



My Africa

by Adamson S. Muula

> Croat Med J. 2006;47:789-91

Specialist Training Programs for African Physicians

Many African countries are liberal in accepting medical degrees and specialist qualifications acquired abroad. This in part stems from the lack of training programs on the African continent that can supply the required or near the required numbers of doctors to serve the populations. As the majority of African states are English-speaking, academic and professional qualifications obtained in other English-speaking countries are more likely to be accepted than those from countries with some other official language. Francophone and Lusophone African countries are also likely to be accommodating to French and Portuguese medical qualifications, respectively.

With regard to specialist physician qualifications, African physicians have the following possibilities; a) qualifications from their own countries; b) qualifications from other African countries, c) qualifications from a re-

gional body such as the West African Colleges or the Confederation of Central, Eastern, and Southern African College of Surgeons (COSECA), and d) overseas qualifications. As a consequence of British colonial history and a deliberate policy to train physicians at a specialist level for the British Commonwealth nations, UK specialist qualifications are common overseas qualifications held by physicians on the African continent. There is, however, constant threat to the training opportunities for African physicians who seek UK qualifications (1,2).

International medical graduates in the UK

International medical graduates have been an integral part of the UK National Health Services since it was established in 1948. Training in the UK has been an important option for medical

specialists in most of the English-speaking world. In 1948, many African countries were still under British colonial rule, many had no medical schools and those with medical schools lacked specialist training programs in their countries. In the recent past, entry into the UK for medical training could be gained in one of the following ways.

a) Successful performance at the two-part Professional and Linguistic Assessment (PLAB), which is conducted by the General Medical Council. While the first part of the examination can be held at satellite sites close to the potential candidate's place of residence, the second part has to be written in the UK. Obviously, this causes considerable travel and living expenses for a doctor coming from developing countries, where a significant proportion of population barely survives on their earnings.

b) From Professional and Linguistic Assessment, international medical graduates may then join the UK National Health Service in training or non-training posts.

c) Some physicians first complete part I of the Membership of the Royal Colleges, eg, Royal College of Physicians, in their home countries before moving to the UK. Part I membership examinations generally require factual knowledge of basic sciences and knowledge about clinical applications. African physicians study the required textbooks in their home countries before sitting the examinations in regional centers, eg, Harare (Zimbabwe), or in the UK. Subsequent levels of qualifications are obtained after a required period of working experience in the UK. In Malawi local faculty at the Malawi College of Medicine normally provide coaching in preparation for external entry-level specialist examinations.

d) Some physicians would take the qualifying examinations for the Vocational Training Scheme in order to undergo the 3-year training for (specialist) general practitioners (GP). However, in 1979, GP training program stopped enrolling international medical graduates until 2001, when it was observed that the UK would not meet the demand for GPs from the locally trained physicians and started

accepting international medical graduates again.

The current situation in the UK, as far as international medical graduates are concerned, is that of confusion. On the one hand, it appears the UK will no longer receive international medical graduates from outside the European Union. On the other hand, it seems that the UK will continue to train specialists for other (developing) countries but will get tougher in as far as retention and return are concerned. It would seem that both positions will be implemented to varying degrees.

Major thrust of the revised UK immigration policies

The UK accepts international medical graduates for work or training but priority is given to physicians from the European Community (EC) suitable for that position. The UK's Home Office Statement of Changes to the Immigration Rules HC 974-March 2006 had placed stricter requirements for international medical graduates. First, international medical graduates would have entered the UK for work or training only if there was no physician from the European Community (EC) suitable for that position. Certainly, if this were to be followed to the letter, no African physicians would be permitted to go to medical specialist training or work in the

UK. The regulation also meant that those that had already sat Professional and Linguistic Assessment-1 would not have been able to continue their education in the UK and risked their investments. Regulation HC-974 has, however, been replaced by Regulation H-1016, which I would suggest, is more realistic and takes into consideration the training needs of international medical graduates. However, entry into the UK has never been harder than presently.

Stricter immigration requirements for overseas trained doctors have the following potential implications or consequences:

a) Potential to curb the brain drain of physicians from Africa (3). African health systems continue to lose significant proportions of their physicians (and other health professionals) to the developed nations. The UK, United States, Australia, and New Zealand are an important destination for African health professionals. One of the main reasons why many of the African physicians migrate to the UK is precisely to obtain specialist qualifications. The current immigration changes will certainly make it harder for African physicians to move out of their countries. Whether this will improve the overall quality and quantity of health care services in the developing nations remains to be assessed.

b) Limiting the number of African doctors who obtain internationally recognized specialist qualifications. If physicians from Africa cannot do training in the UK unless it can be demonstrated that there are no suitable candidates from the EC they will lose their major specialist training option. This may have negative consequences for the future training of African physicians on the continent, as many of the leading experts in medicine and its specialties were UK-trained. Aside from that, this also should prompt African medical educationalists to seriously consider developing, consolidating, and supporting home specialist programs, rather than relying on training opportunities in another country.

In order to reduce the over-reliance on international medical graduates for its domestic physician need, the UK has increased its intake of undergraduate medical training. In 1997/98, a total of 5062 students entered medical schools in the UK. In 2005/06, the number increased by 56%, to 7898. The increase was much more marked for England where, within the same period, enrollment rose by 68%, from 3749 to 6298.

Future of physician specialist training in Africa

As stated above, specialist training programs in Africa are no-

where near to satisfy the need. Some countries such as Egypt, Sudan, Kenya, Nigeria, and South Africa have several institutions training physicians to specialist level and in several disciplines. However, South Africa and Nigeria continue to suffer from significant brain drain.

Medical specialist training programs in Africa have a lot of potential to develop. Africa is not just a follower of medical advances but also a leader in innovation. It was where the first successful heart transplant was performed, by Dr Christiaan Neethling Barnard (4,5). Despite this pioneering effort in medical advances, there is a huge deficit of medical specialists on the African continent, mostly due to inadequate investments. According to Ameh et al (6), Nigeria, with a total population of over 126 million, about 50% of which are children, has only 35 trained pediatric surgeons, with only 2 qualifying in this specialty each year.

Africa will need international assistance to develop and sustain physician specialist training programs. Preventing African physicians to obtain training in the West, when access in their own home countries continues to be problematic cannot be a good thing. However, over-relying on another country to provide training for your citizens has significant challenges, too.

Time has come for Africa to invest significantly in its own postgraduate or specialist programs. There will continue to be a group of pessimists and detractors who would argue that Africa needs more of "bare foot doctors" (7), and that specialist qualifications for physicians are a waste of resources. Nothing can be further from the truth. Africa needs a balance of the skills mix that any other western country has.

Acknowledgments

Adamson S. Muula is supported by the Fogarty AIDS International Training and Research (AITRP) program grant.

References

- 1 Statement of changes to the immigration rules HC 1016-March 2006. UK immigration and nationality directorate, Home Office, London. 2006.
- 2 A point-based system: making migration work for Britain. Available from: <http://www.fco.gov.uk/Files/kfile/Analysis.pdf>. Accessed: August 9, 2006.
- 3 Muula AS. Is there any solution to the "brain drain" of health professionals and knowledge from Africa? *Croat Med J*. 2005;46:21-9. [Medline:15726672](#)
- 4 Brink JG, Cooper DK. Heart transplantation: the contributions of Christiaan Barnard and the University of Cape Town/Groote Schuur Hospital. *World J Surg*. 2005;29:953-61. [Medline:15983715](#)
- 5 Hardy JD. The first lung transplant in man (1963) and the first heart transplant in man (1964). *Transplant Proc*. 1999;31:25-9. [Medline:10083000](#)
- 6 Ameh EA, Adejuyigbe O, Nmadu PT. Pediatric surgery in Nigeria. *J Pediatr Surg*. 2006;41:542-6. [Medline:16516632](#)
- 7 Kan GQ, Zhang LX, Wu JC, Ma ZI, Liu CW, Sun FZ. Chemotherapy for pulmonary tuberculosis in a rural area of China. *Tubercle*. 1985;66:1-7. [Medline:3984034](#)