INTERVIEW WITH PROF. O. GUREJE

Conducted on by the Board members

Annals of Ibadan Postgraduate Medicine.

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Prof Gureje: Welcome

AIPM: We would like to know you sir.

Prof Gureje: I am an Ijesha man, born in 1952. I had my primary school in Ilesha, secondary school in Akure and Lagos. Attended University of Benin for Medical Education and housemanship in Ife subsequently.
Residency in Abeokuta and in England for fellowship – University of Manchester for 2yrs (honorary research fellowship), came back here (UCH), started academic carrier, had sabbatical and leave of absence at the University of Melbourne but essentially, I have been here.
Other details you want me to fill in?

AIPM: This corresponds with what we know about you.

AIPM: We would like this interview to help residents, not only residents in UCH but residents in Nigeria and Africa and perhaps the world to know more about the subject matter, Psychiatry. Why psychiatry?

Prof: Good question. I was not convinced I wanted to be a doctor. I wanted to be a writer, wanted to be in the literary axis. I eventually did medicine. When I wanted to do psychiatry, it was more deliberate. I was an unusual way for someone to pick a specialty. I constructed a grid, allocated different specialties to different columns, how challenging it was, how academic, professionally fulfilling, my needs, financial prospects, all sorts of things that would come into the mind of a graduate of medicine.
Then I arbitrarily allocated marks. From the grid I zoomed in on 3; Neurosurgery, Neurology and Psychiatry.
But I reckoned that there was no technology support for neurosurgery. Neurology was too dry for me but psychiatry had a little more of the unknown and more challenges.
As I was interested in writing, psychiatry held more appeal. Once I did that people said it was madness as there was the usual stigma associated with mental disorder and if you were going to be a doctor and wanted to specialize, people will expect you to do something that will bring in money. How could you end up in a place that was unlikely to bring you money? Anyhow, that was how I chose psychiatry, it was deliberate.

AIPM: obviously no regrets sir.

Prof: Absolutely not. If I had any dream about how I wanted my life to be some 30-40yrs ago, the dream would not be different from what I am doing now. No regrets at all.

AIPM: Why the name behavioral health sciences, is it because of the stigma associated with psychiatry?

Prof: Not really, it is because the discipline of psychiatry could be perceived narrowly and the practice of psychiatry both clinical and academic would not conform to that narrow perception that people ordinarily would have.
Some of the most outstanding contributions to psychiatry come from people who are not psychiatrists but clinical psychologist, cognitive neuropsychologist etc. Astonishing landmarks being made come from neuroscientists who are not even clinicians but work in laboratories.
In recognition of that, some departments – a good department has clinical psychologists, neuroscientists, in other to capture that, that is why behavioral sciences had to be used. It is just to capture the atmosphere of the discipline.
I have also nursed the idea that one day, we would also be able to have the full sphere of services. In fact, in Lambo's time, we had trained nurses and matron and the name on the door to this office which I now occupy was behavioral services then.
As far back as that time, Lambo called the place behavioral sciences. That is the reason why behavioral science is preferred.

AIPM: In the last couple of years, we have seen more residents taking psychiatry as their first choice, in 1996, there were 130 psychiatrists, the number as almost doubled now. How can the residency training in psychiatry or behavioral sciences be improved in Nigeria and UCH in particular?

Prof: The figure even surprised me, that is the figure of people produced not necessarily practicing in Nigeria.

AIPM: Not people working in Nigeria, people produced in Nigeria.

Prof: Oh yeah! The number of psychiatrists working in Nigeria at the moment is actually about 149 at the

moment. Twice that number is working in England. You are right that the number of residents has increased. A friend of mine always asked me any time we met how many psychiatrists we had in Nigeria. I always answered "about 70" and would say don't you ever get above 70?

In recent years, the figure has increased dramatically for residency; we still get a good number that leave the country after training so that has not translated to the number of consultants that are practicing in the country.
What will enrich the training of psychiatrists with the limitation just identified now – that is, the limitation of number of consultants on the ground. These people get trained by the seniors – by consultants. If we do not have enough of them around, you are not going to get a very qualitative programme. If you have 1-3 consultants on ground in a hospital and that hospital is accredited to train. How much training can that hospital deliver? Even the limitations of the system here in which a resident is employed in UCH but he can't go and have a six month rotation to tap in to various subspecialties. For instance, if there is a forensic psychiatrists in Abeokuta and you didn't have one here, someone can go there to do a rotation or a neuropharamocologist in Ife, one not here, a resident can also rotate. But because that kind of training is not possible because of the administrative structure, who will pay the salary, who will pay for the call duty and all those kind of things, so we can not put limited resources we have together, we need a mass of trained people to do this effectively.

That also means sub-specialization is not something that is feasible. If we get someone that is trained in one or two sub-specialties and they come here, because of the nature of the system, not enough of them, most of them do their work in general psychiatry that tends to affect their expertise in the subspecialty. Large numbers do not have focus in their subspecialty and that tends to affect their subspecialty.

These are some of the reasons the training is not as effective as it should be. There are things that need to be done for e.g. if we are willing to retain people that are being trained rather than losing them to brain drain. In the meantime, establish some relationship with people in the diasporas so they can come home and deliver lectures so you can tap into their knowledge. I know countries that do that in a more structured way; that way you can improve the training even before you produce sufficient number of trainers.
The question you have just asked is reflected in the percentage of people who pass the exam every year. The pass rate is usually about 20% appalling, not because the people are dullard but because the training has been very difficult for them.

AIPM: How do you react to the statement that the issue of mentorship is not well developed in this part of the world?

Prof: It certainly is not. Any forum that I have the opportunity, I mention this. Clinical work is apprenticeship, the same with academic work and that is why when you go through a system in which you have a masters or a PhD, it is a form of apprenticeship. That is not very well developed here for a number of reasons.

Many people become professors relatively early in their career which is fine. Many of them would have sponsored their own research up to that time, they haven't had any support. They have been doing it in order to produce enough work to get promoted, so when they get promoted, there is no incentive for them to spend their own money to do research. Some of our professors are actually for all practical purposes retired professors. We need continuity of work to develop mentorship. To have a research project that is going on, you must as an academician, be someone who is ready to work with others and encourage people to work with you, you will get people who will come and learn while doing the project. They learn in the process. And to get that kind of thing going on in different places, you need a critical mass of people conducting research for several years. Of course, that mentor/mentee relationship is a two way affair – you must have people who are willing to learn and the mentor must be willing to teach, to encourage rather than to run people down. So that will be the platform in which that relationship can be built.

The first one is that continuity of work; continue to have the ability to do research and to attract younger ones to work with them. The reason why that is not very feasible is because of the very gross limitation in terms of research support in this country. In Nigeria, there is no agency set up by the government to support research that people seek grants from in a competitive manner and get the best proposal funded like in the US with the National Institute of Health or the Medical Research Council in Britain. That makes it very difficult to have a continuous body of work that younger ones can learn from. Of course, there is also the fact that if something is not currently going on, the convention around it does not develop, the person we are talking about i.e. the professor hasn't himself been a mentee of someone, so cant see the value of being a mentor, there is a disconnect between these relationships.

These are some of the reasons we don't have this relationship. Having said that, I have been somehow disappointed in some younger people who, really maybe because of what I'm saying here, I have several people working with me and I have several younger ones that have always worked with me over the years that I enjoy because we have meetings, the discussions are one of the unquantifiable benefits of this kind of work, discussing with people, exchanging ideas. You'll want to get up in the morning hoping you will have that meeting and have that brain storming session but people that I have actually invited who I feel that there is something that I have in my research that would be actually good for them in their own subspecialty would just come and after listening to the explanation, they just don't show that motivation to benefit and tap from it.

The thing that makes that a bit painful for me is that they cant see the benefits, it is not just writing papers or something, it is also that you get yourself attached to a funded research, maybe next time you are going to be a co-investigator, you then have a foot in the door because you can then apply for your own grant after. If you don't have that, it is so difficult for your to break through especially because as we have said, we don't have it in Nigeria and places where you apply to for grants will want you to show antecedent of what you have done/achieved. So I don't see why some of the younger ones don't see that kind of opportunity.

I have several other people who are taking advantage of the system but I am sometimes surprised at how it is so difficult to get some people to get motivated to do this.

AIPM: So the mentors and the mentee relationship has to established before a good mentoring program can be developed?

Prof: A mentoring program is like you sowing a seed and there has to be a soil for it to germinate, you can't say you are attaching 2 or 3 people for me to mentor if they are not doing anything; all they are going to do is bring their project to me, their book for part 2 fellowships. That is not really a very fertile ground for mentor and mentee relationships. It is deeper than just supervising one project, you encourage them to write papers, when that is done, encourage the person to write another, and I am also writing too and putting your name and you see what I write, I see what you write, I correct it and sometimes we fight. Not the residency program that we are doing even though that is all we have and we have to build on that as well but I just hope we recognize the importance of building stronger relationships. That to me is the crux of the matter that you have got to have something that nurtures that relationship of mentor/mentee.

I don't think supervising one's fellowship exams is sufficient for a relationship. I can't say that is the ideal mentorship that one should strive for. Of course that is useful and people can develop on that. Let me give you my own example, if I was asked, I would say Prof. Osuntokun was the most important mentor, he's the one on top of the list and it developed not because of my being asked by him to come and be part of the dementia research project, it had started much earlier than that and it started by me also pestering him and him encouraging me, he was in Abeokuta, when I was there, so he would develop an idea and he would say go and see if you can follow this up, it may be retrospective, case note reports etc. I write it and I give it to him, he eventually reads it, that was what nurtured that relationship; it was not just one solitary thing. He was the supervisor for my PhD but if that was the only thing he did, I would not have regarded him as my mentor, he would have been one of my mentors but I would not have regarded him as my main mentor. That is exactly what I mean. It has to be based on something deeper and most times, that is not there because most times, our senior people lack the support they need to keep working to keep attracting young ones.

AIPM: How do you manage your time between academics, publishing and family life?

Prof: There are several aspects to writing; you are talking about journal articles. Cumulatively, I have over 250 publications, they are not solitary works by me, many came from collaborative projects, some of which have been going on for several years, so some of the publications would have been written by others within that team of course, we circulate it amongst ourselves and make comments and all of that, and that is part of what a good academic environment should offer, so that when you do that, you find that your efforts are multiplied – a multiplication of efforts.
The more you do, the more you get support and get others to do it too – you have a group – mentor/mentee.

How is it possible to have written so much? The first thing I think is passion; be really interested in what you are doing, if not, nothing can motivate you. The passion has not reduced; I still come to the office and work with others with the same passion. The next paper I am writing is as important as the one I have written before. I think also I have had the benefit of good training, I've had very good training. Once

exposed that way it gives your clinical experience a flair that is also very useful for your research. I have been lucky in the sense that any opportunity that I get, I try to learn from people, I was saying when we had this lecture organized by the MDCAN, you know the research methodology, I am on some editorial boards of some prestigious journals, including the journals in epidemiology, but I never really had a specialized training in epidemiology, all I learnt was along the way and some of them through workshops and some through colleagues, people who have worked internationally who are really good people, pick up different things along the way, before you know it, you are an expert yourself but you have actually stolen other peoples brains. If your working collaboratively you work together, you should have integrity, you develop trust e.g. I was not planning to go to the Annual American Psychiatric Association meeting but last minute, someone offered to pay for me. It is part of the opportunity having made yourself credible that people offer you opportunities.

These things are demanding, no matter the passion, you are not super-human, some things will suffer. I will wish to spend more time than I am able to with my family. You need an understanding partner in that sort of situation.

Good training, discipline, making the best use of opportunities you have, get rid of that chip on your shoulder, humility is important, that does not mean you take rubbish, just means you are not harsh or arrogant, when arrogant, you cant learn.

These are the things that will help someone achieve and do more.

AIPM: Going back to the training, psychiatrists in Nigeria seem to concentrate on pharmacotherapy instead of psychoanalysis. Which is better?

Prof: Very few people do psychoanalysis anymore. The first to note, mental disorders just like physical disorders are a broad spectrum, the treatment also differs, e.g. a patient with DM, some will be on insulin others wont, but all will benefit from education.

In psychiatry, it is called psycho-education and that is treatment. You can't say one is better than the other; it depends on where the person finds themselves. What we do know is that for a broad range of mental disorders, medication would be indicated, medications are not arbitrary, these are formulated by strict neurosciences based understanding. There is pharmacotherapy e.g. if someone is depressed, we know what goes on in the brain or if they have panic attacks, we know what to give. There is also psychotherapy; we know the ones that work and the ones that have been tested by RCT. Their effectiveness can also be demonstrated in the lab under neuro-imaging, so psychotherapy that will change those things in your brain that medications ought to do. People used to think of psychotherapy as some kind of 'magic'. It's actually therapy that works which may not be surprising.

Fact is that if psychotherapy can make a particular part of the brain to get more active, why would it not function as pharmacotherapy. We do know now that some psychotherapy actually bring about some changes in the brain, and there are disorders for which there are only medications at the moment but others that psychotherapy may be the best. There are many where combination of the two could help the patient better. Psychotherapy is also a very skilled thing, it's not just talking. Part of what is lacking in our training is that we have not got enough specialists who have undergone training in psychotherapy. However, they get exposure to other forms of psychotherapy other than the more specific rigorous ones. Unfortunately even in medications – there is limitation, many times we don't have the medications that are current.

AIPM: Nigeria is a third world country, lacking in most basic infrastructure. How has this affected your productivity as a researcher?

Prof: The first thing is you can do good research wherever you are, within the constraints of the situation. So don't think that even if you are in endo, the limitations would not allow you to be published in JAMA or lancet, you just need to be innovative and know areas in which you can do good work.

Do research in a standard vigorous manner that contributes to knowledge, the journals do not have just neuro-imaging.

That is not to say that you won't be affected by no power and e-mail not going etc. luckily, things are a little better now.
Cultivate the habit of scanning through journals in your field. It is a dis-service to limit oneself to local journals. In spite of the limitation, one can still do good work as long as you are not thinking of just falluting things. Limitations are there, but we should not let them hold us down.

AIPM: I read that your interest in psychiatry ranges from mental health problems in primary health settings, the connection between mental and physical health, clinical studies in schizophrenia, those are your major

interests, mental health problem in primary health setting.

Prof: The broad spectrum of mental disorders were mentioned before and include the ones that are very common and the ones that affect the person in the corridor; maybe one out of 10 persons you meet but its not the one that gets a person bound, but they still cause disability and those ones are also common, the physicians will not recognize this, so they could have somatization and real physical problems co-occurring with this, there is no reason why they cant be treated at that level if the recognition and if the management expertise is available.

So the CHEW – Community Health Extension Workers could be trained to recognize these sort of symptoms. In fact if all of the people who have this sort of illness were to go to psychiatrists, they would have thousands of patients to attend to.

Psychotic patients that get bound, one of the reasons why that happen is that there is lack of knowledge. Research here shows that half of the populace believe that mental illness is caused by spiritual means.

People in the village and town may not have the concept of medical treatment for those disorders and believe it can only be treated by traditional healers etc.
The numbers of specialists are few and these are concentrated in the cities, so the villagers would have to go to those that claim they can treat such in their communities.

For several years, there has been training of the primary health care providers to recognize these illnesses, and supported by 2° care. But the way our health system is ordered 1° health system under the LG and secondary care under state and no communication between the two.

AIPM: What direction should the Nigeria health care sector follow?

Prof: A better integration of the 3 tiers and a better pathway of communication between one and the other. The way the constitution is structured, it makes it difficult to care for patients.

1. Funding – no sufficient funds, and available funds not properly directed except the fund from outside for specific purposes, e.g. malaria.
2. More Communication – a structure where 1° care should receive better training and are supported by the 2° care, without which morale falls.

Nigeria has more than the minimum/dr ratio according to WHO and a more effective way of using our doctors would produce better results with improved health indices.

There should be an efficient two way referral system.