FROM THE COLLEGE OF MEDICINE

A Surgical Re-tread

J Lawrie

It is given to few to be at the foundation of two new Departments of Surgery, in two new Medical Schools, in two different parts of Africa.

Such has been my good fortune. Back during the Nigerian civil war, still disrupting the South, it was decided that the time had come to start a Medical School in the North, for a vast area of Savannah, nearly a thousand miles square, for thirty million people. And now, after several years of anxious waiting, I am again part of a small new surgical group within the College of Medicine, Malawi.

It is an unique opportunity. Though separated in time by twenty years, and in distance from West Africa to Central Africa, many aspects of the two ventures are surprisingly similar, while others are totally different.

I thought it might be of some interest to those involved in the medical services of this country, new and old, to consider some of the comparisons, from an entirely personal point of view. These random thoughts in no way represent any official policies of Nigeria, nor of Malawi.

There, as here, we took over the existing Government Hospitals, there being no money, and no time, to build a teaching hospital. This policy was readily accepted by the new teaching group. We agreed with the epistle according to Jessop whereby . . . "A medical School can be established on the basis of the existing District Hospitals, adequate for teaching and for clinical research, *provided* . . . " - and on the problems involved in "providing", this laudable concept and philosophy foundered. Such necessary provisions as good communications, reliable transport, maintained accommodation and additional staff-all sounded simple to the planning committees but proved costly and difficult to put into effect.

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We managed adequately for several years. The students were keen, and became competent doctors, and stayed with us. Suddenly came the great U-turn, the betrayal of Jessop — an ivory tower would, after all, be built. Immediately, all realistic funding for the old hospitals dried up.

Psychologically it was demoralising, as all attention, all publicity, and all distinguished visitors were diverted from the busy old General Hospital to the new foundation. In the long term, it has proved disastrous — the great concrete bastion lies out in the bush to this day — uncompleted and unused.

Ivory towers have been discredited throughout Africa for a quarter of a century, yet the temptations persist.

The imperative alternative is purposeful determined expenditure on annual upgrading and continuous expansion of existing hospitals. It will be interesting to see the way ahead here.

There, as here, we were committed to community health. Sadly, the end products, district doctors, were few. Service in far places in any country attracts only the rare dedicated soul, and is less the result of exhortation from the great and the good, or indoctrination from any curriculum, but far more to the salaries offered, the career prospects, jobs for wives and schools for children. Doctors enjoy the company of others, and need mutual stimulation and support. The prospects for this in Malawi appear to be more promising and realistic.

There, unlike here, the students were free range home grown products, and completed their course within our own Ahmadu Bello University in Zaria, both the preclinical years and three clinical years, in Zaria Hospital and our associated rural district hospital at Malumfashi. Staff and students knew each other socially, appreciated each other's difficulties, and worked together amicably with a common purpose.

Here, we are faced with the unusual and unpredictable phenomenon of Malawi students, having finished most of their course abroad, first in the tranquil backwater of St. Andrews, and then among the hectic rarities of London, to return for a short nine month exposure to the realities of Queen Elizabeth Central Hospital.

Upon their response to this unprecedented challenge will depend the future viability, and credibility, of the College of Medicine. It will not be easy.

There, unlike here, the working environment offered a gradual transition from student life to trainee doctor. Surgery had one Senior House Officer, one Registrar and myself, rather thin on the ground, but these junior doctors were Nigerians, qualified in Ibadan, and they were therefore ideal role models, which our new students could naturally follow, and thus did the department grow and expand. Here, very differently, our new students will encounter an unusual health care team, of clinical officers and medical assistants, who bear the brunt of the endless load of illness in this country - cheerful and efficiently. Our students, so soon to be doctors, will have to blend, tactfully and helpfully, with this essential team, and jointly carry the flag forward.

Ex-Nigerians are frequently charged with having had a relatively easy run — Nigeria being then a wealthy oil producer. Maybe so, but the funds were thinly spread over a huge country with more than 100 million people.

My particular share of the spoils, as a "Foundation" Department of Surgery, was one clerk, one typewriter, and a budget of 250 pounds. Departmental transport consisted of my own Landrover, in which I drove the students 75 miles to our rural hospital, or if I fell asleep, they drove me.

However, we grew and prospered, in 15 years, into a large productive and happy group of 30, several Professors with different interests, Lecturers and Senior Lectures, all of whom went on to special training, higher degrees, and research projects — and came back. Funding was always minimal, and related directly to service needs.

Money therefore, though welcome from time to time, is not the whole answer to medical services and health care.

Perhaps the most striking difference, there and here, lay in the existing basic medical services, on to which the new Medical Schools were grafted. There, the University created, as one of its integral training and service components, the "Institute of Health", which was in effect the total medical and paramedical services for the large area in which we functioned. These included the School of Nursing, Laboratories, Radiology, Pharmacy, Housing, Transport and Community Welfare and Rehabilitation Services.

The academic staff were directly involved with the functioning of all these interdependent groups. Here the established background is quite separate, and development will depend crucially on the common aims, joint progress, and the good will and adequate funding within the Ministry of Health.

A thorny problem, in all developing medical schools, is the timing and extent of specialisation within surgery. There we were necessarily jacks of all the surgical trades, struggling also to be masters of a few special interests. Declaration of separate specialities, was delayed until there was clearly a sufficient clinical load to justify them. Premature specialisation fragments the clinical teaching, with wasteful delays and inevitable gaps. Integrated teaching is difficult enough, but disintegrated teaching is a disaster. These are not simple decisions — in some ways specialists appointed arbitrarily from abroad may be under-utilised and non-productive, while without them some areas of pathology within the population may lie unrecognised — "we don't see much of that here" — until revealed by the fresh eye of the expert. You find only what you look for.

Our new hybrid medical students will have an even harder task than most medical pioneers. A foreign medical background, largely irrelevant to their future needs. An uncharted future in an unusual medical environment. Patterns of disease, responses to injury, indications for elective surgery — all clouded, distorted and frustrated by the enigma of immunodeficiency. Alma Ata notwithstanding, there certainly will not be "Health for All" but I wish them, us, well on the thorny road to 2000, and I welcome them to this most absorbing kaleidoscopic and evergreen of all professions, even to a surgical re-tread.