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College of Medicine, University of Ibadan 2004 College Lecture "Curriculum change and the College of Medicine, University of Ibadan"

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The Provost of the College of Medicine, University of Ibadan, the Deputy Provost, the College Secretary, all Deans of Faculties of the College of Medicine, Heads of Departments and Professors here present, my teachers, academic and professional colleagues Senior, contemporary and junior, students of the College of Medicine, University of Ibadan, distinguished ladies and gentlemen.

I would like to thank the Provost of the College of Medicine, Professor IF Adewole, for inviting me to deliver this first College Lecture. It is indeed an honour and a rare privilege and I hope to justify the invitation. During this lecture, I shall report on aspects of my year as a Fellow of the FAIMER Institute for Medical Education. Drawing from this experience I shall also make some comments on the state of medical education in our College and the need for a review of our educational strategy. A few people have asked me how a surgeon could leave the joys of the operating theatre to seek formal tutelage in medical education. I hope to also show that medical education can also be exciting.

The award of any degree that certifies the success of specifically directed and measurable human endeavour usually means that an individual (the honoree) is receiving the degree on behalf of the village of people who contributed in one way or another to the success of the project or examination. This village of people are 'the honored', and I would wish to thank representatives of my 'village'. I however apologize in advance for not being able to mention everyone by name, for as you all know I am a 'home boy' and therefore have a very large village of supporting people that included most of the people in this room.

First, I would like to thank the erstwhile Provost of the College of Medicine, Professor Temitayo Shokunbi who introduced me to, and nominated me for, the FAIMER Institute. He invited me to his office one sunny afternoon in March 2002 to brief me on the origins, aims and objective of the Institute and the advantages to be gained by being accepted to the Fellowship. Having confirmed that Pavlov's experiment works equally well in humans, he informed me that the closing date for applications was four weeks away and I had to identify and write-up a proposal for a curriculum change project that would be good enough to compete with other applications from all over the world. Considering the amount of work this entailed in that time frame, I chose to believe that he intended to confirm a quality he had seen in me that I did not know existed, and I would like to thank him again for his vision. However, I must state that I have since been informed that there may have been another reason for my nomination, and I shall expand on this later. I would like to thank the present Provost, the Deputy Provost and the Dean of the Faculty of Clinical Sciences of the COMUI, Professors IF Adewole, Kikelomo Osinusi and Olaitan Soyannwo for their support and advice throughout the year and beyond as evidenced by this lecture. I must acknowledge the erstwhile and present Heads of my Department (Surgery) Professor OA Adebo and Dr JK Ladipo for granting me the time off to attend the two sessions of the Institute, for allowing me to insert my project module and examinations for the same into the relevant Surgery posting timetables, and along with my senior colleagues, Dr Okeke and Mr Shittu, for providing an enabling environment for the project. So also, Dr Debo Adeyemo who is the first FAIMER Fellow of this College and was my mentor for the FAIMER year. He provided immensely valuable information, support and advice at every stage of the year and was also a resource person for my project. I must equally thank the other resource persons for the course, Professors Omotade of the Institute of Child Health, COMUI and Funmi Olopade of the University of Chicago and Drs Ojemakinde (formerly of the University College Hospital and now of LAUTECH Osogbo), and Osarogiagbon and Ojesina of the United States. I must also acknowledge the assistance of my senior colleague Professor Oluwatosin who in addition to other contributions conducted one of the examinations of the project in my absence. Other people who deserve special mention at this time are: Professor Adesola Ogunniyi for his quiet but steadfast support at all levels; my Co-Fellow of the Institute 2002, Dr Bosede Afolabi (of the College of Medicine, University of Lagos) who was a fellow sufferer of the myriad of problems that usually attend projects of this magnitude. Last but not the least is Dr Dania Simpa who was my (unpaid) assistant during the year, and therefore participated in the execution and analysis of the various aspects of the project. Finally, I would like to thank all the students who participated in the project. I assure them that it was as much an experience for me as it was for them.

The rest of this presentation is dedicated to all my tutors who are those from whom I have learnt and/or continue to learn over the years. This group of tutors includes; my teachers, academic and non-academic col-

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leagues, residents, of course my students who have been the most generous tutors of all.

Part 1

Introduction

The Old Order Changeth

So stated Professor Emeritus Toriola Feyisetan Solanke (of blessed memory) in his Valedictory lecture in 1990[1]. The evidence of the change in the old order is everywhere, and lecturers in medical schools are increasingly being required to undergo formal training in medical education to ensure effective delivery of information to their students. This made the opportunity to attend the FAIMER Institute a golden one.

What is FAIMER

The Foundation for Advancement of International Medical Education and Research (FAIMER®) is a nonprofit foundation of the better known Educational Commission for Foreign Medical Graduates (ECFMG®). Founded in 2000, FAIMER has taken over some of the activities of the ECFMG as shown on the slide **[Figure 1]**.

Fig. 1: Activities of FAIMER®

- Tracking of Medical Schools Worldwide
- Research and dissemination of knowledge on medical education and the workforce of medicals schools
- Educating the educators via:
  - Consultation
  - Institutional grants
  - International Fellowships in Medical Education (IFME)
  - ICAME Institutes

Programme description of the FAIMER Institute

The FAIMER International Consortium for the Advancement of Medical Education (ICAME sm) Institute is a yearlong, part-time fellowship programme designed to teach education methods and leadership skills, and to promote the development of professional relationships among participants. Institute Fellows attend two residential sessions in Philadelphia, one year apart, which mark the beginning and conclusion of the fellowship year. In the intersession period, Fellows work on a curriculum innovation project at their home institutions. Additionally, Fellows interact with Fellows of the previous class, and with the class succeeding them, during the residential sessions.

Part 2

The pursuance of excellence and the FAIMER fellowship year

The late Professor BO Osuntokun is well known for his charge in his "Nunc Dimitis" that 'success is temporary whilst excellence lasts forever'[2], a truth that he himself is proof of, and I tried to make this charge my guide during this fellowship.

FAIMER Institute 2002

Twelve participants, including myself, were selected from over 100 middle and senior level medical educators from 65 respected academic institutions from South America, Asia and Sub-Saharan Africa, the three regions of eligibility for the year's Institute **[Figure 2]**. It is noteworthy that the number of applicants has increased tremendously each year as the program has become better known.

Fig. 2: FAIMER® Institute 2002 Fellows

- Avinash Supe, Professor - INDIA
- Rima Beriashvili, Professor - GEORGIA (Rep. of)
- Bosede Afolabi, Lecturer I - NIGERIA
- Elizabeth Wasserman, Snr. Lecturer - SOUTH AFRICA
- S.M. Wasim Jafri, Professor - PAKISTAN
- Kristina Weil, Assistant Professor - CHILE
- E.O. Olapade-Olaopa, Snr. Lecturer – NIGERIA
- Henry Campos, Dean - BRAZIL
- Jose Cueto, Professor - PHILIPPINES
- Zalina Ismail, Associate Professor - MALAYSIA
- Nor Azila Mohd Adnan, Professor, - MALAYSIA

The sugarloaf sessions

The two sessions of the FAIMER Institute 2002 took place at the Sugarloaf Conference Centre, Philadelphia, USA. On arrival for the first session, I realized from the size of the additional course material that we were in for an intense programme.

The Institute covered topics that could be broadly divided into:

A. Leadership in Academic Medicine – 64 hours
B. Medical Education and International Medical Education – 127 hours
C. Curriculum Innovation Projects of individual Fellows – 162 hours

I will now describe some of the relevant highlights of these topics briefly

A. Leadership in academic medicine

Academic medicine requires both leadership and management. The importance of the variability of personalities and leadership styles, the ability to manage meetings, decision making options, change and conflict management and network building for effective leadership and management were also explored at several sessions.

B. Medical education and international medical education issues

International standards in medical education

The scientific basis of medicine is universal, therefore there is a high degree of equivalence in medical schools worldwide. As such common international standards can be defined for basic medical education. These *global set of standards* are useful as a basis for internal evaluation and quality improvement and can also be used for peer review and accreditation purposes by external bodies.

The main points taken into consideration during the sessions were

1. The similarity of problems in developing countries viz:
   - The explosion of student population
   - Limited facilities and faculty
   - The lack of standardization of entry criteria (including non-medical factors).
   - The decreasing quality of medical graduates.
   - The minimal impact of Medical schools on their society due to 'Brain Drain'.
2. The need for development of global standards of medical education, Accreditation Bodies, and the interconnection between health-education and healthcare delivery
3. The importance of the inclusion of community responsiveness in medical school lectures and examination questions in order to ensure the graduates are socially responsive doctors.

Conclusions

At the end of these sessions the following conclusions were drawn:

1. Global solutions need to be modified in each country to accommodate the peculiarities of each society.
2. The mission and objectives of medical schools should be adapted to the scientific, socio-economic and cultural development of the society.
3. The factors that contribute to the brain drain from developing countries need to be tackled so their native Physicians may stay in and/or return. These include: political instability, poor role modeling for youths, the disabling environment, the globalization of markets and quality of life issues. Other factors are the persistence of the 'old guard' and the resultant limitations in the development of the younger professionals and opportunities for them to contribute to their societies.
4. The curriculum of each medical school should be reviewed regularly and adjusted in keeping with developments in the biomedical sciences, the behavioral sciences, the social sciences, the clinical sciences, and changes in the demographics profile and health/disease pattern of the population, and socio-economic and cultural conditions i.e. graduates of medical schools should be prepared to meet the needs of the environment they will enter.
5. The process of program monitoring and evaluation, student assessment and the methods and the number of examination should be modified according to changes in educational objectives and learning goals and methods of each medical school.

Curriculum development

The two primary requirements for the development and implementation of curricula were identified as: Development of Faculty, and Assessment of students.

1. Faculty development

Medical School faculty should be given ample opportunity to train (preferably formally) as medical educators and assessors, and as program evaluators. Training in medical education would equip medical faculty with the skills required not only to effectively impart knowledge, but also to inculcate the principle of life-long self-directed learning in students using directed self-learning methods. The strengths and weaknesses of the various teaching styles were discussed to enable objective choice for different settings and student populations and characteristics. The different models evaluated included: the traditional learning system, problem-based learning, case-based learning and system-based learning. Academic staff should also be encouraged to take courses in leadership and management which skills are very necessary as already mentioned earlier.

2. Assessment of students

Learning and assessment (feedback) involve exchange of information between the teachers and the students. Therefore assessment occurs at the same time as the learning. It is now accepted that assessment drives learning, and that students will adapt their learning techniques to suit the assessment method being used to evaluate their competences. This means the medical school/department must first decide on the objectives of its training programme (i.e. what type of doctors it would like to produce), then select the methods of assessing that the student has attained this objective, and then decide on the curriculum that would enable the student to acquire the competences required to pass the assessment. In this regard, the 'ASK' (Attitudes, skills and knowledge) model of medical education is now the most widely accepted model of directing medical training. Accordingly, it is necessary to ensure that suitable assessments are used to test the relevant competences. Assessment methods should be reliable, valid, objective, discriminatory, consistent with learning and practical. Several methods for assessing clinical skills were discussed. These included: Long case/Short case. Multiple Choice Questions (MCQ), Multiple Examination

Questions (MEQ), Objective Structured Clinical Examination (OSCE), Objective Structured Practical Examination (OSPE), Essays, Portfolio, Viva voce, amongst others. The differences between these assessment methods, and the benefits and limitations of each of the testing techniques were evaluated. At the end of this session, the following points about assessments were stressed:

1. Different assessment tools are used to test different competences
2. Assessments are only as effective as the assessors.
3. All assessment techniques are effective if used properly.

Visit to medical institutions

Visit to the ECFMG and Robert Wood Johnson Medical School, and the Medical College of Pennsylvania

We spent a day at each of these institutions. These visits were instructive, and presented Fellows with an opportunity to see and participate in different systems of medical education and assessment at first hand.

ECFMG – At the ECFMG, the current role of the organization in certification of foreign medical graduates in the US was explained. The aims and objectives of the Clinical Skills Assessment (CSA) as a performance assessment test were also explained. This examination was described as the gold standard of OSCEs as it is a very high stake examination for which the candidates paid very high fees. We were taken round the examination complex and observed a CSA in progress.

Robert Wood Johnson Medical School, New Jersey – At this institution we had several sessions on a vertically integrated curriculum that is centered on body systems. Of note is that the fact that the vertically integrated curriculum runs in parallel with the traditional curriculum, and the students are allowed to choose which curriculum they would like to be instructed by on entry into the school.

Drexel University College of Medicine, Philadelphia – At Drexel medical school, we joined integrated sessions on the Problem Based Learning system that runs concurrently with the traditional curriculum. Fellows also participated in two small-group learning sessions during which they acted as observers and as facilitators. We also spent time in the Critical Care training room and had a demonstration session on the models.

The curriculum innovation project

Projects were a major criterion in the selection of Fellows for this Institute. These projects were to be used by the Fellows in practicing strategic planning, project implementation and student learning and evaluation in their institutions. The projects were modified after presentation to co-fellows, FAIMER Faculty and invited independent reviewers who were experienced medical educators.

Summary of Curriculum Innovation Project[3]

My intersession curriculum innovation project was 'The introduction of molecular medicine in the College of Medicine, University of Ibadan'. The aim of the project was the inclusion of the formal teaching of this well-established specialty in the undergraduate curriculum of the College in order to increase the application of molecular biology in diagnosis and treatment of diseases by improving knowledge of its graduates of molecular medicine. The Year 1 Clinical set (2002) of students were selected for the project which comprised of a series of didactic and interactive lectures along with additional resource materials (handouts and an interactive CD on the subject). An end of posting examination was done at the end of the module. The project was evaluated using pre- and post-test questionnaires and the analysis of the examination results as well as the attendance and other registers. The results revealed that the students' interest in molecular medicine was above average, and that majority of them found the lecture module useful as it had increased their understanding of the topic. In addition, most students would recommend the course to their colleagues and wanted it included in the curriculum. However, the participation of the students in the interactive and self-directed learning sessions was poor as was their performance in the end-of posting examination. Interestingly, whi :: most of the students had opted not to obtain the additional resource material during the module despite recognizing their usefulness, almost all did after the examination. In conclusion, the project was successful in introducing the formal teaching of molecular medicine in our College. It also gave an insight into the learning pattern of our students, suggesting that (at least presently) they have grasped the concept of self-directed learning. However, it also confirmed that indeed 'assessment does drive learning' style of students. As such, attempts at improving the quality of our graduate should perhaps begin with the improvement of our assessment methods.

The social aspects of the Institute 2002

During the Sugarloaf sessions, Fellows and faculty were treated to several social outings, during which we ate, sang, and danced. These events served to enhance the bonding of the group and the relationship between Fellows and Faculty. On the final night of the year the Fellows were treated to a sumptuous dinner ceremony during which the much awaited certificates of completion of the fellowship were presented.

Part 3

The State of Medical Education in Nigeria

For some must watch while some must sleep

This quotation from Shakespeare's Hamlet was chosen by the late Professor Famewo's as the title of his inaugural lecture in 1993[4] and in my view best explains the rationale for this part of my presentation.

We are all witnesses to the gradual but definite decline in the quality of education in our country. Indeed, figures released by UNESCO early this year (The Punch, January 26, 2004) indicate that the literacy levels have fallen to critical levels [**Figure 3**]. This decline in quality has also been noticed in university graduates as well and is said to reflect the quality of education in our tertiary institutions. Recently, several senior academics have spoken out in this regards and called for a concerted effort to stem the tide. Notable amongst them was Professor Augusta Omanor of the Department of Linguistics, University of Ibadan who gave several examples of the inadequacies of the command of the English language of her postgraduate students during her inaugural lecture at the University of Ibadan in December 2003[5].

Fig. 3: Newspaper Reports on the State of Education in Nigeria

However there are those who believe that the Colleges of Medicine may have been spared this decline. But Professor M Aghaji, Provost of the College of Medicine of the University of Nigeria Nsuka, disagrees. In his interview with the Guardian of 5th February 2004 [Figure 3], he stated, and I quote 'There is general frustration in the country over the quality of students who are coming into the Universities. The admission through JAMB is one of the problems and we believe that admission into the COM should not be through JAMB alone.....funny enough when we went through the University we wanted to learn. Now people don't want to learn. They only want the certificate. We are now producing a group of graduate that are unemployable. They don't have the education, they don't have the skill, they cannot do anything. It is dangerous for the country.' He went on 'Lecturers are poorly paid ... they come here to teach because they do not have any other option'. His comments have since been supported by those of the Vice-Chancellor of the Olabisi Onabanjo University at the 1st Retreat of the University's Faculty of Clinical Sciences and those of Professor Kale during his 2003 University Lecture series[6].

But has the COMUI escaped this decline in quality of teaching and learning? Are the findings of my project a pointer to the state of medical education in our College or are they isolated findings? How well are the core competencies being inculcated in our students? The ultimate test of this process is the performance of our students in our examinations. I therefore reviewed the results of the 2000 set of students in both the summative final examinations and the formative end-of-posting examinations of the major clinical departments as an index, and this analysis was quite informative [**Figure 4**]. In the Junior Paediatrics end of posting test, 29% of students passed. The pass rate improved to 62% in the Senior Paediatrics test. In contrast, the pass rate in the OBGYN mid-posting test was 72%, and this decreased to 53% in the end-of-posting test. At the recent Part III MBBS final examinations results however, the results 'somersaulted' again with 33% of students passing Paediatrics and 73% passing O&G. Indeed the cumulative results make the heart skip a beat as only 30% of the students passed both subjects, 43% were referred in Paediatrics, and 3% in OBGYN, making a significant 46% in total with a single reference [Figure 5]. The remaining 24% failed both subjects. But, what about the other two clinical departments? In the Medicine end-of-posting tests, the pass rate increased from 28% in the Medicine I test to 34% in the Medicine II test. The results in Surgery were at least consistent (if poor) with a 4% and 5% pass in Surgery I and Surgery II respectively. If the results of the Part III examinations are predic ive of the performance at the forthcoming Part IV examination, then the heart goes into complete heart block. Indeed an out-

sider reviewing these results would be forgiven if he surmised that they indicate that, the performance of our students' at our own examinations is at the very best inconsistent, but quite poor overall. By extrapolation, the same could be said of their acquisition of attitudes, skills and knowledge during their clinical postings, and sadly the ability of their lecturers to impart and assess the same. These co clusions are already being voiced in quiet tones, that are getting louder, in other (lesser) teaching hospitals where the clinical skills of recent graduates of this College have been found to be significantly below par, a most unfortunate and unacceptable situation.

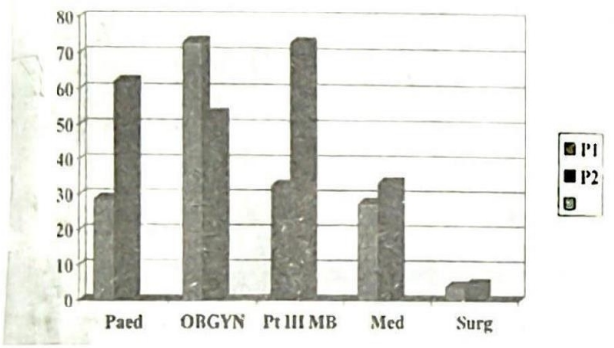


Fig. 4: Cumulative results of the end of posting and Part III MBBS final results of the 2000- set.

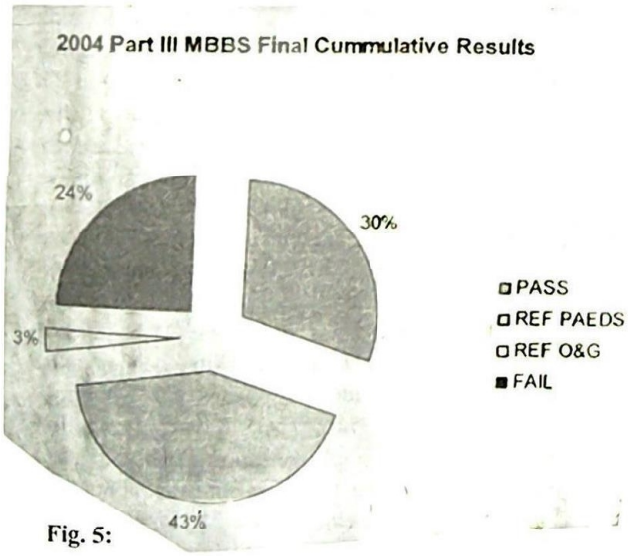


Fig. 5:

As we all know, along with effective tutelage and the right attitude to learning, the prevailing environment also plays a role in the quality of product ..' any institution. So what is the state of the hospital environment in which medical education is being delivered? Starting from Sani Abacha's statement in 1983 that *'Hospitals had become mere outpatient clinics* through Abubakar Umar's 'improvement', that (21 years later), our *'Hospitals have now become mere mortuaries'* to Professor Kale's recent re-categorization of the levels of healthcare in this country as: *Primary, Secondary, Tertiary and Obituary*[6], we may have an idea that the situation is unsatisfactory. Another unfortunate index of the standard of healthcare is the increase in the number of coffin makers (up 700% along the Total Garden – Mokola Roundabout road) and their relocation closer to hospitals (the source of their raw materials). Of course when the hassles of the procedure of obtaining care in most of our teaching hospitals are considered along with the increasing cost, it is not surprising that the confidence of the public in these once famous hospitals has been shaken. This apprehension may be responsible for the now not uncommon mayhem seen in teaching hospitals, that sometimes end in acts of violence against medical personnel in the full glare of staff and students. Concomitant with this decline in the standard of orthodox healthcare is the rise of the alternative medical 'doctors', from 'Yem-Kem' and other NAFDAC-approved homeopathic doctors, to the traditional medical practitioners, and the various ecclesiastical ıedical interventionists. Consequently, most people are ıow very reluctant to come to teaching hospitals except when all else has failed. There has therefore been a sharp decline in the number of patients attending to these institutions, and most of those who do come present late in the course of their diseases, and after having spent all their money in other centers. They therefore do not have funds for the relevant investigations and treatment which results in a worse prognosis, poorer management and ultimately a higher risk of death. In conclusion, if the truth is to be told, the situation in most teaching hospitals is hardly conducive to proper undergraduate or postgraduate instruction, or indeed, research or service for that matter. Fortunately, this situation is being address aggressively at the present time (at least in the UCH)

But perhaps it is not all the fault of the Colleges of Medicine (and Teaching Hospitals), and their staff and students. According to Chief Layi Osunkunle in his rejoinder to a publication on the decline in discipline in Nigerian schools in January 1976 stated that *'The Home, Society and Government have their own share of the blame'* [7]. This statement is equally relevant now when the decline in standard of university education is considered. Government policies on education have been notoriously shortsighted, and the chronic under-funding of universities and health institutions and the forced admission of large numbers of students without the necessary increase in funding, infrastructure or personnel need no further elucidation. Recently the Acting CMD, Dr Ehigiegba of the UNIBEN Teaching Hospital warned (the Guardian January 5, 2004) that the institution was heading for col-

lapse due to lack of funds. We are also aware of the unfortunate impact of poor home training and the lack of parental guidance and interest in scholarship, as well as the direct and indirect effects of ill-gotten wealth on the society and its children. All this crowned by repeated promises of assured pathways that lead to success with little work from several sources. Why would, indeed should, such students be as attentive to learning as the students of old?

Mr. Provost, we can either bury our heads in the sand and take the position that the situation is not as bad as stated above, or take these points seriously. But all is not lost. What is required of the COMUI and its academic staff is that they remember that by accepting their positions they must watch whilst others (students, politicians and the rest of society) sleep on matters concerning medical education.

Part 4 – Curriculum Change and the College of Medicine, University of Ibadan

A time for (the) amendment (of life). OOA

This was the title of Professor Akinkugbe's UCH 40th Anniversary Lecture in 1997. We are told that the only thing that is constant is change and the great sage himself has undergone several changes in the years I have known him.

Our society continues to change and medical education has to adjust regularly in response to these changes in the society in order to remain relevant. The COMUI therefore needs to foster the recognition and understanding of these perspectives by her students and inculcate the competencies that will enable them to discharge the required responsibilities. But change is not easy, but that the only thing that is constant in life is change.

The major amendment required of all stake holders is that of their attitude to their responsibilities. The stakeholders in this case are the Government, COMUI, the UCH, the academic staff and the students. The students need an amendment of attitude to their responsibilities to learning, discipline and character building, the academic staff an amendment of attitude to their responsibilities as trainers, assessors, role models and custodians of the gourd of Hippocrates, the UCH as the teaching laboratory of the University, the College an amendment of attitudes to its responsibilities as the custodian of the pathway by which most doctors in this country are produced and thus the primary determinant of the standard of medical education and practice in the nation, and finally the Government as the main financier and overall policy maker. I would like to state categorically that without this fundamental change in attitude, any other amendment to the curriculum, no matter how seemingly extensive will be largely cosmetic and in the end, ineffective. I shall now focus on some areas for the stakeholders to consider for amendment.

The Government.

Funding and policy making

This is perhaps where university education has suffered most in the recent past as less and less informed people have been in charge of our fate in this country and we are of course now reaping the benefits of the ignorance of those times. The Government at all levels, but most especially the Federal Government, must wake up to its financial and policy responsibilities to medical (and other) education and training, and this does not simply mean giving them more money. Rather, significant portions of policy making and funding should be devolved to University authorities that should be empowered to determine the training objectives of these citadels of learning. University autonomy would certainly be a way forward, but we can not run away from a redistribution of the burden of the cost of training at the tertiary level, particularly as this is becoming more and more resource intensive, with medical education being a prime example. This would also have the added effect of redistributing performance monitoring of students and the system. In keeping with the new dispensation, our leaders in academia must impress on Government of the need for meaningful and effective policies preferably with the long term focus. The dilapidated infrastructure and equipment in the Universities should also be attended to urgently.

Security

University campuses and lecturers have not been left out of the increased insecurity in the country, and no less than 2 have been killed in the past month alone. Whilst medical schools are somewhat protected from the near anarchy that exists on most main campuses, the Government Security Services should be enjoined to live up to this aspect of its responsibilities even as we continue to pay unofficial tolls on our roads. Lecturers or students can not be expected to perform at their best whilst living in the fear of violence for any reason but especially for carrying out their statutory duties.

The College of Medicine.

Curriculum Review

It would appear that the core of our curriculum has remained largely unchanged since the inception of this medical school. Yet society and medical information have undergone so many changes that it is impossible for that curriculum to produce physicians equipped with the competencies required for effective practice today. Our curriculum should be wholesomely reviewed now and amended regularly thereafter (perhaps every five years) to take into consideration the changes in the society. Our medical students now need to be competent in areas such as: molecular medicine, bio-informatics, health economics and management, ethics and research to name a few. Furthermore, considering the character of the students being

admitted, we also need to include courses on professional values and attitudes, communication skills, critical thinking, information management and career guidance. Medical students should also be exposed to the various levels of secondary tertiary health care in order to prepare them for the reality of medical practice outside UCH

As I mentioned earlier, the process of curriculum development or review begins with the College (via its Curriculum Committee) deciding on the type of doctors it would like to produce. These guidelines are forwarded to the various Faculty Curriculum Committees who (bearing in mind that assessment drives learning) would first design effective methods of assessment and evaluation of these competencies. Finally, a curriculum is designed that would direct students along a learning path that would lead to the acquisition of the core competencies required to pass the examination [Figure 6]. This is a change from what obtains today in the College where curriculum

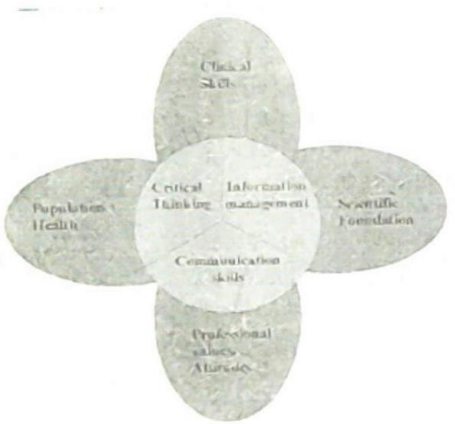
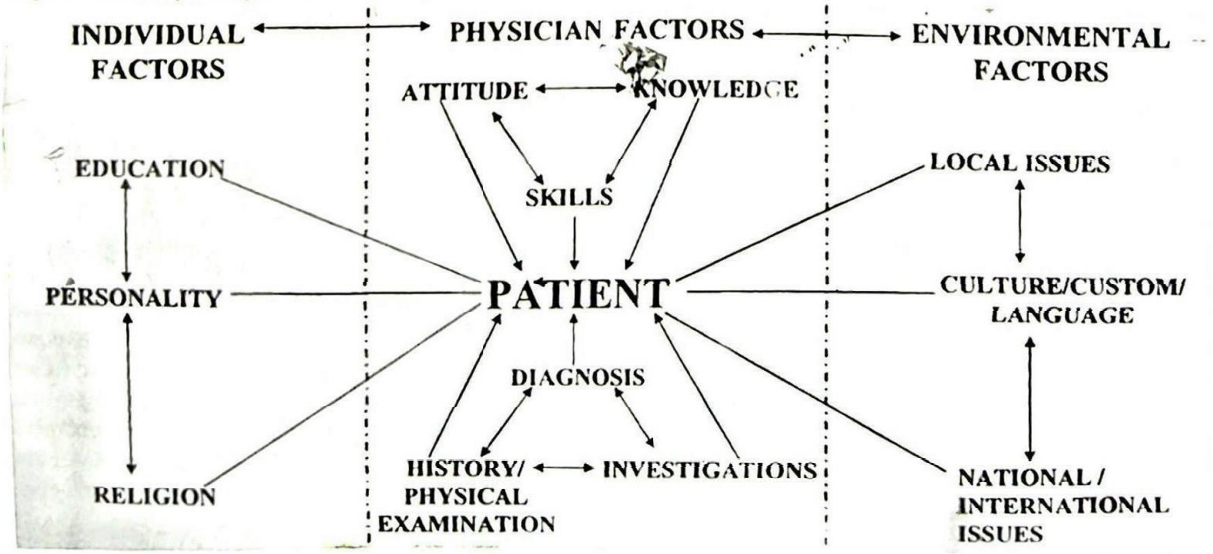


Fig. 6: Core competencies desired of medical students universally.

review begins from the Department through the Faculties upwards to the College. This system was designed for different times and may not produce a curriculum as synchronized as the alternate system, and I urge the College to consider the change. There has been a lot of talk about the newer curriculum methods, especially problem based and system based learning. Having had some experience in these techniques, I would like to counsel against the wholesome adoption by the COMUI as what is good for one society may be inadequate for the other. Whilst there is no doubt that they can be very useful in teaching some modules [Figure 7], what would be most effective is the modification of our curriculum by our academic staff, for our students, to ensure the effective healthcare of our own society. Some integration of the curriculum is also urgently required. I am aware that this was attempted many years ago but abandoned due to problems with logistics. I would however wish to recommend a horizontal integration of our curriculum with system-based teaching perhaps first at the Clinical School to ensure minimal upheaval in the system [Figure 8]. I recently reviewed the schedules of Introductory and Core lectures of the Department of Medicine and the Surgery I and II lectures of the Department of Surgery. This scrutiny revealed 42% and 31% overlap of the Introductory Medicine and Surgery I, and the Surgery II and Medicine Core lectures respectively. These lectures deliver essentially the same information and are thus suitable for integration and may be the place to start. A more concerted effort should ensure that information is given systematically thereby avoiding repetition by different departments, and also freeing up time to include the new topics mentioned above. A review of the length of individual postings is also long overdue to enable proper review of the curriculum. This would also provide the much needed time to teach newer topics. Finally, the COMUI

Fig.7: Central paradigm of socially responsive medicine



must establish a process of curriculum evaluation. The objective of this process is to assess the effectiveness of the teaching and assessment methods in achieving the training objectives of the College.

the initiation and maintenance of the resuscitatory efforts responsible for this recovery of sanity. The COMUI must therefore ensure that the UCH partners it effectively in the changes necessary to effect the alteration in its curriculum. Particularly as the medical students that the UCH is

Fig. 8: Responsibility and approval charting of stakeholders in curriculum development of COMUI

Decision/Task	Provost	College Curriculum Committee	Dean	Faculty Curriculum Committee	Head of Dept	Faculty Members (Academic Staff)	Students
Training objectives and selection of core competencies desired of COMUI graduates	A	R	C	C	C	C	C
Assessment methods to evaluate acquisition of desired competencies	A	A	A	R	R	C	I
Design of curriculum to ensure acquisition of desired competencies	A	A	A	R	R	C	C
Teaching and assessments of the specific attitudes, skills and knowledge that compose the desired competencies	I	A	I	A	R	R	I
Curriculum Evaluation	I	R	I	R	C	C	C

Key: I = Inform: R = Responsible; C = Consult; A = Approve

The University College Hospital

Most people in this audience would remember the quotation in Bailey and Love's Short Practice of Surgery that 'To practice medicine without books is to sail an uncharted sea, but to practice medicine without patients is not to go to sea at all'. It is therefore crystal clear that any curriculum change that does not include complementing changes occurring *pari pasu* in the UCH would be futile. This is because the UCH is as much a stakeholder in the training of medical students as is the COMUI. Admittedly, in recent times it is often forgotten that the primary reason for the existence of teaching hospitals is as the 'laboratory' where Colleges of Medicine produce medical students. This activity is closely followed by the training of other cadres of health professionals, research and lastly (if not least) service. Whilst we must concede that the prolonged decline in the economy provided a heady cocktail that resulted in a disorientation of this raison d'etre, it would seem that these institutions are now in the 'morning after hangover phase', and hopefully will be sober soon and get back on track. We must salute those responsible for fostering at the moment on the short term will upon graduation as normal or malformed products become its staff on the medium and ultimately long term as Residents and Consultants.

The Academic Staff

Self development

The Academic Staff should ensure that they are familiar with the educational strategy and curriculum design of the COM. They must participate actively in the curriculum change and the formative and summative assessments of medical students and provide a feedback to the students on their performance and to the curriculum committee on the effectiveness of the methods. They must ensure that examinations they set effectively test the desired competencies and are conducted in a conducive atmosphere. Furthermore, academic staff should obtain formal training in medical education, and the information in a recent bulletin of the University on this issue makes this imperative. It is no longer accepted that postgraduate professional medical qualifications equips university lecturers adequately

to impart knowledge to undergraduate (or indeed) postgraduate medical students. They should also update themselves regularly in their chosen field and acquire computer and bioinformatics skills so they can deliver current information effectively to their students. Whilst accepting that some lecturers are naturally gifted, most of us would benefit from formal guidance in the acquisition of these skills, and the COMUI should consider organizing workshops and symposia on medical education especially using local and international resource persons, as well as sponsoring attendance of interested staff at international courses and fellowships such as the FAIMER and IFME programmes. I am aware that FAIMER would consider co-funding one such workshop.

Relationship with Students

It is important that both the COM and its Faculty accept that there has been a change in character of their students and teaching environment such that teaching styles of old can no longer be effective and must be amended. In any case, a teacher's competence is judged by the competence of his or her students. As such, the faculty should get to know their students in terms of person, attitude, aptitude, study techniques and career plans so they can provide appropriate tutelage and guidance. There should also be a move to small group teaching with a reduction in didactic lectures and an increase in interactive tutorials and /or PBL sessions with project works. The ultimate aim of this style of teaching is to encourage students to embrace and practice self-directed learning. They must ensure that they are aware of the style and level of medical practice in their community and the international scene so as to be able to prepare the students for reality upon graduation. In addition, Academic Staff must ensure the maintenance of discipline amongst themselves and their students.

The Students

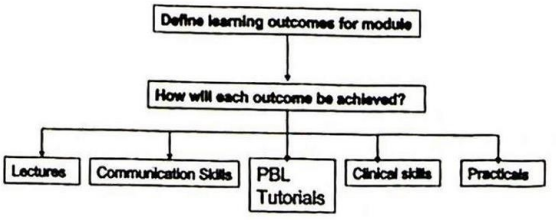
Self-directed learning- "The Rediscovery of Duncan's Line"

Students of the COMUI need to accept that, regardless of their *a priori* assumptions about medical school, they have to be more active in the process of acquisition of the necessary attitudes, skills and knowledge required for competent practice in future. To this end they will have to acquire clinical and computer skills and familiarize themselves with library and internet resources that would allow for more effective search and acquisition of information. Our students must also accept that, despite any information to the contrary, practice always makes perfect and this applies to the acquisition of clinical skills too. At the recent Surgery II OSCE examinations, two students carried out rectal examinations without gloves, and one other used the middle finger. Whilst acknowledging the role of stress in these inadequacies, it does demonstrate that these students had not practiced enough to attain the expected level of familiarity with that clinical examination. This is in contrast to the eager students in the years past who thoroughly examined any patient they could lay their hands on. Our students need to work as hard as they 'pray', and should use the same strategies they apply when seeking miracles at 6.30am on a Saturday [Figure 9] to mobilize themselves to teaching sessions at 8am on week days wherein true miracles can be claimed though the acquisition of competencies. As a matter of fact, it has always been the responsibility of all students to repeatedly evaluate the state of their competencies and the rate of acquisition of the same to ensure that they are making steady progress. This was the philosophy behind the well known COMUI yard-stick of success 'Duncan's Line' [Figure 10]. According to Professor Duncan himself, belonging to a class of brilliant students drawing a line behind his name on anatomy test result sheets was borne out of his desire to ascertain that he was progressively acquiring the necessary knowledge and skills without prejudice to the performance of his peers. Of course there are other interpretations of the circumstance, but whatever the case this unusual step was perhaps the first recorded attempt at self evaluation in this medical school. It is a philosophy that our students would do well to emulate in these days of large classes and the explosion of information. Finally, medical students should identify suitable role models amongst their lecturers and seek career advice and counselling from these mentors.

Fig. 9: Types of curricula

- Traditional non-integrated curriculum
  - Current curriculum of COMUI
- System-based integrated curriculum
  - Suggested curriculum for COMUI
- Case-based integrated curriculum
- Problem-based integrated curriculum

Fig. 10: Different teaching methods in curriculum design



Mr Provost, as I mentioned at the beginning of this presentation, there may have been another reason for my nomination and selection to the FAIMER fellowship. The 1998 set of students claimed to have 'bound' me (and by extension Professor Shokunbi and the FAIMER execu-

tives), to ensure that I was away from the 2002 Part IV Finals hence my nomination and selection. Considering the benefits of this kind act, in thanking the 1998 set of students I wish to state that, my personal convictions about the futility of the same notwithstanding, I am not averse to future sets doing likewise. After-all, who knows where I would be sent next, Japan has my vote.

Fig. 11: Components of a curriculum

Well defined educational objectives
. Selection and organisation of contents
. Teaching, assessment and learning methods
. Evaluation of the curriculum

Fig. 12: Department of Anatomy, University College London Results of Part I MBBS Examination – July 1955 Vel primus, velcum primus

• FN Udeh	- Passed
• KA Harrison	- Passed
• OO Akinkugbe	- Passed
• AA Oshindero	- Passed
• E Okafor	- Passed
• B Oni	- Passed
• KA Olafimihan	- Passed
• S Nwosu	- Passed
• D Onyeaso	- Passed
• GTK Duncan	- Passed
• ORI Dota	- Failed
• OP Onu	- Failed
• AK Uri	- Failed
• Om Ugo	- Failed

Conclusion

In conclusion, Mr Provost, distinguished teachers, colleagues and students. I hope I have shown that, it is imperative that this great College of ours adjusts its curriculum in order to maintain the standard of the doctors it produces at the level it has become well known for. The students must realize that it is that reputation that will set them apart on graduation. On the other hand the faculty and executive of the College must realize that they will be judged by the quality of their graduates. This College is in need of a curriculum change, but I would counsel against the wholesome adoption of any new system in use elsewhere. As I hope I have also shown, each medical school must develop its own curriculum to suit its society and students. Hence it is in all our interests that in changing the old order, we must pursue excellence whilst watching, even if others around us are asleep. We must continue to assess ourselves so we can make the necessary amendments that will ensure the improvement of the standards of this great institution *soli Deo Gloriam*.

Having said all that, I would like to thank all those who have contributed to making this presentation a success most especially the Provost and the College Administrative Staff, the Heads of Surgery, Paediatrics, Medicine and Obstetrics and Gynaecology for giving me access to the scores of the end-of-posting examinations, Professor Oluwatosin, Drs Amanor-Boadu, Roberts and Oladokun for assisting with data collation, Dr Simpa for his assistance with data analysis, Professors Osuntokun and Ogunniyi for proof reading the script and their advice, Dr Afolabi and Funsho Ogundele for their IT skills, the Administrative Staff of the College and the Department of Surgery, my Research Assistant (Mrs Kuku) and my Secretary (Mr Omoleke), the families of the late Professors Solanke, Osuntokun and Famewo, Professors Akinkugbe and Duncan for providing advice and historical information and for granting me permission to use their pictures and other properties, and you all for being a wonderful audience. Finally, I would like to thank Almighty God for his guidance and grace, for my pedigree, as few people get to choose their teachers and none their parents, and for bestowing on me a coat of many colors.

I hope that this report has been acceptable to some if not all, but all presentations, successful or otherwise must come to an end. For those who I have left still wondering what the message of this lecture is, I leave it to the Diva and Fellows of the FAIMER Institute 2002 to summarize it in the words of our forefathers.

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