stretch our imagination and consider a well-trained surgeon as a market product but let us consider his training as a long-term national investment the like of which does not immediately reflect in a profit and loss account.

We cannot remain passive observers when all we hold dear continues to crumble around us on the altar of micro-economic considerations. We cannot remain silent while those who have the ears of government ignorantly or deliberately spread the frenzy of privatization or commercialization into teaching hospitals in return for political patronage or other considerations. In as much as there is a cost to services, there must be a cost to training. If we must sell the services in the national hospital, Abuja at economic prices, let the government buy the services in LUTH and in 20 other teaching hospitals in Nigeria, at economic rate for training purposes.

The challenges and amendments

In these trying times, the challenges we face in training and accreditation are many and this lecture proposes to deal with some of them.

1. The challenge of a Conceptual Framework for Development

Consumed by the moment of rejoicing, self-congratulation and a sense of relief after several years of hard work for accreditation purposes, new teaching hospitals quickly forget the conditions attached to their full or partial recognition for training functions. They fail to set the goals and the priorities for development and create the organizational structures necessary for their fulfillment. They fail to reappraise the strength, weaknesses, opportunities and the difficulties ahead for the attainment of the set goals and objectives. They fail to fashion out the strategies necessary to cultivate new staff and keep suitable manpower to generate the resources required in the new dispensation and to survive the unexpected development that must surely come. What monitoring mechanism should be put in place to ensure the attainment of the promise embodied in their mission statement, if any, is seldom conceived. These are real essence and justification for strategic planning.

A strategic plan is often considered a waste of time because faculty or college leadership changes and prospective candidates often have their own agenda. The Universities and their associate Teaching Hospitals are misled into thinking that the attainment of an accredited undergraduate or postgraduate program is an end-point in itself. Yet, both institutions expend a great deal of resources in uncoordinated ways so much so that the challenges to good professional medical education grow rather than abate. The pressure to increase student intake is mounted by government, community leaders, university peers on the faculty authority until it succumbs. The Hospital Boards are not consulted yet the Boards have a responsibility to

"construct, equip, maintain, and operate the hospital so as to provide……proper courses of instruction for medical students of the University" in order to

"ensure that the standards of teaching provided at all establishments controlled by itself and the standards of treatment and care provided for the patients at those establishments do not fall below those usually provided by similar establishments of international repute."

Our painful experience is generally that Teaching Hospitals and their associate Universities function as if they have divergent purposes. How often do the Universities make appointments without prior consultation with the Hospital Boards that may not have made financial provisions for additional clinical supplementation, call-duty and other allowances? This is a challenge that may have been avoided if the University had a focus which is co-terminus with the associate Teaching Hospital. The justification for a Teaching Hospital is the existence of a Medical School yet the primitive instinct to defend territory persists between the Ministries of Education and Health, both of which, prior to 1957, existed under one roof of the Ministry of Social Services. So powerful is this instinct that two professors of medicine simultaneously headed both ministries between the late 1980s and early 1990s and could not resolve the ambiguities. Our best effort at the holistic approach to medical education was the almost autonomous structure of Lagos University Teaching Hospital for medical education, research and services at its inception, but the Will and the Courage were not there to sustain it.

2. The challenge of Student/Trainee Intake and Selection

The problems of inordinate and uncontrolled student/trainee intake cannot be underrated. Admission numbers should be determined by the size of the school and the facilities available for training: the expansion of physical facilities preceding the increase in intakes. I am currently the Chairman of a Teaching Hospital Board accredited with the understanding that student intake should not exceed 50. The current intake is 190, yet nothing significant has been added to the facilities in the 14 years since its initial full accreditation.

In addition to a controlled number of student admissions, many would consider a selection process designed to hopefully recognize student motivation and appreciation of the need for compassion in the practice of medicine. The spirit of humility, tolerance and the virtues of good interpersonal relationships can be promoted by such interviews notwithstanding the potential weaknesses of subjective assessment.

The practical implication of 'University Autonomy' are yet to fully unfold but nobody needs be a clairvoyant to predict that university education will be more expensive for individuals and their sponsors. Income generation in the Universities will translate to increases in fees in as many forms, shapes and sizes as the ingenuity of the various university councils can contrive. Medical education, as is the case in other parts of the world, will bear the lion's share. To make the financial burden lighter, there will be the temptation to trade higher student intake for poorer standard of instruction and quality of programmes.

Whatever might be the difficulties, I propose as a pragmatic option now, that any institution seeking the accreditation of its medical programme at undergraduate and postgraduate levels must prepare and submit a strategic plan as part of the application process for the development of the institution, in the succeeding 5 years, against which the applicant elects to be accredited or re-accredited by the Medical and Dental Council of Nigeria.

3. The challenge from uncoordinated capacity building

Nearly all the universities have postgraduate schools and fund postgraduate training. It is remarkable that medicine is the only discipline that I know in which the universities except in the case of the University of Maiduguri have no part in the development of their clinical medical teaching manpower. The major route to specialist manpower development, from which the universities make academic appointments is outside the university system. The course content for the training of prospective lecturers and professors in the medical sciences has no major input from the universities. The teaching hospitals which provide the facilities for the training of Resident Doctors do so in the clinical science areas without regard to the needs of basic science departments, which teach the scientific rationale for the clinical understanding of disease processes and the principles for their treatment. I am aware that a few colleges have shown concern for these lapses. But, the Universities and the associate Teaching Hospitals are yet to demonstrate the level of sensitivity to the desirable objectives of the National Health Policy. The manpower needs, in the implementation of our health policy must be backed by specific monetary votes in hospital budgets. We must, as the saying goes, put our money where our mouth is.

The uncoordinated development thrives even within the hospital system which is exclusively under the control of respective Boards of Management. While poverty *per se* has affected surgery, there has been a collateral damage to other disciplines on which surgery thrives. The most important of these is in the specialty of anesthesia. I had this to say during the closing ceremony of the 30th Annual Conference of the West African College of Surgeons in Lagos on the 9th of February 1990:

" It has been our common concern whether our syllabuses reflect the need s of our people. To this end our programmes have been reviewed and revised. We shall be introducing some diploma programs at subspecialty levels particularly in anaesthesia and ophthalmology this year. This is to ensure the availability of safe surgery at our sub-tertiary institutions. Our responsiveness to the health needs of our people, at the cost our government and people can afford is really not in doubt".[9]

We have been vindicated, but the impact is yet to be fully felt. The need for a diploma program in anesthesia has grown stronger with increasing poverty and with the need for a greater access of patients to surgery. The fully trained fellowship experts are too valuable in various types of our operating rooms and for the service in our recovery wards. If our system tolerates "nurse anesthetist", surely there must be a place for doctor anesthetist too. Oyegunle, in the 26th inaugural lecture of Olabisi Onabanjo University, Ago-Iwoye in January 2003 rolled out the chilling statistics of under 400 trained anesthetists in a Nigeria of 120million people, 12 of who are in Ogun State and 1 in Olabisi Onabanjo University Teaching Hospital to meet the needs of 18 Consultants in Surgery, Obstetrics and Gynaecology. He gave little hope for the future when he revealed that only 2.8% of the awarded post-gradauate fellowships of the National Postgraduate Medical College were to anaesthetists over a period of 20 years.

My chairman, a pragmatic option, for a start is to make holders of the diploma in anesthesia consultants in 1-3yrs after qualification. They will handle the 1 and 2 grade cases of the American Society of Anaesthesiologists (ASA) classification, and leave the fellowship holders to care for the very ill patients, to intensive care medicine, to research and training. The quick ascendancy to the top soon stimulates interest in the specialty so much so that there will be fewer posts for the number of applicants. The selection process will favor those who have acquired more practical experience and have made progress towards higher academic attainment. We must learn from history. It was the way MRCOG replaced DRCOG, it was the way FFARCS replaced DA , and it was the way FRCOphth. replaced DO in the UK. **We must, Ladies and Gentlemen, learn to build our houses from the floor not from the roof.**

Let me reaffirm, once again, that the lack of coordination in staff development extends beyond medical and dental personnel. The Medical and Dental Council, in the guidelines on minimal standards 1984 rightly underscored the point in these words:

"It is not good enough in our circumstance for a medical school in Nigeria to train doctors only without relevance to their need for supporting staff, such as laboratory technologists, radiographers , public health inspectors, nutritionists, health educators etc"

The need is for a "critical mass" of health professionals at all levels of healthcare. The case has been clearly made at the highest level of surgery. Of what use is modern day surgery without anesthesia, without medical microbiology, without clinical biochemistry and immuno-biology, without hematology and the experts in these fields. But, are the responsibilities shared among members of this critical mass of health workers appropriate to the skills they may have acquired. I have previously called for a reappraisal of job descriptions through task analysis and a redefinition of constituent professional fucnctions.[11] Why should a nurse serve meals, carry bed pans, make beds, tepid sponge patients, pack corpses, send and receive laundry items on the ward? Florence Nightingale achieved fame through her activities in the Crimean War of 1544 but her contribution to healthcare, to my mind, was the intellectualism she brought into nursing.

My favourite example of skills was the training of nurses to do 35,000 cataract extractions under supervision in The Republic of Gambia in 1998 following which their skills were further upgrade to lens implantation.[12] We cannot validly argue that this had nothing to do with poverty in surgery. The contention is that poverty may thus afford us with the opportunity to think again and again what we can do with our limited resources for maximum benefit. The truth is that if we do not continually upgrade skills, we unconsciously breed quacks even within the healthcare team. This neglect has already created untrained "surgeons" out of the theatre orderlies and theatre nurses? How many uteri must be needlessly and immorally perforated, how many vasa deferentia must be lost, how many bladders must be opened, how many fecal fistulae must be created before we act? These are surgical complications even in the hands of the best surgical craftsmen, how much less in the hands of quacks! But must we watch while the reputation of surgery dives further and further?

4 *The challenge arising from deficient research infrastructure*

Research using basic laboratory tools for clinical investigation has become almost impossible due to poverty and the consequential introduction of user-fee charge and other income generating mechanisms. The proliferation of medical schools, where research is limited by policy, infrastructure and opportunity, poses serious challenges to the growth of medical education. The appreciation of the technique of enquiry, the relentless pursuit of new ideas and the acquisition of new skills with the rapid expansion of technology makes research essential in impoverished state. I remember a visit to Bombay, India a few years ago where I saw the development of bio-dressings for burns and the development of shunts for internal hydrocephalus. Those developments were fuelled by need and inability to fund imported equivalents, which do not give superior benefit. *If it is the intention of Government to turn Teaching Hospitals into commercial enterprises, the negative effect on medical education and research must be overridden by funding the institution to meet the needs of appropriate, teaching, research, examinations and certifications.*

Many will contend that this is an advocacy of mediocrity because we too must generate new knowledge for the sake of knowledge, discover new products or hitherto unknown constituents of disease. But these are the research imperative of poverty which we have politely hitherto referred to has appropriate research. Finding the resources to install, to maintain, to replace obsolete equipment and to provide chemical and reagent for their utilization are the appropriate responses in the face of poverty. Poverty

alleviation, the new political cliché, must start with providing an enabling environment to tackle poverty at the roots.

5. The challenge of appropriate teaching and learning facilities

Recent advances in information technology have changed the dimension of teaching and learning skills. The computer has become such a basic tool that the quality of medical education may, in the near future, be determined by its availability to every student. Good journals and informative articles, at affordable prices, may be only available on the internet. Many books are now only on CD ROMs. The West African College of Surgeons, at its recently concluded 43rd conference in Abuja, January 2003, even put the Abstracts of Papers on a CD Rom. Medical libraries, as we knew them, have changed dramatically. *Telemedicine* has become part of the standard tool of medical instruction in the republic of Senegal. It is no use pleading poverty; the case that is being made is the restructuring of the educational system within what is totally available to break the vicious cycle of poverty, ill-health, diminished productivity, poorer health and greater poverty. Surgery has always been a science and a visual art. More and more surgery is now through endoscopes and the conventional methods in surgical apprenticeship must *per force* change. Poverty will widen the gap in the acquisition of new skills but we cannot afford to lag behind, as the old surgical tools become unserviceable and irreplaceable. Tosin Ajayi[13] struck the right note at a recent Conference of Chairmen and Chief Executives of Federal Tertiary Hospitals when he observed as follows:

"Today, it is a reality that our healthcare providers are beginning to find that the training that they have had and the systems in which they currently operate equipped them for a world that no longer exists."

6. The challenge of postgraduate medical education

Doing very well what one is capable of doing at all, is "Excellence" since excellence is an index of function; but there is a limit to which this can be so if the circumstance of performance remains constant or continuously deteriorates. A poor, or an impoverished nation like Nigeria, cannot have a high standard of service or training because material well being *in the public purse* plays a significant part in staff recruitment, motivation, performance, promotion and retention. Notwithstanding the recent increase in salaries to university teachers, the dearth of good teachers is currently a serious challenge in many of our medical schools due to the plurality of poor pay, academic frustrations, unfulfilled professional expectations, the proliferation of Federal Medical Centres and the advent of an enlarged private sector participation with the competition that follows its trail. Yet we must raise the standard of training if surgery must survive the strangulation of poverty. The need to be familiar with recent advances in health sciences and with new technology, the cost effective reality of Day-Care Surgery, the spectrum of diseases which require emergency interventions in the rural communities, the skills required for working in isolation using obsolete or improvised tools and equipment in areas with under-developed infrastructure, are reasons for raising, not lowering, the standards of training.

7. The challenge of insularity

Earlier in this lecture, I described the dichotomous approaches to medical education and training as a struggle since 1957 to protect territory between the Ministries of Education and Health. The objectives of Primary Healthcare will continue to elude us given our poor inter-sectorial linkages between health, education, agriculture, water resources, environmental care, works, housing etc. This internal insecurity, I have come to learn by recent experience, is inherent in our social fabrics. Some of what we ascribe to poverty

does not exclusively derive from it. Many are partially political, many more are due to greed, selfishness, corruption, lack of patriotism and misconceived societal values.

There is no society that I know which has achieved greatness by a policy of exclusion. The first man in Outer Space and the first man to walk the surface of the moon owe those bits of Soviet and American history to the captured scientists of defeated Germany. The most powerful and the richest nation in the world continues to scan the universe for the best of other nations to build additional structures and institutions in their land that will endure long after the hired hands have departed from the surface of the earth. Those who built the pyramids in Egypt were not all Egyptians. Today, Egypt continues to urge mankind to visit those pyramids in the 7th millennium. Medical training institution must confront the policy of exclusion at all its facets .All accredited medical schools and hospitals with accredited training programmes must open their doors, gates and windows to men and women with relevant experience and appropriate skills in building Nigerian institutions. They must not only do these, they must do more .They must look for, search for, and encourage appropriate staff to come and stay in their institution, not by giving them temporary special privileges, but by the simple application of the principles of justice and equality. Prejudices, by whatever coloration, must give way to due recognition of merit and hard work, be it in appointments, elections, selections ,and promotions. The consolidation of the gains of the past, the introduction of new ideas in the solution of old problems, the acquisition of additional skills in the management of apparently intractable problems, the higher profiling of the image of the institution beyond the narrow confines of geography and demographic purity ,accelerate growth and sustain development.

A much more sophisticated development of this idea is the promotion of inter-institutional exchange programmes and/or functional collaboration between Teaching, Non-Teaching and other Specialty Hospitals by the rotation of all categories of staff through structured two-way training programmes. This is a pragmatic option for the maximal utilization of available manpower and the enhancement of the clinical and administrative services available to the people. It is a practical option in the face of limited resources. An important condition, however, is that the non-teaching and specialty hospitals must be accredited for the purpose.

In a keynote address to the Pan-African Association of Surgeons in Abuja, 1997, I had this to say on the subject:

"The bias towards academic fulfillment, the opportunities for group teaching and discussions, the exposure to research methodologies and statistical appraisals, and the inculcation of teaching instincts by interactions with medical and nursing students strengthen one side of training. This is complimented by a period of service in accredited non-teaching hospitals with the opportunity for an expanded volume of day-to-day responsibilities of surgical practice, in a more realistic environment of future service. A greater sense of independence and confidence is rapidly developed while leadership qualities and management skills find wider expressions than is usually possible within the hierarchical structure of a teaching or specialty hospital"[14]

A logical response to poverty alleviation is the husbanding of all available resources and an internal restructuring of functions for increased efficiency within little that is available. I suggest that the initiative for a closer examination of this proposal should be taken by the National Postgraduate Medical College of Nigeria on the recommendation of Faculty Board of Surgery.

Conclusion

Mr Chairman, I have attempted to examine with you the realities of the surgical sciences and practice in an economy in recession. Our primary requirements are courageous men and women, in the broadest sense of the word, who can come to the rescue by a visit and re-visit to pragmatic options in a dark tunnel whose light is yet to glow. The cycle of poverty, ill health and inability to emerge from the cauldron threaten the nature and the extent of the practice of surgery, as we know it. To prevent a total collapse at this stage of our national development constitutes the greatest challenge and responsibility in order to find a new way of doing old things. We cannot disclaim responsibility neither must we despair. A Messiah will surely come.

Thank you for the honour and for listening so patiently.

Lagos ,Nigeria

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