Medical Education: Should Undergraduate Medicine be Post-baccalaureate?

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SUMMARY

In 1960 the first 13 medical students fully trained in Nigeria to internationally accepted standard graduated from the then University College Ibadan, earning the Bachelor of Medicine, Bachelor of Surgery (MBBS) London degree. Since then thousands of doctors trained to international standard have been produced from different medical schools in Nigeria.

The Medical & Dental Council of Nigeria has now registered about 50,000 doctors most of whom trained locally in Nigerian universities. The doctors were admitted into the universities with SSCE or its equivalent as the minimum entry requirement. These doctors have acquitted themselves by admirably working hard to in various capacities, including research, teaching and clinical services, to address and solve the health needs of Nigerians and beyond.

Recently the National Universities Commission (NUC) proposed and may soon implement a policy that would make the university first degree the minimum qualification for entry into medical schools in Nigeria. The new policy advocates a 4 year medical undergraduate curriculum. However this would in effect translate to a minimum of 9 years post-secondary school to produce a medical doctor. Given the perennial instability in the health and educational sectors in Nigeria as well as the difficulties in obtaining placement for internship, it may practically take up to 15 years post-secondary school to fully register a doctor. Therefore the new NUC policy will have the effect of producing aging young doctors which will in turn put the lives of Nigerians at increased risk.

Whatever be the flaw with the current 5 or 6 year straight MBBS programme is not due to the fact that SSCE or its equivalent is the minimum entry qualification. A minimum medical school entry qualification that has served Nigeria well for more than 50 years should not be jettisoned without convincing scientific evidence that it is detrimental to Nigeria's health policy and medical education process.

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INTRODUCTION

In 1960, the first 13 doctors fully trained locally in Nigeria to internationally accepted standard graduated from the then University College Ibadan, earning the Bachelor of Medicine Bachelor of Surgery (MBBS) London degree. However training of doctors locally in Nigeria antedated this. An attempt at training medical doctors in Abeokuta in 1861 by white Christian missionaries was stillborn. Indeed formal training of medical doctors locally in Nigeria began in 1930 with the establishment of the Yaba Medical School. In 1955 the Kano Medical School was established with the aim of producing medical doctors that would serve in the then Northern Region of Nigeria.

MINIMUM ADMISSION REQUIREMENT & TRAINING DURATION

Since 1930 up to now, the minimum requirement for admission into the medical schools in Nigeria has been Senior Secondary School Certificate (SSCE) or its equivalent. Thus the majority of the candidates were admitted with the SSCE or its equivalent after the candidates had satisfied the examiners in the concessional entrance examinations. However a few candidates gained admission to study medicine in Nigerian universities after obtaining the Higher School Certificate (HSC) or its equivalent or a university first degree in biological or physical sciences. For those admitted through concessional entrance examination the training endured for 6 years while those with HSC or university degree trained for 5 years to obtain the MBBS degree. Thus the admission requirement has been flexible with the SSCE as the minimum qualification. The Medical & Dental Council of Nigeria has now registered about 50,000 doctors most of whom trained locally in Nigerian universities. These doctors have acquitted themselves by admirably working hard in various capacities, including research, teaching and clinical services, to address and solve the health needs of Nigerians and beyond.

However since nearly 2 decades, there has been a persistent disruption of the academic calendar in Nigerian universities due to incessant industrial actions. The medical school in particular suffers double jeopardy in that its programme is not only adversely by the industrial actions of university workers or university students' riots but also by those of health workers. Thus theoretically the medical school training is 5-6 years but in reality it takes up to 8 years in most of the medical schools. The disruption of training causing its prolongation is unsatisfactory

and has been of concern to all stakeholders in medical education and health services in Nigeria, including the National Universities Commission (NUC), the Medical & Dental Council of Nigeria (MDCN), the Nigerian Medical Association (NMA), parents, students and the general public.

THE NEW NUC POLICY ON MINIMUM ENTRY REQUIREMENT & TRAINING DURATION

Recently the NUC proposed and may soon implement a scheme making the university first degree the minimum entry qualification for admission into medical schools in Nigeria. The theoretical advantages of this major policy change include graduation of older more mature doctors; only those who really want to study medicine would apply and not those whose parents have forced to study for the profession; training would be apparently fast tracked shortening the duration to 4 years. The most important reason for this major policy change is to graduate older and mature doctors. Obviously the proponents of this policy are fascinated by the medical education system in the United States of America (USA) which they intend to 'copy and paste' on the Nigerian medical education landscape. The NUC is no doubt aware of the flaws that currently undermine medical education in Nigeria and is anxious to correct them. However, solution to the problem does not lie in adjusting entry qualification to a minimum of university first degree. When about 100 years ago the medical education in the USA was in turmoil, the problem was not solved by just changing the minimum entry qualification. Rather a renowned educationist, Abraham Flexner, after a commissioned tour of the medical schools in USA and threats to his life notwithstanding, made far reaching recommendations that sanitized the system and subsequently the medical education and practice in the USA became the envy of the world, especially those in developing countries.

Of late the process of selection of medical students via Joint Admissions & Matriculation Board conducted examination has been criticized as allowing those intellectually and psychologically ill-prepared for the intense and prolonged medical school training to be admitted. But the university medical schools have opportunity to interview or re-test those seeking admission into their schools. If the universities fail in this aspect of their duty having first degree as minimum entry qualification would not solve the problem. Since our schools (secondary schools and even universities) scarcely have specific career guidance for the bulk of the students, the career choices will continue to be guided by parents, guardians, peers and other extraneous factors.

MEDICAL EDUCATION OBJECTIVES

The direction and contents of medical education are driven by societal needs. Our health needs, our socio-cultural milieu, including our social and economic infrastructure are different from those of the USA or other developed countries. Therefore the medical education objectives differ. The specific medical education objectives in Nigeria as endorsed by both the NUC and the MDCN are

- To provide sound scientific & professional basis for the training of doctors capable of working anywhere in Nigeria with other health workers
- To provide such training as would equip these health personnel to render primary health care (PHC). In this regard there is a definite need to re-orientate the curriculum to give greater emphasis to primary health care
- Teaching of Primary Health Care should be multi-disciplinary, involving all clinical and preclinical departments
- The training of doctors should be community-based. In keeping with concept of social responsibility all health training institutions should make a definite commitment to provide community service
- To produce doctors who would satisfy internationally recognised standards, and who could undertake further training toward specialisation anywhere in the world
- To produce doctors with sufficient managerial ability to play leadership role in health care delivery

Thus the Nigeria's medical education objectives rightly emphasise primary health care. Consequently the medical school curriculum in Nigeria stresses teaching the student the health care needs of Nigerians without compromising international standards as well as problem-based & community-oriented training. On the other hand the objectives of medical education in developed countries aim mainly at the establishment of a scientific foundation sufficient for understanding the principles of medical practice as well as acquisition of new knowledge through meaningful postgraduate studies and active research. Although the training also prepares the medical students for some practical professional functions after graduation, in Europe and North America, specialisation in specific branches of medicine form the pivot of professional practice.

Therefore social and cultural needs warrant a greater emphasis on practical professional functions in training a doctor who would work in developing countries. In trying to copy a country we should take into consideration the totality of the factors that make that country's system efficient. The fresh medical graduate in Nigeria is expected to, and indeed does, take more responsibilities than his counterpart in the developed countries; he works under more difficult conditions and is credited with the ingenuity of improvising tools to salvage his patients. It is tempting to surmise that this enormous responsibility will be better handled by an older doctor. The Medical & Dental Council of Nigeria and also the courts of law in Nigeria adjudicate in cases of medical malpractice and negligence involving doctors. In no case has it been alleged, let alone prove, that the youthfulness of the doctors was the reason for the malpractice or negligence. The new policy by the NUC means that theoretically it will take a minimum of 9 years to graduate a doctor (8 years of university schooling and one year of national service). In practice, given the perennial instability in the health and educational sectors in Nigeria, this will perhaps be not less than 12 years. Furthermore, considering the problems with securing positions for the mandatory internship it will be up to 15 years post-secondary school before the doctor becomes qualified for full registration. If he wants to be a specialist he will then train for another 6-8 years. The new NUC

policy will have the unintended effect of making the youngest doctor in a medical team to be not less than 35 years. If this satisfies the need for graduating presbyopic and menopausal men and women as young doctors, how well does it augur for effective and efficient medical services in Nigeria?. Experience has shown that not many doctors who studied medicine after first obtaining a university first degree bother about pursing a residency training programme. Conversely studies have shown that candidates who performed well at the premedical and concessional entrance examination continue to score high in professional examinations in the medical school. These bright young doctors are those likely to complete residency training and thus provide our nation with the needed specialists.

Even with our present system, a good proportion of doctors graduate at a relatively old age. The Nnamdi Azikiwe University is one of the institutions in Nigeria that have continuously enjoyed industrial peace for over a decade. Thus medical students' academic programmes are not delayed. An analysis of its graduates in 2006 showed that 25% were aged more than 30 years and 15% were already presbyopic! Studies from different parts of Nigeria have documented that the onset of presbyopia in Nigerians occur at an age far below that reported for Caucasians. But the important message here is that the presbyopic doctor will not be able to see clearly (without optical aids) to set up intravenous infusion on patients even in broad daylight. In our circumstance he would be required in most cases to perform this task at night using candle light or torch light or hurricane lamp even in urban hospitals. The aching, stiff waist and limbs of an ageing young doctor will deter him from responding to emergency cases as expected. Of what use is a hospital without efficient, reliable and responsive emergency service? The NUC has the power to implement its policy but I should caution that the health of Nigerians would be at great risk with the emergence of ageing young doctors.

Obviously there are issues that render medical education in Nigeria inefficient. Some of these are lack of teachers, poorly equipped laboratories, small clinic & laboratory space, overcrowding in classrooms, clinics and wards, poor remuneration of staff, inimical private practice by staff, truancy by staff, admission in excess of official quota, insufficient learning aids, poorly equipped library, etc. These problems which require both political and administrative will to solve are not caused by having SSCE as the minimum entry qualification. The SSCE as a minimum medical school entry qualification that has served Nigeria well for more than 50 years should not be jettisoned without convincing scientific evidence that it is detrimental to Nigeria's health policy and medical education process.

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