

SPECIALTY CHOICE OF RESIDENTS IN THE UNIVERSITY OF NIGERIA TEACHING HOSPITAL, ENUGU 1989 – 1999

By

LAWRENCE U. OGBONNAYA¹; ADA P. AGU¹; ELIZABETH U. NWONWU¹; & CHIMDIA E. OGBONNAYA²

¹*Department of Community Medicine & Primary Health Care, Ebonyi State University Teaching Hospital, Abakaliki;*

²*department of Ophthalmology, Ebonyi State University Teaching Hospital, Abakaliki*

SUMMARY

Objective: To analyze the specialty choice of residents in the University of Nigeria Teaching Hospital Enugu from 1989 – 1999, and to assess the ratio of community physicians to the clinical specialties of residents.

Method: The record of admissions into the residency training programme in the University of Nigeria Teaching Hospital Enugu was analyzed. Simple percentages and proportions of residents in the different specialties were computed and compared with one another and with community medicine.

Result: The ratio of community medicine to the other clinical departments of Surgery, Internal medicine, Obstetrics & Gynaecology and Paediatrics is 1:7. When compared individually, each of these four were at a ratio of about 2:1 to community medicine.

Conclusion: This study and other studies from other parts of the nation show that Nigeria is producing more core clinicians than community health physicians. As the nation's health policy is anchored on Primary Health Care, Community Health Physicians may be better suited to implement the nation's health policy. It would therefore be beneficial to increase the number of community Health Physicians produced by training institutions in Nigeria.

Key Words: Residency training; Health manpower; Primary Health Care; Community physicians

INTRODUCTION

The health system can be broadly defined as the coherent whole of many interrelated component parts, both sectoral and intersectoral, as well as the community itself, which produce a combined effect on the health of a population¹. Health manpower development is of course a part of this system, and affects every aspect of its operation².

A nation's residency training programme constitutes a crucial structure on which her health care system rests³. This is because the programme supplies the system with the top level and specialized medical manpower and provides teachers for the medical school. In

order to guide activities throughout the entire health manpower development process in a definite direction, it is of great value for the health leadership in a government to issue clear statements of national health policy containing goals, priorities and main directions². Nigeria's first health policy was formulated in 1986 and further reviewed in 1996⁴. This policy embraced primary health care as its bedrock. It is expected that this policy thrust should guide health manpower development priorities at all levels, including the residency training level, in order to raise the requisite number of the specialized manpower required to properly implement it. Studies conducted locally and

Correspondence Address:

Dr (Rev.) L.U. Ogonnaya, Department Of Community Medicine & Primary Health Care, College Of Health Sciences, Ebonyi State University, Abakaliki

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internationally among medical students, interns and practicing doctors consistently show a disproportionately higher preference for the core-clinical specialties of Obstetrics and Gynecology, Surgery, Paediatrics and Internal medicine⁵⁻¹³.

Though the choice of any vocation or course of study is the result of a complex interplay of social and personality related factors¹⁴, such social indices like riches, prestige and job satisfaction have been shown to be strong incentives that determined medical specialty preference⁵⁻¹⁵. It has been argued that government should show more direct interest in what residents specialize in, to ensure that specialty preference in residency training reflects a nation's health policy¹⁶.

This study was conducted to examine the choice of specialty by residents who undertook residency training in University of Nigeria Teaching Hospital Enugu between 1989 and 1999; and to see if their choice pattern is in consonance with the nation's policy on health manpower development; and finally to discuss the implications of the findings on the nation's ability to implement its health policy.

MATERIALS AND METHODS

A 10-year (1989-1999) record of residency training from admission to passing the part 1 fellowship examination in either or both the national post-graduate medical college of Nigeria and the West African postgraduate medical college was analyzed retrospectively. The years 1989 – 1999 were chosen because it is reasoned that the adoption of primary health care as the bedrock of our national health policy in 1986, and the further strengthening of that policy position in 1996 should significantly have affected manpower development priorities nationally. The study was conducted between July and September 2001 at the UNTH Enugu.

Written consent for the study was sought and obtained from the management of the University of Nigeria Teaching Hospital. The personnel department of the institution supplied the record of residency training within the years studied. All the residents who were offered

admission into the residency-training programme of the institution within the decade under review were included in the study.

The biodata of residents, number of admissions into the various departments offering training per year and the number in each specialty that had passed at least the Part 1 fellowship in at least one college was documented and presented in tables. Simple percentages and proportions were worked out and compared between the specialties; and between community medicine and the core clinical specialties to see the trend. Furthermore, comparison between community medicine and the combined 4 core clinical specialties of Obstetrics and Gynecology, Surgery, Internal medicine and Paediatrics was done. Finally, the data from UNTH Enugu was compared with the data from the National Postgraduate medical college within corresponding years to see if there was any statistically significant difference between the specialty choices in Enugu and the national records.

RESULTS

Between 1989 and 1999, two hundred and sixteen (216) residents were admitted for training. This gives an average of 21.6 residency places per year with a standard deviation of +/- 17.9.

Analysis By Year

The intake of residents showed a gradual rise from 1989 to 1992, after which there was a sharp fall in 1993 and 1994. The peak rose strongly in 1995 but fell soon after in 1996 and thereafter began another steady rise to another peak in 1999. See figure 1.

Analysis By Department

Twelve departments have been involved in the training of residents in UNTH. See table 1.

Sex Distribution Of Residents

Out of the 216 residents admitted so far, 56 or 25.9 % were females while 160 or 74.1 % were males. The difference is statistically significant ($P < 0.01$). Intra-departmentally, Community medicine has produced a significantly higher proportion of female residents than males. Out of 19 residents, 14 or 73.7% were females while 5 or 26.3% were males. This is followed by Ophthalmology where 10 out of 18 residents (55.6 %) and Paediatrics where 10 out of 29 (34.5%) residents were females. See Table 1. Overall, Community medicine has produced the highest number of female residents. Out of the total 56 female residents, 14 or 25% came from it. This is followed closely by Paediatrics and Ophthalmology who had 10 or 17.9% of the total each.

Comparison Of Community Medicine With The Combined Four Core-Clinical Specialties.

Placed side by side the core clinical departments of Obstetrics and Gynecology, Surgery, Internal medicine and Paediatrics, Community Medicine has a ratio of 1:2 with each, and when compared with the four combined a ratio of 1: 7.

Comparison Of Enugu Data With National Data

A comparison of specialty choice data from UNTH Enugu with the national data from the bulletin of the National Postgraduate medical college of Nigeria ¹⁹ shows a lot of similarity. The difference is not statistically significant ($P > 0.05$). See table 2.

FIG 1 YEARLY ADMISSION INTO RESIDENCY

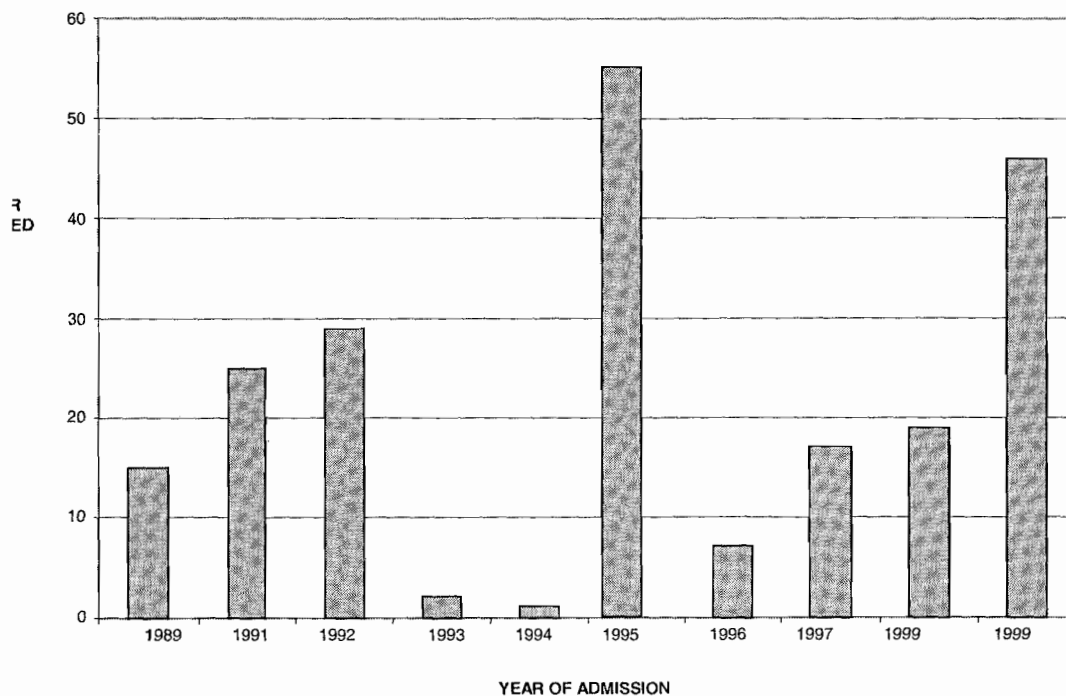


Table 1 Sex / Departmental Distribution Of Residents.

S/NO	DEPARTMENT	SEX		TOTAL
		MALE	FEMALE	
1.	SURGERY	35 (97.2)	1 (2.8)	36 (100)
2.	OBSTETRICS/GYNAECOLOGY	30 (85.7)	5 (14.3)	35 (100)
3.	INTERNAL MEDICINE	25 (75.8)	8 (24.2)	33 (100)
4.	PAEDIATRICS	19 (65.5)	10 (34.5)	19 (100).
5.	COMMUNITY MEDICINE	5 (26.3)	14 (73.7)	19 (100).
6.	OPHTHALMOLOGY	8 (44.4)	10 (55.6)	18 (100)
7.	ANAESTHESIA	9 (69.2)	4 (30.8)	13 (100)
8.	RADIATION MEDICINE	10 (90.9)	1 (9.1)	11 (100)
9.	OTORHINOLARYNGOLOGY	8 (88.9)	1 (11.1)	9 (100)
10.	PATHOLOGY	7 (87.5)	1 (12.5)	8 (100).
11.	MAXILLO-FACIAL SURGERY	2 (66.7)	1 (33.3)	3 (100)
12.	PSYCHOLOGICAL MEDICINE	2 (100)	- (0.0)	2 (100)
	TOTAL	160 (74.1)	56 (25.9)	216 (100)

NB: Figures in parenthesis are percentages.

Table 2 Comparison Of Enugu Data With The National Data

SPECIALTY	ENUGU DATA	NATIONAL DATA
COMMUNITY MEDICINE	19 (12.5)	65 (10.8)
PAEDIATRICS	29 (19.1)	104 (17.3)
INTERNAL MEDICINE	33 (21.7)	158 (26.3)
OBSTETRICS & GYNAECOLOGY	35 (23)	116 (19.3)
SURGERY	36 (23.7)	157 (26.2)
TOTAL	152 (100)	600 (100)

$X^2 = 0.43$; $P > 0.05$; $df = 4$

DISCUSSION

This study analyzed the specialty choice of residents who trained at the University of Nigeria Teaching Hospital Enugu from 1989 – 1999. It is similar to that of Bojuwoye *et al*⁵ in that it studied the specialty choices and not merely the statement of intents, which most of the previous studies on students and interns tend to focus on. The most popular specialty choice among these residents was Surgery, Obstetrics and Gynaecology, Internal medicine and Paediatrics. This is similar to the findings of previous studies⁵⁻¹⁵ and reflects the national trend¹⁹. Many explanations have been adduced for the strong preference of medical graduates for high technology tertiary-care specialties. One is that the environment where medical students are trained is that of a sophisticated

referral hospital²⁰; and the history of medical education in Nigeria shows that the philosophy of training of our doctors was dominated by the teaching hospital and disease- centered model of modern Europe and North America from 1948 to about 1977²¹⁻²². However, the National Universities Commission has formulated a medical education policy aimed at re-orienting medical training in all medical schools in the country towards Primary Health Care²³. Yet very few schools are implementing any articulate community oriented training programme of students²⁴. Nkangineme²⁶ summed up our medical education as being “excessively outward looking and pointed out that we pre-occupy ourselves with international standards and are training our students for the international market at the expense of our local

needs and interests. He pointed out that the immediate result is that while our students are not sensitized to our immediate and long-term health priorities, we dissipate our national resources training 'cheap' and very functional medical manpower for practice in the health-care models of the developed countries. He concluded that in this way our medical education contributes to the 'brain and capital drain phenomenon' as these young graduates keep migrating to Europe and America to work and further specialize in the "high tech" medicine"²⁵.

It is now generally understood that an adequate number and appropriate mix of specialist health personnel is essential for the successful implementation of health programmes. Sadly though, health professional education has not traditionally concerned itself with the number or nature of graduates. This observation has led to the general criticism that the education of health personnel is not sufficiently relevant to the priority health problems in society²⁰. Most doctors have had little training in the wider aspects of health. The sophistication of their biomedical and clinical training is not matched by comparable training in relevant social sciences, and they have little opportunity to learn from role models how to address the social, economic and political forces affecting health. The postgraduate discipline that teaches this is community medicine. The community physician is equipped with the skill to conduct community diagnosis and subsequently plan health actions to deal with the relevant health problems of a defined population in the context of Primary Health Care. This makes him/her competent to function as a medical officer of health (MOH). Nigeria runs a three-tier health system – primary, secondary and tertiary. Statutorily, PHC (which is the bedrock of our health policy) is the responsibility of the local government. Secondary care is the responsibility of the state while tertiary care is predominantly the responsibility of the federal government. There are 774 LGAs recognized by our constitution currently. A community physician should serve

as a medical officer of health (MOH) in the health department of each of these LGAs to give leadership and translate policy into programmes.

CONCLUSION AND RECOMMENDATIONS

It appears we are not training the correct mix of specialists for our health care system. We have produced disproportionately far more bedside clinicians than community health physicians. For a country that has our kind of epidemiological and health indices, and have primary health care as the bedrock of its health policy, the ratio of community physicians to the bedside clinical specialists being trained as revealed in this study is too low for comfort and it does not seem the trend is about to change.

Many suggestions aimed at attracting medical students and young doctors to unpopular specialties like community medicine have been put forward in the past⁵. We recommend that they be implemented, in addition to a deliberate policy of inducement for community medicine better than what obtains now.

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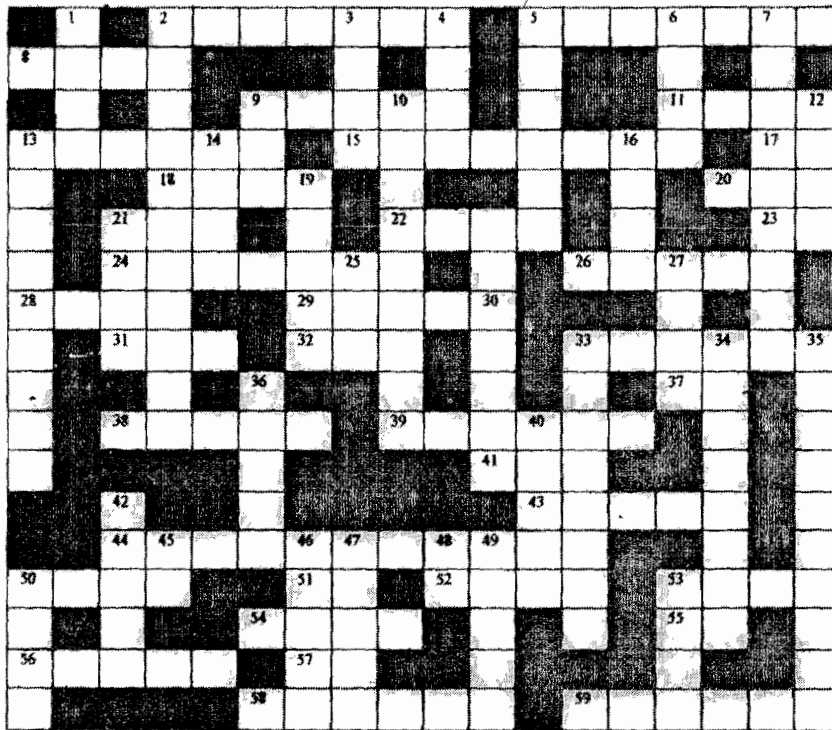
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Clinical Puzzle



CROSSWORD PUZZLE 2

Across

- | | |
|---|--|
| <p>2. Loss or absence of sense of smell (7)</p> <p>5. An individual with monophthalmos (7)</p> <p>8. A furuncle (4)</p> <p>9. The fundamental unit of length in the metric system(5)</p> <p>11. Having the form of, resembling (4)</p> <p>13. A complete set of chromosomes derived from one parent (6)</p> <p>15. Neuroplasm of the axon (8)</p> <p>17. A denial (2)</p> <p>18. To become submerged</p> <p>20. Bashful (4)</p> <p>21. Past tense of eat (3)</p> <p>22. Systematic discrepancy between statistical values (4)</p> <p>23. Thank you (2)</p> <p>24. One hundredth (7)</p> <p>26. Used in wound dressings (5)</p> <p>28. A German instrument maker (4)</p> <p>29. Denoting a wild untamed animal (5)</p> <p>31. An atom, carrying a charge (3)</p> | <p>32. The seventh letter of the Greek alphabeth (3)</p> <p>33. A name associated with a dressing type (6)</p> <p>37. A river (2)</p> <p>38. A genus of small mosquitoes found in tropical regions(5)</p> <p>39. Related to a rooflike covering (6)</p> <p>41. A hub (3)</p> <p>43. A gap junction (5)</p> <p>44. Relating to the common bile duct (11)</p> <p>50. A poorly localized pain (4)</p> <p>51. The 18th letter of theEnglish alphabeth (2)</p> <p>52. A high mass of land (4)</p> <p>53. The zygomatic bone (4)</p> <p>54. A popular name for the crocodile (4)</p> <p>55. Not off (2)</p> <p>56. French for heart (5)</p> <p>57. Behold (2)</p> <p>58. A shunt or auxillary flow (6)</p> <p>59. Almost complete absence of oxygen (6)</p> |
|---|--|

Solution on page 38