MEDICAL RECORDS
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AWOJOBI CLINIC ERUWA

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THE BIRTH OF

MEDICAL RECORDS AT AWOJOBI CLINIC ERUWA

Since inception on 27th October 1986, Awojobi Clinic Eruwa has been modeled after Mayo Clinic, Rochester, USA. As a clinical student at the University College Hospital, Ibadan, Nigeria, I had read the book, MAYO: THE STORY OF MY FAMILY AND MY CAREER and looked forward to the day I would establish a similar health institution in Nigeria. That ambition informed the name of our hospital. The community of Eruwa had been so much involved in the establishment of ACE such that it was natural to include Eruwa in the name of the clinic. As depicted in the logo, the abbreviation of the clinic is 'ace' – first of its kind, with the inclusion of a star – the largest structure known to mankind.

In the past 25 years, we have seized the opportunity in guest lectures and attendance at conferences and symposia to inform and update the medical community of the activities at ACE. So, in line with the tradition of Mayo Clinic which publishes Mayo Clinic Proceedings, we want to initiate the publication of MEDICAL RECORDS AT AWOJOBI CLINIC ERUWA, MEDRACE.

MEDRACE will start off with Dr Oluyombo Awojobi's account of the 52nd conference of the West African College of Surgeon that took place in Monrovia, Liberia in February/March 2012. This first and subsequent issues can be downloaded on www.ifrs-rural.com

Dr Oluyombo A Awojobi. 18th March 2012.
Consultant Rural Surgeon.

2012 WACS CONFERENCE AND SURGICAL TURF PROCTECTION IN NIGERIA

Last year, I became a fellow of the West African College of Surgeons, WACS, by election 28 years after I declined an offer from my teachers, Professors O O Ajayi and S A Adebonojo. My objective was to influence the training in the college such that it could develop a middle level surgical manpower very much like a strong middle class in the civil society. I had based my hopes on the pragmatism displayed by the founding fathers of WACS in 1973 who, quite rightly, appreciated that the specialists to be trained by the college should be more service orientated and realizing that with better quality service on a large scale came better teaching/training and research. That was why the need for dissertation at the final examinations, as in the National Postgraduate Medical College of Nigeria, NPMCN, that preceded it, was not a condition to the attainment of the fellowship. Fellows who wanted to be academic surgeons could do so using other additional means. Nigerians constitute 80 per cent of WACS.

In the ensuing years, the faculties of anaesthesia, ophthalmology and Ear Nose and Throat saw the need for middle level manpower training and so introduced the diploma course in their programmes. The holders of these diplomas, especially in ophthalmology, are doing good jobs at the secondary health institutions. In the Gambia, where there was a dearth of doctors, a Nigerian ophthalmologist, Dr Hannah Faal, empowered nurses to extract cataracts, the major cause of blindness in that country and much of West Africa. Much of that later.

A subtheme of the conference in 2011 in Dakar, Senegal was middle level manpower training and the president of the WACS made a strong case for it in her inaugural address. I believe this influenced the choices of the themes and subthemes of this year's conference in Monrovia, Liberia:

- The role of surgery in post-conflict countries in West Africa
- Middle level health manpower development in West Africa
- Surgical strategies for reduction of maternal and child morbidity and mortality in West Africa
- Surgical practice to meet the millennium development goals in West Africa.

After being inducted a fellow in 2011, I sent a proposal to the chairman of the faculty of surgery on 31st July 2011 titled: TWENTY FIVE YEARS OF THE SURGICAL FELLOW – IS THE GENERAL SURGEON BECOMING AN ENDANGERED SPECIES IN WEST AFRICA? I advocated for the introduction of a diploma course in general surgery like the faculty of ophthalmology. I followed this up by submitting an abstract of a paper for this year's conference titled THE NEED FOR MIDDLE LEVEL HEALTH MANPOWER DEVELOPMENT IN WEST AFRICA.

In the meantime, there was an intense internet debate on SURGICAL TRAINING IN NIGERIA conducted on the platform of HEALTHCARE INFORMATION FOR ALL BY 2015, HIFA2015, a UK-based NGO. Concerning middle level manpower training aspect of the debate, the opponents were worried about how the products of the training could be monitored so that they would not go beyond their limits. To this, I responded that in Nigeria, the first degree permitted any doctor to perform any surgery within his/her ability and the conduct of the medical officers and the super-specialists is under the control and monitor of the Medical and Dental Council of Nigeria, MDCN. So, further training of the medical officer would ensure better outcome of his practice than otherwise.

Another aspect of the debate was the legal basis by which the National Open University of Nigeria, NOUN, could initiate an MSc (Primary Care Surgery) programme with a high dose of surgical skill acquisition in accredited hospitals. I reminded my fellow debaters that the NOUN was like any other university with the peculiarity of catering for working class Nigerians that included doctors and the MSc (Primary Care Surgery) would be like the MPH and the MSc (Surgery) being run by the University of Ibadan for doctors without diploma or fellowship. These academic degrees are not registrable with MDCN but with the National Universities Commission, NUC, should the holder seek employment as a teacher in the university.

These two issues were the main features of the phenomenon of SURGICAL TURF PROTECTION exhibited by the opponents of middle level health manpower development in Nigeria. It was even extended to the case that a general surgeon who performed the 'occasional' prostatectomy could not describe himself as a urologist as if the rural patient cared about who relieved him of his agony.
This was the background to my trip to the 52nd annual conference of the WACS that took place in Monrovia, Liberia between 26th February and 3rd March 2012.

At the opening ceremony on 27th February, the president of the Republic of Liberia, the pro tem president of the Senate of Liberia and the minister of health welcomed delegates, 24 years after the last conference in Monrovia. They wished they could enact a law requiring delegates to obtain exit visas so that surgical manpower could be assured for some months after the conference! The minister of health, a fellow surgeon who has been practising in the rural setting for three decades, informed the conference he felt much safer in his theatre than in the ministry. He looked forward to returning to his theatre after his tenure as minister.

In a goodwill message sent from the president of NPMCN, he informed the conference that membership certificate would not be issued because state governments in Nigeria would then prefer to employ members to fellows. Here is a situation where governments in Nigeria are preaching and pleading that the products of all training institutions should be self-employable and not dependent on government for jobs but an arm of the government is bent on the reverse. This situation is possible in the Nigerian public service because remuneration is not based on productivity and ability to solve challenges otherwise, what should be the response of NPMCN to the fact that over 95% of cases coming before the MDCN disciplinary tribunal were of surgical mishaps in the hands of medical officers without formal surgical training? I guess their answer is BUSINESS AS USUAL.

At the meeting of the faculty of surgery later in the day, it transpired that

- The results of the two examinations in 2011 were as dismal (33% pass rate) as in the past with internal examiners noting the deteriorating standard of surgical skill. There was no discussion at the meeting on how this could be solved. BUSINESS AS USUAL.
- Accreditation of various teaching hospitals showed that the number of training posts did not match the number of eligible doctors seeking residency training. Again, there was no suggestion on how it could be resolved. BUSINESS AS USUAL.
- A decision had been taken to introduce the successful defence of a dissertation for the final examinations to be effective in 2015. This was done to improve the research capability of fellows. This came about because the NUC was demanding that teachers in the colleges of medicine must have academic degrees to justify their employment in the universities. Fellows of NPMCN had argued that the curriculum of its residency training which included a dissertation was equivalent to

a PhD. Of course, this is not true as I am a fellow of the NPMCN (1983) and it takes more than the dissertation to obtain an MSc. But of course in Nigeria, much of discussions among academics are emotional and not evidence-based. I have referred the NUC to some of the Master's dissertations of my teachers in the archives of the University of Ibadan. The WACS is introducing the dissertation because it feels the NPMCN is winning the case with the NUC for now.

- The issue of middle level manpower training had been discussed exhaustively at the July conference in Dakar and rejected wholesale but, the council of WACS had requested the faculty to reconsider the issue. The details of the exhaustive discussion were not available in the circulated minutes and here again was the case of the tail trying to wag the head. I did not get an answer to the question I asked if my proposal was considered at the faculty board meeting that took place in October 2011 after its submission.

On 29th February, at the scientific session on Manpower Development, I presented my paper to a full house:

THE NEED FOR MIDDLE LEVEL HEALTH MANPOWER DEVELOPMENT IN WEST AFRICA

"Twenty five years after the first fellow in this faculty by examination, the output of general surgeons has not been impressive compared with the subspecialties especially orthopaedics which is already making a move to be a separate faculty. When that happens, general surgeons will realize they are becoming an endangered species.
"The results of the past and latest examinations are not heart-warming and with the introduction of dissertation into the examination process, the outlook is not good from the experience of the National Postgraduate Medical College of Nigeria.

"While the WACS was established to produce specialists in surgery and related disciplines, it cannot shy away from its responsibility to the community in the provision of safe and essential surgery otherwise its relevance to that society will be questioned. This is what has brought about the phenomenon of WHERE THERE IS NO COMPETENT DOCTOR because trainers in this faculty are the same that train medical students to become

doctors. The quality of these doctors is being reflected in the dismal performances at the parts 1 and 2 examinations.
"In Nigeria, most surgeries are performed by medical officers without formal surgical training and in many instances by non-physicians. Prof S K Gyoh, former chairman of the Medical and Dental Council of Nigeria, MDCN, who was also WACS 16th Sir S L Manuwa lecturer, as the first president of the Association of Rural Surgical Practitioners of Nigeria, ARSPON, delivered a paper at its 2008 first annual conference in which he said:

"The surgeon is the most frequently sued specialist in the health profession. Records at the Medical and Dental Practitioners' Disciplinary Tribunal show that over 95% of the cases were for operations that went wrong, though many of the procedures were not necessarily performed by doctors with formal surgical qualifications. The outcomes of operations are more manifest and less arguable than those in internal medicine."

"He recently reported an epidemic of faecal fistula in Benue State, Nigeria. Most of them resulted from appendicectomies performed by non-physicians trained by doctors.

"Having spent close to 29 years in rural southwest of Nigeria, majority of the operations I have performed included external hernia repair 39.4%, excision of lumps 13.3%, hydrocelectomy 5.9%, laparotomy for infection, obstruction, trauma and gynaecological diseases 13.5% and caesarean section 5.7% constituting 77.8% of 16167 operations.

“In other words, over three quarters of the operations I have performed could be handled by a well-trained medical officer. And here comes the need to train middle level surgical manpower if the faculty of surgery of the WACS must remain relevant to the needs of the society it was established to serve.

“In this college, if Dr Hannah Faal could train nurses to extract cataracts in the Gambia and Emeritus Professor A Adeloye could empower non-physician clinical officers to insert ventriculo-peritoneal shunts for congenital hydrocephalus in Malawian children, why could the faculty of surgery of the WACS not empower DOCTORS to ameliorate the surgical burden of the rural people of the West African sub-region?

“Whatever we all say about the conditions in the rural areas of West Africa, especially Nigeria, there are medical officers in these areas who are doing their best in the given circumstances and the least this faculty can do is to further encourage them by empowering them surgically. That is one way this college can remain relevant in the health care delivery system in West Africa.

“In conclusion, I wish to end my presentation with this quote of our past president, Prof O O Ajayi:

“The surgical training programme at the WACS “must be relevant, flexible, and adaptable **to reflect our needs at all the three tiers of the health care system** and we cannot lose touch with new developments and technologies that can be used to manage the changing patterns of disease or the emergence of a new pandemic of diseases common in industrialized countries. The ability to make virtue out of necessity is the greatest and immediate challenge of all”.

“I thank you all for your kind attention. *Merci beaucoup!!*”

Prof Ajayi reminded the audience that surgery in the rural setting (the terms he preferred to rural surgery) had been the subject of discussions for many years and the issue was a continental challenge which the Pan African Association of Surgeons would be discussing further at its next conference in Addis Ababa in December 2012.

Another delegate reiterated the issue of how to monitor this cadre of surgical practitioners to which I repeated my previous position.

The crystallization of surgical turf protection by the fellows opposed to middle level manpower development came when the next presentation featured: MEDICAL STUDENTS’ CHOICES OF POSTRGRADUATION SPECIALTY IN THE GAMBIA: THE NEED FOR CAREER COUNSELLING.

It was reported that no medical student wanted to specialize in ophthalmology because they did not want to compete with the nurses who had been empowered by Dr Hannah Faal!!

At this point, I told the audience that if fellows of the faculty of surgery of the WACS and the NPMCN persisted in their opposition to middle level manpower training and certification, the NOUN would fill the gap with the MSc (Primary Care Surgery) for Nigerian doctors.

At the closing ceremony on 2nd March, forty two diploma certificates were awarded in anaesthesia and nine in ophthalmology.

The president of the College of Surgeons of East, Central and Southern Africa, in a brief lecture titled: SPECIALIZATION AND MEDICAL TRAINING – AN AFRICAN ENIGMA?, informed the audience of the pragmatic ways the college had solved the surgical challenges facing the majority of rural dwellers in those regions of Africa by training the cadre of clinical officers from non-physicians. He suggested that in the context of sub-Saharan Africa, general surgery should be termed acute care surgery. He urged the WACS to think 'out of the box' to reach out to the populace it serves stressing that what the patients wanted were skilled health care workers offering available and affordable services with empathy and compassion in a convenient environment. "It was iinconsequential if the health care givers were specialists, nurses, clinical officers, non-physicians or traditional healers." He ended, quoting Prof Ajayi, 'Innovation is the hallmark of our ability to function in a given circumstance' and Africans should find African solutions to their challenges.

The president of the Republic of Liberia, represented by the deputy minister of health, declared the conference closed by admonishing the WACS not to follow (blindly) the west in facing the surgical challenges of the sub-region. She re-echoed the view of the honourary fellow of the WACS, president of the American College of Surgeons, at last year's conference in Dakar.

The question is 'Has the first slave trade permanently changed the psyche of the West African?'

Oluyombo A Awojobi **2nd March 2012.**

POST SCRIPT

On our return journey to the airport on Saturday 3rd, I was informed by a council member of the WACS that the council, at her post-conference meeting, had sent 'marching orders' to the faculty of surgery to prepare the curriculum for membership to be presented at the next meeting of the council. This gladdened my heart because the head was now wagging the tail.

While away in Monrovia for six days, the junior lady medical officer, a graduate of University of Lagos, who joined our practice in September 2011, had performed three caesarean sections for obstructed labour and forceps delivery for an eclamptic mother. All mothers and babies were doing well. This performance epitomized my mission in WACS and my trip to Monrovia. There are not many like her who would want to acquire surgical skill without a certificate to show for it.

The struggle now shifts to the NOUN.

Oluyombo A Awojobi **3rd March 2012.**