The Price of 'Development'

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I feel delighted and highly honoured to deliver this lecture today and here in Ibadan, for all the obvious reasons.

I thank the Benjamin Oluwakayode Osuntokun Trust and particularly the Osuntokun family, most especially Professor (Mrs.) Olabopo Osuntokun and Professor Jide Osuntokun, her brother-in-law. The Trust deserves all of our support in order to continue Professor Kayode Osuntokun's posthumous contributions to humanity. They can be assured of our solidarity with them. The Osuntokun family is a very successful Nigerian family, and the richly deserved love they have for Kayode and their sincere devotion to his memory will keep his legacy alive.

I am proud, yet humbled to join the impressive array of highly distinguished medical doctors, teachers, scholars and scientists who have delivered lectures here before me. Most importantly, while I welcome this opportunity to, once more, pay tribute to our departed colleague, friend, world stage showpiece and medical science prodigy, Professor Benjamin Oluwakayode Osuntokun, it is both hard and cruel, and most agonizing, to face the reality that this is only a memorial lecture, and that we have, indeed, lost him. Eight years is too short a period of time to even begin to heal the wound of the tragedy, of the sinking feeling of deprivation and irreparable loss. While we accept the Supreme Will of God, we do so with awe and trepidation that, in the Shakespearian fashion, such terrible 'harm should come to such a fair show'. Let me repeat what I once said: Kayode was cut down, I would say in his prime, at the premature age of 60. One of the few consolations in losing Professor Osuntokun in his prime is that we shall always remember him as a healthy vibrant young man in full possession of his strength and faculties. Not even his death can deny us that solace. We also have his

incredibly large number of high quality medical and scientific papers and books to continue to learn from him.

The previous distinguished lecturers have so thoroughly catalogued the achievements of the late Professor Osuntokun, making it unnecessary for me to attempt to be another chronicler, especially as people like Professor Salako and Professor Essien knew him intimately since they were students together here. What is more, my worthy predecessors have put together and discussed the very wide and very important areas of 'clinical and scientific medicine' that Professor Osuntokun worked in.

Kayode the Man

When I arrived at the 'Promised Land', a term the late Professor Alastair Smith used to describe the clinical course, after having passed the 2nd MB examination, Kayode and his set, including Dr. (Mrs.) Osuntokun, were already about to complete their pre-registration housemanship. In other words, he was four years ahead of me. His brilliance as an academic was already a legend. By the time we started our own pre-registration training, he was back in UCH as a senior member of staff, having successfully passed his MRCP (London) examination (at one sitting) and having received much grounding in neurology in Newcastle, a place that retained a soft spot in his heart. We always looked forward to the Thursday afternoon Department of Medicine ward rounds where he used to regale us with stories about neurology patients and their rich assortment of striking physical signs. For example, there was the lateral medullary syndrome of Wallenburg or thrombosis of the posterior inferior cerebella artery, either term quite a mouthful.

I really got to know Kayode when I was working and studying for the MRCP (London) in the Middlesex Hospital, under the late Dr. PAJ Ball, who had formerly been a senior lecturer/ consultant in the Department of Medicine in Ibadan in the days of the great Professor Alexander Brown. I was staying at the hostel called Astor College on Charlotte Street, very near to the hospital.

Kayode came on one of his many visits to London and was also staying at Astor College, where Dr. Ball was warden. We spent long hours together. I was new to London, to British medicine, to the MRCP. Kayode spent much time advising me on what to read, how to read, where to go and so on. He helped me not only to realize how much needed to be done, but how to do it.

From then on, we never looked back. It therefore was not difficult for me to return to Ibadan after serving my kind sponsors in the North Eastern State Government for about 15 months. Kayode and Professor O.O. Akinkugbe who was the Dean at that time, made Ibadan feel more like home than I could ever have hoped for.

In the 1974/75 session, Professor Osuntokun was elected Dean of Medicine, and he made me sub-Dean of Clinical Studies, a job I was doing along with my duties in the department, until I was appointed the executive secretary of the National Universities Commission in April 1975. It was very difficult for me to tell him the news, and he just had to find out on his own and confront me. But he was, as usual, quite understanding and generous to a fault. Leaving Ibadan for Lagos made me to leave the college, but it made no difference to our relationship.

I do recollect a few incidents during my service as sub-Dean (Clinical) that I consider worth mentioning, especially as the requirements of the 30-year law must now have been met.

The national crisis of 1966, and the civil war it led to, impacted negatively on the college and the hospital in terms of loss of staff and some services. Notable among the latter were the 'medical records'. I made bold and suggested to the Dean that we would be better off if the hospital again started from square one to with keep new records – because I could not see how the old records could ever be set straight. The hospital was then only 17 years old. I hope that UCH has now fully computerized its records. Otherwise, I cannot imagine what the situation would be 30 years after 1974.

The university and its Faculty of Medicine decided to start a 'Dental School'. As usual, this was an 'illegality', because it was not approved by the National Universities Commission as the law required. That was not the only illegality. The Law Faculty and the Engineering Faculty of Ibadan also have an interesting history. Anyway, we were all working hard on it – the Dental School, not the history – in the Dean's office, when I was appointed by General Yakubu Gowon to be the executive secretary of the National Universities Commission (NUC). One of their early letters to me was to respectfully inform me that the Ibadan Dental School was not approved. I mentioned this to Kayode and all he said was, 'now that you are there things will change'. He then proceeded to immediately send out letters of admission to the first set of students. I had the task of securing the Commission's approval to allow Ibadan to continue with their 'illegal' school. The chairman of the NUC, the Late Chief Simeon Adebo, was an enormous help, of course, but I sometimes wished that my first meeting as executive secretary had been less stormy.

The Commission, in drawing up the academic brief for the seven new universities (plus Benin, number eight) established in 1975, approved that each of them would have a College of Medicine. Kayode decided that Ibadan too must have a College of Medicine. 'Does it make sense to you, Jibril, that a brand new university will have a college of medicine and Ibadan will not?' It did not. He wrote the entire 'brief', got it signed by the acting vice chancellor, and sent it on to the NUC. Ibadan had her College of Medicine.

An interesting side observation is that in those new universities, the vice chancellors, who were not medical doctors, welcomed the idea of a college. It was the medical doctor vice chancellors who refused to call their units colleges, but made them only faculties. If you want my guess as to the reason, it must have been that those vice chancellors did not cherish the idea of young and uppity provosts strutting around. Later, under new management, both of those faculties became colleges.

General Yakubu Gowon, who was then head of state, went to some function and pronounced that each of our then medical schools (Ibadan, Lagos, UNN, ABU, Ife, Benin) should admit one thousand students every academic session. Informal inquiry to the head of state by someone from the Dean's Office who went to the same school with the general, revealed that he was quite serious about this, although he could be talked to. The vice chancellor of Ibadan then was the Late Professor H.O. Thomas. He knew that government was serious, but he had something more important to tell us. 'Do what you can and bring out all your problems and needs. But do not ever say that you cannot meet the target, because medical school X will surely say that they can do it'.

I also recall that while I was in the National Universities Commission, Kayode organized and sent a busload of very senior and very obliging colleagues from Ibadan to go to a Nigerian Medical Association Meeting at the Lagos University Hospital (LUTH), in order to block a decision that was to be taken to go on a nationwide strike. One of the militants organizing the strike was very bitter with me and said something like this: 'The moment I saw you, I knew that you came here to spoil things for the doctors. You went to bring your people from Ibadan to vote against our plans, OK'. I repent on behalf of both Kayode and me.

We were not always successful. The Postgraduate Medical College (PMC) situated in Lagos, in the College of Medicine, University of Lagos (CMUL), was having difficulty securing additional accommodation to enable it expand, and the College of Medicine was just not willing to give any more space, saying that they just had no more space to give. At that time, the president of the PMC was, in fact, based in Ibadan where there was room because of the Biode Clinical Sciences Building donated by the pharmaceutical industrialist, Mr. Kayode Fashina. The CMUL proposed a meeting of the PMC to discuss the matter. They came with a formidable delegation led by the provost himself. He said,

among many other things, that he could not understand how Ibadan could be trying to hijack the PM College when, in fact, Ibadan had earlier on and all along, refused to identify with the new College Fellowship Programme, which, he charged, Ibadan dubbed 'the Lagos programme' and opted for its own Ibadan-planned M. Med. We said, 'OK. How about the extra space?' 'Oh, the extra space is here in Lagos. The College of Medicine will give the PMC all the space they want'. The college thus stayed in Lagos; and they were given a generous allocation of space, which was what we set out to achieve. In that case, maybe, with Kayode, we were always winning all the time.

That was Kayode Osuntokun, never a dull moment. He was an indefatigable all rounder, a seaman who never rested on his oars. After his MRCP (London), he worked for and achieved his MD degree and later passed the examination for, and received the D.Sc. from the University of London. He became a professor at the age of 34. Both of these successes are rare indeed. It was on account of all these prodigious achievements that the federal government honoured him with a national honour, the Order of the Federal Republic (OFR).

His type of D.Sc. has been effectively eclipsed by my own type of D.Sc., honoris causa, of which I have three now. Never mind! On each occasion of conferment, I solemnly undertook never to use the degree to look for a job. Kayode also received the honoris causa D.Sc. from a number of universities including Maiduguri. We considered it a great privilege to honour Professor Osuntokun.

Kayode never used his super qualifications to look for a job. Never! If he did, he would have secured any medical job he wanted anywhere in the world and he would have been out of Nigeria long before 1975 and for good. I sometimes imagined how much he would be paid in the United States or in the Persian Gulf area, where his name must have been well known as a world class neurologist.

He served on endless international medical committees and study groups overseas. One of these assignments, during which they were studying pain, led a Nigerian newspaper to label him 'Professor of Pain'. He also went on plenty of attachments to teach, to share experiences or to sharpen the state of the art. The last preoccupation I called 'academic dialysis'. I remember at different times, visiting him at the Hammersmith Hospital, London, at the Addenbrooke Hospital in Cambridge and at the National Institutes of Health, in Bethesda, Washington DC.

For all the foregoing, it was in Ibadan that he stayed, and stayed put. One of his contemporaries referred to UCH as 'our old castle' and those who graduated and then worked there as 'its guards'. Kayode, surprisingly to me, took up the job of chief medical director of UCH. When I asked him why he did that, he replied, 'We have to rescue this place'. With that, he inspired the young, and might indeed have saved this hospital and medical college for others to come after him and carry on serving their turns.

Professor Osuntokun's scientific work has already been discussed by others, as I have already mentioned. There is, however, one piece of work that should be cited here, because I was privileged to report it verbally to a meeting of the Federal Executive Council shortly after the paper was published. In one of his collaborative studies on dementia, Kayode and colleagues found that the brain (the mind, if you will) of Africans degenerated less rapidly with age than that of white folks. This is very important for us and justifies the claim of elders that leadership should be by experience. Besides, it confirms the African saying that 'the words of our elders are words of wisdom'.

Nothing said so far should give the impression that Kayode was either aloof, or had no time for other things, especially for his family and friends. He led a very busy but a full and enjoyable life. He was extremely considerate. When he finished his deanship, he wrote a personal hand-written letter to every senior

member of staff of the College of Medicine. But, all this did not mean that he suffered fools easily or could be taken for granted. Those who attempted it rued the day they tried.

I recall the story he told me of one driver who was driving too fast in some official car. The driver would not listen to his entreaties to slow down a bit. Whereupon he urged the driver to stop so he could ease himself. He got out of the car and said to the recalcitrant driver: 'My friend, you seem to be in a great hurry to get to somewhere important. I will wait for you here. When you finish your business, you can come back for me'.

Kayode possessed those leadership qualities which make it possible to lead the younger generation and our society into the 21st century. The late Kayode Osuntokun saved lives, eased suffering and pain and restored dignity. He taught and produced new doctors and nurses and other health professionals; he gave invaluable advice for the promotion of health throughout the world (ie, towards the prevention and eradication of disease and reduction in morbidity; and the cutting down on economic and opportunity cost of disease). The Kayode Osuntokuns of this world advanced individuals, families and nations. In short, they contributed to national and world development, and to the continuing ascent of man.

I remember that as he was approaching retirement (or change of desk), I recommended to him to join the Nigerian Senate. He seemed quite interested and we discussed at length on the parties, etc. He might or might not have tried to go to the Senate. That, we shall never know because of the cold hands of death. His response, however, was very encouraging. And you can see that I practice what I preach!

And 'Development'?

I crave your indulgence to let me speak briefly on development because it is obviously important in a lecture to do with a pioneer like Kayode Osuntokun. Development is a very complex and

highly contested idea. It is very difficult, virtually impossible, to define. It has serious protagonists among most politicians and governments, as well as among the intelligentsia, the economists, the mercantilists, and among the voters. But, it also has opponents particularly among scholars, religious teachers, other ethicists, the ecologists and the conservationists. Politicians nearly always espouse the idea of 'development' because they consider it 'easy sell' to the gullible voters, and because politicians and their supporters prefer the emotive bandwagon to cool analysis. Linking the idea of development to the sustenance of and access to political issues makes it a prime ingredient in the tussle between opposing politicians and among their parties. For some politicians, every good word in the dictionary promotes development. Every bad word retards it.

Sometimes, its vagueness is a welcome act of constructive ambiguity. I once remarked that, if the doctors are to be as confused about medicine as the economists are about economics, no patient would ever come out of any hospital alive. It is because the idea of 'development' is so complicated that probably the best way to define it would be to say what Lord Longford of the UK once said of pornography: 'I cannot define it, but, I can recognize it when I see it'.

It is because of these problems of definition and conceptualization that 'development' is put in quotes in the title of the lecture. Whatever you end up with, on the road to development, at least one half of the world will still think that you actually moved backwards. The complexity of the concept of development annoyingly contrasts with, for example, the simplicity and the honest ring of, say, a banana. A banana is a great fruit, tasty and filling, with a consistent taste. It has a naturally hygienic packaging which is easy to remove and ready to eat. It is also soft and can grow practically anywhere in the tropical world, if there is water. The banana stalk is green and environmentally friendly. What is more, you can tell when it is ripe and when it is not.

Why can't development be like a banana? It cannot, because life is just not made to be that easy. I once attempted to deal with the idea and the issues of development, in a lecture I gave in December 1998 at the Centre of Investment, Sustainable Development, Management and the Environment (CISME), founded and led by Prince Lekan Fadina, a patriot and an environmental buff. That lecture, or my agony, can be found on my website: www.Jibrilaminu.com

Like everything else worthy of its name, 'development', in whatever shape, form or colour, has its price. Even when it is just a mirage, it has its price. An efficient, imaginative and accomplished 'development plan' will yield dividends in the form of whatever was wanted. But the more clumsy, the more inappropriate and the more reckless the approach to it, the more expensive. In fact, every plan has its own set of penalties, until it sometimes begins to look like one was better off before developing. In any country's attempt at development, the price is paid by every citizen in different currencies. Since we are concerned here with health, including the form and the strength of the health of the people, the health system and the health workers, I thought it would be worthwhile to reflect on some of these things as they manifest in the doctor, in the institutions for medical education and nationally in Nigeria, as well as worldwide.

Development, whether considered as economic growth or economic development, whether a blessing or a curse, has certain characteristics. Inescapably, it is an investment in change, since you cannot be better or worse than you were without being different. Since, however, things change even without active intervention, *development can be considered an investment to actively bring about a desired change*. This can be expanded to include development in terms of the pervasiveness of modern economic behaviour and the ability of people to absorb modern technology. A working definition of development can be regarded as a combination or amalgam of economic growth and

modernization. This will enable us to have an idea of the price tag, and also to measure the results of the investment.

What have we achieved or what were the results of all the planning and resource allocation in pursuit of economic growth and modernization in the country, since 1960, and since 1970? How has all that affected the doctor, the health care system, medical education and the general health of the country? What has been the trend in the rest of the world?

While it is difficult, and almost impossible to answer these questions satisfactorily, or on a one-to-one basis, ie, cause-and-effect, it is possible by selective examination of the condition or status of each of some individuals, institutions and communities to have an input into the result of the 'development' efforts, of the active pursuit of some desired change through national planning, resource allocation and total economic activities. Let us start with the doctor who personified the investment for better health as an essential correlate of 'development pursuit'.

The Doctor and 'Development'

There is no academic or professional discipline that is more impacted by development or scientific advancement than medicine. This is understandable because the human being first and foremost applies new knowledge to enhance or guarantee his survival. People are always working at their best when trying to conquer disease, delay death and prevent infirmity. Besides, in the war on disease, there is always a serious disease waiting to be challenged or assailed and immediate problems solved.

Let us start with the doctor's most visible symbol – the stethoscope. The stethoscope was said to have been invented by a Dr. Laennac. Before its invention, doctors used to put their ears directly against the relevant part of the body of the patient in order to diagnostically listen for some characteristic sounds. This method of listening and body contact has led some people to postulate that the stethoscope was actually invented by a jealous

husband, who just had to watch helplessly while a young doctor listened to his wife's (the patient's) heartbeat.

Some of the developments in response to change are dramatic. I recall for instance, the case of an old professor who, during a ward round, heard the word osmolality used and sought to correct the young doctors that the word was osmolarity. On being told that *osmolality* and *osmolarity* were different, he promptly submitted his retirement notice and left. Such is the rate at which change sometimes occurs.

Seeing that I was away from medicine for some time, one of my former students in Maiduguri, long qualified as a doctor now, decided to test the simultaneous effect on me of (a) advances in medicine during (b) my 'desertion'. He sent me a summary of five different case reports and also enclosed the correct diagnosis of each in a sealed envelope. I got four of the five cases right, the last being a case of 'Guillain-Barré' syndrome with a rather unusual history. If he had chosen any of the new diseases, I would have been had. In his next unsolicited communication, he enclosed a ₦50 note 'to help in your campaigning'. He must have decided to consign me to politics for good.

Among the many great advancements made in clinical practice, a few stand out as providing great relief to the doctor. The first is the EKG auto-analyzer. It seems to me that students now dc not have to learn how to use the EKG auto-analyzer, since an investment in the computer will give them, as practicing doctors, the results right away. This also seems to be the situation in cardiovascular haemodynamics using the 3-D echo, with its elegant pictures, including what I call the Mercedes Benz sign for the healthy aortic valve.

Then of course, the CAT Scan and the MRS have made anatomy as taught by the Alastair Smith School, to stand out blowing trumpets as you study section after section of the gross anatomy of any part of the body you want. I can tell you that it is not funny to see a detailed picture of the cross-section of your cerebellum or mid-brain.

In the battle against genetically transmitted disorders, it will soon be routine to have a report on a detailed whole body genetic profile, the genome, before getting married. Professor Ralph Hendrickse used to advise us that, to avoid the genetic transmission of sickle-cell disease, we should say to any young lady in whom we had an interest: 'Excuse me, please, can we have a dance? But, first of all, what is your Hb genotype?' Now, you can say: 'First of all, how is your genome?'

Advances in all areas of medicine are simply staggering. For example, if your patient is the vice president of a very rich nation, he can have as many small vessel coronary attacks as he likes. You, his doctors, can put a defibrilator 'in situ' in as many places as needed. If your patient cannot get a heart transplant because he is a foreigner in the country where this is done, you may soon be able to order an artificial left ventricle for him – indeed, the term 'hard hearted' takes on a whole new dimension.

If your health care system invests in some of these advancements, it would be development at a fair price. With an opportunity to invest in these sorts of dramatic medical advancements, what is the price of a 'Development Plan' that wastes or embezzles funds, denying the people these opportunities for what is beginning to amount to the quest for eternal youth and symptomless immortality. These medical advances are not always so rosy, as they have not been well thought out, and the price may be too high.

In the more advanced countries, the doctors do enjoy these developments but sometimes at a cost to their ideas and their professional status. They now have to share certain professional decisions with others, who may or may not be doctors. An insurance plan under the Health Management Organisations (HMO) system emphasizes certain 'economic' measures, which the doctors are finding very hard to live with. Imagine a 64-year consultant or (attending physician) having to discharge a patient well before the date he or she would have considered clinically correct for discharge in order to cut costs to the HMO. The young

HMO executive, who might have been taught by the consultant, determines the admission period, to save money.

A consultant friend in one of the teaching hospitals in the United States told me that the first time he had to treat an HIV/AIDS patient, he felt like running away. The fear of approaching the HIV/AIDS patient reminded him of the days of smallpox. The Clinton dictum, modified for this case would say: 'Let us run away from AIDS and not from AIDS sufferers'. This is a hard sell even for the doctors. HIV/AIDS is a disease of development and we know its price. There are others.

This calls to mind the outburst of Mr. Ted Turner (CNN) at a ceremony at the UN Headquarters in New York launching the Final Phase of the World Poliomyelitis Eradication Campaign. Everyone was there: The secretary general and all of his relevant colleagues, as well as ministers and ambassadors representing the world. Mr. Turner spoke: 'I gotta say something. Here we are trying to eradicate one disease, poliomyelitis, while, right now, there is some nut in some dingy laboratory out there busy creating disease!'

I have never heard a more succinct condemnation of biological weapons. Mr. Turner was the man to speak, having donated one billion dollars to the UN to pursue its humanitarian programmes in the world.

Let us look at the case of poliomyelitis prevention. Is there anything I am missing about the virus in Nigeria? I never thought that I would live to hear of the tale of an antigen contaminated accidentally or deliberately and given in order to hurt the recipients, in this case, children. What is so difficult in resolving this case, if there is an *a priori* reason to believe that charge is anything but frivolous? Who is stretching our credibility so thin? I had the honour of attending that UN meeting to launch the last phase of the War on Polio. It has been eradicated in most countries, except a few, including Nigeria. We should ensure that these unnecessary wranglings, which merely reflect our sad

mistrust of each other, do not leave Nigeria as the last country to eradicate polio in the world.

Medical Education

Education is one of those areas that change enormously over time, but it is also one of those spheres which manifest the paradox: 'the more it changes, the more it remains the same'.

In the Federal Ministry of Education, where I schooled for four and a half years, I once had the privilege of attending an American seminar, organized by Americans, consisting almost entirely of Americans, but held in the University of Oxford, England in the summer. That was when I developed a healthy respect for the idea of what I call intellectual osmosis: Come to a place and then, by just being there you absorb its spirit and grandeur and learning and everything, effortlessly. The Americans appeared to be very adept at that sort of thing. I recall that the very populous American Bar Association also held one of its annual general meetings 20 odd years ago in London, England. The only other occasions when I experience intellectual osmosis, is when I enter my now quite sizeable library in Song and sit down among the books, most of which I never read, and yet come out feeling great, and intellectually recharged.

The seminar at Oxford, was made up of some American state governors, and top-level officials of the US Department of Education and many of the state departments of education. A few of us were sprinkled in, including the President of Israel, Mossad, guard dogs and all. Plenty of time was spent on an American classic bestseller by that folksy philosopher, Robert Fulgrum: *I Learnt All I Ever Needed To Know in Kindergarten*. We were not able to disprove Fulgrum's 'rude awakening,' as it were.

Another thing I learnt there was about the capricious nature of education. Imagine my consternation when a senior official from the California State Department of Education, delivered a paper on how difficult it was for them to keep children in school.

Why? Because, school could just not compete successfully with the world outside in capturing and retaining the interest of their pupils. Apparently, the school system could not compete successfully with television, CDs and DVDs, games and sports, rock concerts, Disney world, Baywatch, and general outdoor activities. That outrageous revelation elicited an outburst from me: 'Do you really mean that after I would have done everything to win the impossible war of the crunch on the input of resources for finding teachers, space, facilities, legislation and everything, just to give our children basic education, I will only be rewarded with the new war of having to struggle to get the children to go to school at all?'

Medical education is no different from other forms of education in this country, being severely challenged by the universal law of demand and supply. The demand for medical education is rising, even as the supply has remained static (or even dwindling). Demand here not only refers to the number of students seeking admission for medical education, but the need for our colleges of medicine to keep up with the rapid advances in medical knowledge and surgical techniques so that our graduates are relevant and knowledgeable in their chosen areas of specialization. Under such circumstances, Aminu's application of Boyle's law of physics to higher education holds well. That is to say: whereas Boyle's law in high school physics says that, *where the temperature is constant, the pressure of a gas is inversely proportional to the volume,* the application of this law to education is such that where V represents demand, and T represents the input of resources, P, the academic standard, varies inversely with the demand. Where the resource input is falling, the fall in academic standards is logarithmic (meaning very steep), because of the meaning of the formula:

$$P = \frac{RT}{V}$$

where R is constant. In this case, the formula has built into it, among other things, the factors of the behaviour of the student,

teachers and workers unions; V (demand), as the division ruthlessly cuts down standards, if P (input) is constant, let alone where it is falling.

One of the principal factors constraining the input of resources is, of course, emigration of medical teachers and other doctors, to the greener pastures of the Persian Gulf, and elsewhere, to satisfy the acquired tastes that are no longer accessible to a doctor (and the entire middle class) in a botched-up economy. I stop here because one of my new year's resolutions for this lecture is to be a good PDP party man, and not to bash the government, and the unions, ie, constructive neutrality.

A noticeable effect of the expansion of demand without expanding resources is what Professor Adetokunbo Lucas once told us with respect to the bewilderment of a clinical student who was confused by changing 'physical signs' in the patient. A clinical firm used to have seven to eight students round the patient at teaching or review ward round. Each student could feel a large but non-tender lump, or liver or spleen, and leave the patient in peace. Nowadays, by the time 30 or more enquiring hands feel the lump, the physical sign might have altered. The lump would now be tender.

Apart from the problem of lumps and pains, there is also the additional problem that, whereas the teacher knew the name and performance of each of the students, the massive rise in enrollment, without a requisite expansion in staff and facilities means that the student and his/her teacher may meet and part courteously as perfect strangers.

Distorted development – whereby demand (usually stimulated by acute expansion) cannot be satisfied by available or allocated resources – lowers the standard of medical education. We are not talking here about the consequent impairment of the ability to write and deliver an address in the classroom. We are talking about the serious matter of human life being endangered by the substandard training of medical professionals, as well as by poor or unavailable teaching hospital facilities. I have always

maintained that the teaching hospital represents the last hope of the common man with a serious illness, since he cannot be flown out to London, Wiesbaden or Jeddah, or any of such places which may ensure the man's survival.

When I reflect on the poor facilities in our university teaching hospitals, it brings to mind the results of a recent comparative study carried out on the quality of our teaching hospitals, where our great alma mater, UCH, was placed at the bottom of the pile of teaching hospitals. This was complemented by another study comparing universities, in which our premier university was rated rather low.

My first reaction on hearing of this allegation was like that of the inimitable Mohammed Ali. When Ali was told that in a computer match, where he was placed against Rocky Marciano, one of the great White Hopes of the past, he, Ali, was beaten by his adversary, Ali retorted , 'that computer must have been made in Alabama'. I observed that the studies were conducted and published by our rivals in Lagos, for Lagos.

If there is any truth in that study, those who gave up their youth and their lives for this university and this teaching hospital – people like Alexander Brown, George Edington, Latunde Odeku, Kayode Osuntokun, and so many others – must be feeling betrayed, wherever they are now. This is not the time to ask why. It is only time for all of us, and I mean all of us, to rise up and restore Ibadan. This is the place to which each of us owes so much, which is now sadly paying too high a price for being at the receiving end of the nemesis of our great country's acts of commission or omission, in the pursuit of what we call 'development'. But, as I said, I hope that the study is just another tale of envy.

Development and National Health

This country, Nigeria, in spite of everything, has made a tremendous and laudable investment in a bid to restore and to

promote the health of its people. Health was also promoted through other sectoral provisions, such as better nutrition, better shelter, and a richer lifestyle – in terms of clothing, domestic comforts, easier transportation and communication. All of these were put in place, particularly when the world oil market was buoyant and during those brief spells when the country enjoyed a committed and credible leadership, as well as shared vision about the nation and its future. Between 1970 and 1981, the nation experienced a great boom in its foreign exchange earnings and made sacrifices, both domestic and international, that enhanced its foreign policy and diplomacy, its regional and world image, and positions as well as performance in the arts and in games and sports. At the end of this period, however, the fracture in our fortunes became stark and the economy slumped. This was followed by the collapse of the Second Republic, and by what appeared to be a prolonged crisis of national unity, identity and fellow feeling. The collapse of the oil market in 1982 brought to the fore the structural weaknesses that had been gathering momentum, such as declining productivity; excessive dependence on a single commodity, oil; excessive welfarism; extravagant lifestyles and overspending, particularly on the part of government; failure to build societal institutions; and, not surprisingly, corruption and indiscipline. Democracy could not be sustained or even salvaged and the country entered into a prolonged period of painful adjustments and experimentation, scapegoatism, and the spectre of everyone for himself and God for all of us.

These problems, which cannot be blamed on any single factor, individual or group, except as a manifestation of escapist scapegoatism, exposed deep distortions in our economy – in our social set up, in our politics, in our attitudes to each other and to the country – distortions which we had in various ways and several times tried to correct, unfortunately in a half-hearted effort, only to making things worse sometimes.

But the nation held on. Nevertheless, the stark human instinct for survival, of everyone for himself and herself, gave undue advantage to the strong over the weak – those ordinary people who form the vast majority. That is to say, those with fat bank accounts (no matter how it was acquired); the coercive powers of armaments; the advantages of a good education, official positions, ethnic or other connections, had a great head start.

Every leader (and we have had quite a few) and his team make, upon arrival, pious pledges, to an unfortunately already chronically cynical and deeply offended people, particularly the youth. The people have been witness to repeated acts of betrayal, and the likelihood that the new dispensation is also going to disappoint them looms large in their conscience. That makes the job very difficult, even for the most well-disposed leaders. Since we have no alternative, we just have to keep on trying to correct things, knowing that nobody has a monopoly of honesty, patriotism, or a bag of solutions to cure all our ills.

Neither you nor I have the time or the inclination to try to pontificate on corrective measures. This is for another occasion. Suffice it to say, we need to be able to identify the nature of the malaise, of the damage and distortion caused by our rough road to 'development' since the 1960s, particularly since the 1970s, and most particularly, since 1993. I leave all that to the experts and only respectfully invite you to look at the area of general health and well being. The World Health Organisation (WHO) still describes health as *a state of physical, mental and spiritual well being and not just the absence of disease or infirmity.*

There is need for us in Nigeria to analyze the WHO definition which is a summary of the conventional world wisdom on the matter of health. For example, what is well being? Wealth? Medals in games and sports? Or regular religious observance? Or is it the paradox of boundless political, constitutional and personal freedom but tucked in behind barbed wire, caged dwellings and armed security operatives because of physical insecurity of life and property? We can discuss all these as indices of well-being

particularly as several schools of thought on development hold that economic growth or even economic development as these are conventionally and commonly understood in the Western culture lead only to *well-have* and not to *well-being*.

We do not plan adequately for posterity in most of the things we do: in the provision of youth employment after education, in logically planned rural development, in preventing excessive congestion in the cities, in family planning and, most important, in ecology. Finally, it is said that development is not just living on the present; it is actually borrowing from the future. We do not seem to have heard of that. The attitude seems to be: Posterity? Future? What are those?

The population is exploding at a terrific rate, and there is a high proportion of young people. They are the most exposed, the most disadvantaged and the most uncared for, whenever we talk of unemployment, HIV/AIDS and other STDs, or even road traffic accidents and social unrest. They will also be the ones who may grow up to inherit an ecologically barren country, and if some of our intellectually barren politicians have their way, grow up to find that they have no country.

Nigeria shares with the rest of the world, particularly Africa, some problems arising from poverty or economic distortions or both.

Of course, diseases of development or those spread by development – like the recent Severe Acute Respiratory Distress Syndrome (SARS); or zoonoses, like foot and mouth disease; or even the mad cow disease – do strike some nations causing loss of human and animal lives and the destruction of wealth and nature. There is also the issue of weapons of mass destruction (WMD) – nuclear, chemical or biological). Luckily, we have been somewhat spared, at least for the time being. But, there are still three health problems associated with our development efforts, which need to be mentioned, if only briefly. These are (i) poor food and drug control; (ii) HIV/AIDS; and (iii) hypertension and cardiovascular disease.

Lack of control of the quality of food and drugs in the market is one of the high prices we are paying from the persistent distortions in our development. The indiscriminate administration of drugs has also produced various forms of drug resistance, illnesses from drug side effects, death from treating a severe illness with fake drugs. The scenarios are many. If we were making the drugs in this country, rather than importing, it might have been easier to exercise quality control. A combination of greed on the part of traders, betrayal of trust on the part of supervising officials as well as callousness and a shameful lack of patriotism on the part of both has maimed and killed many innocent Nigerians. It is staggering to be told that up to 80 per cent of the drugs in our markets could be fake, imported particularly from the 'lands of the rising sun'.

Lack of proper drug control has another equally serious aspect, narcotics. Nigeria is a major transit camp on the narcotic trail from the Far East to the West – Europe and America. Besides, Nigerians outside appear to have become major barons in the international drug trade. Though it may be difficult to believe this, and although it is officially acknowledged by the US government that Nigerian narcotics handlers do not necessarily pass it through Nigeria, the US authorities have told us that up to three-quarters of the narcotics distributed in the Chicago area of the US are brought in by Nigerians. A number of Nigerians were identified as 'lynch pin' figures in the narcotics trade, such that we had to extradite three top barons among them before Nigeria could be *re-certified* by the US Government in early 2001. Being decertified or a non-recertified status means the country is regarded by the US government as unfriendly, because it is deemed to be one that aids and abets the violation of American interests. Even when diplomatic relations remain, little economic or military co-operation will exist. It can thus be seen how seriously the US takes the role of our country as a transit camp for drugs that could get into the US.

We need not only the control of the quality of drugs, we have reached a point where we can and must ensure that all prescription medicines are available only on prescription written by a validly registered medical doctor. What is being said about drugs, can also be said of food. The difference is that food can be even more dangerous, since it is taken by everyone on a daily basis for sustenance.

Praise must be given where praise is due. The present federal government is definitely very much alive to this issue of narcotics and is doing its best. The agency in charge of this area deserves a pat on the back, and a lot of encouragement: from government, the media, the medical profession, the traders, and all of us. These officials also deserve the best protection government can provide, to enable them to carry on with their laudable work effectively; with minimum risk. The food and drug sector is an area eminently suited to legislative intervention to enhance consumer protection; more laws are needed to enhance public safety.

HIV/AIDS suffers (or enjoys) a lot of sterile debate on its causation. I do not doubt that our so-called affluence and development contributed to the spread of HIV/AIDS. So, HIV/AIDS is a price of development, including the peace-keeping activities we voluntarily undertake, whereby our young service men and women go to other countries and contract it.

On this HIV/AIDS issue, the new civilian administration is doing extremely well within its resources, considering the fact that, before the changeover, little was being done by anybody here except foreign-funded NGOs or multilateral agencies. This effort needs to be intensified and multiplied many times over. This is the one case where all the available funds could be justifiably channelled.

Two little points – it seems that the real meaning of the 5-6 per cent HIV infection rate in Nigeria has not permeated the national consciousness; the population, from recent reported trends, could be up to 180 million people. In addition, the fact

that about 25,000 Africans die every day from HIV/AIDS has not registered with us at the right level of impact. Furthermore, two of the most prevalent killer diseases - malaria and tuberculosis – diseases we once believed were under control, because we had the necessary drugs to cure each attack, are now back with a vengeance because of immuno-suppression by HIV/AIDS. What is more, malaria and tuberculosis are now largely resistant to the drugs we were confidently using before.

Our people should be made to realize that, in some African countries, up to 40 per cent of the people are infected with HIV. These countries, and even ours, could be depopulated in about a quarter of a century, leaving only the old and infirm, people too old to resist the influx of new immigrants from the lands of the rising sun, who will just move in to take over the rich continent. If that happens, we would not be the first civilization or world community destroyed by disease and pestilence. But, we would be the first to be wiped out by a disease we could have easily prevented and even treated with some success.

The overindulged Nigerian, over-confident of his lucky star, needs to have the fear of God more forcefully driven into him, to the effect that AIDS is real, and that AIDS kills and can kill him (or her). It is no respecter of status, connections, baseless optimism or *wayo*.

Hypertension and cardiovascular diseases are both affected by patterns of lifestyle, that is, they are diseases of development. This distinguished audience needs to be told little about that. Besides, anyone can see the evidence of the high prevalence of predisposing factors in nearly all affluent Nigerians – obesity, bull neck, and general overindulgence in food and drink, irregular hours of work and sleep, lack of exercise – the lot. The only area where we score good marks, and that is just a stroke of good fortune, is that Nigerians do not smoke as much as other people – e.g., Europeans, Arabs and the Chinese – and they do not drink as much alcohol as some other African nationals.

Hypertension, one of the potent risk factors for coronary artery disease, is very prevalent here. Some say that up to 25 per cent of Nigerians have it. Checking for blood pressure is an effortless and painless process that takes only a few minutes, and which people can safely and easily be taught to do by themselves or by some family member. Yet, many of us continue to suffer and die from avoidable complications of hypertension, including stroke, heart failure or kidney failure; largely because we choose to record our blood pressure, only after it is too late, and the irreversible has occurred.

Knowing the seriousness with which hypertension has been tackled for the past 50 years now in the United States, especially among our African American brothers and sisters, it is amazing that there is no community programme here in Nigeria for diagnosing, and treating hypertension on a permanent basis. There have been some short-term or cross-sectional studies, but much more needs to be done. Advantage should be taken of the investment in diagnosis, investigation and treatment by the advanced nations, and of the results of pharmaceutical research, which have produced reasonably cheap, and remarkably effective and well-tolerated drugs. The patient needs to know that in hypertension, the level of blood pressure is the killer. If you lower the level sufficiently, and on a sustained basis, the dangers of hypertension *per se* are largely averted. Treatment also removes hypertension as a risk factor of more serious cardiovascular disease. With adequate and regular treatment, up to 80 to 90 per cent of responding hypertensive patients caught early and with no other associated diseases, will lead normal lives and achieve normal life expectancy.

The more serious cardiovascular disease, apart from the complications of hypertension, is coronary artery disease or ischaemic heart disease, of which untreated hypertension, even at mild levels, is a potent risk factor. There are many other risk factors, of course, including and especially *diabetes mellitus*, heredity, obesity, lack of exercise, male gender, ageing, high

serum level of low density cholesterol and high serum level of triglycerides.

In my happy youth here as a student and as a young doctor, I only saw cases of coronary artery disease in Nigerian patients living here who had high serum cholesterol, from diabetes mellitus or the nephrotic syndrome or from other causes; or patients with coronary embolism. Even those were uncommon. We still had hypertension, and some of us smoked.

Today, it is different. All over the country, there are, especially among the ranks of the elite, more and more reports of sudden deaths from myocardial infarction (heart attack) and angina. Coronary artery bypass surgery is almost invariably performed outside the country. Coronary artery disease has arrived. In a public lecture given in October 1996, under the auspices of the Nigerian Academy of Science, I referred to coronary artery disease as 'The New Challenge to the Nigerian Heart'. It is here and has come to stay. It is a great tragedy, especially if one considers that for a very long time, coronary artery disease has been the leading cause of death, killing about 40 per cent or more, in Europe and the Americas. And it has been particularly devastating to our African American brothers and sisters, whom, in our new found opulence we are beginning to resemble more and more, thereby looking less and less like our lean-pursed African brothers and sisters in the poorer African nations. Take a look at the *Who's Who* of our leaders of the 50s and 60s. They look slender compared to us; even those we considered to be obese.

What has happened to us has also happened to some other Third World countries in a similar situation as ours. In Singapore, for example, heart disease was the number four cause of death in 1948. Since 1990, it has been number one. Much is known about coronary artery disease. We are, in a way, fortunate that the harrowing experience of others with this disease has compelled medical researchers to undertake wide, deep and prolonged research over almost every aspect of the disease. The results can

be applied to us because the only thing which determines whether you get coronary artery disease or not is the set of risk factors you have accumulated and for how long. Being a dashing Nigerian is not, as far as we know, a negative risk factor. So, once again, let us call each other's bluff and face the reality that the swift executioner has arrived and has increasingly been going about his lethal business.

As in the case of hypertension, the amazing thing is that we do not seem to be doing anything about coronary artery disease, even in hospital medicine, let alone establishing viable community programmes to control the risk factors. It is time we started.

The risk factors include enforcing road traffic regulations. Abuja, conceived of and developed as a new capital to enhance our unity, is now with its beautiful roads, acquiring the notoriety of being one of the most dangerous motoring cities in the world. If you cannot even observe simple traffic regulations, you have a lot on your table to do in order to even start to control and reverse the ominous trend of coronary artery disease.

I would like to mention one final group of diseases, and that is cancer. Many more cancers can now be treated if caught early, and some, like cancer of the prostate, have relatively simple and reliable methods of early detection. I mention cancer because, with early detection, we might have avoided being here today.[1]

I am arguing with myself and, absurdly, with what we already know as the 'will of Allah'. Nevertheless, religious injunctions do not forbid us to mourn, especially the loss of a jewel like Kayode Osuntokun. In his time, he mourned the dead even though he was pious in his religion and realistic in his life to know that all of us are here today, gone tomorrow, for all flesh is grass, or, as the scriptures of the other great religion repeatedly say 'Every soul shall taste death'.

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[1] Professor Oluwakayode Osuntokun was a victim of prostate cancer.

I well recall Kayode's reaction to the loss of another great and gifted mind, the late Professor Latunde Odeku, in 1974. Professor Odeku fell ill and was admitted into UCH as my patient. Every time I visited him, however, *I found that Kayode,* at that time head of the Medicine department, was already there, as if he was the house physician. When Odeku died, Osuntokun's grief was there for all to see. He arranged for an appropriate and fitting funeral service. He wrote a moving funeral oration, used in the service. He appropriately honoured Latunde Odeku, naming the Medical Library the E. Latunde Odeku Library. He never stopped talking about that great neurosurgeon until the end of his own time.

His reaction was no different when a young man of promise, Mr. Segun Aribatise, a brilliant medical student (A-ones in all subjects in WASC) died in a ghastly road accident. Kayode hated such an unnecessary waste of unfulfilled talent.

So do we. That is why we shall always mourn the loss; fondly remember his friendship and generosity of spirit; and always take solace in his great family, his incredible intellectual and scientific writings, and his contributions that gave cure and comfort to many a miserable patient and lasting knowledge to many a young doctor and student. We cannot do any less, for, arguably, the most brilliant and hard-working medical student and doctor to have passed through this university and hospital, if not in the entire country.

I thank you for your kind attention.