Amendment of the Nigerian Medical Residency Training Act

Dear Editor,

I was an invited speaker at the scientific conference of an association of resident doctors in Nigeria, where an opportunity arose to speak about the medical residency program in Nigeria. I had the privilege to share my perspective on the need for amendment of the Act of Parliament that regulates the program, the Medical Residency Training Act (MRTA), 2017. The contradiction in the dual role of regulating and training as is undertaken by the National Postgraduate Medical College of Nigeria (NPMCN) exposes the resident doctors/trainees to arbitrary changes in curriculum and cost of training, with an unintended consequence of worsening brain drain of early to middle career doctors from Nigeria.

An early attempt at postgraduate medical education in West Africa started with the efforts of Dr. Victor Anomah Ngu from the University College Hospital, Nigeria. This effort birthed the Association of Surgeons of West Africa (ASWA) on December 3, 1960, in the board room of the University College Hospital, Ibadan, Nigeria, with the appointment of Sir Samuel Layinka Ayodeji Manuwa as the inaugural president. Postgraduate medical education in Nigeria and West Africa continued to evolve till ASWA metamorphosed into the West African College of Surgeons (WACS) in principle by a resolution in January 1969 in Accra, Ghana. However, the two bodies, ASWA and WACS, continued to exist till January 4, 1973, when the association ceased, and its assets and liabilities were transferred to the college in Benin City, Nigeria.

Along the line, the Medical and Dental Council of Nigeria (MDCN), which was the regulatory body for medical practitioners in Nigeria, was concerned about the need for postgraduate medical training in order to ensure the availability of an appropriate workforce with requisite knowledge and skill for Nigeria. The Medical and Dental Practitioners Act No. 9 of 1963 was, therefore, enacted to empower the MDCN to assume the status of a postgraduate training body without appraising the contradiction of a supervisory body assuming the status of a training institution. Six years later, Decree No. 44 of 1969 which gave powers to the MDCN to award diplomas, was promulgated by the Nigerian military government. The roles were finally separated by the National Postgraduate Medical College Decree No. 67 of September 24, 1979 (Cap N59 Laws of the Federation 2004), which established the NPMCN.

The NPMCN continued to undertake the training and examinations for the fellowship into various postgraduate specialties of medicine, surgery, and dentistry until the enactment of the MRTA of 2017. The MRTA, thus, returned the initially separated roles of training and regulation domiciled with the MDCN to the NPMCN, albeit with a blurry demarcation of roles regarding supervision and regulation between the two bodies. The only clear intersection is that the fellowship awarded by the NPMCN and other sister medical colleges is expected to be registered as additional qualifications with the MDCN without any input to what it registers. By this, the NPMCN not only trains postgraduate physicians and dentists for the Fellowship Diploma and the Doctor of Medicine but the body also regulates the training it administers. This calls to question the balance in control along the continuum of training and regulation. For instance, undergraduate medical education is administered by the universities; however, the universities are regulated by the National Universities Commission (NUC), while standards of medical education in the universities are regulated by the MDCN.

It can otherwise be said that undergraduate medical training is administered by the NUC's overarching administration, while the standards are determined by the MDCN. In the case of the postgraduate medical colleges (NPMCN, WACS, WAC Physicians), the colleges approve the curriculum, administer the training and examinations, accredit the training institution, determine standards, and decide on fees for examination and other adjunct courses like revision courses and other "mandatory" courses that are organized by faculties within the colleges. These practices go unchecked, and the trainees are subject to the whims and caprices of the Faculty Board and the Senate of the colleges. To cap it, the sponsorship that the trainees get is determined by the NPMCN with little or no input from the West African colleges and total exclusion of trainees in the state and private tertiary health institutions. Unfortunately, this manifold nature has continued to expose the fellowship and the degree awarded by the NPMCN to affront by sister bodies, especially the NUC.

The world continues to struggle with the challenges of migration of skilled health workers; however, the impact in West Africa, and especially Nigeria, has been very severe since the outbreak of COVID-19. This is worsened by the push factors that have constantly reduced the number of applicants for postgraduate specialty medical education in Nigeria. One of the major push factors is the arbitrariness of the policies of the postgraduate medical colleges in the area of curriculum development, duration of programs, and cost of attendance of training, to mention a few.

In addressing these inherent challenges, there is the need to separate training from regulation through an amendment of the MRTA. The regulatory responsibilities may be transferred to the MDCN, while the NPMCN and other sister training institutions focus on training. By this, the curriculum, courses

and standards, as well as the sponsorship of the training colleges, may be harmonised. This is in line with the MDCN's role in regulating medical education and practice. In addition, the sponsorship net can be extended to trainees in the state and private tertiary health institutions as a condition for accreditation of such institutions by the MDCN.

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