

**INDEPENDENT REPORT ON THE PRESIDENTIAL
COMMITTEE ON A HARMONIOUS WORK
RELATIONSHIP AMONGST HEALTH WORKERS
AND PROFESSIONAL GROUPS IN THE HEALTH
SECTOR IN NIGERIA**

**SUBMITTED BY
THE NIGERIAN MEDICAL ASSOCIATION**

NOVEMBER 2011

TABLE OF CONTENTS

Summary of Recommendations 1

Introduction 6

Our Responses to the Findings of the Committee..... 13

Causes of Disharmony according to the Committee 14

The Negative Impact of Disharmony on Prompt, Pleasant, Effective,
Efficient Delivery of Healthcare..... 29

To Develop and Propose an Action Plan for the Behaviour Modification
of All Health Workers in order to Restore and Sustain an Excellent
Relationship Among them 30

Terms of Reference 32

The Way Forward 35

Conclusion 36

SUMMARY OF RECOMMENDATIONS

1.1 To ensure that all health professionals have equitable opportunities of rising to the peak of their career it is recommended that the Assistant director (AD), Deputy Director (DD) and Director nomenclature be dropped for all health professionals as already done in the case of medical doctors in the hospitals. Where the Government wishes to go ahead with the above nomenclature, then all medical and dental practitioners on Grade Levels 15, 16 and 17 (or equivalents) must automatically be so designated in the spirit of justice, fairness and equity.

1.2 It is recommended that CAP 463 LFN, which is the principal instrument regulating the operations of the Teaching Hospitals, should remain unamended.

1.3 It is recommended that action should be expedited on giving legal backing to the Federal Medical Centres and Specialty Hospitals along the provisions of CAP 463 LFN.

1.4 The post of Chief Medical Director/Medical Director should be restricted to medical and dental practitioners as they are most suitable for such offices, and scientific study recently has proven hospital run by doctors are better than those run by business managers.

1.5 Government should encourage qualifications that are actually relevant to practice in the health sector.

1.6 Government should be very cautious in the proliferation of schemes of service and autonomous professional groups within the health sector as this has been partly responsible for the disharmony in the healthcare system in Nigeria.

1.7 Chief Medical Directors and Medical Directors of Health Institutions should be encouraged by Government to implement existing Schemes of Service that are not contentious and comply with provisions of the law.

1.8 To reduce or eliminate the disharmony arising from remuneration and pay relativities of health workers, the NMA recommends that proper relativity in remunerations be re-instituted.

1.9 The NMA recommends that the present constitution of Management Boards, which is statutory and adequate, should be upheld, and that whenever the composition of the Boards are expanded, equity should be maintained.

1.10 The structure of the Federal Ministry of Health should not be adjusted, and Recommendation 1.1 above be implemented to enhance the career prospects of all health professionals and allow them to rise to their peak where vacancies exist.

1.11 On pay disparity between health professionals in the employ of the Federal Government and their counterparts in other tiers of Government, the NMA recommends that the Federal Government should, as a matter of priority, encourage States to look into the remuneration of their health workers with a view bringing into parity.

1.12. The NMA recommends that acts of quackery and malpractice be appropriately sanctioned by the Regulatory Bodies of various professions and other law enforcement Agencies.

1.13. The creation of the office of Surgeon General or Chief Medical Officer for the Federation is highly recommended to shield health services from the influence of politics and guarantee sustainability of programmes and policies as governments change.

1.14 To remove or drastically reduce the distress arising from poor working conditions, the NMA recommends that the Federal Government should increase budgetary allocation to the health sector.

1.15 The pervading indiscipline in the health sector which manifests in lack of respect for hierarchy and professional colleagues is a clear case of insubordination and an act unbecoming of a health professional. It also constitutes a violation of professional ethics. The NMA therefore recommends that such acts should be sanctioned in line with the provisions of the Public Service Rules and Code of Professional ethics.

1.16 The Perennial staff shortage in most public hospitals and health institutions in Nigeria, especially at the primary and secondary levels of healthcare, puts undue pressure and stress on the

available staff at all Healthcare Institutions. Government should pay attractive remunerations and improve infrastructure.

1.17 To promote healthy competition with an overall objective of achieving better service delivery, the CMDs/MDs should take the initiative of rewarding outstanding performance through an appropriate reward system, in line with the Public Service Rules.

1.18 On the appointment of a Health Minister, it is recommended that until the office of the Surgeon General or Chief Medical Officer of the Federation is established the medical practitioner remains the best option for the nation.

1.19 On appointment of Chairman, Medical Advisory Committee (CMAC), the current democratized process of selection of eligible candidate from a pool of medical and dental consultants should be sustained.

1.20 The term “medically qualified” and “non-medically qualified” refer to medical/dental practitioners and allied health professional respectively. Also “Consultant” refers to a medical/dental practitioner with Fellowship qualification and has been so appointed. These global definitions need no other interpretation, and therefore, does not require any amendment of the Act CAP 463 LFN.

1.21 Strike by professional associations should be strictly regulated by their regulatory bodies to avert frequent disruption of duties.

1.22 The Residency programme should continue as established, be expanded and plans made for immediate commencement of the overseas clinical attachment as approved by Government.

1.23 Postgraduate Colleges of the type for Medicine and Dentistry for allied health professions do not exist anywhere in the world, and is unnecessary. The existing universities are capable of meeting their demands for relevant higher education.

1.24 In order to tackle the confusion which now exists in the membership of unions in the health sector and the resultant membership overlaps, we recommend caution be exercised in dealing with

the matter and efforts made to respect freedom of association as enshrined in the constitution of the Federal Republic of Nigeria.

1.25 It is recommended that the Federal Government and the Federal Ministry of Health adhere to all enabling laws on the composition of Regulatory Councils and Boards of the parastatals of the Ministry.

1.26 Regulatory bodies should be empowered and encouraged to enforce their codes of Conduct/Ethics and to promptly sanction erring members.

1.27 Regulatory bodies are also to ensure that such topics as Leadership, Management, Communications and Interpersonal skills are incorporated into their training curricula and CPD programmes.

1.28 Periodic workshop by Regulatory bodies, Training Institutions and Professional Association on Management, Leadership and Communication issues need to be organized to keep health professionals abreast of developments.

1.29 Clinical Governance and global best practices must be at the centre stage of all activities and actions in the health institutions.

1.30 The violent behaviour and conduct of the allied health workers, especially the medical laboratory scientists must be curbed now before it grows into a monster.

1.31 Indoctrination of students of allied health professional against medical practitioners by their teachers must be checked. These students leave school with in-built aggression and hatred against medical doctors.

1.32 Professionals should be assessed on ethical code of their profession as part of their promotional examinations.

1.33 All reported cases of indiscipline should be dealt with decisively.

1.34 Stringent control measures against quackery in the medical practice through regulatory monitoring and control of activities of members of the health professionals.

2. Introduction

2.1 The Nigerian Medical Association (NMA), the umbrella professional association for Nigerian physicians and dentists, has long been aware of the “disharmony” in the health sector, its various manifestations and devastating effects on the quality of healthcare service delivery to Nigerians. The NMA, being desirous of a harmonious working relationship between all professionals in the health sector, is always keen to work for the achievement of this singular objective – “delivering the best possible healthcare services to the patient, and by extension, to the population at large”.

2.2 The NMA was initially elated at the constitution of a Presidential Committee on a Harmonious Work Relationship Amongst Health Workers and Professional Groups in the Health Sector in Nigeria (hereinafter referred to as “the Committee”) with the following terms of reference (TOR):

2.2.1 To identify and critically examine

2.2.1.a the root causes of disharmony among health workers and amongst professional groups in the health sector in Nigeria.

2.2.1.b the negative of this phenomenon on the prompt, pleasant, effective and efficient delivery of health care to those needing it.

2.2.2 To proffer sustainable solutions that would eradicate the ill-will amongst the different professional groups in the health sector and amongst Health Workers in the country in general.

2.2.3. To develop and propose an action plan for the behaviour mortification of all health workers in order to restore and sustain an excellent work relationship among them.

2.2.4. To develop and propose a simple test rules (etiquette) that would guide the behavior of all

categories of health workers towards one another and to patients, their families and friends.

- 2.2.5. To propose sanctions for any contravention of the set rules as may be adopted for general applications from relevant sections of the Public Service Rules and from the Code of Professional groups in the health sector.

We had hoped that stakeholders in the health sector will come to the table with evidence of information as regards what constitutes the “best interest of the patient”, and seek ways to ensure that the structure that serves that need is upheld. The NMA is profoundly disappointed that as the committee proceeded in this sacred task, given the unique opportunity, the “best interest of the patient”, “international best practices” as well as “judicious use of resources” (human and material) were relegated to the background or ignored completely. In time, it appeared that the committee was misguided, and sought to reach outcomes beyond its terms of reference. The various agitations and their piecemeal manifestations by certain persons in professions allied to medicine (Allied Health Professionals, AHPs) began a long time ago, having roots in what they considered the “undue” influence of the “medical doctor” in matters of patient care, allocation and deployment of resources to meet the stated objectives of the healthcare sector.

2.3 It is pertinent to draw attention to the fact that certain basic, globally-recognized and accepted definitions of terms, persons and professions have been completely re-written to suit the purpose of justifying the recommendations of the aforementioned committee. This, when subjected to close scrutiny, will be found to seek undue legality for the inordinate aspirations of AHPs seeking to upstage the medical doctor, by seeking direct access to the patient, without the requisite training or licensing required by extant laws in the country. The NMA recognises that this behaviour is the result of AHPs seeking greater relevance in the sector, and is of the opinion that this should not be to the detriment of the patient and the health system. It is indeed obvious that the grandstanding of AHPs does not advance the interest of the patient, as our experience and many reports from patients have shown that AHPs have resorted to disrupting the process of healthcare service delivery, to the frustration and consternation of NMA. Indeed, many AHPs have very often gone beyond their briefs in relating to patients in health institutions (public and private) thus engaging in quackery. We wish to state without fear of contradiction that the NMA remains the best advocate for a healthcare sector that serves the best interest of the nation.

2.4 For the avoidance of doubt, we shall undertake to state clearly and unambiguously that modern healthcare service delivery systems are not a creation of Nigeria; it is the product of international collaboration that shares information on what constitutes practice guidelines and ethics (international best practices) in a constantly evolving world.

2.5 Definitions: The NMA seeks to refer all stakeholders, including the government and the general public to basic definitions and terms used globally in the healthcare sector:

2.5.1 “Medicine” - is derived from the Latin words “*ars medicina*” which means “– **the art of healing**”. The Merriam-Webster dictionary defines **Medicine** as “*the science and art dealing with the maintenance of health and the prevention, alleviation, or cure of disease*”. The Cambridge Dictionary (Online) defines Medicine as “*The treatment of illness or injury or the study of this*”. The Oxford Dictionary defines Medicine as “*the science or practice of diagnosis, treatment, and prevention of disease*”. These definitions do not split the responsibilities, as it is embodied in only one profession.

2.5.2 “Medical” is derived from “*medicine*” and is defined as “*related to the treatment of illness and injury*” by the Cambridge online dictionary. The American Heritage Dictionary of the English language (4th edition) defines medical as “*of or related to the study or practice of medicine*”

2.6 All these definitions are available in published dictionaries, and freely available on the internet. A “medically-qualified” person, is therefore, someone who is trained in the “science and art of maintaining health, diagnosing, treating, curing and alleviation of diseases of the body and mind” having obtained any of these degrees - MBBS, BDS, BChD, BMBCCh and MD, as recognised by the Medical and Dental Council of Nigeria. It does not refer to other professionals in the health care sector, who are generally referred to as “healthcare workers” or “healthcare providers” in “professions allied to medicine, or AHPs”. It therefore implies that only medical/dental doctors are medical workers, staff or personnel. All other workers in the healthcare sector are collectively referred to as being in professions allied to medicine, or allied health professionals (AHPs).

2.7 We also wish to draw attention to the fact that an effective healthcare system has to be centered on the patient in order to “prevent diseases, maintain health, rapidly diagnose, treat, cure or alleviate illnesses, diseases and injury to body and mind”. The deployment of material and human resources should be done in such a way that best serves this need. Hence the bureaucratic machinery to serve this purpose should not be cumbersome but be as simple as possible, utilizing the minimum overheads without prejudice to the provision of optimal working environment and conditions of service and welfare of the personnel needed to make this work.

2.8 A Brief History of Medicine:

2.8.1 It is important that we examine, albeit briefly, the history of Medicine and of professions allied to medicine in order to understand and appreciate the role of doctors in establishing these professions, and why medical doctors continue to play leadership roles in their educational development and practice.

2.8.2 Medicine was established, nurtured and developed by ancient doctors from about 3000BC. The doctor did everything alone for many centuries. In those earlier years the doctor diagnosed diseases like diabetes mellitus by physically tasting patients' urine after observing that ants and butterflies gather at the spot urinated upon by some patients. Curiosity and adventure led Dr. Thomas Willis, (circa 17th Century) to imagine that whatever attracted the ants and butterflies must be sweet. He tasted their urine and compared them with his, and discovered that the patients' urine had sweet taste as opposed to his. This was the earliest case of evidence-based medicine. For many centuries the doctor worked alone relying on his God given physical senses of sight, touch, taste, smell and hearing to arrive at diagnoses and instituting therapy, and monitoring response. Drs Imhotep, Hesy-Ra, Hippocrates and Avicenna were prominent physicians who appeared in historical works. They prepared their own medicines, or potions, performed their surgeries and looked after their patients. Edward Jenner, Alexander Flemming, Robert Koch, Paul Ehrlich and Rudolf Virchow were physicians who dedicated their careers to investigations in their laboratories. The discovery and or production of some medical appliances (either developed, aided by or as requested by the doctor) helped to advance medical services. There were at this period no allied health professionals as exists today, except sorcery, witchcraft, voodoo practitioners. With the discovery of the microscope, medical doctors working in their laboratories discovered the invaluable link between basic sciences and clinical science which completely removed Medicine from the realm of humor (or spiritism) and brought it to the scientific arena. With the industrial revolution the

concept of quality assurance which was a tool in the hands of industrialists, was brought into Medicine by Dr. E.R. Jennings, a Chemical Pathologist, further refining the practice of Medicine.

2.8.3 What then is the issue? What is the source of “disharmony” in the health sector? The disharmony in the health sector is manifested by AHPs disrupting the process of healthcare services delivery by obstructing, upstaging, or usurping the functions of medical doctors through covert and overt means including direct disobedience, threat of bodily harm, verbal abuse, undermining the confidence of the patient in the medical doctor and falsely ascribing to themselves, the abilities and competence that were never part of their training curriculum in the first instance. They do these to seek greater relevance in the eyes of the public and thereby deceiving the public. Some have attempted this role-seeking behaviour to include a modification or padding of their curricula and unnecessary extension of duration of training in order to claim equality with the medical doctor, thereby wasting scarce resources.

2.8.4 The services to the patient by AHPs are not only relegated to the background, but largely neglected in practice, because of this undue and unwarranted competition for space and influence with medical doctors. This phenomenon has over time, resulted in untold agitations for wage parity with medical doctors, and also for separate regulatory and legal instruments to govern these professions none of which originated independent of medicine, and none of which functions alone in serving the “best interest of the patient” or the healthcare sector. We need to state that these laws contain numerous offensive and contradictory clauses when put alongside previously existing laws in the country. These considerations were overlooked by the Committee.

2.9 Leadership:

2.9.1 Another contentious issue that the Committee identified is the “assumption” of leadership of the health team by the medical doctor, which to them is a cause of disharmony. We must at this point raise the issue of conflicting and duplicitous legislative and regulatory environment in the health sector in Nigeria as a direct consequence of agitations of AHPs. We acknowledge that there is vast increase in knowledge, of all fields of human endeavour including, but not limited to medicine and professions allied to medicine. Hence, the statement by personnel in fields allied to medicine that they have come a long way, and have “come of age”, has little significance, and pales to nothing compared to the giant strides that medicine has made over the years. If therefore, the whole purpose of professions allied to medicine is to serve the interest of the patient, medical doctors must

continually make significant input into how they train their students and how patient-care business premises are operated, to ensure they do not go beyond the capacity bestowed on them by virtue of their training, thus indulging in quackery.

2.9.2 It is also derivable, from the above, that medical doctors be involved in matters leading to certification and accreditation to ensure that the competencies and services provided by AHPs are such that meet the needs of the patient. Indeed, this is the situation in many countries of the world. The medical doctor is always involved in all matters that have a bearing on human health, and leads the team in this regard.

2.9.3 Advances in allied health professions cannot be sufficient reasons for the physician to abdicate his role as the leader of the health team and the central healthcare provider. Indeed, advances in medicine far outweigh any in professions allied to medicine. There is no reason, and there will not be, for any country in the world, to delegate the core practice of medicine to persons who have no medical training or licensing, as certain AHPs would have the country believe. These false pretensions are self-serving and misleading.

2.9.4 In advocating for the best interest of the patients and the healthcare sector, the NMA would advise that access to the patient be controlled by laws, norms, regulations, rules and directives to govern the health sector, limiting this access to those persons medically trained and qualified according to the universal rules and practices of medicine. Persons working in professions allied to medicine serve a **supportive role** in the doctor-patient relationship, by virtue of their training, competence and licensing. The NMA will not support the creation of legal or administrative instruments that grant unguided access to patients in the practice of orthodox medicine by persons other than medical doctors and dentists. We note with dismay the unscrupulous practices of AHPs who have over time, deceived individuals, the general public, and the government, by making spurious claims of cure and ability in areas in which they have no formal training and competence.

2.10 We would again like to draw the attention of the government to the deplorable state of healthcare infrastructure and the poor conditions of service of healthcare personnel in Nigeria as one that deprives the average medical staff and AHPs of morale and drive in offering best services. This historically has been responsible for the brain drain phenomenon. It is also a major source of hostility and disharmony as doctors are perceived as taking the decision for AHPs. We categorically

state that the attitude of healthcare personnel in Nigeria has partly been responsible for the increasing propensity of Nigerians to seek healthcare abroad, (including countries like India, Egypt, South Africa, Germany, United Kingdom, United States, Canada, Saudi Arabia and Kuwait) due to the attitude of taking their frustrations out on patients. The healthcare structures that serve these countries so well are indeed well known.

2.11 These overwhelming evidence were indeed disregarded by the Justice Bello Committee in a most distasteful manner, compelling the withdrawal of the NMA from further participation in the Committee and its activities. It is on the basis of the of the foregoing that the NMA is compelled to submit an alternate report, based on the need to serve the “best interest of the poor and down-trodden Nigerian patient”, who cannot travel abroad to meet his healthcare needs, and attempting to set in motion the need for the institutionalization of “global best practices in the health care sector”, so as to effectively and efficiently deploy the resources available to this sector. It is **ONLY** by so-doing that Nigeria can have any hope of reversing the decay in the health sector, with each player, or group of players, staying within the confines of their professional training, competence and calling, serving the “need of the patient”, and indeed competing in the global market that healthcare delivery has become. It is the way to produce a healthy population that in turn can be productive. This indeed, is the strength of nations.

3. Our Responses to the Findings of the Committee

3.1. From the foregoing, discussions and analyses of positions presented in the various submissions of associations and unions to the Committee, as well as the perusal of documents and websites of institutions abroad on how medicine is practiced and the Committee's Report, it is obvious that there are challenges, which threaten to destabilize the originally stable, well-structured, efficient and effective healthcare system to the detriment of patients and the society. At the core of these challenges are:

- 3.1.1.** The attempts by Allied Health Professionals (AHPs) to displace the medical doctor from his traditional central place and leadership role in healthcare, especially patient care.
- 3.1.2.** The tendency of AHPs to venture into the traditional roles and responsibilities of medical doctors, even when they lack the requisite training and expertise, and then use this as a basis to demand for parity in the terms and conditions of service with medical doctors.
- 3.1.3.** The tendency of AHPs to seek to function independent of the medical doctor, who is the leader of the health team and the ultimate bearer of liabilities in patient care.
- 3.1.4.** The quest for the introduction of complex, expensive and unnecessary bureaucracy in the health sector in an attempt to evade and take over the oversight functions of medical doctors in the healthcare system in Nigeria.
- 3.1.5.** The creation of structures that erode the influence of medical doctors in policy and decision making bodies in health institutions, resulting in decisions and policies that are at variance with quality and safe healthcare in Nigeria.
- 3.1.6.** The systematic sabotage of the healthcare system by AHPs, particularly in hospitals, through deliberate destruction and vandalisation of equipment, avoidable delays in service delivery, disappearance and mutilation of patient medical records, etc, all in an attempt to portray the medical doctor as a poor manager or administrator.

4. Causes of Disharmony in the Health Sector according to the Committee (TOR 2.2.1.)

4.1. The Committee rightly observed that there is “deep seated disharmony” among health professionals in the health sector and identified the following causes:

4.1.1 “Attitude of Medical Practitioners”

4.1.1.1 The Committee in arriving at its recommendation relied on biased information when it reported that “*it was informed of the attitude of doctors of seeing themselves as leaders in the health team without due regard to other professionals in the team.*” The Committee erred when it accepted this statement as the major cause of disharmony in the health sector without reference to the submissions of all stakeholders and the plethora of documented evidence before it to justify the simple fact that globally, a medical doctor is the leader of the health team. This is unfair, unjust, inequitable, deceptive and misleading. We submit that the above assertion is incorrect and that the issue here is not about the attitude of medical doctors but of AHPs not accepting the global reality that medical doctors are the all-time leaders of the health team. However, medical doctors, as good leaders do recognise the important supportive roles of AHPs in patient care. We note that in a multi-professional sector, the principle of superiority of cadre operates, and in the health sector, the medical/dental profession is the ultimate cadre.

4.1.1.2 To examine this issue further, we refer to the statement of Dr. Richard W. Schwartz, a physician working for the Kentucky College of Medicine who possesses an MBA, that “*...precisely because they are at the center of clinical service and delivery, physicians are the ideal leaders for healthcare in the 21st century.*”

4.1.1.3 At the institutional level, looking at the performance of various managers of government institutions over time, it is a clear and undisputable fact that medical doctors have maintained services in the health industry under their care better than holders of MBAs, MHAs and PhDs in other fields. We are proud to say that none of our teaching hospitals have folded up no matter the challenges that they face. Corporations and institutions run by other professionals with MBA, PhD and similar business and administrative qualifications collapsed with catastrophic consequences – these include Banks, Nigerian Railway Corporation, Nigerian Airways, Nigerian National Shipping Lines, Nigerian Coal Corporation, Nigerian Mining Corporation, Cement

Companies, Motor Assembly plants, Marketing Boards, Fertilizer Companies and Refineries to mention but a few. These and many others were not managed by medical doctors.

4.1.1.4 The clinical pathway of the health-seeking behavior of the client or patient is aimed towards serving his/her “best interest” and must be replicated at the unit, departmental and health center/institutional levels, and also in organs of government e.g. agencies, parastatals and ministries if their purpose indeed is “to serve the best interest of the patients”, as only the medical doctor is trained in an all-round manner, understanding the needs of the patient, and able to respond to it in a timely, holistic and professional manner. It is on this basis that the natural leadership of the healthcare team by the medical doctor is not in doubt.

4.1.1.5 By definition, Medical Leadership consists of having fully trained physicians (medical doctors) occupying leadership roles relevant to the practice of medicine. Physician leadership includes planning, budget and control, monitoring and evaluation, resource management, decision making, quality assurance, recruitment and clinical service, as well as implementing changes and improvements in hospital and clinical settings. Medical leadership also goes alongside adequate team building activities and appropriate sharing of decision power. In this perspective, there is no room for an all-powerful Chief Executive Officer (CEO) having nothing in common with the team he is leading. On the contrary, good medical leadership intrinsically depends on the acknowledgement of the important supporting roles of all the levels of healthcare workers involved in the functioning of a health institution.

4.1.1.6 In practically all African countries medical doctors head health institutions. In Zambia for example (see Appendix I, pages 11 – 12), the Health Professions Council clearly states (under Medical Practice in Zambia: Leadership and Governance) that

"The Medical Doctor is a Team Leader at:

Ward level

Health Facility level

District level

Provincial level

National level

It went further to state that "Leadership and governance are critical in:

- Management of a Health Facility/Health Service

- Effectiveness as a professional
- Efficiency in the delivery of health services
- Accountability

4.1.1.7 In the US, Canada and Europe, there is increasing evidence that points out the fact that hospitals run by medical doctors are better managed and have better patient outcomes than hospitals run by non-medical administrators (see Appendices II, III, IV & V, pages 27 – 42). This is leading to the reversal of hospital headship back to the medical doctors. A Chinese proverb says *“if you want to know what lies ahead, ask those returning through that same road.”*

4.1.1.8 Global health institutions such as WHO, UNICEF, UNFPA, etc are by convention, headed by medical doctors.

4.1.1.9 Here in Nigeria, the Federal government of Nigeria handed over the National Hospital Abuja to International hospital management experts called "International Hospital Group (IHG)" **at a colossal management service charge of N600,000,000 per annum** in 2002. Within one year they received over 2 billion Naira to run the hospital. All the AHPs in the institution and in other hospitals in the country hailed this move in the hope or expectation that doctors were going to oppose it. Without prompting, the doctors in the hospital resolved to give IHG maximum support and cooperation to the delight of the NMA.

4.1.1.10 The IHG spent nine months drawing up a business plan, and in the end marked out some services for closure because they were ***not profitable***. Those to be closed were Dentistry, Ophthalmology and ENT. Forty percent of the staff were to be retrenched to save costs. The outcome was that services were collapsing despite the huge amount given to them (more than what six hospitals put together got over the same period). They refused to promote staff to avoid incurring further expenditure. Doctors quietly watched with keen interest. Suddenly, the Joint Action Committee (JAC) of the hospital led by the Senior Staff Association rose against the IHG experts; these were the same people who hailed them on arrival. Thereafter, government was compelled to constitute an assessment committee at the end of their first year of operation to assess their performance.

4.1.1.11 The outcome of the committee's work and report was the pre-mature termination of the IHG contract due to abysmal failure and total lack of focus and direction. The hospital practically collapsed in their hands. Nigerians took over again (precisely, the Nigerian medical doctor) and started rebuilding what the so-called "experts" in hospital management had destroyed. As if to make it impossible for the rebuilding to take place and to test the ingenuity of the Nigerian doctors in hospital management, capital votes were not released to the hospital for a few years thereafter. The hospital moved on and has continued to march on with greater strides till date with better services, including an emergency response system, no staff retrenchment and more services introduced. This is because patient care is at the core of the medical doctor's training and practice; and they are best suited to take the hard decisions which non-doctors cannot take and most probably do not understand in the first instance.

4.1.1.12 Looking at other sectors we cannot imagine a situation where the judge ceases to be the head of the court and concentrates only on hearing cases. Lawyers certainly will not accept this. From the perspective of those clamouring for non-physician headship of health institutions and parastatals, it would seem to be much easier for an administrator with MBA without a legal background to head or administer a court. Why is the leadership of the court and other arms of the judiciary not being positioned for all-comers who work in the Judiciary? In the aviation industry the core of the service is safe movement of persons. Irrespective of what the safety officers or engineers do or how excellent the services and smiles of the air hostesses might be, the overall safety of passengers is entrusted in the hands of the pilot. He is the head of the actual service delivery and he dictates what others do. Similarly, in the department of administration, the executive officer cannot head the department in preference to an administrative officer, even though they both have university degrees.

4.1.1.13 In the Military there are many professionals including medical doctors, nurses, lawyers, pharmacists, the Chaplains and Muslim clerics, artisans including tailors etc. Can any one of these dream of being appointed to combat command positions of service chiefs or divisional commanders irrespective of their training background and ranks? Can they be asked to develop battle strategy? Can anyone be a Naval Chief if he is not a sailor or Chief of Air Staff if he is not a pilot? Are these other professionals not soldiers or Ministry of Defense staff? Did they not go to school? Do some of them not have Masters and PhDs and Fellowships? Do they not operate in War

Zones and during war times? The answer is obvious to all: they are not the core professionals in these areas.

4.2 The Committee's Resolutions and Our Comments/Recommendations:

4.2.1 “That more Directorates should be created in the Tertiary Hospitals so that officers can rise to the peak of their career in line with the scheme of service.”

4.2.1.1 The creation of additional directorates that only cater for the ambitions of persons in professions allied to medicine, in order to draw higher remunerations, as well as whittle down the influence and responsibilities of the medical doctor is not only unjustifiable, but smirks of outright self-aggrandizement, and would not serve the “best interest of the patient”. Therefore, tertiary Hospitals do not need more Directorates to be created for any group of health workers to rise to the peak of their careers.

4.2.1.2 We support the Government policy that any university graduate can aspire to reach the terminal grade level (GL 17 or its equivalent). However, the terms or nomenclatures Assistant Director (AD), Deputy Director (DD) and Director should not be used as this will connote superiority over the superior medical/dental cadre, which does not use those terms/nomenclature but in some cases operate within the same department. This will pose serious challenges to the organizational structure, work flow and maintenance of discipline and responsibilities.

4.2.1.3 The creation of more directorates would be counterproductive as it will bloat the bureaucracy and make it unwieldy and skyrocket the cost of running the health system. This will automatically imply that all medical doctors on grade levels 15, 16 and 17 or equivalents will immediately be re-designated AD, DD and Director respectively with all the perks of office in the spirit of equity, justice and fairness.

4.2.1.4 We recommend that:

- 1) The AD, DD and Director nomenclature should be dropped for all allied health professionals as has already been done in the case of medical doctors in the hospitals. This will enable deserving allied health professionals to reach the peak of their**

careers.

2) Where government wishes to go ahead with the AD, DD, and Director nomenclature, then all medical doctors on GL 15, 16 and 17 MUST automatically be so designated in the spirit of fairness, justice and equity. Anything short of this will be unacceptable to the NMA.

4.2.2 “That decree 10 of 1985 (cap 463 LFN) should be reviewed and re-enacted. However, the position of the Nigerian Medical Association is that the Act should subsist as the problem was not with the Act but its implementation.”

4.2.2.1 The Committee erred when it convinced itself that changing the Act will solve the problems in the health sector. The Act makes it possible for all health professionals to remain together and work as a team for the benefit of the patient with a clearly defined leader which ensures integrated service to the patient.

4.2.2.2 It appears that the reasons for the proposed amendment of the Act are to blur the clearly defined leadership and bloat the bureaucracy as earlier elucidated.

4.2.2.3 We recommend that the Act should remain as it is.

4.2.3 “That the post of the Chief Medical Director/Medical Director should be open to all Health Professionals. However, the NMA held that doing so was contrary to the provision of the Act.”

4.2.3.1 Apart from points earlier made, a recent study in the US has firmly established the fact that hospitals run by medical doctors perform better than those run by business managers.

4.2.3.2 We recommend that:

The post of the Chief Medical Director/Medical Director should remain exclusive to the medical and dental practitioners in the overall interest of patients and society

4.2.4. “That the title of the Health Institutions should be re-designated as Chief Executive Officer (CEO) but the NMA is of the opinion that the status quo be maintained.”

4.2.4.1 We wish to posit that this CEO nomenclature is commonly used by corporations and other commercial profit-oriented business outfits. It is most unsuitable for a hospital service which is a social service.

4.2.4.2 **We recommend that:**

The Chief Medical Director/Medical Director connotes both technical and administrative nature of the position and therefore should be retained.

4.2.5 “Preferential treatment given to medical practitioners in training institutions to the Detriment of other Health Professionals.”

4.2.5.1 This statement is untrue. Every discipline has its peculiar training programme and career pathway.

4.2.5.2 The training of medical and dental practitioners has not deviated from the globally accepted pattern and as such, has in no way affected the training of AHPs.

4.2.5.3 The Medical and Dental Council of Nigeria (MDCN) is the only statutory regulator of medical and dental training and practice in Nigeria. The enabling Act empowers it to ensure that those seeking to become members of the profession possess the necessary skills and knowledge.

4.2.5.4 It is therefore, within the exclusive jurisdiction of the MDCN to determine the quality of persons and institutions suitable for effective and efficient training of medical doctors as well as the framework for delivering the training.

4.2.5.5 The clinical (medical) laboratory is an integral part of the field of Pathology (Laboratory Medicine) which is a group of medical specialties. The enabling Act of MDCN empowers it to regulate the operations of the clinical laboratories in Nigeria.

4.2.5.6 The AHPs now run degree programmes up to PhD, making the recommendation of the Committee to be redundant and obsolete.

4.2.5.7 **We recommend that the current practice that allows every discipline to run degree and post-graduate training programmes should be allowed to continue.**

4.2.6 “Discrimination in the Remuneration of Medical/Dental Practitioners on the one Hand and the Health Professionals on the other.”

- 4.2.6.1** We note here that the issue of relativity in the pay is yet to be addressed to the satisfaction of the medical doctors, as the original relativity was distorted with consolidation of salaries and some allowances.
- 4.2.6.2** Government should as a matter of priority resolve this short-changing of medical and dental professionals, which at the moment is to the advantage of allied health professionals.
- 4.2.6.3** For the avoidance of doubt there is nowhere in the world where there is pay parity between the medical doctors and the AHPs.
- 4.2.6.4** **We recommend that proper relativity in remuneration should be re-instituted.**

4.2.7 Composition of Boards of Management of Health Institutions

- 4.2.7.1** Again the Committee "was informed" and made no effort to verify the facts.
- 4.2.7.2** The Committee failed to note that whereas there is only one department of Pharmacy, one of Medical Records, one of Physiotherapy and one of Nursing, there is a minimum of sixteen Departments in Medicine and Dentistry in any tertiary hospital, with a slightly smaller numbers at the secondary level. It is therefore, erroneous to believe that a single doctor can represent the interest of all the different specialist doctors on a Board.
- 4.2.7.3** If every clinical department in a hospital should have one representation on the Board, the doctors and the dentists will outnumber others put together by a ratio of 4 to 1 or more; but this is not so. Sometimes there are only 2 - 3 doctors on the whole Board including the CMD and CMAC whose memberships are statutory.
- 4.2.7.4** AHPs have been appointed even into chairmanship of Boards. The immediate past Chairman of the Board of National Hospital was a Pharmacist; that of FMC Bida was a Medical Laboratory Scientist, and that of FMC Owerri was another non-doctor to mention but three.
- 4.2.7.5** **We recommend that the present constitution of the Boards which is statutory and adequate, should be upheld. Government needs to be cautious not to**

extend the disharmony already existing in hospitals into the Management Boards.

4.2.8 Structure of the Federal Ministry of Health

4.2.8.1 We had thought that the disharmony was restricted to hospitals. By using the words “seeming imbalance”, the Committee actually accepted the fact that there is no real imbalance in the structure of the Federal Ministry of Health.

4.2.8.2 The Committee’s venture into the structure of the Federal Ministry of Health amounts to exceeding its mandate.

4.2.8.3 **We recommend that our earlier recommendations on career advancement be implemented to enable deserving and productive staff in the FMOH to reach the peak of their careers without the need to restructure.**

4.2.9 “Non-implementation and selective Implementation of Scheme of Service in the Health Sector.”

4.2.9.1 As stated earlier the system does not need more Directorates for health workers, whether doctors or AHPs to reach the peak of their careers. The implementation of earlier recommendations on the matter of Directorates will suffice.

4.2.9.2 Again, we wish to note that there is no cadre without a scheme, else the cadre is non-existent.

4.2.10 Disparity in Remuneration between Federal and State Medical and Health Personnel.

4.2.10.1. **We agree with the Committee's position on this matter.**

4.2.11 Operation of the National Health Insurance Scheme (NHIS)

4.2.11.1 We did not see how this contributes to disharmony in the health sector. The Committee went beyond its mandate by delving into this matter.

4.2.11.2 **We recommend that since the NHIS was not invited, it would be out of place of to take any action without first hearing from them. It should be contacted on this for proper guidance.**

4.2.12 Non-adherence to Job Definition and Description in the Health Sector

4.2.12.1 We agree with the Committee.

4.2.13 Absence of Office of Surgeon General

4.2.13.1 The argument of the Committee here clearly shows how overtly biased it was in carrying out its assignment.

4.2.13.2 Wherever an issue was considered to be in favour of the medical profession it was condemned, while all others considered in favour of allied health professionals were recommended for acceptance.

4.2.13.3 After agreeing that the office of Surgeon General exists in the USA and Great Britain (and in-fact had existed in Nigeria in the past as Chief Medical Officer for the Federation), and describing its creation in the country as counter-productive because of likely agitation by allied health professionals and the fact that the field of Medicine is multidisciplinary, the Committee failed to acknowledge the fact that Medicine in USA and Great Britain are also multidisciplinary, and that allied health professionals also exist in those countries.

4.2.13.4 The office of the Surgeon General or Chief Medical Officer of the Federation as proposed is meant to shield the healthcare delivery systems from direct influence of political flux, and ensure sustainability of programmes and activities even as governments change. It will also ensure stability and harmony in the entire health system contrary to the view of the Committee, just as the offices of Auditor General, Accountant General, Statistician General, Surveyor General etc stabilise their sectors.

4.2.13.5 In the US, UK and other countries, there are professional heads (Surgeon General or Chief Medical Officer) for the health systems different from the political heads (Secretaries of State for Health, Minister, etc). Nigeria needs to re-establish the office of the Chief Medical Officer/Surgeon General of the Federation as professional head of the health system in line with the transformational agenda of Mr. President.

4.2.13.6 We strongly recommend the re-establishment of the office of the Chief Medical Officer of the Federation or the Office of Surgeon General of the Federation.

4.2.14 Recruitment of untrained/unlicensed personnel to practice in medical records and other fields.

4.2.14.1 We agree with the Committee's resolution on this issue.

4.2.15 Poor Working Conditions and Healthcare Environment

4.2.15.1 Much as we detest the working conditions in some hospitals we disagree with the notion that they are sources of disharmony.

4.2.15.2 Some of the equipment are deliberately vandalized or damaged just to portray the leadership of the hospitals as poor in management.

4.2.15.3 We recommend, however, that funding to hospitals should be increased.

4.2.16 Indiscipline in the Health Sector

4.2.16. Indiscipline is encouraged when offenders are not punished.

4.2.16.2 There is also extensive interference with disciplinary matters from many quarters including from those who expect things to work optimally.

4.2.16.3 We recommend that the public service rules which is clear regarding discipline should be enforced irrespective of who is involved.

4.2.17 Perennial Staff Shortage

4.2.17.1 The shortage at the primary and secondary levels are due to two main factors, namely poor remuneration and absence of social amenities and dilapidated infrastructure and equipment at those levels.

4.2.17.2 We recommend that

1) All governments pay attractive remuneration and improve infrastructure such that practitioners at those levels would find some pleasure and relative comfort with their families in those localities.

2) State and local governments seek ways of arranging with Federal institutions within their localities to allow their (Federal) staff render some services in the local Council and State health facilities on agreed terms.

3) Accent to the National Health Bill will facilitate or enhance the movement of health workers to rural communities.

4.2.18 Reward System

4.2.18.1 We agree with the Committee on this.

4.2.19 Appointment of Health Minister

4.2.19.1 Here again the Committee went far beyond its mandate by delving into a political issue exclusively at the prerogative of Mr President, and made comments that suggest that it is unhappy with the appointment of the Honourable Minister of Health and the Honourable Minister of State for Health. This is disrespectful to both the Honourable Ministers and Mr President.

4.2.19.2 Neither the doctors nor the allied health professions are involved in the selection, screening, appointment and assignment of portfolios to Ministers. Therefore, discussing such an issue is just executing the agenda of the allied health professions as abundantly evident in its report.

4.2.19.3 While we recognize Mr President's constitutional powers regarding the appointment of Ministers and allocation of portfolios, it is imperative that in the absence of the office of Surgeon General or Chief Medical Officer of the Federation, a medically qualified person is most suited for the office of the Honourable Minister of Health and Honourable Minister of State of Health as professional and administrative heads of the health system.

4.2.19.4 We recommend and also advice that Mr President's constitutional right must be respected by all public servants and agents of government.

4.2.20 Appointment of Chief Medical Director/Chairman, Medical Advisory Committee and Medical Director/Head of Clinical Services

4.2.20.1 The allied health professionals fail to understand that medical and dental consultants who are academic staff of associate universities are bona-fide staff of the teaching hospitals, and spend up to 70% or more of their daily work hours in the hospitals rendering clinical services.

4.2.20.2 The only difference between these staff and other staff of the hospitals is that they do not earn their basic pay from the hospitals (since the law does not permit earning two basic pays for a full day's job). To argue that these eminently qualified doctors should not be appointed CMAC is one made in very bad taste, and therefore a nullity.

4.2.20.3 We recommended that the appointment of CMD/CMAC and MD/HoCS should fully involve all Consultants in the affected centers through open and transparent democratic processes as statutorily provided and expedient.

4.2.21 Discriminatory Definition and Application of Certain Terminologies in the Health Sector

4.2.21.1 Every profession or industry has its own language and Terminologies, which literally may mean something different from what it means within the industry or profession.

4.2.21.2 We remain firm that the term "medically qualified" refers to the medical and dental practitioners only.

4.2.21.3 Similarly "Consultant" refers to a medically qualified medical or dental practitioner with a Fellowship qualification in any of the medical or dental specialties and who has been so appropriately appointed as in the scheme of service. These are very clear terms with no ambiguity and used globally.

4.2.21.4 We recommend once more that there is no need whatsoever to tamper with the Act CAP 463 LFN.

4.2.22 Definition of the Status of the Resident Doctors in the Hospitals

4.2.22.1 To say that the status accorded resident doctors here is a cause of disharmony amounts to serious mischief.

4.2.22.2 Residency training is the same all over the world. In the past, Nigeria spent huge sums of money to train resident doctors abroad to become specialists.

4.2.22.3 While other countries in the world are phasing out the cadre of general duty doctors, the Committee has recommended the decimation of the residency programme of medical doctors.

4.2.22.4 A postgraduate Fellowship in Medicine or Dentistry changes the scope and complexity of the duties of the holder of such qualification, and entrusts him with much greater professional responsibilities and liabilities for the interest of the patient.

4.2.22.5 Resident doctors are not only in training, but also provide full medical services and the period is recognized for pension purposes.

4.2.22.6 Consultants in training institutions work with resident doctors to ensure periodic vacancies for new entrants into the training programme, and to sustain intense academic activities and research which are the main drivers of quality patient care.

4.2.22.7 **We recommend that the Residency programme should continue as established, be expanded and plans made for the immediate commencement of the overseas clinical attachment as already approved by government.**

4.2.23 Absence of Postgraduate College for Allied Health Professionals

4.2.23.1 The recommendation of the Committee on this issue is an attempt by AHPs to equate themselves with medical and dental practitioners through the backdoor. The recommendation is irrelevant, incompetent and has no basis or precedent in medical history.

4.2.23.2 There is no where on earth that a postgraduate medical college includes allied health workers. Even where courses are run for AHPs by medical colleges, it does not make them members or fellows of the college or give them the same responsibility as the medical doctors.

4.2.23.3 Postgraduate Medical Colleges became necessary centuries ago when it was realized that the conventional universities provide academic degrees that do not provide the necessary clinical skills and knowledge required by a medical or dental practitioner to function at optimum level as a specialist Consultant.

4.2.23.4 **We recommend that government should completely ignore this Committee's recommendation as it was done in ignorance.**

4.2.24 Industrial Unions and Professional Associations

4.2.24.1 The Committee's recommendation may need further clarification before any action. A holistic approach may need to be adopted in dealing with issues raised here, and at the same time be cautious of the constitutional right of freedom of association.

4.2.25 Non-compliance with Laws of Regulatory Agencies under the Federal Ministry of Health

4.2.25.1 Government should comply with statutory provisions with regards to the compositions of the agencies.

4.2.25.2 We are more concerned with the obvious conflicts and aberrations in some of these laws, and which government needs to resolve expeditiously.

4.2.25.3 Government may wish to consider the merging of all Regulatory Councils of the allied health professions into one as applicable in some developed countries. This will save cost, improve efficiency and give room for better control.

4.2.25.4 We recommend particularly that Regulatory bodies like the MDCN should be allowed to operate in perpetuity as progress made in regulatory and disciplinary matters are lost during periods of dissolution. This has encouraged professional misconduct over the years.

5. The Negative Impact of Disharmony on the Prompt, Pleasant, Effective and Efficient Delivery of Healthcare (TOR 2.2.1b)

5.1. It has clearly been established that there is disharmony in the health sector among the professionals, and that this situation impacts negatively on healthcare. It is also to be noted that the recommendations of the Committee have manifest potentials to further plunge the sector into total darkness. It is worthy of note that this disharmony among the professionals exists only among workers in government service. All the allied health workers in private hospitals are absolutely obedient and supportive to the medical doctors in their daily activities. The doctor is in total control and cases of indiscipline are dealt with promptly.

5.2 The obvious effects of the disharmony include, but not limited to,

5.2.1 Loss of team spirit in health care.

5.2.2 Relatively poor service delivery

5.2.3 Relatively poor quality of products of our training institutions

5.2.4 Inability to improve while on the job.

5.2.5 Obstruction to training and research; records are sometimes deliberately removed or destroyed

5.2.6 Difficulty in changing obsolete methods of operation and adopting global best practices

5.2.7 Avoidable harm to patients; in some cases resulting in avoidable deaths

5.2.8 Poor work ethics, and professional misconducts and rascality.

6. To Develop and Propose an Action Plan for the Behaviour Modification of All Health Workers in order to Restore and Sustain an Excellent Relationship Among them (TOR 2.2.3)

6.1 In dealing with this TOR, three basic principles apply

6.1.1 All systems have clear and well defined leaders. The medical doctor is the leader of the health team, and all other members of the team must respect this hierarchy and the dignity of one another as regards body language, spoken and written words. Conversely, the medical doctor as a good leader should carry other members along.

6.1.2 Patient care must be anchored on global best practices and not on emotions, sentiments, intrigues and subterfuge.

6.1.3 There are varying degrees of interaction amongst professional groups in the health sector, with the medical doctor and the patient at the core of the interaction. The activities of others depend largely on the outcome of the interaction between the doctor and the patient. Where the doctor declares a no case situation others have no job to perform.

6.2 Behavior change is required by everybody in the health sector namely, staff, professional associations, managements, governments and their agencies.

6.2.1 Such behavior changes must be determined, influenced and focused on patient care.

6.2.2 Expected and appropriate behavior is incorporated in the codes of conduct and ethics for medical and dental practitioners. It should be the same for the AHPs.

6.2.3. The regulatory bodies are best suited to ensure that these codes are imbibed by members of their professions. The curriculum for appropriate professional behaviour should be drawn by respective regulatory bodies as part of their core functions.

6.2.4 The AHPs should be called to order against the orchestrated plan to ensure that the doctor is discredited at all cost, through various acts of sabotage of the health system.

6.2.5 At the level of government, schemes of service that engender and fuel crises should be withdrawn and modified. No other scheme of service should be introduced into the system or produced for any group of health workers without ensuring that all stakeholders are in agreement. The act of indiscriminate churning out of schemes of service for AHPs without consideration for their negative consequences should stop.

6.3 We note with serious concern that Sections 8.3 to 8.5 of the Committee's report were designed

to further entrench the bias of the Committee. It is simply a summary of its earlier uninformed positions couched in different forms. Reading between the lines, the Committee said nothing new other than that the doctor should be pushed out for the AHPs to take over. These paragraphs should be completely disregarded.

6.4 On the contents of sections 8.6 to 8.8, we have these to say

6.4.1 The revised curriculum of the medical schools and the those of the postgraduate medical colleges have all taken care of all aspects of Management, Leadership and Communication skills training

6.4.2 The standard of practice that we subscribe to is the global standard considering that medicine and dentistry have global application.

6.4.3 Disciplinary actions should be promptly taken against erring staff to serve as deterrent to others.

6.4.4 Professional ethics is taught in medical schools and already included as a subject for examination.

6.4.5 The MDCN has been enforcing compliance with ethics/codes of conduct but frequent dissolution of the Council coupled with delays in reconstitution is a major setback.

7. Terms of Reference 2.2.4 and 2.2.5

TOR 2.2.4: To develop and promote a simple set of rules (etiquette) that would guide the behavior of all categories of health workers towards one another and to patients, their families and friends

TOR 2.2.5: To propose appropriate sanctions for any contravention of set rules as may be adopted for general application from relevant sections of the Public Service Rules and from Codes of Professional Conduct of all the professional groups in the health sector.

7.1 All the expectations from these TOR are well covered under Clinical Governance (see Appendix VI, pages 43 – 48)

7.2 They are also substantially addressed in the professional code of conduct and ethics of the various groups, the Public Service Rule and the laws, including State Ministries of Health enabling Acts on Registration and Inspection of health facilities. All that this is required is diligent enforcement.

7.3 There is no need for any Ombudsman in the way the Committee recommended. The Managements of the various health institutions should be courageous in dealing with infractions. “If you spare the cane you spoil the child.” This has brought about the present situation.

7.4 There is need for everybody to stop behaving like the ostrich when it comes to matters of discipline. No new set of rules will make any impact unless there is the Will to enforce them. Those in administration should stop their acts of conspiracy, delays and destruction of evidence already in the files.

8. The Way Forward

As a way of drastically reducing or completely eliminating the retrogressive disharmony in the health sector we make the following submission:

- 8.1** That the Justice Bello led Committee (The Committee) report should be disregarded. Most of the recommendations were extremely biased, made in bad taste and lacked credibility. Therefore, any attempt to implement it will certainly lead to unimaginable damage and crisis in the health sector.
- 8.2** The independent report submitted by the NMA looked at issues raised in the Committee's report from very realistic and holistic perspectives and should therefore be carefully studied with a view to implementing the resolutions and recommendations.
- 8.3** Government should consider the option of introducing the Public Private Partnership (PPP) model into the hospitals especially in the capital intensive areas such as radiology, clinical laboratories, physiotherapy, pharmacy and catering services. This will create stability, reduce cost, improve services and training and attract new resources. These models already exist in some Institutions in Nigeria with good results.
- 8.4** Truth is bitter, but it also sets one free. The allied health professionals must be clearly and unambiguously made to understand their supportive roles in the healthcare setting and respect the leadership role of the medical doctor.
- 8.5** Arising from above is the urgent need to have a holistic review of the schemes of service of all cadres of staff in the health sector with a view to streamlining them to fit into their traditional roles and responsibilities. Similarly, the Acts of all the Regulatory bodies should be reviewed to remove all conflicting and aberrant sections. Where conflicts presently exist, the Government should take a decision on how parties should conduct themselves pending reviews.

- 8.6** Global best practices must be fully applied in all aspects of our healthcare delivery system. Only experts in the healthcare system can do this with the full backing of appropriate enactments, regulation, policies and adequate funding.
- 8.7** Performance benchmarks and indicators should be introduced into the healthcare system. CMDs/MDs whose institutions perform below the benchmarks should not be allowed to continue in office.
- 8.8** Top Management Committees of all health institutions should include all clinical heads of Department to add value to decision and policy making.
- 8.9** A situation in which professional associations and their regulatory bodies collude with the National Universities Commission to proliferate courses and certificates, coupled with unnecessary elongation of durations of training needs to be checked, as this amounts to drain on the economic resources of Government. Sometimes entry qualifications in cadres are raised without justification and approval by government.

9. Conclusion

The NMA was pleased to be invited to participate in the Presidential Committee on a Harmonious Work Relationship Amongst Health Workers and Professional Groups in the Health Sector in Nigeria which was inaugurated by the Honourable Minister of Health on 9th of August, 2010.

After reviewing memoranda and scientific evidence of what constitutes international best practices, and perusal of the extant laws of the land as applies to the health sector, the NMA considered it expedient and wise to draw the attention of Government to the root causes of disharmony in the health sector and its devastating consequences.

The desire and inordinate ambition of persons in professions allied to medicine to wrestle leadership from the medical doctor at the unit, departmental and institutional levels for the purposes of societal acceptance and financial gains, is central to the disharmony.

We had hoped that all members of the Committee as constituted, will work collaboratively and selflessly to produce a report worthy of responsible professionals and top administrators, who should always strive to protect the best interest of patients and society. Rather, the NMA is profoundly disappointed that the committee wasted the unique opportunity given to it, and produced an anti-people, short-sighted, misguided and unacceptable report.

The NMA therefore had no alternative than to reject the Committee's Report and to produce this independent report in keeping with its abiding policy of always doing only what serves the best interest of the patient and society. This, it has done in this report and hopes that Government would take a careful look at all the recommendations, with a view to implementing them and returning sanity to the health sector in Nigeria.

DR IDRIS OMEDE
PRESIDENT, NMA

DR BALA AUDU
SECRETARY GENERAL, NMA