THE UNIVERSITY DEPARTMENT OF SURGERY IN CONTEMPORARY NIGERIAN SOCIETY

BY PAUL OMO-DARE

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THE UNIVERSITY DEPARTMENT OF SURGERY
IN CONTEMPORARY NIGERIAN SOCIETY

An Inaugural Lecture delivered at the University of Lagos
on Friday, 11th November, 1977

By

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Mr. Vice-Chancellor Sir,
Deputy Vice-Chancellor,
Provost, College of Medicine,
Distinguished Guests,
Ladies and Gentlemen.

I have information from reliable sources that today's Inaugural Lecture is the twenty-seventh (27th) in our University series and the fourth (4th) from a chair of Surgery in this Institution. It is therefore with a great sense of fulfilment and humility that I address you this evening: fulfilment at coming to discharge, belated though it be, a duty now established by our tradition as one of the first responsibilities of a new occupant of a professorial chair in this University; and humility, because of my awareness that in discharging this duty I follow a remarkable lineage of distinguished and erudite predecessors.

Mr. Vice-Chancellor Sir, as I see it, the principal advantage which an occasion such as this gives the new occupant of any of your academic chairs is the opportunity it provides him to formally articulate his thoughts, define and air his views, and maybe declare his hopes on some area(s) of the University's responsibilities to society. Having therefore considered a number of topics within these ambits which might be of interest to this august audience, I came to the conclusion that it will be most appropriate for me to explore with it, my thoughts on some aspects of our emerging national health service care and delivery plans against the challenges and problems which they pose to and impose upon the academic surgical community in contemporary Nigerian society.

I intend to review with you my interpretations of the significance of these problems and discuss with you the opportunities which the challenges offer us to help evolve a
health care system, practice and distribution of utmost relevance to the needs of this nation.

In passing I wish to observe, Mr. Vice-Chancellor, that at no other time in the history of this nation have the academic medical communities faced so much problems and challenges as those that confront them today, nor have their ranks ever been such targets of so repeated, severe and at times bitter verbal and written attacks. There has been in recent times an explosion of articulated concern from the public and the government of this country on various aspects of Nigerian medicine: the standard of practice of its health personnel, their sense or lack of sense of responsibility, dedication and humanity in the use of the knowledge they have become inheritors of, and about the pattern of distribution of available health care throughout the country vis-a-vis the ever apparent unwillingness of health practitioners to work and serve in rural areas.

Although these problems are not new, they have generated enormous pressures, I believe, as a result of the nation’s rising socio-economic circumstances and the usual rising expectations that attend these.

Mr. Vice-Chancellor Sir, my brief in the present exercise is to relate the challenges these problems and pressures pose to the Nigerian University Departments of Surgery. I wish to emphasise however that what I have to say has relevance for all departments of the colleges, schools or faculties of Medicine, of health sciences and their associated medical centres throughout the length and breadth of this nation.

The fact that the term ‘Medicine’ is used to denote the whole field covered by the Faculty, School or College of Medicine in a University, and is also used in the narrower sense to denote that field which teaches ‘Internal Medicine’ may be a source of confusion in the minds of some, noting an academic surgeon apparently expanding his declared brief to speak about surgery, to embrace speaking on the whole of Nigerian medicine. To them, Mr. Vice-Chancellor, surgery is
a thing apart — apparently concerned with a technical aspect of health care (i.e. surgical operations) and the acquisition of requisite surgical judgement. But, 'surgery is medicine and something more' and its practitioner has been accurately described as a physician who uses the knife as an important part of his armamentarium in his practice. His preparation for practice is, and I believe should continue to be step-wise through training at the undergraduate level to the status of physician thence unto that of a surgeon and finally the surgeon-specialist — all the time with a vibrant spirit totally committed to scientific methods in the practice of his art.

It seems proper Mr. Vice-Chancellor that I should make this statement of credentials to afford a base from which this august audience may form an opinion about remarks that follow.

Starting by briefly surveying the present Nigerian medical scene, ladies and gentleman, we will with ease identify six (6) major issues which confront us with problems and veritable challenges:

The first is the task of training sufficient numbers of health personnel to meet the health care needs of the nation.

The second is the issue of developing programme(s) which will inculcate in each health worker the right attitude of mind for health care delivery and implant in each the sense of responsibility, integrity, and above all, humanity, which have been the hall-marks of the medical profession down the ages and about failing manifestations of which the nation has raised justifiable alarm.

The third is the now controversial problem of setting the minimum standard of proficiency that training should be aimed at achieving before independent practice is allowed — an issue upon the
resolution of which the quality of health care to be available to the Nigerian public will be determined.

The fourth relates to the place of research in patient health care delivery and within the internal university politics — its place in the assessment of teachers for academic posts and promotions.

The fifth problem is the serious issue of the image of the health practitioners and specifically of the attitude towards them of a Nigerian society which has become more aware of its rights, expects more from health personnel, has become more cynical about them, has less faith in them and is seriously becoming progressively hostile to intellectualism in medicine and the paramedical supporting areas.

Finally, there is the serious problem of how to create and define an identity for ‘Nigerian Surgery’ — befitting the leadership role the country has assumed amongst the black races and nations of the world: aiding in transforming the apparent total dependence of the black communities of the world on other nationals’ benefactions to the medical art and sciences to active contributions by them to equally enrich the world’s advancing medical knowledge on the basis of respected partnership with the non-black communities.

Each of these major trunk issues no doubt has a number of related branch problems and there are other matters of importance that I cannot touch upon within the time limit of this discussion.

Before embarking on discussing these problems fully and in order to orientate ourselves to see more clearly the magnitude of the health manpower needs and deficiencies of medical facilities in this nation and maybe thereby understand better some of the problems relating to the health
care plans and thoughts about health care delivery service projected for the nation, I shall give a brief preview of available statistics on these. I wish at this stage to acknowledge my indebtedness to the Federal Ministry of Health, the Nigerian Medical Council and the Lagos State Ministry of Health Statistics Division, for access to their records.

The estimated mid-year population of the Republic of Nigeria in 1972 was 68 million. At an annual growth rate of approximately three per cent, the calculated population of Nigeria for this year (1977) should be approximately 78.8 million; for 1980 it is expected to be about 86.1 million, for 1985, 99.8 million, and for 1987 (the end of this decade), it will be 105.9 million.

Against these, the strength of available medical and dental personnel in the whole federation in 1972 was 3,236. In 1977 it is recorded as 3,941; in 1980, government expects it to be 8,092; in 1985 the target envisaged is 14,974 and in 1987, again the end of the present decade, 17,826.

These latter figures have been computed from the present number of registered medical and dental practitioners, the number of students expected to qualify from the existing six medical schools, contributions expected from the seven new schools taking off about now and hopefully expected to begin graduating practitioners from 1981, as well as estimated expectations of 500 Nigerians entering foreign medical schools annually, should all of them elect to return home to join the services on completion of their training. Allowances of five per cent for wastages as a result of failures and two per cent for wastages resulting from deaths, retirements and other life exigencies, have also been made in arriving at these net total expectations during the decade.

Professor Dosekun has recently speculated that by 1985 we would probably have on the national register 10,780
doctors and dentists. Based on the parameters of government’s projections as shown above, the more optimistic figures of 14,974 for 1985 and 17,826 for 1987 have been worked out. These however presume that future events develop exactly the way we anticipate and the way things are planned for them, but we all know that they seldom do.

The doctor population ratios for six developed nations around the world and for Nigeria are as shown on the next poster (Table 1).

**TABLE 1**

Number of doctors per 1,000 patients in some developed countries of the World.

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of Doctors</th>
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<tbody>
<tr>
<td>1. Taiwan</td>
<td>3.2</td>
</tr>
<tr>
<td>2. Israel</td>
<td>2.5</td>
</tr>
<tr>
<td>3. United Socialist Soviet Republic (U.S.S.R.)</td>
<td>2.4</td>
</tr>
<tr>
<td>4. United States of America (U.S.A.)</td>
<td>1.6</td>
</tr>
<tr>
<td>5. United Kingdom (U.K.)</td>
<td>1.2</td>
</tr>
<tr>
<td>6. Japan</td>
<td>1.1</td>
</tr>
</tbody>
</table>


It reveals how grossly inadequately Nigeria compares with regards to medical and dental practitioners with these nations. Moreover, it will be seen that irrespective of whatever figures we accept, at the end of this decade in 1987, the
doctor — population ratio expected at best to be 1 to every 5,942 Nigerians, a figure which will be about a sixth the ratio in Japan, seven years ago in 1970, and about one-twentieth the ratio in Taiwan seven years ago in 1970. Put more bluntly, even in ten years time we will be 6 to 20 times worse off than the two far Eastern countries were seven years ago.

Similarly, review of available statistics for health facilities for 1972 shows gross deficiencies — there were in that year one hospital bed for 1,700 members of the public in Nigeria, one maternity bed for 13,000 women in the population. In addition, there were only 201 health centres, 2,060 dispensaries and 746 maternity centres throughout the length and breadth of the country. The targets aimed at for 1980 by the government are respectively one hospital bed per 1,00 population, 1 maternity bed for 4,000 women in the population.

Let us still, for clearer understanding, look at the nation's problem from another perspective. A breakdown of the causes of admissions to hospital beds and of attendances at out-patient clinics of our health centres indicate that the major causes are due to preventable diseases — infections like gastroenteritis, pneumonia, complications of malaria like nephrosis, marasmus and kwashiokor. These in the year 1972 accounted for 40 per cent of total out-patient attendances and 34.1 per cent of in-patient admissions into hospitals. It can confidently be anticipated that these will be reduced considerably if not totally excluded from the lists of this nation's major health concerns by effective tackling of environmental hygiene and malnutrition, preventive immunisations, by health education and promotion, improved agriculture coupled with better food preservation and distribution, supply of wholesome water to all Nigerians wherever they may live, enactment and enforcement of laws or bye-laws to prohibit unhygienic habits which
tend to spread infections and parasitic infestations such as sputum spitting in public, micturition in open gutters, defecation whenever and wherever the urge manifests, and prevention of overcrowding. These areas of public health, it will be seen, need to be approached from a multidisciplinary multiprofessional angle.

Whilst I will agree that the nation’s total health bill will fall as a result of greater efforts aimed at preventive health care measures than hitherto, I would like to differ from those who have given the impression that the efforts and financial commitments on the curative arm of health care services will in fact be found by this orientation to be disescalateable. Studies of Health statistics from the developed countries of the world in fact seem to indicate that elimination of preventable diseases leads to increased life expectancy in the population, and by inference to increased demand on the social services particularly health care services available. Continued survival should naturally result in increased possibility for individuals to develop other categories of diseases like the degenerative, metabolic and-or neoplastic (cancerous) diseases. The net result cannot therefore be an expectation of diminishing expenditures in finance, facilities and personnel on the curative health services with the control or elimination of the diseases colloquially grouped as the diseases of want and ignorance. The reverse, as I have now explained, appears to be the case.

Let there be therefore, no illusions, Mr. Vice-Chancellor, in the minds of our planners and the nation’s decision-makers that the answer to our health problems lies substantially in de-escalating expenditure on the curative sectors to upgrade the preventive sectors. This, in my view, Mr. Vice-Chancellor will be a myopic view which unfortunately has a large number of very vocal and powerful protagonists.
Against this general background, I shall now proceed to consider some of the more important problems which confront Nigerian surgery and therefore the academic surgical communities which make up the university departments of surgery in the health task development the nation has set itself over this decade.

Mr. Vice-Chancellor Sir, it is appropriate that I should make my standpoint clear on four areas at this juncture, less I may be misunderstood.

Firstly, I believe what the Nigerian public wants in its health service arrangements is not just an accelerated health manpower generation to meet the number of personnel the nation needs, but concurrently, a quality production to give the safe and high standard of health care that should be the right and the expectation of all Nigerians. The rush with which the more affluent and politically more powerful members of the community have hitherto travelled out to the developed countries to get a so-called ‘best’, which medical care can offer, whenever they had even the common cold, bears testimony to this latter desire. And my view is further strengthened by the following editorial of the Daily Times of Thursday, October 25, 1977 commenting on the controversy relating to growth in number of Nigerian universities and the public expectations on their performance:

‘Our attitude to the problem is a practical one .......... for we may end up by congratulating ourselves on the number we eventually produce ...... (And we have no quarrel with that) it ought however to be reminded that what will matter in the end is not the fascination with numbers but a preparedness to make all ..... work according to acknowledged standards all over the world.’
Secondly, the present speaker, Mr. Vice-Chancellor, Sir, does not share the view held by some the 'half a loaf is better than none' when this aphorism is applied to health care. My professional experience over the years has hardened my belief in a contrary view that in health care — certainly surgical health care, half a loaf is at times worse and more dangerous than none.

Thirdly, Mr. Vice-Chancellor, I believe no matter what may be said to the contrary, Medicine and its branches are basically social in their attitudes; they are for society — not for society as a whole, but for each and every individual composing society. There is never in my mind any question about what the job of the doctor should be — it is to help the sick and the injured to his utmost ability and this he must do whatever the framework in which he practises and we must in the cradle of his transformation from student to doctor ensure that that ability is up to an accepted minimum level.

A considerable degree of independence of thought, judgement and action must be the surgeon’s if he is to perform this essential function at this expected level. In the context of our environment as elsewhere the independence must extend to this recurrent, honest, close scrutiny of plans and pronouncements on health care delivery scheme he works within or is to work within. His conclusions may not always be in line with majority view but he is because of his training and calling under an obligation to speak loudly about his sincere reservations and genuine fears on apparent miscalculations as he sees them, most particularly when they appear to him to be on plans tailored towards popular expectations and apparent desires but which may not be in the long-term interest of his patients or of the society he lives in. He may not always be right — he is human: but by speaking up he may invariably cause a second look to be had on such issues usually for the better. Academics should be able to do this even at the risk of being labelled antisocial
and uncooperative so long as their motives are for the good
of the people and the country.

Fourthly, Mr. Vice-Chancellor, it is my belief that as
of right every Nigerian irrespective of his/her place of domi-
cile should benefit from the national health care provisions
available and do so within easy reach. Thus, I contribute to
the tenet that there is an urgent need to extend the benefits
of modern medicine to the rural areas.

What then are the problems confronting us in progress-
ing plans to attain an ideal health care service throughout
this Nation and what challenges do these pose for the Nige-
rian Universities Departments of Surgery which are expected
to and must more vigorously address themselves to their
roles as the birthplaces and the cradles for the core personnel
to run the services, train the teachers to continue the pur-
veying of medical knowledge and maintain the continuity
of the health professions, to be centres for the advancement
of the boundaries of knowledge, on health care planning,
delivery and practice for this Nation.

The first of the major problems in undergraduate
medical training is getting the medical and dental University
student entrants in the numbers which will enable us to
accelerate graduating doctors and dentists yearly to meet
even the projections of Government.

The situation as of now is that less than 300 candidates
a year succeed in getting the present basic requirements at
the Higher School Certificate Examinations to qualify for
Medical School places. When we supplement this by the
spill-over from previous years who qualify by passing their
remaining one or two papers failed in previous attempts, and
those who cross over after starting allied courses in Universi-
ties in previous sessions, as well as those who enter through
the Universities' preliminary programmes we cannot as of
performances in these examinations in the country, government projections for health and the stiff competition for these candidates by other professions.

I next want to spend a little time on reviewing the problems posed by the current dearth of medical teachers and against this give my views – on the long term effects of the recent increase in our medical school establishments in the country. There is distorted thinking by some that established older institutions in this country are overstaffed, and that their academic teachers are falling over each other. Some quarters have expressed the old well-worn favourite arguments that this does not make for equitable spread of the most powerful promising instrument for our health care distribution throughout the federation.

Mr. Vice-Chancellor Sir, I am aware that unfortunately far too often in this country the trend towards expediency and short-term solutions has tended to confuse clear thinking particularly on health care matters. What is more unfortunate is that this trend manifests often amongst intellectuals whose thinking and pronouncements are expected to be scientific, more dispassionate and realistic in the overall long term interest of the nation, particularly at these delicate times when our prayers are that we should be thinking and feeling more like Nigerians rather than Nigeria sectionals. A few weeks ago no less a person than an academic/administrative head of an important higher centre of education in this country dismissed as the tantrums of older sib(s) coming face to face with the realities of sharing with a newly arrived brother or sister in the family the previous care and attention totally lavished on them before the arrival of the new comer, when asked to comment on some of the misgivings and doubts expressed from some quarters about the Federal Government’s decision to start seven (7) other universities in the country right now. The basis for these misgivings were essentially the dearth in university teachers – which is
the moment count on more than 500-600 qualified candidates for local medical training annually. It is relevant to state at this juncture that in a previous inaugural lecture the relevance of the Higher School Certificate as a desirable pre-requisite for acceptability into Medical School training has been queried on the basis of impressive statistical analysis of available data on subsequent medical school performance — and results over the years. What however we have not resolved nor had advice upon, is what should be used as the yardstick for selection if we jettison the Higher School Certificate.

These observations query the tenents, ay, the very basis of suggestions for rapid increases in medical school intake now. They raise fundamental questions relating to the lack of pre-planning as a desirable pre-requisite for embarking on progressing the recent plans by government to increase the number of medical schools to thirteen (13) before all arrangements to ensure their full utilisation have been completed i.e. training medical school teachers — particularly as we know that there is a world shortage of these teachers — and ensuring a pool of students to properly service meeting entrance requirements in adequate numbers yearly.

Where are the medical school entrants to fill the now established medical schools to come from? Some have suggested that the present standards of requirements should be radically down-graded; though none has doubted the need for a sound foundation in the physical and biological sciences as fundamental preparations for embarking on medical studies and training. Although time does not permit analysis, I venture to suggest that even if entrance requirements were lowered to good science student passes in the W.A.S.C. — G.C.E. Examinations we would still fall short of adequate numbers for full use of these schools on the basis of present
tive work, I maintain, Sir that none from the former group would last a month because of the burden.

About three years ago, the College of Medicine stepped up its annual admissions to over 200. Considering the effect of the gross fall on Teacher/Student ratio, it needs no genius to imagine how much of individual attention this can permit, and how less thorough interaction between Teacher/Student must now be. In the College we are now involved in utilising all the recent advances in educational methodology that audiovisual aids can offer. We believe that these will help us in improving teaching communication and the learning process and allow for individual student's study pace. But Mr. Vice-Chancellor Sir, medical and dental training particularly surgical training remains in its best, when training is by the apprentice system in its truest, fullest and oldest connotation. I maintain that there is a level of academic Teacher/Medical student ratio below which you can not go without grossly lowering the quality of the end product and the level of excellence of performance of the Doctor/Dentist, etc. produced thereby.

We may be able to afford to discard a machine wrecked by other professional apprentices not closely supervised and directly guided while 'learning' on it. To do the same with a surgical apprentice learning on a patient is unthinkable. It may lead to an irreparable damage, loss of human life or reduction in the quality of the life of the unfortunate victim if he lives for us to tell the tale. Thus in centres where training of Doctors/Dentists and Specialists is undertaken there is a Teacher/Student ratio below which we cannot expect to fall without sacrificing the quality of training and acceptable standard of training permissible before independent practice is allowed.

Furthermore, one crucial point is conveniently forgotten or overlooked by those who are now arguing about over-
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Furthermore, one crucial point is conveniently forgotten or overlooked by those who are now arguing about over-
staffing in some of the teaching medical centres and/or Departments or Faculties of Medicine in our Universities. The advances in scientific knowledge in medicine and surgery in the last 20 years are equal to, if not more than, all previous progress made in these areas. The significance of this fact and its implications with regard to medical education offers an appalling challenge today to the teachers. For years it has been impossible for anyone to encompass the whole field of surgery either in practice or in teaching. The same is true for all departments. The necessity for specialisation was born from the need for greater knowledge in depth in special areas as well as for increased teaching facilities for transfer of knowledge.

The staffing of our new medical schools will remain a major problem not only to the Nation and the respective new schools in the face of a world shortage of medical teachers but it will pose further problems to the older ones in that it will as in the past be the resort for new schools to draw their needed staff by depleting the older ones of also badly needed academic teachers.

It is also no more regarded enough to become an academic teacher for a clinician to be willing to teach at the medical school. In the past their experience or prior training in teaching was not considered necessary for their appointment as academic medical teachers. The medical students silently got what they could from the presentations which they were powerless to influence. There are those outside our University walls who still believe that the ability to teach is a divine gift bestowed upon the doctors with their degree on qualifying and as such they argue that we should supplement what we lack in numbers of academic teachers now by selection from qualified and newly qualified physicians and surgeons working in non-university medical or affiliated centres.
The content of material presented to students today require careful planning and monitoring and students freely criticise teachers and materials or resort to violent demonstrations in the face of poor presentations.

Medical school classes have already exceeded the capacities of the physical facilities and faculty strength. The coming into existence of the newer seven dictates an urgent rethinking for sanity’s sake. The departments of medicine in the older schools I believe, should be encouraged as a matter of urgency to take up the challenge in conjunction with University Faculties of Education and train medical teachers urgently for this Nation and they should receive adequate subsidies to do this effectively. In my view this would be a worthwhile investment and the surest way of on-the-long-run making effective worthwhile impression on the level of practice and delivery of our health care service.

Another problem that the University Departments of Surgery and therefore the Colleges/Faculties of Medicine are facing arise from the enormous pressures by government, activist groups, and others urging a reduction in the duration of the undergraduate medical/dental training period from its present five years to a very much shorter period as a way of accelerating rate of medical manpower generation. Opinions are however divided on what should be considered a reasonable reduction to still produce an effective doctor. We are being urged to cut out details/inessentials to let these wait to be gathered post-graduation through working experience. None to my knowledge has so far satisfactorily identified what should be reasonably left out of our present syllabus of medical/dental training. And what is more important, none has been able to come forward to indicate that the medical graduates of the various Universities in Nigeria on present programmes and curricula end up over-trained for the responsibilities they assume on qualifying.
On postgraduate surgical specialist training, the Nigerian University Department of Surgery’s experience is still limited to a few years. Nonetheless its advantages are already quite obvious — it has helped to conserve available medical manpower in the country during the training period and in ensuring a training which in content and applicability bears greater relevance to the needs of the country.

We however still face the problems of

1. Deciding how many surgeons and essential surgical specialists will meet the actual needs of the country. We have, I believe, as the prodding force in the professional bodies in Nigeria and the ECOWAS region taken the proper decision that a basic training in general surgery should be undertaken by all surgical trainees so that each may relate to the Nigerian environment and function maximally wherever he or she may practise.

2. Unbalanced growth amongst all the medical specialists. For proper post-graduate training programme in surgery, it is essential that the facilities for training be there or alternatives worked out where possible, we should have available sufficient numbers of other specialists to ensure proper training — e.g. Anaesthetists, Radiologists, Pathologists, etc. This has not been the growth history of medical and surgical specialties in this country and it is hampering our rate of surgical manpower output for the Nation.

The time, I believe, has come for thorough investigation of not just the total need but the pattern of distribution of the needs in number of the health personnel if we must avoid wastage and underusage of manpower in some areas on the one hand and underproduction on the other.
This can best be done by the University Academic Medical Communities.

What then is the short term answer to the Nation's plight on shortage of medical manpower? Given our present circumstances, training medical and dental students the conventional way will fail to yield the number of doctors and dentists the Nation ideally needs over the next decade or two. I think it is time Nigeria dwells less with the fascination of happenings in other lands and with catching cliche and addresses herself more seriously and realistically to valid considerations.

People for example have talked of our borrowing a leaf from the U.S.S.R. and from China by directing our attention to the quicker production of mini-doctors or barefoot doctors but we already in this Country for over six decades have had a core of barefoot 'doctors' — what are the Hausa/Fulani itinerant 'Agunmu' sellers or the Yoruba 'Gbogbon'se' purveyors who travel from town to town, from market to market to sell herbal preparations to the needy sick. The differences between Nigeria as of now, China and the U.S.S.R. experiments are that in the latter two the herbal preparations have been officially evaluated as have the dosages to be prescribed: Secondly, they are handed over to the sick, free of charge. Those who have been great protagonists of adoption of the Chinese — U.S.S.R. experiments are engaged in a very catching cliche because the needy masses are unaware of this parallel existing within their own environment.

We also will not dwell on the question of production of mini-doctors' a topic which had been extensively debated and I believe now dropped for ever. For as I mentioned above the Nigerian Society does not only need health practitioners in adequate numbers, but also is entitled to adequately trained health practitioners and it is not here a case of a half a loaf being better than none.
I however share the view of those who have held that Nigeria needs to look into training other cadres of health personnel capable of being rendered by a short training to effectively partially stand in for the medical doctor and dentist particularly if we are to be able to place within the reach of every Nigerian modern health care notwithstanding their place of abode, within the immediate foreseeable future.

Where I part company with most, however, is on the choice of who should be trained for this work. The advantages of training a cadre for shorter periods as clinician aids or assistants in large numbers than available qualified students as doctors/dentists are so apparent that they need no enumerating. I have already Mr. Vice-Chancellor stressed the necessity for a sound background in the Physical/Biological and Social Sciences as a pre-requisite for training to fulfil the role of effective health care. Registered nurses have this essential background. All now have full secondary school education and most considerable additional academic preparation. The minimum training for registered nurses is 3 years with many nurse practitioners proceeding on to post-qualification training in the various specialties covering the whole spectrum of health. They already are familiar with much that forms the content of medical and dental training. It is my view that selection from this cadre for additional 6-12 months training and orientation will provide the health sector with effective medical clinician assistant/aids and at a rate that will have a quick remedial effect on our health manpower shortage. There are already many more thousands of trained nurses on the Nation’s register than doctors/dentists and new entrants are being trained yearly in many more thousands a year than are students as doctors. By making the service conditions of nurses attractive many young secondary school leavers will enrol for the three-year nurse training course and graduate apace to replace the deficit that will otherwise be created by the upgrading of the established nurse-practitioner by further training to effectively aid in
reinforcing the medical-dental practitioner force as quickly as Nigeria now appears to need this cadre of manpower for its health care services.

If we are to make any improvement in our health care services we have no alternative to increasing the right type of manpower. We will not do it by increasing the wrong type.

**RESEARCH**

I will now move on to considering the problems posed by the divided views on the role of research in patient care and on the value that should be placed on research activities and publications in considering practitioners for academic posts and/or promotions. This remains controversial and always generates emotions amongst protagonists of views that it should be rated high and opponents of these views.

Of the many problems which confront the University Departments of Surgery, internally, those related to research are of the greatest concern. I am unshaken in my belief, Mr. Vice-Chancellor, that it is surgical research which gives University surgery its distinction, and that was largely responsible for the meteoric rise of the image of Academic Surgery in Nigeria during the past three decades.

The opportunity for research has in my view attracted the best young minds to the excitement and challenges that characterise the University Medical Centre.

Furthermore the practising physician/surgeon uses almost entirely knowledge transferred to him from the past and practitioners receive payment for the use of this knowledge without much thought of their debt to the past. In my opinion if the practising physician/surgeon contributes nothing but in transfer of old knowledge to those who must succeed him and contributes nothing by the discovery of new
knowledge either through his experience or experiments he is only a parasite in his relation with his profession.

To Society, he may still be regarded as a useful member but he is useful only in so far as he is considered a purveyor of medical knowledge to the consumers i.e. patients.

The University in my view Mr. Vice-Chancellor, has an obligation to society to ensure that the Academic Surgeon like every academic teacher recognises the truth of his or her debt to the past and continues to add to the continuity and progress of his or her profession by 'Teaching and Researching' and the state is under an obligation to ensure this by adequate funding to ensure continuing improvement in patient care.

SOCIETY AND THE IMAGE OF THE HEALTH PROFESSION

Mr. Vice-Chancellor Sir, the major goals of our medical education efforts are, in my opinion, to impart knowledge for proficient care of the sick, to teach commitment to service and to ensure that our trainee is well grounded in the right attitudes in his day to day work.

Society's present outcry against the apparent lack of sense of commitment and the attitude to work of our products represents a direct censure on our training programme. We already know that the amount of information the medical and the dental students have to learn has led to an overcrowding of the curriculum. Can we prune this? I have argued not — we are victims of the daily explosive growth in medical knowledge and we are obliged to prepare our students not only for the present but also provide them with the sound foundation for the immediate future in medicine and medical care.
It has rightly become the battle cry that our youths must be well grounded in our culture and the history of our race. Hence for the first year after admission to the medical school, at least in the University of Lagos, they go through a course in African History. I venture to suggest that with proper dialogue, this can be embodied in the pre-University (pre-medical school) curriculum. My son who is undergoing this programme told me a few days ago that much of what he is being told tallies precisely with his history lessons in secondary school. Maybe it is important in the present plight of the black race trying to find its roots that the programme needs re-emphasis. I cannot help but think however that for medicine and in the medical course the same result would be achieved if we substitute for the time now devoted to the African history programme the teaching of medical ethics, history of Nigerian Medicine, the influence of Western colonisation on its growth and development, comparative studies of medical history of the Western and Eastern world and the duties which modern medicine owes to society.

With regards to the history of Nigerian medicine from ancient times, we may well need concerted effort to upgrade and update research into this area and funding this, Mr. Vice-Chancellor, will be money well spent. The result of the inclusion of a programme such as now outlined, by its possible effect on our products in medicine and dentistry would produce a salutary change in the image of the health professions which the public now carries.

EPilogue

Mr. Vice-Chancellor Sir, I have been advised that an occasion such as this is never adjudged complete and well rounded up without the inaugural lecturer alluding though it be in a little way, to his modest contribution(s) to thinking and practice in his field if only to give some support to his approbation to profess.
Over the last decade, as I have grown older in local professional experience, I have become more and more convinced of Nigeria's remarkable opportunities to make special contributions to medicine. I would particularly like to briefly highlight three main areas in which the results of our own research support this thesis:

First, there still exists a vacuum in knowledge of the ethno-medical history of the Negro, by which I mean the evolution, status and milestones in the evolution, the interpretation and evaluation of the Negro Group Ancestral Medicine and Medical practice. Comparative studies in the Caucasian relate for posterity the works of Galen, Hippocrates and Celsus, the scholars of Salerno in Italy, the evolution of the barber-surgeon in England, American medicine and surgery in the new world. In the Middle East we have handed down to us the Babylonian code Malarabe, and in India and the Far East the work of Sustra. Out of all these rise before the budding medical practitioners health heroes, medical and surgical colossuses like John Hunter and Monyhan in surgery, Smellie in Obstetrics and Gynaecology, Motron and Simpson in Anaesthesia. These provide the roots, and give the inspiration leading to the continuous efforts to advance the frontiers of medical knowledge. In Nigeria we need the roots - a knowledge of our medical past - to provide us comparative spring boards and reinforce our belief in our racial capability to make comparable distinctive contributions. I am encouraged in my belief that Nigeria has the unique opportunity to help bridge this important gap to our roots by the results of a brief dalliance with studies of the Yoruba Oral Literature as contained in the IFA literary corpus which we had as part of a broader study of Keloid - an ugly skin scar which hitherto had defied medical cure. I was delightedly surprised to find that, contrary to beliefs held and contained in recorded world literature, that the condition was first described in 1806 in Europe by Alibert, IFA provided evidence to show that the Yorubas were more
than ten centuries before that well aware of the condition, had characterised it, knew of its genetic/familial basis of occurrence, its tendency to recur whatever the treatment; and, more surprisingly, information gathered by us from two chapters from the IFA literary corpus — the Osase and Ejigbo — laid the foundation which led us in our later studies to discover that it has an immunological basis and also led us more recently to the first line of treatment that has given us hope that it is curable\textsuperscript{9, 10, 11}.

This pleasant 'shock' discovery led us to further studies of the IFA literary corpus, and discovery of the existence of a medical educational system by apprenticeship by the ancient Yorubas which compares extremely favourably with present modern medical school training and examination methods. We further now have information demonstrating that over three-quarters of the 256 ‘Odus’ (chapters) of the IFA literary corpus is medical: giving descriptions of various diseases, their possible complications and prescription — herbal recipes, psychotherapy in forms of incantations, etc. for treating and preventing them as well as the prognosis.

Here is my view Mr. Vice-Chancellor is a compendium or medical textbook comparable to those by Celsus, Galen and Sustra to be explored and evaluated. Yet Nigerian scholars appear to fight shy of doing so, and protagonists of our cultural heritage remain oblivious to plea for funding.

Furthermore our findings from Nigerian Museum studies correlate with our findings in those of the ‘Odus’ (Chapters) of the IFA literary corpus which we have been able to analyse, and yield in addition a verifiable array of superb medical illustrations of various disease entities that make me bold to claim that our medical ancestors were certainly the equals or betters of their contemporaries in many parts of the world, not only in arts (sculpture and music), but maybe in medicine and surgery.
Another area of unusual opportunities I believe Nigeria has in making special contribution to medicine lies in exploiting what herbal medicine has to offer.

We are quite aware of the excitement that the discovery by Nigerian workers of the anti-sickling effect of constituents of Orin-Ata had on us here in Nigeria and more recently in the United States where it is being inaccurately publicised as discovered by American workers who took up the work after the early reports by our own scientists with whom the Americans were in fact working as co-researchers on follow-up studies.

In a little laboratory, in the unit which I lead in the Department of Surgery, we are at the moment very excited about the promise of results from animal experiments of a number of herbal recipes we have been investigating on wound healing. We had collected from native herbalists from various parts of Lagos, Ogun, Oyo and Kwara States over 40 herbal recipes reportedly used for treating wounds and ulcers from ancient times and comparatively studied them with standard hospital drugs. We proceeded to investigate the bacteriological effects of twelve of these and found that four have very potent antibacterial properties. We are now involved with investigating whether these are disinfectant effects, antiseptic effects or something more.

Studies in the U.C.H. Department of Surgery by our oncology colleague, Mr. Durodola, again working on some herbal recipes from Kwara State herbalists have shown excitingly promising anti-cancer effects.

We know and are trying to tap for use the proven 'corticoid ring' constituent of a species of one of our yams (Alo) as well as its effect on various lesions.
The plant known as *Asofeiyeje* in Yorubaland is used by herbalists as a potent sedative to calm the violently excited. It is now also known to contain a rauwolfia species which is one of our most potent antihypertensives.

The opportunities abound for Nigeria to contribute to medical and surgical knowledge. With due respect Mr. Vice-Chancellor Sir, I would like to associate myself with Emerson who opined on history as follows: ‘The use of history is to give value to the present hour’ to which I will add — and to give basis for future development. The academic departments of surgery and medicine in all Nigerian Universities have an obligation to help upgrade the status of, ensure the recognition and acceptance on equal footing for Nigerian surgery and medicine throughout the world. I believe by addressing ourselves to discovering our medical roots, evaluating our native medical practices and exploiting research investigations of the diseases peculiar to the Nigerian and the Negroid races like sickle cell disease, keloid, aihum lymphogranuloma strictures — and diseases known in other parts which are more common here like cirrhosis of the liver, hepatoma, etc. or still more florid in the developing than in the developed countries, we can attain this goal.

In conclusion Mr. Vice-Chancellor Sir, I will echo the views of J. D. Hardy who opined that 'There is no more sustaining value in life than the opportunity to serve, to labour in a vineyard where the fruits of such labour are immediately and daily apparent. The academic surgical life is constantly challenging, endlessly fascinating and forever rewarding in terms of contribution to the lives of others. Such rewards are given to few professions'.
The Nigerian University Departments of Surgery face great challenges — many problems in working to meet these challenges. It is my view that they have a great heritage to tap from and a great opportunity to serve well, provided they are unfettered by financial constraints and enjoy complete professional freedom consistent with academia.

I HAVE DONE.
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