# VIEWS OF EARLY CAREER DOCTORS ON RESIDENCY TRAINING AND CLINICAL PRACTICE IN NIGERIA: A QUALITATIVE REPORT FROM CHARTING STUDY

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## Abstract

In Nigeria, Early Career Doctors (ECDs) constitute a significant number of the doctor's health workforce and play a crucial role in health service delivery. However, there is a paucity of data concerning attitude, perception, and challenges in training and skill acquisition faced by ECDs undergoing residency training in Nigeria. This study is a component of Challenges of Residency training and early career doctors in Nigeria (CHARTING study) a multicentre and multidisciplinary study that explored the views of ECDs on residency training and clinical practice in Nigeria.

## Methods

Focus Group Discussions (FGD) were conducted among fourteen respondents, to address specific aspects of the residency training program and encourage respondents to express themselves about issues relevant to their personal experiences as regards the assessment of practice and proffer recommendations. Discussions were digitally recorded with an audio recorder. Audio-recordings was transcribed verbatim. Transcripts were analysed, and coding was done using NVivo 12 program.

## Results

All the study participants expressed various degrees of dissatisfaction and challenges such as lack of up to date knowledge, poor&contingent rewards, workload distribution, lack of mentorship, and unequipped facility during the residency training program. Majority of the study participants considered the program is currently skewed towards service delivery at the detriment of training and research.

## Conclusion

The study provided robust information on the knowledge of the trainees' perception of the residency training program in Nigeria as well as the challenges of residency training among ECDs as regards their experience and practice; it also proffered recommendations to mitigate the challenges.

**Keywords**: Career, Internship, Postgraduate, Registrar, Trainee, Residency, Doctors, Dentist, Early Career Doctors, Nigeria, Education, Graduate Medical, Residency

## Introduction

Early Career Doctors (ECDs) constitute a significant proportion of health workforce in Nigeria and entails medical & dental intern, resident doctors and medical officers in the rank of medical officer and senior medical officer in Nigeria.[1-3]. Globally, ECDs also constitute a significant fraction of the doctor's health workforce and play a crucial role in health service delivery. ECDs also constitute a significant proportion of medical and dental practitioners in Nigeria.

The ECDs are particularly unique as they occupy a unique career phase which is no doubt stressful, often an intensive training period.[4,5]Furthermore, as

they will eventually metamorphose into medical experts, leaders and trainers, it is vital to get interested in them and understand their views about their training and clinical practice during their training programme in the country.

There is, however, a dearth of research on ECDs in Nigeria – with little information available about the perception, attitude and the challenges in training experienced by these young professionals.The few available studies were mainly quantitative studies that used structured questionnaires to assess the information concerning ECDs. The studies may thus, be limited in their ability to collect information with depth which is possible with qualitative study designs. This study, therefore, explored the views of ECDs on residency training and clinical practice in Nigeria. This will provide insight into ECDs in Residency programme in Nigeria. Other reports on other themes collected from the same study population are in the process of being published from the same subset of study.

## METHOD

We conducted two sessions of Focus Group Discussions (FGD) among 14 respondents. The sample size was limited to 2 geo-political zones of the country due to the accessibility and availability of participants. However, the study population share closely related characteristics.We used a purposive sampling method of ECDs in eight training institutions in Nigeria. The FGD guide was designed and carefully reviewed by the FGD team in a logical sequence to address topics related to the research objective. This study is a component of mixed study design of Challenges of Residency training and early career doctors in Nigeria (CHARTING) study, which is a cross-sectional, multicentre, multi-disciplinary and multi-dimensional study of ECDs in Nigeria.[4,6]

### *Data collection*

The FGD was conducted during two official gatherings of Nigerian Association of Resident Doctors(NARD) formerly referred to as National Association of Resident Doctors of Nigeria(NARD), where key members and leaders of each branch come around for the meeting. Statutorily, the National Executive Committee, National Executive Council, and Expanded National Executive Council attend these meetings although other delegates who are members but non-NEC members may also attend.[7]

Voluntary respondents who were various branch leaders and delegates were recruited into the study. A formal request for participants in the study was made in the meeting, and interested individuals were recruited.

We utilised two trained facilitators to collect data, and the sessions lasted for about 1 to 1 hour 30 minutes secluded from the central meeting. The facilitators used a semi-structured FGD guide which was carefully designed to address specific aspects of the residency training program and encouraged respondents also to express themselves about issues relevant to their personal experiences as regards the assessment of practice and proffer recommendations.

Discussions were digitally recorded with the use of an audio recorder (Sony ICD-PX470 Digital Voice Recorder) while a smartphone audio recorder was used as a backup/ alternate plan with participant consent to ensure that the details of the conversations are adequately captured. Two sessions were conducted, and it continued until data saturation(all the questions in the FGD guide were responded to by the majority of the participants)was achieved. Audio-recordings were transcribed verbatim.

### *Sample Description*

Following our recruitment process, fourteen respondents agreed to participate in the group discussion about their experiences and challenges of the residency training program.

To ensure the privacy and confidentiality of the respondents, they were given a unique identifier. Among them, 85.7% (12) were male, while 14.3% (2) were females. Eight respondents were from SW(57.2%), while six respondents were from SS (42.8%). The

Respondents were from various centres within the geo-political zones; University College Hospital, Ibadan (UCH) -2, Obafemi Awolowo University Teaching Hospital (OAUTH) - 2, Lagos University Teaching Hospital (LUTH) - 2, LAUTECH Teaching Hospital (LTH) - 2, Rivers State University Teaching Hospital (RSUTH) - 2,Federal Medical Centre (FMC) Yenagoa - 3 and Niger Delta University Teaching Hospital (NDUTH)- 1. Employment cadre of respondents includes one (7.1%) house officer, one (7.1%) senior medical officer, four (28.6%)registrars and eight (57.2%), senior registrars.

### *Analysis*

Transcripts were analysed and thematically coded according to the research themes that emerged from the discussion. Coding was done using NVivo 12 program. Open coding was also used to identify specific themes that emerged from the discussions. Themes and subthemes were generated and supported with illustrative quotations from the discussion.

### *Ethical considerations*

The National Ethics Review Committee, Federal Ministry of Health approved before fieldwork commenced (NHREC Approval Number NHREC/01/01/2007- 26/06/2019). Written and verbal consent was gotten from participants before conducting the session. All information obtained from each participant, including personal details, were treated with the utmost confidentiality.

## Results

The result of our analysis showed that respondents opined that there are challenges and gaps in the residency training program in Nigeria. We identified three core themes that represented the experiences and participant's assessment of the residency training program while the last theme focused on other challenges of residency training and recommendations (see table 1). These themes were presented with supportive quotes to buttress respondents' opinions further.

**Table 1: Summary of FGD findings**

| OBJECTIVE | THEMES | COMMON SUB-THEMES |
|---|---|---|
| ***To explore the views of early career doctors on residency training and clinical practice in Nigeria*** | ***Description of Residency Training Program*** | |
| | Unfavourable conditions | The residency programme is skewed mainly towards service delivery |
| | | Perception of the inadequacy of operations of the programme |
| | Workload | Residency training in Nigeria is a bit tedious |
| | Time constraints | Most of the time is directed towardsclinical service via viz patient care with little time for other things. |
| | Mentorship | Mixed opportunities for mentor-mentee relationships |
| | Physical environment | The inability of training centres to provide accommodation for all residents |
| | | Inadequacy of resources for the training |
| | ***Assessment/Challenges of residency training*** | |
| | *Assessment of Practice Dissatisfaction* | *Dissatisfied with:* |
| | Reward system | Pay benefit/contingent reward/promotion, living condition and selection of applicants into the residency program. |
| | Mentorship | Lack of mentorship and power/authority abuse by sometrainers. |
| | Social support | Working relationship with colleagues/supervisors, marital life and extracurricular activities. |
| | Emotional support | Psychosocial support. |

| | | |
|---|---|---|
| | Workload | Workhours distribution and quality of care(heavy work burden). |
| | Physical environment | Facilities/equipment's for services and training |
| | **Suggestions and recommendation** | |
| | Intervention by hospital management and government | *Formulation and implementation of new policies as regards*: |
| | | Job description/specification. |
| | | Excellent remuneration & benefits. |
| | | Standardization of operationsof the residency training program. |
| | | Review of the programme for international competitiveness. |
| | | Provision of research laboratories and grants. |
| | Entry into the residency program | Selection into residency training at training institutions should be more merit-based. |
| | | Designated committees should guide the employment of ECDs into the training institutions. |

**Description of Residency Training Program in Nigeria**

All the participants in this study freely expressed their perceived view of the residency training program in Nigeria. The degree of stress being exposed to during residency training was popular among the respondents. All the respondents unanimously claimed to have experienced unfavourable conditions during their residency training programmes such as a high degree of work, insufficient time, lack of mentorship, and poorly equipped training facilities. As reflected in the below verbatim expressions:

"Residency training in Nigeria is a bit tedious because most times, most residents do a lot of work in taking care of patients …" (R1 SW).

"Generally looking at the residency training I think it is poor" (R1 SS).

"We have a problem with mentorship, residency program is supposed to be a program where you should be mentored by a tutor all through your training, but you know in this part of the world we don't have that" "We rarely have centres that are well-equipped for this training, so it is more or less like a self-effort thing" (R2 SS).

"Let me say we are not so conformed with the universally accepted practice outside the country and therefore, and this has discouraged many people in joining the residency program as it is" (R2 SW).

Besides, one of the discussants gave an assertion that was entirely different from the above points on the residency training program:

" It might just be better that we call it postgraduate clinical training because the word residency means the residents are resident within the hospital. So the questions are how many hospitals really have all their resident's resident in the hospital? To the best of my knowledge, especially in the southwest, there is no hospital that accommodates all residents within the hospital" (R8 SW).

Another evident fact from this discussion is that the majority of the participants appeared not to be aware of the criteria for selection into the residency training program. Although it is believed that the selection is based on the doctor having passed primaries, some still felt that entry into residency training in training centres/institutions had to be influenced, as opined by some of the participants. Some of the views of the participants:

"Who knows" "personally I don't know how I got into …, I don't know the criteria. I just did exam,

and they said I passed I don't know my score; I did interview I don't know my score the next thing they called me after of course, you have to do the normal leg work which we all know that in Nigeria today you need some extra push even if you passed or you succeed in interviews you may not get in" (R7 SW).
"I think once a doctor has met the requirements of having primaries; he should be selected irrespective of whether he knows somebody or not" (R3 SS).
Residency training has three objectives; service, training and research. However, participants (100%) stated that these objectives are skewed towards service only at the detriment of others. Also, the emphasis was made on disproportion of these objectives (60%, 20%, 20% respectively) as priority is mainly on service. The respondents believe there are gaps in their training.
The below transcripts illustrated the described analogy:
"I will look at the residency in three parts: service, training and research with the way residency is structured ok I feel those three objectives have to be met. However, in most institutions, the objectives are skewed towards mainly service to the detriment of the other two objectives" (R7 SW).
"I will apportion 60% to service while I will give 20% to training and research respectively" "Priority is on service, service and service. People get stressed up, overworked" (R5 SW).

**Assessment of Practice Dissatisfaction/Satisfaction**

From the generated transcripts, all participants aggressively reported to be dissatisfied with the training experience in terms of pay/fringe benefit/contingent reward, promotion, working relationship with colleagues/supervisors, psychosocial support, living condition, workhours/workload distribution, extracurricular activities, marital/social life, quality of care, facilities/equipment's for services and training.
"We are not satisfied at all" (first eight respondents)."I think it has not been very palatable on my side. Residency training has not been fine, albeit we just do what we can do to move on" (R2 SS).
"We are grossly dissatisfied" "Also we don't have closing hours" (R5 SW).
"The in-person motivation for me where I am training is not there where you are owed two years' salary where do you get money for research, to take care of yourself or to even to subscribe to journals and pay for articles" (R8 SW).
"I come from state institution where our pay is not encouraging because the whole thing about residency training is geared towards service delivery (service delivery). We also don't have time for the training itself and for research and asides that everybody is almost overworked" (R2 SS).
"I cannot be satisfied with the money, I cannot be satisfied with the relationship with my superiors I feel many of them have mortgaged our future, and I am saying this with all sense of humility and responsibility, do we have work hours? So we can never be satisfied" (R7 SW).
On the other hand, a participant stated that she was satisfied with the mentorship program in her centre but emphasised on financial constraints and unrewarding system.
"My own personal residency experience is good, and it is bad being that I come from a centre where our mentorship is very good. We have the consultants that are always available for us, and they give us time, but the bad part of it is the pay (R1 SS).
Participants highlighted other challenges of residency training as; irresponsibility, lack of up-to-date knowledge, mentorship program and power/authority abuse of trainers. As reflected in the below verbatim expressions:
"The trainers too need to take responsibility because we are there because of them that is why is called training institution but situations whereby you are in a facility whereby your trainer doesn't even bother what you are doing in the training programme (you know) it affects you as an individual and also affects the program as a whole" (R2 SS).
**"**Still with the trainers, somethings change over and over again so sometimes some trainers have one particular skill, and they have been with it for too long even if it is old fashioned, so they don't go with the change" (R3 SS)
**"**I still believe one of the fundamental issues that affect residency training here in this country is witch-hunting in the sense that may be at the local political level you and somebody has had some political fight and the person happens to be your senior, and the person is now a fellow he or she will be waiting for you in Ibadan to go and fail you, and by the time it happens the first, second and third time the person will be frustrated and even go out of the program" "It has happened in different

institutions, and most of my classmates are victims of that is why I want to bring it forward" (R5 SS).

**Suggestions and Recommendations by respondents**

Based on the challenges mentioned above by the participants, recommendations to mitigate these challenges were proffered depending on the different stakeholders involved.

Hospital management and the government should formulate and implement new policies as regards job description/specification, excellent remuneration & benefits, standardisation of the residency training program.There should be a more structured training program which, among other things, stipulates dedicated time for research – this will encourage residents to do research. Furthermore, selection into residency training should be more merit-based rather than by being externally influenced. In addition, the curriculum should be reviewed to include more courses on leadership and ethics. Provision of research laboratories and grants, training centres' capacity should be enlarged to absorb more doctors for the training. Training programs at the various centres should be more organised as well as there should be research days which will serve as free days so as to encourage residents to do research.

"I feel the best thing is to formulate a policy for the training" "All these job specifications and job descriptions we can look into it" (R3 SS)."Salary is a major incentive for people" "In the early 70s and 80s a lot of people were in private practice because it paid more than residency training. We may be tilting towards that direction now staying abroad is better than staying here" (R5 SW).

**"**I think importantly we have to standardise our residency training vis-a-vis validating it with what we have outside the country" (R6 SW).

"I think once a doctor has met the requirements of having primaries; he should be selected irrespective of whether he knows somebody or not" (R3 SS)."I think as part of our curriculum from the medical school, leadership should be inculcated because as medical doctors by virtue of that our position we are already leaders somehow" (R5 SS).

Respondents also proffered recommendations as regards prompt employment and replacement in the programme and a designated committee/board that guides the employment of ECDs into the training programme without delay:

"I think apart from having primaries. First, doctors that have just graduated or have finished their youth service can actually be given the opportunity as a MO(Medical officer) to go into these different fields; they can write primaries there and be re-admitted" (R5 SS).

"I think there should be a board that is set up and all hospitals should be part of the board to know the spaces that are available so as soon as we have people who have primaries already, they are placed" (R4 SS).

**DISCUSSION**

Residency training programme in Nigeria is a structured, institution-based, competency training programme for doctors and dentists who have acquired a necessary Medical/Dental degree (MBBS/BDS) and upon completion of training are fellows of a postgraduate Medical College and are appointable as Consultants/Specialists in their respective specialities.[8] These rigorous graduate trainings are provided by fellows who serve as consultants in various teaching centres which may be tertiary or secondary in the healthcare system. [7, 9, 10]The program is crucial for the provision of the critical specialist workforce for the Nigerian health system, which is essential to prevent the loss of scarce foreign exchange such as when the training was doneabroad (as was the practice before the 70s).[7, 11, 12]Critical stakeholders include the trainees and their trainers; the government (to enact enabling laws, provide leadership as well as funding), and the general public (who are the beneficiaries of the specialist skills and services).

The results of this exploratory study indicate that there are current challenges that require improvement in order to improve the quality of the residency training program, from the respondents' perspectives.The problems encountered by the resident doctors, appear to be a combination of the general problems of the average Nigerian civil servant, coupled with the burden of a training position in the setting of poor infrastructure.[8]

Respondents expressed dissatisfaction with their training experience in terms of pay/fringe benefit/contingent reward, promotion, working relationship with colleagues/supervisors, psychosocial support, living conditions, work hours/workload distribution, extracurricular activities, marital/social life, quality of care, facilities/equipment's for services and training which is in line with previous studies.

The above findings are not just an overstatement of

facts, as there is existing literature also to support them.[9, 10] Previous studies which explored the surgical trainees' views and noted lack of time/motivation, indifference, poor knowledge of research methods, inadequate training facilities, poor welfare and inadequate sponsorship/ poor remuneration as challenges confronting their training. Another study that examined trainees' perceptive also found that training was inadequate and some deficiencies were identified.

A consequence of the overall dissatisfaction among the respondents is the effect it has on the quality of care given to patients.[13-16] The patient's overall care and management are moderated by factors spawned from the level of skills needed to deliver care by physicians, through the availability of technology to the number of patients seen by the doctor per hour or the number of calls per day as well as the cooperation and skills of support staff.[14, 17]

In recent times, there has been an increased agitation worldwide among doctors on issues relating to job satisfaction.[14] This agitation revolves around the factors as mentioned above.[14] Doctors are more satisfied when they perceive that they are meeting their patients' needs by delivering high-quality care and dissatisfied when they perceive barriers to delivering same. [18] Previous qualitative studies have explored the determinants of American doctors' satisfaction by gathering data using a combination of surveys and focus group discussion.[18]

Interestingly, most of these issues highlighted are mainly administrative/organisational, and a large part is traceable to the employers. Therefore, the resolution of these challenges lies mainly with the various employers; who provide the jobs as well as the platform for training. The trainers are not left out of such resolution, especially by developing of a structured mentorship program, strengthening the current practice training-the-trainer program,supporting the implementation of nationwide residency matching program and generally be at the vanguard of general quality improvement of the residency training program.[19, 20] The effort of administrators in resolving these observations will go a long way in ensuring satisfied resident doctors, much comfortable programme. All these will go a long way in impacting on the patient outcome.

## LIMITATIONS AND FUTURE RESEARCH

The methodological limitation was recognised as only two geo-political zones were represented in the study. However, the result of this study is a valuable contribution to the knowledge of the trainees' perception of the residency training program in Nigeria.

Future research in the area of conducting key informant interviews (KII) with key players in health system on their role in the residency training program will provide further insights on the drivers of the challenges mentioned above, proffer solutions and inform policies on the way forward. A large national quantitative study will also be beneficial.

## CONCLUSION

This investigation provided a robust output on the challenges of residency training among ECDs as regards their experience and practice assessment; also proffered recommendations to mitigate the challenges. Currently, there appears to be a high level of dissatisfaction among resident doctors, which can be resolved via organizational strategies.

### Disclosure

The confidentiality of respondents was protected, and authors' roles were separated from participants' roles. All authors are members of NARD except IA, FF was former executive officer, OO is a current National Executive officer and SO is a current South West Caucus Leader.

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