



**SURGERY IN NIGERIA:**  
**The Will and The Way**

*By*  
**E. A. Elebute**

**FACULTY LECTURE  
DELIVERED TO:  
FACULTY OF SURGERY  
NATIONAL POSTGRADUATE  
MEDICAL COLLEGE**

**ON**

**16TH SEPTEMBER, 1988**

# SURGERY IN NIGERIA: The Will and The Way

*By*

Professor E. A. Elebute

MA., MD, FRCS, FWACS, FMCS.

Past President, National Postgraduate Medical College of Nigeria  
Past Chairman, Faculty of Surgery

FACULTY LECTURE  
DELIVERED TO  
FACULTY OF SURGERY  
NATIONAL POSTGRADUATE  
MEDICAL COLLEGE  
ON  
16<sup>TH</sup> SEPTEMBER, 1988

# SURGERY IN NIGERIA:

## The Will and The Way

Ladies and Gentlemen.

I feel greatly honoured by the invitation of the Faculty of Surgery of the National Postgraduate Medical College to me to deliver this first faculty lecture. Such recognition by one's peers, colleagues and friends as this invitation implies must be one of the highest achievements that one can hope for. I am grateful to the officers and fellows of the Faculty for the honour.

It has not been easy to choose a subject for the lecture because the state of surgery and surgeons in Nigeria today is characterized by many tales of unrealized dreams and frustrated efforts. What aspect of surgical practice, training or research can one discuss without sounding unduly dismal? As I am an incurable optimist and would like to believe that, in spite of our current problems, the future of surgery in Nigeria is bright, I have decided to spend the next few minutes examining the factors that made possible the early development of Surgery in Nigeria so that I may catch a glimpse of the conditions needed to ensure its future development in a way that will benefit the people of our great country. In other words, I wish to

identify the nature of the WILL that propelled the beginnings of modern surgery in Nigeria so that we may find the WAY for its future growth.

Let us start the story from the beginning. Although for centuries there had been the usual barber-surgeons and bone-setters, the real growth of modern surgery did not start until European type of medical care had become reasonably well established in Nigeria.

The first European physicians reached the Nigerian coast as surgeons employed on the slave-ships to care for slave traders and to select slaves who were fit to travel. Such doctors were, at first, of dubious competence. By 1789, a medical examining board was inaugurated at the Liverpool Infirmary when, by Act of Parliament, it became necessary for all ships carrying slaves to have on board a licensed surgeon. With the abolition of the slave trade in the 19<sup>th</sup> century, philanthropic expedition to explore the Niger took with them medical aid and qualified surgeons and physicians. These were followed by medical missionaries.

The first Nigerians to qualify as doctors, namely Williams Davies and James Horton, were selected and sponsored by the Church Missionary Society (CMS). They qualified from King's College, London in 1858 but did not work in Nigeria. The first Nigerian doctor to work in Nigeria was Nathaniel King, who was also partly sponsored by the CMS and qualified in 1874. He was followed by Obadiah Johnson, John Randle, Charles Lumpkin, Leigh-Shodipe, Oguntola Sapara, who all qualified before the end of the 19<sup>th</sup> century.

A host of others followed in the early 20<sup>th</sup> century to help build the foundation of modern medical practice in Nigeria. The writings of Adelola Adeloje, a prominent member of this faculty and Nigeria's foremost medical historian have shown that all these men have certain characteristics in common, namely: academic brilliance which enabled them to win various scholarships and sponsorship to study abroad, strong determination to perform as well as their European colleagues, total commitment to their professional duties, devotion to high moral and ethical standards, in the majority of them, vibrant awareness of the socio-political needs of their people. This courage and foresight is best exemplified

by the story that Horton, one of the first two Nigerian doctors, agitated for a medical school and university in West Africa. In 1861, he wrote to the British Government to advocate the establishment of a medical school; but of course, this recommendation was turned down.

Specialization in surgery did not start among Nigerians till Dr R G A Savage obtained by examination the fellowship of the Royal College of Surgeons of Edinburgh in December 1934. Savage was followed by his contemporary, Manuwa, who had elected to obtain the MD of the University of Edinburgh by thesis before obtaining the FRCS in December 1938. The fellowship of the Royal College of Surgeons was exceedingly difficult to obtain and it was only sterling academic qualities and extreme devotion to hard work that made Manuwa obtain this highly coveted diploma. I do not know much about Savage but I had the privilege of knowing Manuwa at close quarters during the latter part of his illustrious life.

Sir Manuwa had an exceedingly brilliant undergraduate career at Edinburgh University from which he graduated with MB ChB in 1926. As a testimony to his brilliance, I can quote the statement of one of his contemporaries who also had a successful career as a

surgeon. I refer to Sir John Bruce. I was attending a meeting with him in Buenos Aires in 1969. He was then the president of the Royal College of Surgeons of Edinburgh. He asked me about Sir Manuwa's health and then went on to say words like "that fellow Manuwa was just too bright. He beat us (meaning those who were his contemporaries at Edinburgh University) at everything: He even got the knighthood before all of us!" Sir Samuel's meticulous nature could be illustrated by a short personal story. It happened when, as secretary of the Association of Surgeons of West Africa, I took to him a copy of the draft of the Association's constitution. As soon as he read the opening paragraph, he asked me what we meant by West Africa. Noting that I was startled by his question, he rose from his desk and walked to a map of Africa hanging on the wall in his office. I followed him; and he proceeded to make suggestions as to which part of the huge continent should be included in the area called West Africa. Thus, it was that he defined West Africa as that part of Africa bound by latitudes 20° N and 20° S and longitudes 20° E and 20° W. He even advised that we must not forget Cape Verde Island!

Sir Samuel Manuwa obtained by examination the membership of the Royal College of Physicians of Edinburgh after he had effectively retired from active surgical practice. Consequently, he was the president of the Association of Physicians of West Africa just as he was the first

president of the Association of Surgeons of West Africa. I remember with some amusement the occasion, when at the opening of the latter Association's annual conference held in Ibadan in 1963, he read a goodwill message addressed from himself as president of the physicians to himself as president of the surgeons! It is difficult to find a branch of medicine that he did not influence. I remember the pathologist, Luzzato, once stating that the first major haematological publication from Nigeria was Sir Samuel Manuwa's MD thesis on Tropical Splenomegaly, and one of his last major important writings was on the subject of mental health services in Nigeria.

After Savage and Manuwa, the fellowship of the Royal College of Surgeons of Edinburgh did not come the way of Nigerians until the 1950s when it was clinched by Awoliyi, Ezike, Ikomi, Bailey, and one or two others whose names might have escaped me.

In 1949, the Fellowship of the Royal College of Surgeons of England was obtained for the first time by a Nigerian, Horatio Oritshejolomi Thomas. Many of us present here today knew Professor Thomas as a man of great courage and tenacity of purpose. Although his academic and professional merits as a surgeon were unquestionably of the highest possible standards, he suffered from the discriminatory practices rampant in pre-independence Ibadan University College.

He was held down as senior lecturer for thirteen years; but he worked away at his surgery, his research, his publications and his teaching, undaunted by the oppressive atmosphere. I am sure he always felt that his patience and perseverance were amply rewarded when he was called upon to lead the first medical school to be founded and headed entirely by Africans. I remember the new sparkle in his eyes and the fresh vigour in his movements when he called at house 21 on University College Hospital campus in Ibadan to invite me and my wife to a cocktail party for the members of UNESCO commission deliberating on the desirability of starting a university and a medical school in Lagos and through it he made tremendous impact on the growth of undergraduate medical education, the development of post-graduate medical education and the training of surgeons in Nigeria.

I remember that I was attending a clinical meeting when I was passed a note that Professor Thomas wished to see me in his office immediately. Imagine my surprise when I got to his office to be told he wished to consult me on the subject of a suitable motto for the University of Lagos Medical School.

I suggested I should be given some time to think it over. Whereupon he handed me a piece of paper on which he had written the words "in Deed and in Truth" and said: "See if your thinking can produce something more apt than that!"

Immediately, it was clear to me that those words summed up Thomas's philosophy of life and I felt that it was appropriate that the philosophy should be enshrined in the motto of an institution that he founded. I signified my support for the motto.

From my search of the records so far, I can find the name of only one Nigerian who obtained the English fellowship in the 1950s and he is Dr Alfred Oniyeyone Wilkey, our chairman of this evening. He too has demonstrated unparalleled devotion to the course of medical practice in general and of surgery in particular. In addition to his numerous professional achievements, he was the first editor and founder of the Nigerian Medical Journal and has been one of the strongest pillars of the Faculty of Surgery of the National Postgraduate Medical College of Nigeria.

The other royal college which produced a surgical fellow for Nigeria was that of Ireland. Again, my search has revealed so far only one name in the 1950s and that was the late Dr Modebe, who was briefly a lecturer in surgery at the University of Lagos Medical School at its inception, but died soon after the school was opened.

Thus, up to the year before Nigeria's independence, there were less than twenty Nigerians who had specialized in surgery. There is no doubt about the impact of that major political event, i.e the independence of Nigeria on the production of medical

manpower in the country. Under the leadership of the then Prime Minister, Abubakar Tafawa Balewa, and his minister for health Dr M A Majekodunmi, major strides were taken during the immediate post independence period to increase the number of doctors in the country and this led to an increase in the number of surgeons. From a figure of about 20 in 1960, the number of Nigerian surgeons rose to 339 in 1981. Of the later number, only 15 had qualified as surgeons by obtaining through examination, the local diploma of fellowship of the Faculty of Surgery of the National Postgraduate Medical College. It is gratifying to note that this number had increased to 50 in 1988.

Let us now turn to the story of how local training in surgery has developed in Nigeria. To my knowledge, the first organization to take active steps towards local certification of medical specialist in the West Africa region was the Association of Surgeons of West Africa. In 1964, the Association started to discuss the mechanisms of making this happen.

These discussions led to the setting up, by the council of the Association, a committee in January 1968 "to look into the formation of the West African College of Surgeons". That committee consisted of two Nigerians and a Ghanaian, the latter being Professor Charles Easmon, the second president of the Association. The two Nigerians were Professor Thomas and myself. The deliberations of the committee

led to the decision to inaugurate the college in 1969 and I was mandated to prepare the first draft of the laws of the college. Thus, it was that the Association, at its ninth annual general meeting held in Accra on Wednesday 8<sup>th</sup> January 1969, passed a resolution to inaugurate from that date the West African College of Surgeons which would organize training programmes and examinations for surgical specialists. The process for achieving this goal dragged, possibly on account of the complexity of an organization based on several sovereign states, and the College did not commence its examination till nearly ten years later. In the meantime the Nigeria Medical Council set up a number of examining boards to design postgraduate training programmes and conduct examinations leading to the award of fellowship diplomas in various specialties: and the first of these examinations were conducted in 1972. While the efforts of the Nigeria Medical Council were commended by the entire medical profession in Nigeria, it was argued by some members of the profession that the Council, which is the statutory body that assesses and registers medical examinations and qualifications, should not also be a training and examining body. It was on the basis of this argument that I tabled a resolution at the annual general meeting of the Nigeria Medical Association in 1971 praying the Nigeria Medical Council to set up a separate body which would conduct postgraduate training and examination in

Nigeria. The resolution was unanimously carried and council accepted the prayer. This led to the conversion of the Council's examining boards to Faculties within the National Postgraduate Medical College which was established by law in 1979.

At the beginning, the board in surgery was under the direction of two very courageous and very dedicated men, namely Professor H O Thomas as chairman and Professor Latunde Odeku as secretary. Odeku had what he prayed for in one of his poems, "A courage made of steel". For how else could he have created the most modern neurosurgical unit in Black Africa as if out of nothing and in spite of the cynical sniggers of expatriate colleagues at Ibadan. As secretary of the examining board in surgery, he played a major role in fashioning the unique postgraduate programme which Nigeria and other countries of West Africa have adopted and which antedated the changes in similar directions which are now taking place in British undergraduate medical training. I got deeply involved in the affairs of the examining body by accident. I was visiting University College Hospital as an external examiner when I heard that Latunde Odeku had been very ill and recently discharged from hospital. I called on him at home to enquire about his health.

The visit lasted about fifteen minutes as it occurred to me that he still required much rest. When I announced my desire to leave, he went into his study and

came out with a bulky file which he handed to me. He said there was an urgent need for a meeting of the board in surgery and as he was not well enough to summon it, I should do so. This I did after clearance with the chairman, Professor Thomas, who was then the Vice-Chancellor of Ibadan University. It was not long after this that Latunde went back to the hospital for the last time and I was prevailed upon by the members of the board to take on the secretaryship of the Board.

One of the most memorable meetings of the board during that period was the one we held in Sapele at Professor Thomas's home. His hospitality and kindness to us members of the board during the weekend will not easily be forgotten.

As the general field of surgical training developed, the practice of surgical sub-specialties started to appear. The first Nigerian to direct his energies to sub-specialty was Thomas. In 1953, he went to East Grinstead to spend six months working under Sir Archibald McIndoe at the Queen Victoria Hospital in Grinstead. On his return to Nigeria, he wrote: "Although at the present stage of the country's development, we cannot of course hope to rival East Grinstead, there is no reason why we should not do our best to emulate that famous institution". From that time on till he became Vice-Chancellor in 1972, he did his best to

develop plastic surgery both at Ibadan and at Lagos.

Orthopaedic surgery developed in Nigeria under the indefatigable direction of Dr Tom Lambert Lawson who ran the new orthopaedic centre from 1945 to 1950. Although, most of this discussion is devoted to the activities of Nigerians, Lawson deserves special mention though he was British. My personal knowledge of the sacrifice Lawson made to build that centre is derived from the fact that, as a young laboratory technologist, I had the task of cutting the section of a biopsy taken from one of Lawson's fingers. I remember that when I presented the pathologist with the slides, he displayed great shock mixed with sadness. I thought he was reacting to the poor quality of my slides and started to apologize to him. He told me to forget my apologies because the slides were clear enough to show him that the great surgeon had developed cancer of the skin on his finger which he explained to me was probably due to exposure to X-rays! Lawson gave Igbobi not only his skill but his very life. What he started was carried on by Adewole, Bailey, Ogunyemi, Jaja and many others who have worked at Igbobi, Enugu, Kano and various teaching hospitals of Nigeria.

Thoracic surgery was started at Lagos General Hospital by the chairman of this August occasion, Dr Wilkey and of course further developed by ourselves at Lagos University Teaching Hospital and

Fabian Udekwu at University College Hospital, Ibadan. Otorhinolaryngology has developed largely through the efforts of Martinson at Ibadan and Ebosie in Lagos. Paediatric surgery was started by Festus Nwako first at Ibadan and then at Enugu, and Paul Omo – Dare in Lagos. First class unit of surgical gastroenterology has been established largely through the efforts of Adesola in Lagos and more recently Mabogunje in Zaria. Thyroid surgery which was first seriously tackled by Thomas has been further developed by Olurin in Ibadan and Gyoh in Kaduna.

Surgical research first started its major contribution in Nigeria from the hands of Thomas. Many of us have regretted that although he was the first Nigerian to recognise lymphoma (which he called lymphosarcoma at that time) of children as an entity, his open minded approach to academic pursuit made him contribute his finding to Burkitt who then assembled all available facts to describe the tumour which is now known by his name. Maybe the tumour should be renamed the Thomas-Burkitt lymphoma.

Much of the surgical research done in Nigeria so far has been of an epidemiological nature, describing the incidence and presentation of various surgical diseases found in the country. In addition, there has been significant contribution to the knowledge of factors that make surgery safe for the patient in the peculiar environment of Nigeria and

some work has been done on the use of locally available materials for the treatment, such as the use of honey to treat leg ulcers reported recently by Efem in Calabar.

This anecdotal account of the development of modern surgery in Nigeria has been given to show clearly that such development as has taken place was only possible because of the strong will of the first Nigerians to specialize in this difficult and risky field. Unfortunately, after the bold and courageous start, the standards of surgical practice are currently threatened by the problems and difficulties that beset the health sector in general. Every one of us has tales to tell of instances when appropriate treatment of a patient has been denied, often with disastrous results, through lack of facilities, equipment or drugs. This is often attributed to under-funding of health care in Nigeria.

There is a limit to the kind of surgery that can be performed under a tree! The institution-bound nature of modern surgery makes the specialty suffer severely wherever and whenever there is inadequate funding of health care. For this reason, I call on surgeons in Nigeria to play an active role in solving the problems of inadequate supply of money to health care. I believe that this can be done by adopting an entrepreneurial approach to health care. I use the word entrepreneurial in the wide sense implied by the

gentleman who coined the word "entrepreneur" nearly two hundred years ago. Peter Drucker informs us that the French economist, J B Say, coined the word in 1800 stating that the "entrepreneur shifts economic resources out of an area of lower into an area of high productivity and greater yield". Entrepreneurship is not confined to business ventures only. It can be displayed in non-business service fields within either private or government institutions. As surgeons, we must subject ourselves to training in the basic concepts, theories and skills of entrepreneurship and then direct the outcome of such training in search of areas where innovations will direct more money into the health care sector or allow us to circumvent some of the problems created by inadequate funding of the sector.

But inadequate supply of money is not the only cause of our problems. There are problems due to the lowering of the average academic or moral standard of individual doctors through the dilution that has taken place by rapid production of more doctors. There are also problems produced by the lack of honest and effective management in many of our health care institutions. Often, when we consider the frustrations that we experience in trying to practice properly our chosen profession, we are seized with the desire to quit the profession for more profitable ventures, within our nation or to "check out" of our country for nations with conditions that are more conducive to

proper professional practice. Let us continue to be driven by the spirit that inspired Horton, Manuwa and Thomas in their time, that drove Majekodunmi after Nigeria's attainment of independence to work for immediate increase in the number of Nigerian doctors and improve the nation's unfavourable doctor-population ratio, and that is still encouraging most of us to keep on innovating and experimenting to find ways of removing the many impediments currently on our path.

Finally you may ask if you are able to maintain the will to forge ahead, what path should we follow? In the developed countries of the world, a wide variety of new technology has been applied to surgery during the last twenty-five years. Many of these new technological advances have not yet reached our country because they are often expensive and need advanced infrastructural facilities which are at present beyond the reach of our nation. However, it is necessary to examine new areas of technology from time to time and, on the basis of carefully considered cost-benefit analysis, decide which ones can be safely introduced into our country to the benefit of our patient.

Let us now consider a few example of such new technology. Open heart surgery has been growing in the developed world since the late fifties and it is now routine in many countries. Udekwu and his team in Enugu have worked hard to

establish an open heart surgery centre in Enugu. Now that the federal ministry of health has given definite recognition to their efforts and decided to fund the centre, we hope we shall soon see more of open heart surgery at the University of Nigeria Teaching Hospital.

Transplantation surgery has not yet appeared in Nigeria. This is because the care of patient undergoing this kind of surgery is extremely complex, time consuming and expensive. However, there has been a major break - through in the last decade through the introduction of the drug cyclosporine which has improved the reliability of immunosuppression needed to prevent rejection by the patient's body of organs donated by other individuals. I believe the next decade will see further improvement in the agents used for immunosuppression so that the care of patients who have had transplant of organs such as the kidney or the heart will become easier and cheaper. It is at that stage that transplant surgery should be introduced into Nigeria, provided the other infrastructural facilities are available.

There are new technologies used in the treatment of surgical conditions which need to be introduced or applied more widely in Nigeria. Four main examples of this are cryosurgery, laser surgery, microsurgery and the use of shock waves in surgery. Cryosurgery (surgery by freezing tissues) has been used in some of our teaching hospitals. There should be a

careful evaluation of the result of the use of this relatively inexpensive technology, so that the techniques for its use and the areas to which it can be applied can become more widely known among surgeons in the country.

The use of laser beam in surgery is more expensive and requires special equipment. Microsurgery is feasible in our country and is already being used by eye surgeons and some plastic surgeons. These techniques should be encouraged and your Faculty may wish to set up workshops for training more surgeons in the use of operating microscopes. Shock waves are being used mainly to disintegrate stones in the kidneys or gall bladder. More patients with these conditions are now appearing in our clinical practice and the use of shock waves may be introduced in future.

New technologies abound in the areas of diagnosis. Computerized axial tomographic scan (CAT scan) and nuclear magnetic resonance are very useful, particularly in the diagnosis of cancer in various parts of the body, but requires very expensive equipment, requiring expensively maintained environmental conditions to make them work reliably. Redefined forms of angiography are now being used not only for diagnosis but also for treatment in the form of interventional radiology. I came across an example of this in an elderly patient who was bleeding from a lesion in the colon. Angiography done in the U K pinpointed accurately the

site of the angioplastic lesion that was bleeding and facilitated surgical removal of the appropriate part of the colon.

Endoscopy, particularly in the upper gastro-intestinal tract, is now so well developed that it is essential for successful diagnosis and treatment of many conditions of that part of the body. It is imperative that effort should be made by both government and private health care institutions to provide endoscopic facilities in at least six well maintained centres in the country. Ultrasound scanning has become widely available in the country particularly for obstetric patients. It is of great value in the diagnosis of surgical conditions of the upper part of the abdomen. The equipment is relatively inexpensive and has now reached such an advanced stage of development to make it reasonably reliable and easy to use. I must caution, however, that clinicians intending to make use of it should be properly trained so as to avoid making misleading diagnoses.

Apart from the expense of most of these new technologies, the critical infrastructural facility required for their use is constant and reliable electricity supply. Any regime that finally succeeds to make this available in Nigeria will go down in history as having made the greatest single contribution to health care, and I suppose to economic development in general, in our great nation.

There is one important area of basic technology which needs urgent attention if the growth of surgery in Nigeria is to be assured. This is the technique of blood transfusion. We need a well established blood transfusion service to ensure that our patients receive the replacement of lost blood promptly. In addition to the provision of adequate quantities of blood, it is important to ensure that the blood which is to be used for transfusion is free from contamination by such diseases as malaria, hepatitis, syphilis and AIDS. Recently, I had a salutary experience of finding that a patient who I had to transfuse with twenty seven pints of blood remained HIV negative at the end of such massive transfusion. However, we may not be able to ensure that this experience is repeated in other patients without first subjecting the blood to screening for AIDS. It is imperative that all blood transfusion services in the country are backed by facilities for reliable screening for AIDS and all other diseases that may contaminate blood. The alternative to this is to adopt autotransfusion procedures whereby the patient is transfused with his or her own blood, but this has the limitation of being only applicable where the surgical operation for which the blood is required can be planned several weeks before it takes place.

In view of the shortage of funds for health care in our country and the absence of many types of advanced technology, we must direct our attention to activities

which will enable us make the maximum use of available resources for the maximum benefit of our patients. There is a lot of research work that needs to be done to make this possible and I will now suggest areas that appear to me to need urgent attention. Firstly, we must conduct research into basic clinical methods so as to sharpen our skills for diagnosis and for decision making during patient management.

Take the example of deciding if a liver is enlarged or not. A recent study by Hobsley and his group in U K showed clearly how fraught with error is our traditional way of assessing liver size. The study showed how a combination of manoeuvres can make the assessment more accurate. Our work on the grading of sepsis has enabled us to quantitate how severely ill a patient with sepsis is so that we can make timely decision about the introduction of various types of treatment. This type of research often requires relatively simple facilities provided appropriate methodology is selected. For example, for the work on the grading of sepsis we decided that since experienced clinicians can develop the ability to assess the severity of illness by "feeling" we could apply the methods used by psychologist to assess levels of feeling such as happiness or anger; and these methods worked for the assessment of severity of sepsis!

Surgeons in Nigeria must continuously assess through research the

effectiveness of their treatment i.e the extent to which their intervention achieves what it is intended to do. Frequently, this type of research will take the form of randomized controlled trials and it is important that all surgical trainees must be taught the principles of such studies. Sometimes research must be conducted to identify the factors which will determine the extent to which our intervention succeeds. A good example is Gyoh's recently published study of the factors which determine safe and successful surgical removal of giant goitres.

We must work out through research, ways of assessing and thereby improving the quality of care that we give our patients. There are three approaches to the problem of quality of care. The most basic is paying attention to structural aspects such as financial resource, facilities (e.g water and electricity), equipment and staff. I think most of Awojobi's work in Eruwa is in this direction and he has been able to fashion equipment from locally available materials and device treatment manoeuvres suited to the structural background of his working environment. Next is the process that we employ in caring for our patients, such as the investigations we carry out and the timing of our treatment. With regards to the investigation, it is customary in modern medical practice to carry out several investigations to reach one decision. For example, if ultrasound scan of the gall bladder is available, is it necessary to carry

out oral cholecystography as well? Finally, the most direct measures of the quality of care are measures of recovery, of restoration of function and of survival after various treatment manoeuvres.

A commonly quoted aphorism is that the objectives of health care are to reduce the levels of death, disease, disability, discomfort, distress and dissatisfaction. We must carefully collect and analyze statistics that will enable us see if the outcome of our treatment needs to be improved. In 1863, Florence Nightingale suggested in the third edition of her "Hospital Notes" that certain items of data about all hospital in-patients must be systematically recorded, analyzed and published to enable the work undertaken by hospitals to be assessed. I would like to repeat this suggestion to surgeons working in government and private hospitals in Nigeria today so that we can keep a close watch on the quality of care we give to our patients.

Let us now end this lecture by saying a few words about our faculty. Since its inception in 1970, our faculty has gone from strength to strength, and it has produced two children, namely: faculties of ophthalmology and otorhinolaryngology. In the light of the current needs of Nigeria and of constraints in available resources, I fully endorse the decision of the faculty to concentrate its training effort on general surgery for the meantime. However it is important not to lose sight of the

significance of some specialties. The faculty should work out as a matter of urgency the proportions of surgeons working in Nigeria that should concentrate their effort on such sub-specialties as orthopaedics, neurosurgery, thoracic surgery, paediatric surgery and urology. When such important data have been worked out, it will be possible to delineate more precisely the nation's training need in these areas.

Our faculty epitomizes clearly the concept of development of multi-specialist post-graduate training within one organization as we conduct training in several specialties within the Faculty whilst the Faculty itself is a unit within our multi-faculty post-graduate medical college. This organizational format which our college adopted is unique. In other countries, each of the Faculties will be struggling to form a separate college. We must all cherish and keep our own structure which is not only cost-effective but will enable the various specialties to continue to influence each other for the good of the overall health care in Nigeria. The central organization of the college must give every Faculty enough elbow room to perform and develop whilst each Faculty must continue to cooperate maximally with the central organization and make necessary sacrifices to preserve the oneness of the college.

Chairman, distinguished guests, fellows of the Faculty of Surgery of the National Postgraduate Medical College of Nigeria, I know that some of you will say in

the words of the English poet Shelley, that what I have done in this lecture is just to

“...look before and after

and pine for what is not...”

If I have succeeded in inspiring the surgeons here today to face the future of surgery in Nigeria with renewed vigour and undaunted courage, I will feel justified that I have taken so much of your time to trace the story of the WILL which helped to establish modern surgery in Nigeria; and day-dream, as I have done, about the WAY that lies ahead.

I thank you all for your attention.