THE STRENGTHS AND WEAKNESSES OF THE OPHTHALMOLOGY TRAINING PROGRAMME IN NIGERIA – A Participant's Viewpoint

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INTRODUCTION

A newly qualified fellow in ophthalmology who takes up an appointment in a teaching hospital is likely to face a number of challenges. These may include:

- making sound clinical judgment without supervision
- offering surgery to patients requiring it and taking responsibility for the outcome
- providing leadership for other eye care workers
- maintaining the correct job definition by various cadres of workers
- fostering a team approach to eye care
- developing a curriculum for medical students and teaching them the contents of such a curriculum
- advicing the hospital management, local and/or state governments and corporate bodies on the facilities to be provided
- carrying out scientific research and publishing papers in spite of a heavy work schedule

How well does the present residency-training programme prepare a fellow for these challenges and more?

This paper presents a personal view of the strengths and weaknesses of the residency programme as experienced in one of the nation's foremost training institutions (University of Nigeria Teaching Hospital, Enugu) and proffers personal suggestions on how to improve on the strengths and mitigate the weaknesses.

THE PERCEIVED STRENGTHS OF OUR RESIDENCY PROGRAMME

Opportunities for Training and Discipline

Residency training principally offers an individual the opportunity for training and discipline. The trainee progressively acquires the required clinical and surgical expertise while passing through the junior and senior levels of the programme.

In addition to the acquisition of knowledge and skills, a resident is expected to acquire the same positive moral character exhibited by his trainer in such diverse ways as treating one's patients with dignity and not exploiting their weaknesses for any form of material gain. In addition, the resident acquires the discipline of coming to work on time, prompt response to calls and avoidance of truancy. While working under his or her trainers, a resident also learns the proper relationship between colleagues, junior and senior colleagues and between the doctor and his patients. Gradually, the resident develops that type of authority described as Aesculapian, consisting of moral and charismatic authority.[1]

Some trainers take the pains to actually 'police' the residents until they acquire the desired discipline. In many institutions, however, only one or two trainers constitute the pivot of the residency programme; the others seem to prefer to 'mind their own business'.

On the other hand, when trainers set bad examples in such core issues as discipline, punctuality, commitment to duty and relationship with colleagues, the residents training under them naturally acquire these traits because "... every disciple shall be as his master".[2]

Opportunities to Participate in Clinical Conferences and Other Training Activities

At UNTH, Enugu, where the author trained, the Tuesday and Thursday 8.30 a.m clinical conferences were unforgettable. These provided the opportunity to be drilled on the 'whys' and the 'hows' during presentations. The necessary depth of knowledge is progressively acquired, such that in a few years, the previously 'green' resident becomes a confident ophthalmologist. However, some trainers show little interest in these clinical conferences.

Other opportunities for the resident to acquire knowledge and skill are: the grand rounds, the presentation of patients in the clinics, supervised management of patients in wards, supervised surgical exposure, clinical audits and being exposed to research, sometimes through collecting data for the 'chiefs'.

The Opportunity for Clinical Audits

The clinical audits offer trainees the opportunity to confront the truth about each patient that has been

managed, even when that truth hurts. It instills the consciousness that every patient is important. This is because on such 'days of reckoning', every 'sin of omission or commission' is revealed before one's peers, who, of course, have the opportunity to make criticisms. It is not usually easy to be at the receiving end of criticisms, but this practice helps to progressively create that high sense of responsibility required for the practice of medicine in general and ophthalmology in particularly. It must be said, however, that some trainers do not take these audits seriously.

Management and Leadership Training Opportunities

During the period of residency, leadership training opportunities are created in various ways, for example, supervising medical students, house officers and junior residents. These provide opportunities to demonstrate delegated authority and to bear the responsibility for mistakes or uncompleted assignments and are all geared towards training in management. Some specific assignments such as the post of chief resident are aimed at inculcating leadership qualities in the residents. These should be strengthened. In some Western residency programmes such as at the UCDavis Eye Unit, California,[3] every senior resident has the opportunity to be the chief resident. Each senior resident spends four months as chief resident. This arrangement is commendable because it provides the opportunity for residents to refine their leadership and managerial skills, and to develop surgical maturity before completing the residency programme. During this time, the residents schedule and run their own clinics as well as schedule their own surgeries. Administrative responsibilities also include arranging the residents' call schedule.[3]

In the Nigerian programme, residents also have the opportunity of a two-week health management course as part of the requirements for the part II examination. However, a longer and more specialty-specific management course has been recommended by Ogundipe.[4] This will include training geared towards equipping the trainee to cope with private practice.

A Paid Job for the Period

One of the enviable strengths of the residency-training programme in Nigeria is the security of a continued paid job within the time span of the programme. It is true that most training institutions now tie this to timely success at the various stages of the exams, yet the burden of finding a locum to make up for the required postings, as is obtainable in some countries, is removed. In some countries, the arrangement is different. For instance, in the Maryland General Hospital training programme at Baltimore,[5] resident appointments are made on an annual basis and are only renewable for a total programme of 36 months. In this regard, the Nigerian programme has an advantage. For this we must be grateful to the government of Nigeria and the medical elders who recommended it.

Some Level of Sponsorship to Update Courses and Exams

The training institutions usually sponsor a candidate for three update courses (one at each level of exams) and one health resources management course, within the training period. The courses, in no small way, help to prepare the resident for the relevant examinations. Actually, one can boldly say that it may be impossible for a candidate to pass these exams without attending such update courses. Most of the resource persons, who incidentally are also the examiners, seem to compete to deliver the latest knowledge in their areas of interest. With the increasing cost of update courses each passing year, it would have been difficult for residents to cope without this sponsorship.

Opportunities to Participate in Outreach Programmes

The community outreach programmes serve as an invaluable means of exposing residents to the concept of community mobilization and other aspects of the planning of programmes and research. The residents are also exposed to the concept of applying knowledge to solve problems in the society. It is also an opportunity to provide service close to where people live.

During the author's training, there was a regular community outreach programme to Abagana. This is a rural community where the teaching hospital (UNTH, Enugu) has a primary health care practice centre. Screening outreach programmes were organized occasionally to other nearby rural communities. These were screening outpatient clinics. Patients who needed further management and/or surgery were referred to the teaching hospital. These efforts served as a way of advertising the services of the hospital and thereby increasing the uptake of its services.

Fostering the Team Approach in Eye Care

At UNTH, Enugu, where the author trained, there was a tradition of participation by all the other members of the eye care team in the clinical conferences, seminars and community outreach programmes as well as in the annual end-of-year parties. These were all aimed at fostering team spirit. The end-of-year parties were not only a time for socializing among all cadres of the team, but also an opportunity for stocktaking. Decisions were also taken on the way forward. Excellent performances were commended and sometimes rewarded while constructive criticisms were entertained. This practice should be encouraged.

PERCEIVED AREAS OF WEAKNESS

Training Priorities

Most teaching hospitals emphasize the service needs of the hospital over the educational objectives of the

residency training. Furthermore, these institutions lay more emphasis on ensuring that residents do not overstay, than on the educational activities that would ensure that the residents do not overstay. 'While overstaying bogs down the programme, a high drop-out rate amounts to a colossal waste of funds and the limited spaces available within the programme.[6] There is thus the need to ensure a balance.

Training Curriculum

The programme needs to be restructured in such a way that the average resident will naturally complete the training within the stipulated period. Comparing the Nigerian programme with similar programmes overseas,[3,5,7,8] it is obvious that the Nigerian programme lacks structure. The Casey Eye Institute, Oregon[7] divides its three year programme into three-month blocks, which take place in three institutions, with a clearly outlined flow chart for each resident. The first year begins with a two-week orientation to help 'transition the incoming residents into ophthalmology'.[7] At Maryland General Hospital in Baltimore,[5] the teaching methods include 'didactic training through lectures'. Other educational opportunities are given priority over service delivery. These include participation in clinical conferences, attendance at a comprehensive basic science course, special meetings, grand rounds, membership of a journal club, studying the American Academy of Ophthalmology's Basic and Clinical Science course and participating in the yearly Ophthalmic Knowledge Assessment (OKA) series. Many of these teaching methods are also practiced in Nigeria, but more effort is needed, particularly in the area of didactic lectures.

External Postings

From the author's perspective, external postings need to be reviewed. Some of the external postings were very helpful, while some others, such as pathology and internal medicine, do not seem to be crucial and may well be described as an unnecessary prolongation of the training programme. Moreover, residents have the opportunity of being exposed to ocular manifestations/ complications of systemic diseases when these patients are referred to the ophthalmology team for fundoscopy or ophthalmic review. When a resident stays away so long from the ophthalmology department, he seems to lose touch. On the other hand, the author found the surgical rotations, especially through neurosurgery, plastic surgery and ENT surgery, very helpful. Furthermore, rotations through various sub-specialties, as is practiced overseas,[3,5,7,9] will be of greater benefit to the residents.

Low Volume of Surgery in Teaching Hospitals

For one reason or the other, most teaching hospitals do not have enough volume of surgery to expose the residents to the number of surgeries needed to sharpen their surgical skills. The reasons for this are multi-factorial but certainly include the cost of surgeries, the bureaucracy in these institutions, and the fact that most of these teaching hospitals are in the big cities, while those needing these services are in the villages. Residents, therefore, have to make their own arrangements to find a place to improve on their surgical experience or face the risk of completing the programme ill-prepared. In recent years, such centres as the ECWA Hospital, Kano and Mercy Eye Hospital, Abak have been of tremendous help; but how many residents can such places take at a time? Free surgical outreaches may be the only way for residents who have learnt the basics to sharpen their surgical skills. It is recommended that every teaching hospital should endeavour to raise funds to make 'free' surgical outreaches a regular event. Such sponsorship could come from financial institutions and other corporate bodies. Politicians such as state governors and local government chairmen also welcome such opportunities to score political points. The place of these free or subsidized outreaches in creating opportunities for high volume surgery cannot be overemphasized.

Sub-Specialty Exposure

Ophthalmology is an area of medicine with rapidly evolving sub-specializations and their attendant technical sophistication. In the light of poor funding, which is a major problem facing residency programmes in Nigeria,[9] it is difficult for one institution to provide the facilities needed to expose the resident to all the sub-specialties. An organized 'exchange programme' between the various training institutions will help to widen sub-specialty exposure. It is recommended that this be incorporated into the residency programme. In addition, a forceful advocacy is needed to reinstate the suspended one year abroad programme.

Fellowship Examinations

The mode of assessment in the fellowship examinations in Nigeria has generally been described as being rather subjective,[6] leaving room for bias. This problem is not peculiar to ophthalmology. What it implies is that, for committing exactly the same 'offence', two candidates could come out with widely divergent fates. The examination bodies may need to explore modalities for making the exams less subjective.

Inadequate Preparation for Private Practice

For many reasons, not all the trainees will take up jobs in government institutions. There is the need to equip trainees to cope with the challenges of private practice. Ogunleye,[10] talking about training of otolaryngologists, wonders whether the new fellow is really prepared to tackle the following challenges of setting up private practice: how to set it up, location of practice, size of practice, equipment to purchase, drugs and how to

purchase them, how to bill his patients, number of staff to employ, how to fix their salaries, how to cope with fraud if it occurs, how to audit one's practice, and how to carry out research even in private practice. The incorporation of these issues into the management course organized for residents by the examination bodies (West African Postgraduate Medical College and National Postgraduate Medical College) has been suggested by both Ogundipe[4] and Ogunleye.[10] In addition, Ogunleye[10] suggests a rotation through a well-equipped private practice for pre-part II candidates.

CONCLUSION

In conclusion, the residency-training programme in ophthalmology has great potential for preparing a resident for future challenges. There are however, areas of weaknesses such as:

- ✓ An apparent absence of training priorities
- ✓ Superfluous external postings
- ✓ Insufficient commitment on the part of trainers
- ✓ Limited surgical exposure
- ✓ Insufficient sub-specialty exposure
- ✓ Insufficient management training especially for private practice

RECOMMENDATIONS

It is recommended that:

- the highlighted weaknesses be addressed and indeed rectified to strengthen the programme,
- performance targets be set for trainers,
- these targets be evaluated objectively as criteria for the attainment of certain heights.

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