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Outside Europe

British Aid to Medical Schools in Developing Countries

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Summary

If the British allocation for overseas aid is increased more generous agreements could be made with host universities and with expatriate staff. It would greatly stimulate overseas service by specialist trainees if the professional colleges and the universities agreed that they would be willing to substitute in their training programmes a year or two of service in an overseas medical school for one or more of their orthodox appointments. Consideration might be given by the councils for postgraduate education to ways of facilitating service overseas by specialist trainees and young consultants. The suggestion of the Royal Commission for the expansion of departmental staff establishments and training pools requires that the temporary expatriate occupying a supernumerary post is absorbed into the establishment on his return. While this may be done now in individual cases by personal arrangement a national agreement between universities and the N.H.S. would be necessary for these secondments to be made on the large scale commensurate to the need.

For other returning young doctors not yet in specialist training schemes an assurance that applications for appointments by those who had worked in developing countries would receive favourable weighting, by both university and N.H.S. selection committees, would be very helpful.

Introduction

In the past decade or so there has been diminishing enthusiasm in medical Britain for overseas aid. The growth of nationalism in developing countries, the economic difficulties in Britain, the competition for specialist posts, and the introduction of specialist

training programmes have been important factors in impeding the maintenance of the magnificent overseas traditions of British medicine. That the adventurous and generous spirit which inspired these traditions is not dying is shown by the success of the Voluntary Service Overseas organization and the eager enthusiasm of medical students who spend their elective periods in developing countries. There is some evidence that British medicine is now emerging from these constraints and that our medical schools, despite the difficulties I have mentioned, are taking a fresh look at the opportunities for providing overseas aid. There are indeed splendid opportunities for British medicine to maintain good reciprocal relations with the foreign and Commonwealth countries with which our medical ties have been close for so long.

What can be done to reduce the difficulties?

National Pride

We cannot abate the nationalist tide, and it is necessary to remember that even welcoming nationals would rather see their country doing business with equals than being the recipient of foreign generosity.

Affronts to national pride are likely to be reduced in the long term if the original agreements are made in a realistic though sympathetic spirit. National sentiment naturally inclines to promise a takeover of a project at an earlier date than appears probable to the dispassionate observer. The time for optimism and generosity should come later when the project is in rough water, as sometimes happens. The agreement should allow for a phased takeover of the project, whether it concerns one individual, a whole department, or a combined research and service project. The objective of any medical school in any developing country is the "naturalization" of all staff as rapidly as possible. Specialists in any medical discipline are a long time in the making. Fifteen to 20 years from the inception of a new medical school is the shortest possible interval to a complete takeover. Specialist training may reasonably be speeded up in developing countries, for there is surely an acceptable compromise to be found between the overnight creation of specialists plucked from the inchoate and undifferentiated mass of graduates and the measured progress towards the complete professional practised in developed countries.

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Financial Arrangements

In nearly all developing countries chronic poverty is the chief obstacle to be overcome in the struggle towards higher standards, and with an expanding economy the hindrances to progress can be gradually removed. The affluent countries have pledged themselves to devote 1% of the gross national product to overseas aid. Few of them have come near the target. Britain is well down the league table, and her present economic problems make it difficult to give the generous help traditionally expected of her.

Exporting doctors is expensive; wives and families greatly increase the cost, especially if children have to be brought home to boarding-school. Leave must be provided every two years (annually in certain circumstances) and children at boarding-school in Britain should be given at least two return passages each year. For short secondments the bill becomes even more expensive, relative to the quantity of help provided. Secondments of university staff from large departments may be carried without the provision of a locum, but when a locum is required, whether in university or N.H.S., the cost usually falls on the Inter-University Council for Higher Education Overseas, and the total financing of a short-term project must then often seem to be prohibitive.

The usual British practice is to require the host university to make some contribution towards the cost of the project in the first year and then in increasing proportion during each year of its course. In very poor countries, and many developing countries teeter continually on the edge of bankruptcy, this may be an impossible provision, and despite the availability of staff the conceived project may be stillborn. Some countries and the W.H.O., although also phasing an eventual takeover, will bear the whole cost of a project until the time when the developing country is judged ready to accept an additional load. (It may be agreed that these arrangements should require that the university's accurate financial forecast should be available to the foreign partner and that all countries who enter into agreements with a particular university should exchange information with each other. This international exchange of information has not yet become accepted practice.)

An increased governmental allocation for overseas aid in Britain, which should follow her expected economic recovery, would allow the financial arrangements both for expatriate staff and for developing medical schools to be planned on a more generous scale.

Employment of Returned Expatriates

The third difficulty is that of interrupted professional training and the uncertainty of appropriate employment on return. It provides the main reason why young British medical academics—clinical, paraclinical, or preclinical—are rarely to be met with today on long-term engagements in developing medical schools. The conditions in Swedish universities and government health service are more encouraging to overseas service than are those in Britain. Senior governmental physicians are entitled to take leave for service in developing countries. In the universities also staff are given leave for service overseas, and the years of service are deducted from their contracts, which usually run from three to six years. Junior physicians not in long-term appointments on their return from an overseas post are given a favourable weighting to their applications for new appointments.

Emphasis is now being given by the professional colleges in Britain to some degree of flexibility in their specialist training programmes. The Royal College of Physicians of London in its document *Training for Consultants*¹ mentions overseas service as one of the options for the trainee physician.

It is undeniably difficult for British universities, the professional colleges, and the N.H.S. to move towards the Swedish position of active encouragement of support for overseas

medical schools. The medical services in Britain are still understaffed, and the loss of medical graduates to more affluent countries continues. In the medical schools the expansion of student intake has not been matched by a proportional increase of staff. Competitive pressures, economic urges, and family needs tend to keep young men and women doctors serving the home market. Nevertheless, it would be a fine step towards improving the quality and quantity of the British contribution to overseas medical schools if the colleges, including that of the general practitioners, agreed that they would be willing to substitute a year or two of service overseas for their more orthodox training appointments. Although the specialist trainee in an overseas post may not considerably advance his technological development, his gains are of the sort that military service usually brought to the doctor—a widening and deepening of human and professional experience.

The problems surrounding the placement, seniority, and promotion of the young expatriate on his return to Britain have not yet been solved. The Royal Commission on Medical Education, in its report for 1968,² was eager to encourage British aid for medical education overseas and made several valuable recommendations for strengthening it.

In my capacity of dean of the faculty of medicine at Haile Selassie I University during 1969-71 I sought to recruit British doctors for the medical school in Addis Ababa. My experience there convinced me that the availability of specialist trainees and young consultants for service overseas had not improved since 1968 but had indeed diminished. Recruits were in general more difficult to find and were of poorer quality. Fortunately for the British medical image in Ethiopia we were lucky enough to obtain one or two distinguished exceptions.

The Royal Commission was of the opinion that all medical schools in Britain should establish links with medical schools in developing countries. It considered that "fairly young teachers of high ability whose prospects in this country were good" were required in developing medical schools. Such teachers should be given an adequate financial reward and their prospects of promotion at home must not suffer by reason of their absence. The report further said, "links would be easier to foster if the normal staff complements of the British institutions concerned included a margin to allow for the release of staff for overseas appointments,"³ and "undoubtedly the best way to provide teachers for other countries is to second them from supernumerary posts in Britain and assure them of reinstatement, without loss of seniority, on their return to this country."⁴ Apart from the technical assistance lectureships which the Ministry of Overseas Development, as it then was, had established in a few schools long before the report was published no further steps have been taken towards the reinstatement, the retention of seniority, and the protection of promotion prospects of returning trainee specialists. Nor, so far as I know, has serious consideration been given to the recommendations of the Royal Commission by our medical schools.

Supernumerary Posts

The difficulties attending the creation of supernumerary posts are well understood. The "home-based posts" scheme financed by the Overseas Development Administration and now administered by the Inter-University Council requires that the incumbent should spend about three-quarters of five years in an overseas appointment. The idea behind the creation of these posts was generous in that they provide substantial help for academic departments abroad, but they do not resolve the practical difficulties for the home departments. The problem requiring solution in any scheme of secondment from supernumerary posts is the eventual absorption of the returned expatriate to the establishment of the home academic departments. Universities, faculty boards, and individual heads of departments have to be convinced of the importance of medical

aid to developing countries and of the value to young academics of overseas service. They have further to be assured that the selected appointee is fully worthy of election to their staff, even though this may mean the deferment of an appointment for a bright young aspirant who may have emerged in the intervening two to five years.

If the appointee is a clinician, whether senior registrar or consultant, hospital boards of the N.H.S. have to be fully implicated in his appointment and secondment. The exercise adds a post either to the specialist training pool or to the consultant establishment. Although this can sometimes be a matter of individual arrangement it is obvious that if it is to be done on the large scale envisaged by the Royal Commission, and undoubtedly demanded by the needs of medical schools in developing countries, agreement is required at a national level between the universities, medical schools, and N.H.S. The councils for postgraduate medical education would greatly advance the development of overseas medical education if, notwithstanding their compelling domestic agenda, they would consider the possible methods of facilitating the provision of postgraduate medical aid to developing medical schools.

Despite the difficulties individual consultants have in many instances been able to obtain long leave from hospital boards and universities and made personal arrangements for their work to be carried on in their absence. These examples would need to be multiplied many times to provide an adequate supply of teachers, yet these appointments, impelled as they are by a strong desire for overseas service, have been of great value. To increase the availability of such expatriate staff the Overseas Committee of the British Paediatric Association suggest that an additional consultant appointment based on one centre for five years and subsidized by the Overseas Development Administration should be filled by a succession of consultants each of whom should serve for not less than one year.

Valuable service can be given by young doctors at any time after the completion of their preregistration appointments. The necessary arrangements can be made without too much difficulty during the period of senior house officer and registrar posts. Even if doubts are entertained concerning the usefulness of overseas service for trainee specialists there should be none about its value at this stage of training. In an overseas teaching hospital the young expatriate doctor is given clinical responsibilities more rapidly than at home. The work is of exactly the right sort to develop his maturing powers, and enthusiastic senior colleagues are ready to guide and counsel him. If the Todd programme of three years' general professional training is to be introduced, then two years of varied appointments overseas might be regarded as a wholly acceptable alternative to similar posts at home. Essential to the success of such schemes for young doctors will be the public statement by the universities and the N.H.S. that the returning expatriates will be given a favourable weighting on their applications for posts in Britain. This will not mean that every such application will be successful, but it will ensure that selection committees will ask themselves before making an appointment: Are we not justified in giving this job to the returned expatriate?

Overseas Opportunities for Other Academic Staff

The permanent or long-term appointment of departmental heads is the most essential need in a new medical school, but such recruits are very difficult to find in Britain today in any medical discipline. Because of these difficulties the employment of academics, both practising and retired, is regularly discussed and sometimes undertaken. The experiment has the best chance of success when the elderly transplant has had previous experience in a developing country, when his duties are adequately served in seven hours a day and five days a week, and when he has a resilient mind, a well-balanced psyche, and a healthy body. The retired clinical academic should not usually

be appointed head of a department, even when he has professorial rank. He will seldom have retained sufficient energy and enthusiasm to be the leader of a clinical team. The same argument does not apply to his occupation of an administrative post, whether as dean of a medical school or superintendent of a hospital. The frustrations of a medical administrator in a developing country are not less than those of his clinical colleagues, and he is denied the clinician's compensations in the teaching of students and the care of patients, but his duties are less arduous than those that fill the days of the academic clinician.

No contract given to retired medical staff should be for less than two years. The contribution that such an expatriate can make is likely to be proportional to the length of time he spends in the country up to a period of three or four years.

Previous experience in developing countries is helpful in any specialty. It is useful in varying degree in the four basic clinical subjects and in pathology, but it is essential for senior appointments in preventive and community medicine and in psychiatry. Experience in one developing country may not be the ideal preparation for work in another, but in regard to social conditions and disease patterns any two developing countries differ less from each other than either differs from Britain. Community medicine, if we define it as the study and practice of disease in relation to social conditions, represents a most important aspect of any clinical subject in any developing country, and it is concerned with very different problems from those with which community medicine will deal in Britain.

Two observations are often made about the teaching and practice of psychiatry in a developing country. The first is that it is not an essential subject in undergraduate teaching, and therefore its introduction into the medical curriculum may be indefinitely postponed. The second is that it cannot be effectively taught and practised until trained national specialists are available. Although there is some cogency in these arguments they are not wholly acceptable. If the foreign psychiatrist is an expert in social and epidemiological psychiatry the sooner he can be introduced into the medical school the better for the wider education of the medical students and for the training of community physicians. Moreover, no specialist should benefit more from work in a developing country than the social and epidemiological psychiatrists.

Short-term secondments of three to six months are, as I have already said, expensive. They are useful in an emergency (illness or resignation) and in understaffed departments. They are also valuable in a subject for which there is no teacher and which can be effectively displayed in a concentrated course. They should not ordinarily be used in the basic clinical subjects in which sequential continuity of instruction is important. Concentrated preparation for examinations is not good medical education, but teaching periods of a few weeks rather than a few months can be worth while in some clinical specialties, such as dermatology, E.N.T., and ophthalmology. If such "crash" courses are needed frequently they cause considerable dislocation of a planned teaching programme.

Distinguished teachers who move in for a shorter time, such as a day or a week, can provide a stimulus to staff and students which is not readily forgotten. They should have a full working programme and make it plain that their interest in the country—its history, scenery, fauna, or flora—is quite secondary to their enthusiasm for medical education.

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