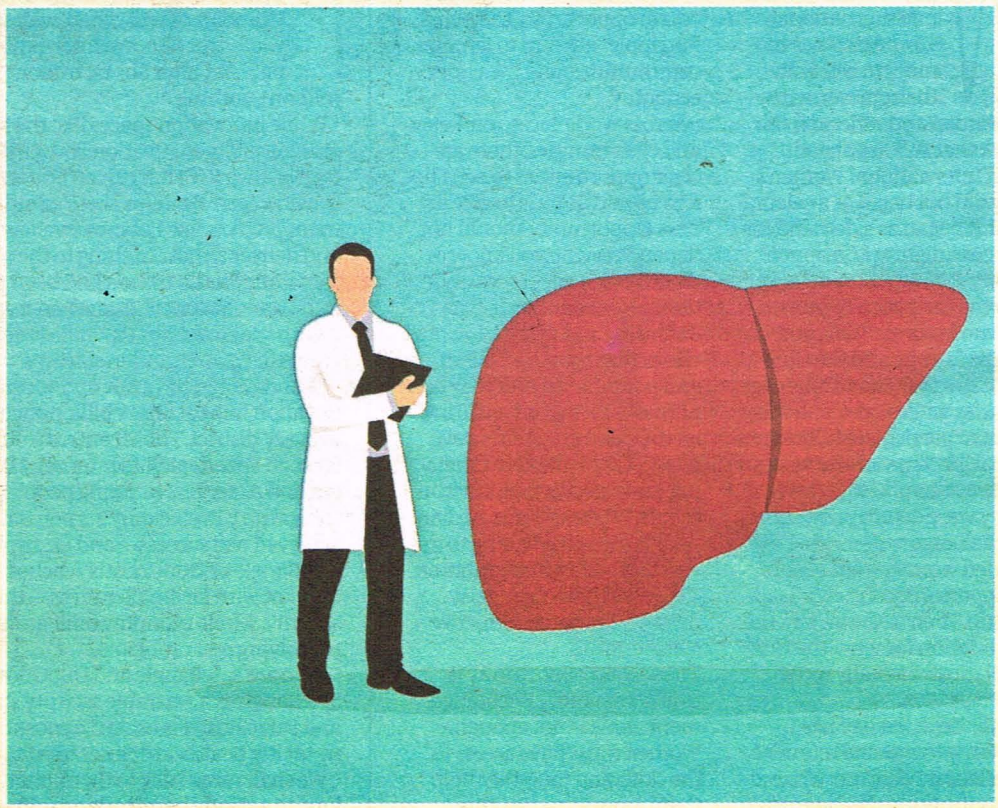
On medical internship reforms



The recent policy requiring newly qualified healthcare workers including doctors, nurses, and pharmacists to officially graduate only after completing internship at their own cost raises important concerns about the direction of medical training in Uganda.

At the centre of this debate is the long-standing perception of medical internship, particularly in public discourse. Medical internship has never been an academic course unit. It is an apprenticeship into independent clinical practice, a structured transition from supervised training to professional autonomy.

Graduates enter this stage not as students, but as qualified professionals who are refining the competencies required for full licensure while also identifying specialty disciplines of interest under guided supervision. It is, therefore, a bridge to practice independence, not an extension of university education.

Why this policy? It appears that the government has not yet found a way to effectively utilise this important human resource that the country produces every year, as evidenced by the growing levels of unemployment among health professionals. This policy simply shifts responsibility to professionals who are already financially strained.

Restructuring this important stage of clinical apprenticeship in the manner currently implemented not only distorts professional progression but also undermines its purpose and raises equity concerns within the health system. Unlike in the past, medical education in Uganda is increasingly accessible primarily to students from financially stable backgrounds.

Becoming a doctor, for example, requires a strongly financed early secondary education necessary for admission into public or private medical schools. Private medical education is extremely expensive and can only be accessed by those with sufficient financial resources. For many talented students from low-income families, both pathways remain significant barriers.

Therefore, policies that add further structural complexity to professional progression may unintentionally deepen inequality. The medical profession risks reflecting economic privilege rather than the social diversity of the nation. This imbalance can contribute to challenges in representation and understanding between healthcare providers and the communities they serve.

Currently, many of our health workers appear increasingly disconnected from the communities they serve, a situation that can partly be attributed to imbalances in clinical training opportunities. One can only imagine how a professional who has invested significant financial resources into training may relate to a mother who arrives at a hospital without money to pay for care.

A health system functions best when professionals remain grounded in the realities of the populations they serve. Strengthening internship as a professional bridge while ensuring equitable access to training and employment would better support our healthcare development.

For reasons of health system strengthening, this policy should be reconsidered. Reforms in medical training should focus on improving quality, promoting equity, expanding structured postgraduate pathways, and ensuring transparent workforce planning. Any changes should be developed through broad consultation with stakeholders, including professional bodies, universities, and healthcare institutions.

Our country's health system deserves policies that enhance fairness, strengthen professional development, and improve service delivery not measures that blur established training structures.

Constructive dialogue remains the best path toward sustainable reform in medical education and practice.

Dr Paul Omagor,
Emergency physician