Human Resources

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A new breed of doctors

Medical education in Nigeria is by and large still geared to international recognition. It is high time to discard this hangover from the colonial past. While maintaining international standards of excellence, Nigeria’s medical schools need to turn out doctors equipped to solve Nigeria’s health problems, not those of other countries.

The aim of medical education in the African Region has long been a subject of debate. Medical training in Nigeria began in the 1930s in a technical college where the brightest students of the land were put through a rigorous course for treating the sick in an ill-equipped general hospital. The graduates were destined to rise no higher than an Assistant Medical Officer in the Civil Service, i.e., an assistant to a doctor trained in the United Kingdom. From that point on, our sights were set on a medical education similar to that offered by British medical schools. This kind of training was all the more attractive as it promised recognition by the British General Medical Council and implied that our doctors could practise anywhere in the world. So it was that the University College Hospital and Medical School at Ibadan, our first, opened in 1948 with the London University curriculum and awarded London medical degrees. Even in the mid-1960s, when Ibadan broke with London University, reviewed its curriculum and began to award Ibadan degrees, there was no fundamental change in the philosophy of the training programme, including the emphasis on international recognition. To date, Ibadan is the most conservative of all 15 medical schools in the country.

Ibadan thus turned out generations of doctors equipped with skills that were inappropriate for dealing with Nigeria’s health problems. As the school’s graduates moved from one university to another, this fundamental anomaly spread to other medical schools.

Pioneering efforts

The University of Ife was the first to try something different. It opened with a determination not to build a large teaching hospital, but to use existing general hospitals and local health facilities such as health centres and dispensaries for its teaching programme. In the process, the University

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A medical education suited to Africa

We in the African Region have inherited doctors, medical school curricula, and a health care system largely unsuited to our countries’ needs.

Our people suffer from high rates of acute communicable disorders and parasitic diseases, including malaria, guinea-worm disease, river blindness, and sleeping sickness. Food insecurity is a major problem in many of our countries, so that acute and chronic malnutrition is widespread. Fertility rates are very high and, as a result, the population growth rate in the Region is now about 3.3% on average. All these problems emanate from factors in the community, where the people live and work.

Over the past 30 years, the World Health Organization has spearheaded the establishment of health care systems which can tackle these problems at the community level. In response to its leadership, our countries have invested heavily in the training of manpower, the development of health infrastructures, and the implementation of programmes to control diseases.

Since the 1978 Declaration of Alma-Ata on primary health care, our governments have intensified their efforts to make health services available to the people where they live and work, at a cost they and their countries can afford. Many of our countries have accumulated considerable practical experience of innovative approaches to health care. For example, countries have developed and used new categories of health workers and experimented with community participation in health activities.

What has puzzled many is that our medical schools behave as if these innovations and initiatives do not really concern them. Thus, they continue to produce doctors suitable for the pre-Alma-Ata era.

The health services we inherited at independence placed more emphasis upon curative than preventive medicine. Further, the need for early diagnosis and treatment within the community was not underscored. Medical care was available to only a small fraction of the population, the elite, who appreciated the value of scientific medicine and could afford to pay for it. The vast majority were left to the mercy of traditional healers whose perceptions of the nation’s health problems were wrong, whose skills were often limited and inappropriate for tackling specific ailments, and whose healing homes were frequently unhygienic. To date, this situation has changed only to a very limited extent.

Our people should learn, through grassroots education, to avoid the perils emanating from ignorance and disease. This should be the major thrust of our future medical education. We should arrest or prevent problems rather than wait to cure them with expensive and often unavailable manpower and finance. It is incumbent upon our Ministries of Health and Education to liaise and collaborate more closely to ensure that primary health care, community-related medicine and a preventive approach to health problems are enshrined in the syllabuses of our medical schools. Such an education should produce doctors with the skills to meet the health needs of our peoples, wherever they may live and work; doctors who are profoundly aware of the sociocultural attitudes of their patients; doctors who fully
appreciate the impact of the environment on mental and physical health and who take due cognizance of the peculiar circumstances of their localities on the disease profile; doctors who will promote the health of all people and who are at the same time trained to the highest degree in the biomedical sciences. Indeed, attention to community and sociocultural factors in the prevention and treatment of disease must never lead to a slackening of the quest for knowledge rooted in science. It is such doctors who will bring about the long-awaited revolution in our health care systems. Our governments must provide not only the facilities to make all this possible but also an atmosphere conducive to change.


would develop both the primary and the secondary health care systems for a population of about 250,000 as a model for the nation’s health care system and for other medical schools. Unfortunately, instead of employing sociologists, demographers, statisticians, public health doctors and general practitioners to build up the primary health care system as a first step in the school’s development, the University brought in academicians in the clinical and basic medical disciplines. It was they who then dictated the direction of the medical curriculum, pulling the school away from its innovative intent and back to the traditional philosophy of medical education. Now I am being asked, as Minister of Health, when a teaching hospital will be built in Ife.

The University of Ife opened with a determination not to build a large teaching hospital, but to use existing general hospitals and local health facilities for its teaching programme.

The University of Ilorin is a true pioneer when it comes to relevant medical education. The students are taught to identify health problems in the community and find solutions for them; at the same time they are equipped with the skills to function in a hospital at an appropriate level in support of community health services. Innovative problem-solving methods of teaching have also been introduced, enabling the students to undertake considerable self-tuition.

These tendencies are also noticeable to some extent in the newest medical schools, such as the one in Ogun State University. But while innovation is seen in the newer schools, change is slow to come to the older ones. Experience shows that introducing a novel type of medical education into a traditional, curative, hospital-oriented school is difficult and requires careful planning as well as the conviction and commitment of faculty members to the new course they have charted for themselves.
With the push to set up this nation’s primary health care system, we believed the medical schools should also participate in this great enterprise. In 1986, all Nigerian medical schools were therefore invited to help the local government in their area to develop its primary health care system by providing technical assistance. It was thought that this would give schools the opportunity to review their curricula and to use the services developed in the local government area to train their students. They would, moreover, gain experience in working closely with a most important arm of government and in learning to take decisions in the face of scarce resources. The invitation was backed in each case with a grant of half a million naira (approximately US$ 75 000) to the local government, and a station-wagon car to the medical school. Very few schools, so far, have risen to the occasion and developed the necessary symbiotic relationship with the local government authorities. Nor has there been any significant impact on curriculum review.

**International standards, not international recognition**

We cannot continue to train doctors to solve the health problems of other countries. We cannot continue to seek international recognition for our medical graduates, which only permits them to emigrate at the earliest opportunity. We must define our own health problems, decide on the skills our own doctors need to tackle them, and equip the medical schools with the necessary facilities to give them those skills. To do this, we need political will.

International recognition must not be confused with international standards, although a high standard of medical education is common to both. Recognition is what countries give to those doctors who they believe have been trained to solve their problems. While our training programme must be up to international standards in terms of quality, it must be designed to solve our own problems.

The people of the African Region cannot wait much longer for their medical schools to discard their colonial heritage and turn towards local problems calling for urgent attention. Political will and leadership by ministries of education and health alike can make all the difference in how the schools respond to that call.