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Focus On Nigeria

John V. Kelly, M.D., F.A.C.O.G.

Nigeria is the most heavily populated country in Africa. More than 60 million people reside in a nation the size of Texas and Oklahoma combined. Approximately equal numbers of the inhabitants are members of the Christian, Moslem and pagan faiths. There are less than 1000 doctors available to provide medical care for this population, a ratio of one doctor to 60,000 people. This contrasts to a doctor-patient ratio of 1 : 750 in the U.S.A. The two medical schools in Nigeria (Ibadan and Lagos) together graduate approximately 80 doctors each year. By 1975 the Government hopes to have approximately 400 doctors per year graduating from Nigeria's schools of medicine.[1] The population increase by then will have far out-stripped even the present doctor-patient ratio.

There are some 300 hospitals in Nigeria; two-thirds of them are administered by voluntary agencies, one-third by the Government. A few hospitals are managed by private industrial firms (Shell Oil, Dunlop Rubber, etc.). Among the various voluntary agencies are the following: Roman Catholic, Methodist, Lutheran, Baptist, Seventh Day Adventist, Sudan Interior Mission, Anglican, Mennonites and Church of God. The Catholic Church has, by far, the largest medical missionary group in Nigeria. In addition to 42 general hospitals with their respective training schools for midwives and nurses, the Church administers some 235 maternity clinics and dispensaries. More than 15,000 lepers are also under the care of Catholic medical missionaries.

The 42 Catholic hospitals in Nigeria are distributed as follows:

23 in the heavily populated Eastern Region,

8 in the Western Region

6 in Northern Nigeria and

5 in the Midwestern Region

They range in size from [illegible]0 beds and a staff of six physicians, all qualified specialists (St. Luke's Hospital, Anua), to 30 beds and a single physician (St. Joseph's Hospital, Ikot Ene).

The hospitals in each diocese are under the religious supervision of the local Bishop, but are otherwise autonomous. They are provided with financial grants from the Government to aid in patient care and the training of midwives and nurses. The hospitals must maintain standards set by the Nigerian Medical Association and the Nursing Council of Nigeria; to this end, they are periodically inspected by teams from the Ministry of Health.

Most of the hospitals are under the management of one of three religious orders: the Holy Rosary Sisters, the Medical Missionaries of Mary and the order of Our Lady Queen of Apostles. All three orders have their motherhouse in Ireland.

DOCTORS

The major problem which faces the Catholic hospitals is the recruitment of physicians. At the present time, there are 76 physicians working for the Catholic Church in Nigeria. Twenty are Sister doctors and one is a Rev. Father-physician. There are 55 lay physicians; the countries of origin of the lay doctors are listed in Table I.

The vast majority of these doctors are general practitioners. Indeed, there are less than 100 qualified specialists, either Nigerian or expatriate, in all Nigeria; more than one-third of these are located at the two medical schools in Lagos and Ibadan. There are at present 12 qualified specialists among the 76 Catholic medical missionaries:

4 surgeons
3 obstetrician and gynecologists
2 internists
1 pediatrician
1 ophthalmologist
1 anaesthetist

RECRUITMENT

Most of the lay physicians stay for a two year tour of duty and then return to their native lands. The acquisition of replacements is a serious and persisting problem. Several methods are used to recruit physicians:

a) Personal contact and correspondence by the physician who is to depart with his friends and colleagues at home.

b) Advertisements in various medical journals.

c) Liaison with agencies such as the Catholic Medical Mission Board and Medicus Mundi. These organizations serve to bring together hospitals which need doctors and physicians who may be interested in medical missionary work.

The hospital will usually pay round trip transportation for the doctor and his family, provide living facilities and pay him a modest salary. The latter is usually in the neighborhood of 5000 dollars per year. The doctor is given a one month vacation each year. If the physician elects to stay for a second two year tour, he is given a 3 to 6 month vacation with pay, and round-trip transportation for his vacation at home.

MEDICAL MISSIONARIES FROM THE U.S.A.

According to a recent article there are more than 750 American medical missionaries serving overseas (excluding the CARE-MEDICO and the Hope-ship programs).[2] It is a curious fact that there are only a few Catholics among these 750 doctors. This situation is reflected in Nigeria where there is only one Catholic among the two dozen American medical missionaries. The Catholic hospitals in Nigeria have had little success in recruiting doctors from the U.S.A. The reasons for such a paucity of Catholic medical missionaries are not clear, but the situation demands improvement. What can be done?

The responsibility for igniting medical missionary vocations among Catholic medical students and physicians should be shared by four groups:

1) The Catholic Medical Mission Board (CMMB)

2) The National Federation of Catholic Physicians' Guilds (NFCPG)

3) The faculties of each of our Catholic medical schools

4) The Mission Doctors' Association.

The CMMB provides medical supplies and equipment to Catholic medical institutions around the world. Its placement service, under the very able direction of Mr. George Kish, arranges positions for doctors, dentists, nurses, and medical and laboratory technicians in overseas hospitals.

The NFCPG has recently established a Medical Mission Committee. It has focused its attention on Latin America. This is understandable in view of the active participation of several local guilds in arranging physician volunteers for short-term tours there. However, the physician shortage in Latin America can hardly compare with that of Africa. Perhaps the NFCPG could consider a more active role in recruitment of doctors for short or long term work on "The Dark Continent." Is it possible that greater dividends could be reaped by NFCPG sponsored publicity programs in the Catholic medical schools and hospitals? As for the non-secular medical schools and hospitals, neighboring guilds of the NFCPG might consider inviting Catholic medical students, house-officers and faculty members to their meetings and mission-help programs.

The Catholic medical schools should assume a major role in the genesis of medical missionaries. It is in the open and idealistic minds and hearts of medical students where efforts to invoke medical missionary service should be concentrated. It is in these few years that the prospective doctor is developing his lifetime plans. He should have maximum exposure to the opportunities and benefits associated with medical missionary work. Recently, a drug company, S-K-F, has subsidized a number of fellowships for medical students who wish to work in Government or voluntary hospitals in foreign lands. These fellowships have received the endorsement of the AMA, and the American medical schools and have proven to be exceedingly beneficial to all concerned. Such a program for Catholic medical students could reap great dividends in the development of future medical missionaries. The Catholic medical schools could initiate such programs — the NFCPG and mission hospitals could subsidize them.

Perhaps the faculties of Catholic medical schools could consider devoting some time to overseas missions? Consultants in any specialty would be welcome guests for short stays at any of the larger mission hospitals and opportunities are abundant. Physicians participating in this type of clinical or academic endeavor not only make a genuine contribution to the people with whom they are working but may themselves acquire a broader understanding of the medical problems in emerging nations.

In recent articles, Rev. Drummond asked "Why a Catholic Medical School?"[3] and Professor Hanlon discussed "The Objectives of Catholic Medical Education."[4] In neither article did the author mention the opportunities which Catholic medical schools have for developing medical missionaries. Do such omissions reflect a disinterest in or lack of awareness of the medical needs of the missions? Perhaps not, but it is a regrettable fact that these schools rarely provide any medical manpower for the missions. Perhaps a re-orientation in the medical curriculum or the addition to it of a program delineating the challenges of medical work overseas would improve the situation. "It should get better — it can't get worse."

CONCLUSION

The medical problems indigenous to Africa are staggering. Even in Nigeria, one of the most advanced countries, there are distressing facts such as the following:

1) Less than 20 percent of pregnant women receive medical care from either a doctor or a trained midwife.[5]

2) One-half of the children who are born alive die before they reach the age of five.[6]

3) The life-expectancy at birth is approximately thirty years.[7]

How can we help? An intensive publicity program re the needs and opportunities in Africa should be prepared and presented to Catholic medical students and physicians. To this end, there should be a coalescence of effort by the NFCPG, the CMMB, the Catholic medical schools and the Mission Doctors' Association.

TABLE I

Country		Country	
Italy	15	Poland	2
Spain	15	France	2
Ireland	6	Holland	2
Germany	4	Egypt	1
England	4	U.S.A.	1
India	3		55

Countries of origin of Catholic lay-physicians in Nigeria.

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Dr. Kelly is serving in volunteer capacity at St. Luke's Hospital, Anua, UYO, Eastern Nigeria.

Doctor, Is There A Father In The House?

Reverend John Tomasovich

The twist in the title of my talk this afternoon reminds me of another situation with an unusual ending. One day a teenage girl came into church during confession time. It was evident she was extremely nervous, and her prayers went something like this: "Dear Lord, I kissed a boy last night and I'm so ashamed of myself. I'm embarrassed and don't know how to tell this to father in confession. I'm afraid and I'm nervous. What am I to do?" In the meantime, sitting in the confessional was a newly ordained priest who was getting ready to experience his first afternoon of hearing confessions. He was also praying something like this: "Dear Lord, I'm nervous because this is the first time I will hear confessions. Help me not to say the wrong thing or give the wrong advice. Lord, don't let me forget the formula for confession. Don't send any difficult penitents today. Please help me because I am so nervous." Finally the young girl went into the confessional box and was waiting, with fear in her heart, for the slide to open. When father finally did open the slide, she blurted out immediately: "Kiss me father, for I have sinned." To which he replied immediately, "How many times?"

However, this title does indicate that there exists a serious basic conflict of obligations in the life of every dedicated medical man. On one hand, by reason of his profession, he has an obligation to his patients. Having freely and willingly chosen a medical career he must dedicate himself to the care and cure of all those who seek his help, who place themselves in his hands and seek him out demandingly, time after time. On the other hand, he has an obligation which not only entails the providing of food, clothing and education for them, but, as head of the house, he owes the complete giving of himself, his love, affection and assistance, to his wife together with the caring for and training of his children.

The problem stems from the sad fact that it is difficult to fulfill the obligation of a husband and father adequately, if he is absent from the family a greater part of the day practicing his vocation of healing. Here the conflict lies — How can he fulfill both these equally serious time and self-demanding obligations?

Let us examine some examples of this conflict in practice. A man knows that dedication to the cause of medicine is certainly a vocation. He knows further that this vocation will make many demands on his time and his talents, that he will often have to defer his personal wishes and desires for the good of his patients. But, before he has even finished medical school or internship, he makes another choice of vocation — that of marriage. So, he has assumed further obligations which are even more sacred and solemn, namely: to love and care for his wife and children and to prepare them for eternity. Both of these obligations are assumed in circumstances where their fulfillment is most difficult. The young medical student must give every minute of his time to prepare himself for the art of medicine, both in theory and in practice. As a resident he is "on call" frequently. In many instances, he will seek out as many added sources of income as possible in order to further support his family. This means his wife is home alone most of the time and her task becomes boring and even bothersome because she has no one to share her thoughts and feelings. When the doctor-father is home, he usually needs his rest or he must be left alone to study and read. This results in strain and tension which aggravates each other's feelings and leads to mutual blame and misunderstandings.

After a man arrives at an extensive practice, his position is in no way improved. He is so busy he is still not home much. His hours are irregular. It is difficult to make family plans and much needed recreation and social life are always in jeopardy of cancellation. This has a tendency to increase bickering which leads the doctor to seek escape in his practice. Now, we have a vicious circle. His colleagues and patients consider him a top man in his field, but his wife is unhappy, his children hardly know him and he spends most of his time either at the office or the hospital or the club.

What is the solution? I don't presume to present you with a simple answer, for I suspect that there is an analogy between the lives of priests and doctors. I secretly have the opinion that the Church enjoins celibacy on her priest-sons because she knows they would make terrible husbands. Please don't conclude that I think all doctors make poor husbands. Rather, only if the problem is clearly understood and recognized as a problem both by the doctor and his wife, and can be discussed without anger, with patience, understanding and good will, some practical solution can be achieved. You know this because all of you here have wrested with this problem at one time or another.

I think there are two main considerations needed for the reconciling of this two-fold obligation of the doctor and the father. First, he must completely understand his role of father and husband and, second, he must establish a correct sense of values in relation to his profession and his family.

What is the role of the father and husband? Well, the father can be considered a *creator*. The example of all Fatherhood is God, the Creator of His children to whom He continually manifests His loving providence. The mark of a true father is found in the conscious sense of his responsibility for the physical and spiritual well-being of his wife and children and his constant concern and loving solicitude for them. Further, his task is the creation of a Christian home-life for his family. He must decide where the family must live, how he shall provide for it, create the correct atmosphere that shall pervade

the relationships of all those who are bound to his care.

The father can be considered also as a *lover.* St. Thomas gives the best working definition of what love is when he said, "to love is to will the good of the other." True love is not turned inward but is directed to others. The father must realize that he must act and live in such a way that the good and happiness of his wife and his children are his primary concern. This love must be a profound commitment for their good. This love must know no limit. The father will soon discover this as it must open up to the children born of his love for his wife. The child, in his earliest years will know only one thing — whether or not he himself is loved. This knowledge which flows into the baby's consciousness with the very milk it drinks, by the air that it breathes and the way it is handled, is crucial to the infant. We are told by psychologists that the physically and mentally healthy child is the child secure in the love of its parents and this pertains especially to the father. Love must be the motivating force of the husband's authority. His position as ruler of his home must be used always to achieve the family's highest possible good and not just his own good. The man who does not see his authority as essentially a means whereby he serves those under his rule neither knows what authority is nor deserves to have it.

A husband can be considered in the role of *Christ.* In the fifth chapter in St. Paul's Epistle to the Ephesians we read "the man is the head to which the woman's body is united, just as Christ is the head of the Church, He, the Saviour on whom the safety of his body depends; and the woman must owe obedience at all points to their husbands as the Church does to Christ." This obedience of the wife is not based upon fear but flows from her relationship with her husband. The husband has a responsibility of guarding and caring for his wife; she is dependent upon him. The ultimate meaning of the wife's obedience and the husband's headship is that the marriage of man and wife images the eternal union of Christ and His Church. Wifely obedience is nothing else but wifely love. A woman who can rely upon her husband is a woman liberated from a man's responsibility and is free to be more fully a wife. Indeed, if a woman does not know this submissiveness then she is unaware of wifely love, remains unfulfilled as a woman and her husband, for want of a wife's love, will remain stunted in his growth as a man. The husband is Christ-like by being unhesitatingly selfless. Remember this, the material things of this world are far less important to a woman than the knowledge that she is loved, wanted, needed by her husband. Only in the security of this knowledge can she give totally of herself. The more perfectly a husband identifies the headship of his family with the headship of Christ, the more he strives to protect himself, to pattern himself and his giving after Christ, the more perfectly will his marriage image the union of Christ and His Church.

The father can also be considered as a *priest* and his family can be called "ecclesia domestica" . . . "a family church" to which he ministers. Although you are aware of a sharing in the Priesthood of Christ by reason of baptism and confirmation, this is also true in a particular manner through your sacrament of matrimony. The father is the spiritual leader of his family-community and shares, in common with the priests of the church, the responsibilities of teacher and caretaker of the souls within this community. This ministry of teaching and care is to be manifested not only in words but pre-eminently by attitude and action. At this point, may I suggest a simple and beautiful custom for you, fathers, the custom of giving the parental blessing to your children each night after their evening prayers. This can be done simply by making the sign of the cross on the forehead of each child and saying words to this effect: "I bless you and may God keep you in the name of the Father and of the Son and of the Holy Spirit, Amen." This simple practice certainly will have a double salutary effect, on the father because it will be a constant reminder to fulfill his role ever more perfectly, and, on the children, because it will dignify his image in their own lives. This is certainly a wonderful exercise of the lay priesthood.

The father is also the *breadwinner* of his family. Everyone usually understands this evident aspect of fatherhood. It is my opinion that most doctors sin in this manner more from excess than from neglect. Maybe it is psychologically resultant from so many years of striving and sacrifice. Nevertheless, it can quite easily happen that the doctor, as a father, can become only the person who pays the bills. While a father is morally bound to provide for his family, to meet their real needs, he must not so exert his talents, to exhaust his powers, to strive for all the unneeded luxuries and, thereby, neglect the spiritual welfare of those to whom he is irrevocably bound. A father must not attribute to money a power it does not have — the power to fill the emptiness created in the human soul when love is absent.

These thoughts on fatherhood, if remembered, certainly will help to ease the tension that exists between the roles of doctor and father.

In the second place, I mentioned above there is a need to set up a right order of values of what comes first in your life. Is there an order of precedence? There certainly is — GOD - FAMILY - MEDICINE. God comes first because He is the ultimate end and goal of the Christian life. The family is second to God. The father will achieve his union with God in relation to how well he fulfills his vocation as father. The vocation of medicine, a vocation within a vocation, then follows as a means of helping him to attain the first two goals. Therefore, the practice of medicine must be a help rather than a hindrance in his orientation to God and to his family. To understand this order of values will not automatically solve this problem in practice, but it will solve this conflict in the mind and this is

important for peace of mind. However, how to solve it in practice? Each one must seek his own solution. For one, it may mean that he may have to cut down on his patient load; for another, he may feel constrained to refer more frequently to younger physicians; for yet another, it may mean less socializing and recreating alone and more family-centered recreation; and for another, it may simply mean developing the courage to say no to many other extraneous commitments.

There is no doubt that t e must be a father in the house y dear doctors. In order to rise t fulfillment of this vocation, must often reassess the meaning fatherhood and its importance, d pray for the courage, wisdom l grace to incarnate that meanin n yourself for your family.

This is an address given by ther Tomasovich to the Catholic Phys ns' Guild of New Orleans at a Brunch f wing the White Mass last year.

ADVICE TO AUTHORS

Articles on topics of potential interest to the Catholic physician *as a tholic and as a physician* are earnestly solicited. A goodly portion of THE LINACR QUARTERLY readers are not members of the medical profession but are engaged i allied health fields, teach moral theology, or serve in hospitals, and material f their benefit would also be welcome. The subject matter may be predominantl philosophical, religious, or medico-moral in nature. Material should be type ritten, double-spaced, with good margins and on one side of the paper only. Mar scripts *(original and one copy)* should be submitted to the Editorial Office of THE NACRE QUARTERLY, 1438 South Grand Blvd., St. Louis, Missouri, 63104. One ad itional copy should be retained by the author. Full editorial privileges are reserved Refer-ences if used should appear at the end of the article and should conform to t usage of the *Index Medicus.* (This format is that employed in the Abstract Section f THE LINACRE QUARTERLY.) A brief but pertinent *curriculum vitae* of the author(s) should accompany the manuscript. The Thomas Linacre Award is made annuall to the author(s) of the original article adjudged to be the best to appear in THE NACRE QUARTERLY during each calendar year.