

Improving undergraduate medical education in Nigeria: Insight into the past

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ABSTRACT

The first three in the series of Society of Gynaecology and Obstetrics of Nigeria (SOGON) lectures on “Frontiers in Medical Education,” in honor of Professor Linus Ajobor, had focused on internship and postgraduate medical education. This fourth lecture is about the evolution of undergraduate medical education in Nigeria from its rudimentary beginning in 1930 to the present. Lessons from the past include the desirability of tailoring medical education toward meeting national needs, doing proper needs assessment before planning and implementation, setting minimum standards for training institutions, and enforcing these standards through a credible process of accreditation. Recommendations for the future include a harmonization of the guidelines on minimum standards published by the Medical and Dental Council of Nigeria (MDCN) and the minimum academic standards published by Nigeria’s National Universities Commission (NUC), and the conduct of joint accreditation by both agencies to maximize efficiency and reduce waste. There should also be mandatory training in pedagogy for clinician teachers, periodic curriculum reviews must be enforced, and simulation laboratories should be provided in all accredited medical schools.

Key words: Curriculum; medical education; Nigeria; pedagogy; undergraduate.

Introduction

I consider it a great honor and tremendous privilege to have been invited to deliver this lecture, the fourth in the series on medical education in honor of a great obstetrician, gynecologist, and medical educator, Professor Linus Ajobor. I am grateful to Professor Mutairu Ezimokhai who first approached me in Sokoto in November 2017, as a representative of Professor Ajobor’s mentees, and requested that I deliver this lecture. He followed up with e-mail messages and telephone calls. I could not but accept to give this oration because of who was making the request and who the lecture was meant to honor. I am glad I did and I think it is appropriate to start by dwelling a bit on the honoree.

The Man Linus Nwachukwu Ajobor

Although my association (if one could call a teacher-student relationship that) with Professor Ajobor dates back to more

than 30 years, I did not know much about his professional accomplishments because he was from an earlier era than I and I never worked in the same institution with him. He had left Ibadan for Benin-City in 1972, two years before I matriculated at Ibadan. The only time I could say I worked with him was on the Executive Committee of the Society of Gynaecology and Obstetrics of Nigeria (SOGON) where he was President from 1999 to 2002 and I was the Editor of the Journal, Tropical Journal of Obstetrics and Gynaecology (TJOG) for all three years of his tenure. In seeking information about him, I sought to obtain his biography from other sources without

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his knowledge. In the end, I was compelled to approach him for the information I needed. I got an abridged curriculum vitae that was 11 pages long and I call it “abridged” because many details were not included therein, including his long list of scholarly publications. Reading through it, one cannot but come to the conclusion that Professor Linus Nwachukwu Ajabor has lived a life full of achievements and demonstration of leadership.

Professor Ajabor [Figure 1] was born on 23rd September 1931, making him 87 years old. That is difficult to believe when you see how young he looks and how quick he is on his feet. God has really blessed him with good health for someone who has been around for so long. He has practiced medicine for nearly sixty years, having graduated from the University of Bristol in 1960. He was certified as an obstetrician and gynecologist nearly 53 years ago, having passed the membership examination of the Royal College of Obstetricians and Gynaecologists (MRCOG) in January 1966 at the first attempt. He was a Senior Lecturer at the University of Ibadan before transferring his services to the new medical school at the University of Benin in 1972. He was promoted Professor in 1976. After he retired from the University of Benin, he continued to practice and to teach undergraduates and postgraduates. Up until 3 years ago, he was still very active in teaching medical students at Igbinedion University in Benin at the age of 85! And quoting from Professor Okonofua—“A young medical student at the Igbinedion University remarked in 2015 that *‘if Professor Ajabor teaches you obstetrics and gynecology and you still do not know the subject, then it means that you will never know obstetrics and gynecology.’* He seems to have the ability to open the brains of students and to put the subject in them.”^[1]

I first met Professor Ajabor when I was doing my residency training at the University College Hospital (UCH), Ibadan. It was during a revision course, we attended at the University of Benin Teaching Hospital (UBTH). I was struck by the emphatic manner he taught, both in the lecture room and at the bedside. He was very clear about whatever he wanted to say and he said it forthrightly. When I learnt that he had worked at UCH before moving to UBTH, my interest was further stimulated and I wanted to know more about him. During his teaching session with us, he talked about a procedure he had described in a publication not long before as being useful in Nigerian patients, called retrograde hysterectomy.^[2] I went to seek the article from the library and read it. Coincidentally, he happened to be my examiner at the orals of the Part I FWACS examinations a few months later. After I had answered several questions successfully, he asked a question describing a scenario where retrograde

hysterectomy was the right approach. In answering correctly, I went on to describe exactly how to do it the way he had described it. I had never seen one done, but I had memorized the procedure so thoroughly from Professor Ajabor’s paper that the examiner paired with him could not help but ask me whether I had done one before. Needless to say, that sealed my performance as the best candidate in that examination.

As Editor of TJOG, I received a lot of support from him in getting the resources to ensure regular publication of the journal [Figure 2]. There was absolutely no doubt that he was a great enthusiast for intellectual pursuits and someone who wanted to commit as much resources as possible to medical education. Through his efforts, one of his former trainees who was then Governor of Rivers State, Dr. Peter Odili, made a large endowment to SOGON for educational activities. Professor Ajabor led the effort to use those resources to establish a library and educational resource center at the SOGON Secretariat that would assist those pursuing specialist training in Obstetrics and Gynecology. Education has always been his passion and the demonstration of that continues in this event.

Frontiers of Medical Education Series

These Frontiers of Medical Education series of lectures were endowed by the “mentees” of Professor Linus Ajabor in appreciation of his mentorship at critical periods in their careers. As an aside, many word purists have issues with the word “mentee” because the verb is “mentor,” not “ment.” Therefore, mentoree is probably a more appropriate word to use to describe someone being mentored. The word “mentor” itself derives from the eponym “*Méntōr*,” the name of a guide or adviser in “*Odyssey*,” the second of Homer’s two epic poems in Greek mythology. I personally prefer the word protégé, but it implies a very prolonged period of mentoring as well as sponsorship, not exactly the kind of relationship we are discussing. I will stick with the words the distinguished former students and trainees of Professor Ajabor have chosen and call them his “mentees.”

The mentees, many of whom are obstetricians and gynecologists, pooled resources together to establish, in perpetuity, a series of lectures in Medical Education in honor of a medical educator *per excellence* who had taught them, motivated them to achieve, and continued to follow their progress as they pursued their careers. Almost all of them have also become mentors to others, establishing a multiplier effect in the influence of Professor Ajabor on generations of medical students and residency trainees in Nigeria and beyond. I am absolutely convinced that when his mentees asked how they should honor him, he chose the theme of

Frontiers in Medical Education; but even if it was not his idea, I am sure it is one that truly resonated with him.

The first lecture was delivered, I will say appropriately, at the 50th Anniversary and 49th Annual General Meeting of the Society of Gynaecology and Obstetrics of Nigeria (SOGON) in November 2015 where Professor Ajobor was also honored with a Golden Jubilee Award by a society he had served in many capacities, culminating in his service as 11th President from 1999 to 2002. The lecturer, Professor Friday Okonofua, is one of the most accomplished researchers in the reproductive health sciences in Africa and his immense contributions to women's health have been recognized severally in many international fora. He had served as Secretary-General of SOGON when Professor Ajobor was President. He is someone I hold in the highest esteem because of his contributions to my career advancement and his interest in my progress. Professor Okonofua delivered a lecture titled "Postgraduate Medical Education in Nigeria: Past, Present and Future." In his recommendations, he called for increased funding for postgraduate medical education, the training of trainers and examiners of residency trainees, and periodical curriculum review, including the creation of a mechanism whereby candidates could pursue the postgraduate Fellowship and the university PhD degree simultaneously.^[1] Many of his prescriptions also apply to undergraduate medical education and their manner of application shall be revealed shortly.

The second lecture was delivered by another distinguished obstetrician and gynecologist who has also been instrumental to my progress career-wise, Professor Nimi Briggs. The title he chose was "Internship is an Important Component of Medical Education." The lecture, delivered at the 50th Annual Conference and General Meeting of SOGON in Akure, Ondo State in October 2016, emphasized the fundamental importance of the internship year to a successful medical career.^[3] He described the chain of medical training as commencing from the high school, moving on to preclinical training, clinical training, internship and culminating in postgraduate residency and academic training that prepares the graduates to be excellent professionals, teachers, and researchers. Internship was a vital link in that educational chain and proper operation of the internship system was essential for a health care delivery system that met the needs of the nation.

The third lecture was delivered by the 16th President of SOGON, Professor Joseph Ifeanyi Brian D Adinma, a friend with whom I have related closely for many years, particularly when he served as Treasurer of SOGON from 1999 to 2005 and I was the Editor of the Society's journal. The title was

"Training the Future Trainer—The Double Barrel Postgraduate Medical Training Model, a Pathway to the Development of Sustainable Obstetrics and Gynecological Specialists in the West African Sub-Region" and it was delivered at the 51st Annual Conference of SOGON in Sokoto in November 2017. The lecture revisited the issue of pursuing university master and doctorate degrees *pari passu* with residency training that had been suggested in the first lecture in the series and dealt with it in greater detail.^[4] One benefit that the lecturer thought this would bring to the postgraduate training and professional practice is that it will encourage sub-specialty training.

Therefore, in the first three lectures, we had seen a focus on the latter portion of the medical education chain, from internship through specialist to subspecialty training. I think it is time to go back to the foundation where those who will benefit from internship and postgraduate specialist training begin their education as the Holy Scriptures say, "If the foundations be destroyed, what can the righteous do?" (Psalms 11:3, KJV).^[5] This fourth lecture will focus on undergraduate medical education in Nigeria from its genesis to where it is today to search for clues that can help lay the foundation for a better future of training doctors for Nigeria's health system. It is appropriately titled "*Improving Undergraduate Medical Education in Nigeria: Insight into the Past.*"

Origins of Medical Education from Hippocrates to the Modern Era

Hippocrates of Kos (*circa* 460–370 BC) is often referred to as the "Father of Medicine" in recognition of his lasting contributions to establishing medicine and its practice as a distinct discipline. He is also known as Hippocrates II because his grandfather, Hippocrates I, was also a renowned physician in ancient Greece. Hippocrates of Kos was the founder of the Hippocratic School of Medicine which separated medicine from theurgy (rituals to invoke deities) and philosophy, establishing the medical profession. He is also credited with advancing the systematic study of clinical medicine, arguing that disease was not a punishment inflicted by the gods but rather the product of environmental factors, diet, and lifestyle.^[6]

Galen of Pergamon (*circa* 129–216 AD), more than five centuries later, built on the foundation laid by Hippocrates by influencing the development of the scientific disciplines in medicine such as anatomy, physiology, pathology, pharmacology, and neurology, while also pursuing knowledge in philosophy and logic, because he believed that medicine and philosophy were inseparable.^[6] A lot of what he and adherents of the Galenic school taught were, however,

not based on direct observation but on conjectures and hypotheses.

The first attempts to study the human body through dissections were pioneered in Europe's oldest functioning university in Bologna where Mondino de Luzzi (1275–1326) produced the first known anatomy textbook based on human dissection. The foundation of modern human anatomy is however largely credited to Andreas Vesalius (1514–1564), professor at Padua, who published *De humani corporis fabrica* (On the Fabric of the Human Body), the most influential book on human anatomy for nearly two centuries.^[6]

Although the followers of Hippocrates belonged to a “school,” it is not in the sense that we regard medical schools today because they never sought graduation. Medical schools attended by students for a period of learning followed by graduation and practice did not come about until the establishment of the *Schola Medica Salernitana* at Salerno, near Naples, Italy in the ninth century.^[6] That school, however, became extinct about half-a-millennium later. The oldest continuously functioning medical school in Europe is the school in Montpellier, France which was established in 1122.^[7] In its earliest days, the school blended accumulated medical knowledge of the Graeco-Latin tradition with knowledge from Arab and Jewish practitioners of medicine, making it the foremost academy of medicine of that era.^[8]

In the English-speaking world, the oldest formal medical school in the United Kingdom was established at the University of Edinburgh in 1726.^[9] Medical education prior to this was based on apprenticeships and learning from observation and the medical school in Edinburgh itself evolved from two centuries of practice of barber-surgeons in the city. The next two schools in the United Kingdom were in Glasgow in 1744 and St George's, London in 1751. The University of Pennsylvania School of Medicine in Philadelphia was the first and only medical school in the thirteen American colonies when, in the fall of 1765, students enrolled for “*anatomical lectures*” and a course on “*the theory and practice of physik.*”^[10] The University of Pennsylvania itself was established in 1740.

From these beginnings, the culture of establishing formal medical schools extended to virtually all the countries in the world, replacing the traditional apprenticeship system that had existed in most cultures from antiquity.

Origin of Western Orthodox Medical Education in West Africa

The first effort at western-style medical education in West Africa was at the “French West Africa School of Medicine” (*École*

de médecine de l'Afrique Occidentale Française) which was established by the French colonial authorities in Dakar, Senegal on 1 November 1918. The students were selected from all over the French West Africa and had one year of basic science training followed by four years of medical training. The graduates (in medicine and pharmacy) were to assist the colonial doctors and pharmacists.^[11] By the end of 1953, the school had graduated 582 doctors, 87 pharmacists, and 447 midwives. Students enrolled in the school from 1950 were allowed to join the French medical education system, having three years of study in Dakar and completing their medical training in France, usually in Bordeaux. The school began awarding its own university medical degrees in 1960.

In 1930, the British colonial authorities, presumably borrowing a leaf from the French, established a medical school in Yaba, just outside Lagos, for the training of Assistant Medical Officers for the colonial health service in Nigeria. It had an initial annual intake of 14 students, from Nigeria, Gold Coast, Sierra Leone, and Western Cameroon. The school was integrated into the Yaba Higher College when the latter was established in 1932. As was the case in Dakar, this institution also trained Assistant Pharmacists. Competition for the few spaces available was fierce. Only the most brilliant students from the few secondary schools in the country were able to gain admission. Those who had the means opted to travel to the United Kingdom for medical education. The graduates, who were to obtain a “Licentiate of the Medical School” (LMS), were intended to practice within Nigeria only. They could not pursue specialist training. They could not even become “Medical Officers.” They were expected to “assist” colonial doctors throughout their careers. The trainers made life very difficult for the trainees, the duration of the program was undefined and attrition rate was very high. In the eighteen years that the school was in operation until the transfer of its students to the new University College Ibadan in 1948, it had produced only 62 graduates.^[12] That translates to about four graduates each year!

University College Ibadan and the First University Medical School in West Africa

In the period leading to the second world war, the quest for higher education by the inhabitants of British colonial territories had reached such a level that the Colonial Office in London was looking for solutions to this demand. There was also the mounting requirements for the human resources needed to assist the colonial civil servants from Whitehall. Anticipating that the demand would grow even more after the war, the Elliot Commission (led by Sir Walter Elliot) was established in June 1943 to report on higher education in British West Africa, particularly on the number of university

colleges to be established and where they would be sited. At around the same time, the Asquith Commission (led by Mr. Justice Cyril Asquith) was established in August 1943 to look into the principles that guide the promotion of higher education, learning, and research as well as the development of universities in the British Colonies. The two commissions submitted complementary reports in 1945.

The Asquith Commission recommended the establishment of University Colleges in East Africa, West Africa, and the West Indies, which would award degrees of the University of London. The commission also strongly recommended the establishment of an Inter-University Council that would act as a forum for the exchange of ideas and information between the representatives from the established British universities and the proposed universities in the Caribbean, East Africa, and West Africa. The Elliot Commission sent in a majority report recommending three colleges for West Africa in Nigeria, the Gold Coast, and Sierra Leone, respectively, and a minority report recommending the establishment of only one college at Ibadan. The latter position agreed with the submissions of the Asquith Commission. The majority report was initially adopted by the Colonial Office in Whitehall when the Colonial Secretary was a Tory. However, after the British general elections of 1945 swept the Labor Party into power, the minority report was adopted by the new government.^[13] Ibadan was chosen as the site for the college to be situated in West Africa and a medical school was to be one of the founding faculties. This was also the case for the East African site in Kampala, Uganda and the West Indian site in Mona, Jamaica.

It was not altruism on the part of the British that led to the insistence that the three new University Colleges in Ibadan, Kampala, and Kingston should start with medical schools. The United Kingdom was on the verge of starting the National Health Service in the homeland and needed to find as many doctors as possible to run it. They could ill afford to send doctors to the colonies, even if such doctors were willing or eager to go. Historical circumstances had made the policy of training West Africans as “Assistant Medical Officers,” fit only to serve under the supervision of colonial medical officers, untenable. The only option was to open proper medical schools in the colonies.

With the opening of the Medical School at the University College Ibadan (UCI), graduates of the school, unlike those of the Yaba Medical School, were trained to international standard and obtained degrees of the University of London up till 1967. Graduates could pursue specialist training and rise to the highest levels of the civil service. At the time of

independence in 1960, the school at Ibadan was the only institution in the country training doctors to international standard and the first set of fourteen to be fully trained in Ibadan actually graduated in October 1960. Between 1948 and 1957, the students had preclinical training at Ibadan and were distributed to different hospitals in London to undertake their clinical training.^[14]

Farming out students to hospitals for clinical training after completing preclinical studies was virtually standard practice in England then. Medical students from the colleges of the University of London and from the British flagship universities in Oxford and Cambridge were made to look for hospitals in London to undergo clinical training after completing preclinical studies in those institutions.^[14] The idea of having a single teaching hospital for the training of medical students in a university was more common in Europe and the United States. The curriculum in use up till the University of Ibadan became an autonomous entity was that of the University of London, but the University College Ibadan had a single teaching hospital, the University College Hospital (UCH), Ibadan which opened in 1957, marking the end of the era of farming out of students from Ibadan to London hospitals.^[15]

How UCH Ibadan came to be established is a long story in itself. When the students from Yaba were moved to Ibadan as the foundation medical students at UCI, it was understood that they would spend the next four years in preclinical studies—physics, chemistry, zoology, botany, anatomy, physiology, pathology, and pharmacology. The intention was that they would then move to the Government/Native Authority Hospital at Adeoyo for their clinical studies. The University of London, accordingly, sent a Visitation Panel led by Dr. T.F. Hunt in 1951 to assess the facilities available at Adeoyo for the clinical postings of medical students who had been registered for, and would obtain, the M.B.B.S. degree of the University of London on completion of their training.

The verdict of the Hunt Visitation Panel was unequivocal. Adeoyo Hospital could never be good enough to train students for University of London degrees. A brand new hospital to be built from scratch was recommended. The new hospital was established by an Act of Parliament in 1952. The temporary use of the buildings of the 56th Military Hospital in Eleiyele as the teaching hospital of the new medical school while awaiting the construction of a new hospital was also outrightly rejected. The Inter-University Council that was established on the recommendation of the Asquith Commission subsequently arranged for the students to be distributed to different London hospitals for clinical training.

The turning of the first sod of the new hospital took place on 1st October 1953 and when the new hospital was officially opened to the public on 20th November 1957, it was one of the most modern hospitals in the British Commonwealth [Figure 3]. Built at a cost of 4.5 million pounds, it was comparable to the University College Hospital, London, after which it was modelled. One of my revered teachers at Ibadan who graduated from Bristol University just before Professor Ajabor told us a story about her awe when she arrived back in Ibadan to work at the new teaching hospital. The facilities there were much more modern than any she had seen while training in Bristol! Thus was the first University Medical School in Nigeria established to the finest British standard.

The march toward university-based medical education in Nigeria was not without some unexpected detours. Strangely enough, after the establishment of the Ibadan Medical School, a Medical Training School was opened in Kano in 1954 which also trained Assistant Medical Officers with the LMS qualification. It was phased out a few years later and a proper medical school of international standard was established at Ahmadu Bello University, Zaria which produced its first set of graduates in 1971.^[16]

Establishment of other First Generation of Medical Schools in Nigeria

At Nigeria's independence in 1960, the University College Ibadan Medical School was the only one training doctors in the country and its annual intake was less than 30. For a population that was almost 50 million, the pace of training had to be accelerated significantly to meet the health care needs of the people. Those in charge of affairs at the Federal Ministry of Health set the machinery in motion, shortly after independence, to set up a new medical school in the capital territory of Lagos. The College of Medicine in Lagos was established by statute and its pioneer set of 28 students had commenced their training on 3rd October 1962,^[17] approximately three weeks before the establishment of the University of Lagos by an Act of Parliament on October 22, 1962. The two institutions, therefore, had two separate laws establishing them, but the autonomous College of Medicine was linked to the University as the body that would award degrees to its graduates.

Following the report of the Eric Ashby Commission on higher education that had been set up by the Federal Government of Nigeria in 1959, the recommendation that more universities be established in different parts of Nigeria was being implemented, largely propelled by the regional governments. Thus, the University of Nigeria, Nsukka was established in 1960, followed by new Universities in Lagos, Ile-Ife, and Zaria

in 1962. The University of Benin was established eight years later as the Midwest Institute of Technology before it assumed its permanent name in 1972. All of these "first generation" universities in Nigeria quickly made plans to establish new medical schools and began to produce new doctors for the nation [Table 1].

While some effort was made at doing an assessment of needs and how resources would be mobilized to sustain them before these institutions and their medical schools were set up, political considerations played an outside roles in the final decisions as to where the institutions were sited and when their medical schools began to admit students.^[13] By the 1970s, these political considerations often preceded or superseded any appraisal of needs or availability of resources for sustenance. In that decade, sustained pressure was brought to bear on Ibadan as the oldest medical school and the one with the largest teaching hospital to increase its annual intake to 500! Those making the demands removed the issue of teacher-student ratio from their equations and thought that putting up bigger buildings and procuring more equipment was all that was needed.

The leaders of the Federal Government-owned medical schools in Ibadan and Lagos tried to make a case for a more gradual expansion commensurate with the quantum and variety of personnel available to train, but they had to accede to some of the demands of their proprietor. Thus, annual intake at Ibadan Medical School which was just about 30 in 1960 and had remained below 50 up till 1970 was increased to 120 by 1973, 180 by 1974, and 240 by 1975. I had matriculated in 1974 as one the 50 students granted what was then called concessional entry (now called 100-Level) into the University of Ibadan. When we started our main medical course in anatomy, physiology, and biochemistry in 1975, we were joined by nearly 200 others. They were from A-Level programs from all over Nigeria and beyond, as well as those who were granted concessional entry to other science courses at Ibadan but were permitted to cross over into the medical school and the new dental school that was opened

Table 1: Year of Graduation of Pioneer Medical Students in Nigeria's First Generation Universities

Institution	Year Pioneer Set of Doctors Graduated
University of Ibadan	1960*
University of Lagos	1967
Ahmadu Bello University, Zaria	1971
University of Nigeria, Nsukka	1973
University of Benin	1977
Obafemi Awolowo University, Ile-Ife	1978

*Obtained University of London degrees until 1967. Prior to 1960, the students had clinical training in hospitals in London, United Kingdom

in Ibadan that year. There was also a significant number of non-Nigerian students, to allow the Federal Government meets the terms of bilateral and multilateral educational cum scholarship agreements the country had subscribed to. There were more than 18 different nations represented in my class from the British Commonwealth, the frontline states of Southern Africa, and other countries such as Cameroon and Bulgaria.

New buildings were being hurriedly constructed to accommodate the increase in student intake, but the facilities were sorely stressed and the teachers were at their wits' end as to how to cope with this huge influx, particularly as we entered the clinical years of training. We were divided into groups and had to use laboratories in batches, with the latter batches attending learning sessions until late in the evening each day. It was not surprising that nearly a quarter of the intake were unable to cross over from preclinical to clinical studies when we took the "2nd MB" examinations in 1977. These students who failed were simply lumped with the set behind, creating an even bigger strain on the facilities and teachers in the subsequent year. Hostel facilities had also become inadequate and, for the first time in the history of the University of Ibadan, medical students were required to spend a year off-campus.

The medical school at the University of Lagos was going through a similar experience. When the Universities in Benin-City, Ile-Ife, Nsukka, and Zaria were taken over by the Federal Government later in 1975, similar pressure for a rapid increase in intake was brought to bear upon them. Although most of us survived, it is certainly not the best way to tackle the issue of meeting the personnel needs of the nation's health system. Although no studies were done to ascertain the quality of graduates, it is tempting to believe that graduates from that rapid expansion period may not have been as well trained as those of the earlier era.

Evolution of the Curricula of Medical Education in Nigerian Universities

A curriculum can simply be described as "a planned educational experience." The word "Curriculum" is derived from the Latin word "*currere*," meaning "track" or "race course," which in the Roman era was understood as deeds and experiences needed to attain maturity or preparation for success in society. The curriculum specifies what is expected in terms of knowledge, attitude, and skills from someone who has completed a course of study in an institution. It is much more than a list of material to be learnt (syllabus), but rather goes on to describe the values underpinning what is to be learnt, state the purpose of learning, and specify how

students are to be assessed during and after the course. The curriculum can be considered from three perspectives: what is planned for the students, what is delivered to the students, and what the students experienced.^[18]

When the first university-based medical training started in Ibadan in 1948, the University College Ibadan being a college of the University of London simply adopted the curriculum of the parent university, with some emphasis by the trainers on common tropical diseases which they were actively researching even as they were teaching the students and offering clinical services to patients. This state of affairs continued in Ibadan until the University became fully autonomous by an Act of the Nigerian Parliament in 1962. One of the first tasks the newly independent Faculty of Medicine embarked upon was to write a new curriculum for the Ibadan Medical School that was different from what was inherited from London. That task was embarked upon in 1963 and concluded within the same year.

Alexander Brown, the first professor of Medicine at the Ibadan Medical School, had developed a keen interest in community health and how structured training of medical students in the community could enhance their competence in dealing with the health problems of the communities they are to serve after graduation. In 1962, he had obtained a grant from the Rockefeller Foundation to start such a program in Igbo-Ora and that was how the Ibarapa Project was established.^[12] As the new Ibadan curriculum was being put together in 1963, this exposure of medical students to primary care in the rural communities became a major novelty in the curriculum, a clear departure from the previous one from London. The program was so successful that the World Health Organization adopted the experiences from there as the basis for the Alma Ata Declaration on primary health care 15 years later in 1978. The basic structure of the old London curriculum was however retained in the 1963 curriculum, although tropical diseases featured much more prominently than before.

The core group of teachers that started the new medical school in Lagos, notably the first and second provosts, Professor Horatio Oritsejomi Thomas and Professor Felix Dosekun, were teachers at Ibadan at the time they were recruited to establish the College of Medicine in Lagos. The curriculum they developed was based on what they had used at Ibadan. As other medical schools were established in the late 1960s and 1970s, more teachers left Ibadan and Lagos to teach in those schools and the curricula were based primarily on the 1963 Ibadan curriculum. Thus, a pattern of near uniformity of curricula, based on the curriculum used in

Ibadan, percolated through the whole structure of medical education in Nigeria.^[19,20]

The notable exception was at Ile-Ife where Professor T. Ige Grillo, who had served as Assistant Professor at Stanford Medical School USA before joining the faculty at Ibadan, convinced the Senate in Ile-Ife that medical students ought to complete a Bachelor degree in the health sciences before commencing a three-year period of clinical training, thus adding an extra year of training compared to the older medical schools. It is difficult to know how Professor Grillo became such a strong proponent that medical students first obtain a Bachelor degree before proceeding to clinical training but he persisted with it. After Professor Grillo left Ile-Ife to start the new College of Medicine and Allied Health Sciences in Sierra Leone, that curriculum was abandoned at Ile-Ife and the institution reverted to the straight six-year course from 100-level that was being used in other medical schools. Incidentally, Professor Ige Grillo repeated the Ile-Ife model he pioneered when he got to Freetown. It was later abandoned there as well.

Although major changes were made to the curriculum in Ibadan in 1974 and 1985, the basic structure remained the same, the main differences being the addition of new content to the syllabus and some modifications to how the assessment of students was done. There was a brief experiment between 1969 and 1974 when an intercalated Bachelor of Science degree in Medical Sciences program was introduced for exceptional students at the end of preclinical training. All were university scholars. One reason adduced was to engender the interest of these students to become teachers of basic sciences after completing their medical training. Almost all of the beneficiaries ended up in the clinical specialties!

In 2004, a fresh exercise in curriculum review was embarked upon and this time, a decision was taken for a radical departure from what had been done since 1963. This involved going through all the steps on which education experts had reached a consensus as being essential to meaningful curriculum review [Figure 4].

The aim of the whole exercise was to produce doctors who are a best-fit for the needs of the people of Nigeria and beyond in the 21st Century. The basic premise was: if we were to produce the kind of doctors our nation would need tomorrow, we needed to devise the process of doing so today. A sound approach to medical education intensifies focus on the community and its well-being as the *raison d'être* for medical training.

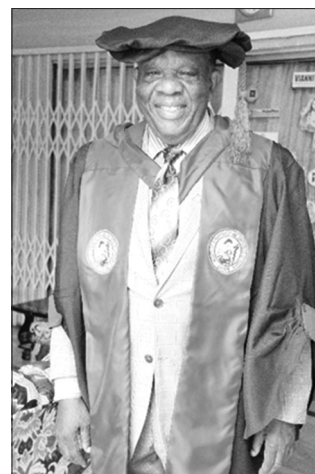


Figure 1: Professor Linus Ajobor

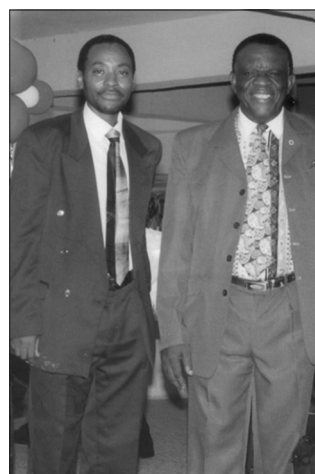


Figure 2: Professor Ajobor with Professor Omigbodun



Figure 3: University College Hospital, Ibadan: West Africa's Premier Teaching Hospital

The curriculum review effort commenced with a comprehensive assessment of the current curriculum by relevant stakeholders to identify its strengths and weaknesses. There was a consensus that the institution needed a home-grown, socially responsive, socially relevant, and socially accountable curriculum. This was followed by the development of a template of what stakeholders expected to be included in the new curriculum that would emerge.

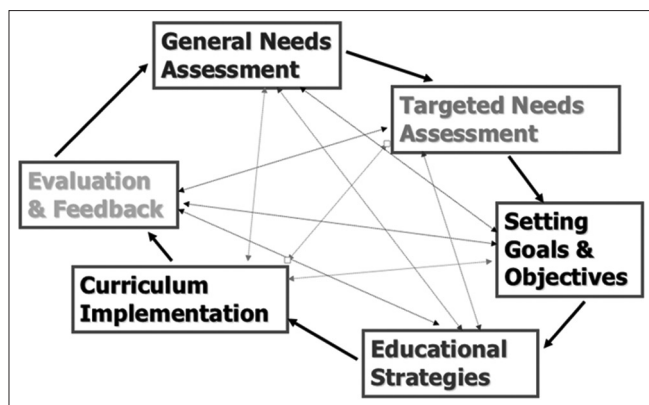


Figure 4: Curriculum Development Cycle

Table 2: Partner Institutions in the West African Network for Biomedical Education

No	Name of Institution	Institutional Representative
1	College of Medicine, University of Ibadan (Lead)	Professor Akinyinka Omigbodun
2	Faculty of Medical Sciences, University of Jos	Professor Innocent Ujah
3	Faculty of Medicine, Ahmadu Bello University, Zaria	Professor A. H. Rafindadi
4	School of Medical Sciences, Kwame Nkrumah University of Sciences and Technology, Kumasi, Ghana	Professor Tsiri Agbenyega
5	College of Medicine and Allied Health Sciences, University of Sierra Leone, Freetown	Professor Sahr Moses Gevao
6	School of Medicine and Allied Health Sciences, University of The Gambia, Banjul, The Gambia	Professor Ousman Nyan
7	School of Medicine, University of Swansea, UK	Professor Stephen Allen
8	Faculty of Medicine, University of Liverpool, UK	Professor John Caldwell
9	The Tropical Health and Education Trust (THET), UK	Professor John MacDermot

Finally, a new integrated, system-based, community-oriented, competency-driven curriculum for the training of doctors in Ibadan was compiled with input from virtually every unit in the College of Medicine and even from other units of the University outside the College.

To derive maximum advantage from its system-based core, a lot of features were included to ensure vertical and horizontal integration of learning across the various disciplines in Medicine and Surgery. Vertical integration referred to those things learnt in different years of training previously being learnt within the same year. For instance, some material that was previously learnt in clinical years was introduced right from the first preclinical year to get the students to appreciate the importance of the basic sciences they were being taught. Horizontal integration referred to material learnt across different disciplines that

were being taught in the same year so that, for example, the students learnt the anatomy and physiology of a particular system contemporaneously. The result of integration was a substantial reduction (approximately 30%) in the overall number of lectures received by the students during their five years in the core medical school, largely because of elimination of duplications. The curriculum has been implemented for the past seven years and a formal evaluation is underway.

Introduction of Minimum Standards in Medical Education

The regulation of the conduct and practice of medical doctors in Nigeria dates back to the colonial era when the Medical Practitioners Disciplinary Board, headed by the Director of Medical Services, was established in the Colonial Department of Health for the medical personnel whose names were on the register of the General Medical Council in the United Kingdom. Largely through the efforts of Sir Samuel Manuwa, the first Nigerian Inspector-General of Medical Services, the Nigerian Medical Council (NMC) was established by an Act of Parliament on 18th December 1963. The Council was first constituted in 1964, with Dr. S.O. Awoliyi as the first President and Dr. M.S. Graham-Douglas as the pioneer Registrar. The name of the NMC was changed to the Medical and Dental Council of Nigeria (MDCN) by Decree 23 of 1988 (now known as The Medical and Dental Practitioners Act, Cap. 221, Laws of the Federation of Nigeria 1990).

The main statutory functions of the MDCN were to stipulate the level of knowledge and skills to be attained for registration as a medical or dental practitioner, to maintain a register of such practitioners, and preparing as well as regularly updating a code of conduct for practitioners. Further legislation in 1992 brought homeopathy and other forms of alternative medicine under the purview of the MDCN. In establishing the level of knowledge and skills to be attained by practitioners, the MDCN decided to adopt the approach of establishing standards for the institutions where such practitioners were trained in Nigeria. Thus was the first *Guidelines on Minimum Standards of Medical and Dental Education in Nigeria* (hereafter called “Guidelines”)²¹ published in 1975. It has undergone two revisions in 1993 and 2006, respectively, and is in the process of being revised again now. I served on the Council and its Disciplinary Tribunal for four years and I was requested to lead the committee to revise the Guidelines for the current exercise. The Guidelines has served as the standard against which institutions were measured during the process of accreditation by MDCN for the past 43 years.

Apart from prescribing the standard of physical facilities (lecture halls, laboratory space and equipment, hostels, *etc.*) and the personnel (preclinical and clinical teachers, laboratory technologists, other healthcare personnel in the teaching hospitals, *etc.*), the Guidelines also sets out topics that must be part of the syllabus used to draw up the curricula of the various universities. While it remained the responsibility of each university senate to approve curricula for their institutions, some topics were required to be included in such documents. Knowledge of such issues was considered to be so important for practitioners who would meet healthcare needs in the nation that the institutions were mandated to include them in curricula before they were accredited to train those who would become practitioners.

As accreditation became established as a function of the MDCN, it was soon recognized that there was a danger of the MDCN becoming a “mere rubber stamping agent” in the process, because all the institutions being accredited then belonged to the Government, the MDCN itself being an agent of Government.^[21] The MDCN recognized the undesirability of the body exercising its powers to deny recognition to a medical college conceived, planned, developed, and financed by the same Government and chose to adopt a proactive approach that would forestall such a situation. The MDCN, therefore, changed its methods from one of inspection, report, and judgment, to one of active involvement in the planning process of these medical and dental schools to ensure that the Guidelines were followed as the medical schools were developed, well before it reached the point of having an accreditation visit. As part of this proactive stance, the MDCN also expressed the view^[21] that other relevant agencies, notably the National Universities Commission (NUC) and the Federal Ministry of Health, ought to work in harmony with the MDCN during the planning stages instead of universities dealing with each agency in isolation or in an expedient order. The first step in this harmonization process should be for the NUC and the MDCN to have uniform guidelines for minimum standards rather than the two separate, sometimes conflicting, documents that currently exist.

Training the Trainers—The Biomedical Education Degree in Ibadan

The 3rd Ajobor Lecturer, Professor Brian Adinma had training of the future trainer at the core of his discourse and dwelt at length about the need for future trainers to have both academic and professional training to prepare them for the role.^[4] What was missing from that “double-barrel” approach was training these future trainers in educational methods to make them more effective in transferring knowledge and skills to their trainees. I wish to suggest a “triple-barrel”

approach instead—professional skills, research skills, and educational skills [Figure 5].

Shortly after I joined the faculty of the College of Medicine, University of Ibadan in February 1988, those of us who had joined the academic staff in the preceding year were invited to a workshop on “academic skills.” One of my senior colleagues and teachers, Professor Oladipo Otolurin, had obtained a grant to hold the workshop in our College. I did not know what to expect but I promptly obtained leave from work to attend the workshop. The experience was eye-opening. We had two main instructors from the United States of America, joined by others from the University’s Institute of Education and a couple of professors from the College of Medicine. For three weeks, we were taken through the rudiments of educational methods, curriculum development, teaching skills, student assessment, basic research skills, critical appraisal of scientific publications and many other tasks. So many new concepts were introduced to us in imaginative ways. I had never learnt so much within such a short period prior to that experience. And they gave each participant several books on educational methods for us to study after the completion of the course. I believe that I owe whatever effectiveness I have had as a clinical teacher largely to that exposure.

After becoming the Provost of the College of Medicine in 2006, I wanted to get as many as possible of the new faculty in the College to be exposed to the kind of training I had in academic skills. We were fortunate to develop a collaboration with colleagues in the UK, Professor John MacDermot of Imperial College, London and the Tropical Health and Education Trust, Professor Stephen Allen of the University of Swansea and Professor John Caldwell of the University of Liverpool. Together with colleagues from universities in other Anglophone countries in the sub-region, the West African Network for Biomedical Education was formed [Table 2]. A proposal was submitted to the European Union EDULINK program to support a project for enhancing the teaching skills of teachers in schools of medicine, nursing, and other health professions in West Africa. Fortunately, the application was successful.

With funds from EDULINK, approval was sought from the Senate of the University of Ibadan for the Master of Science in Biomedical Education to commence at the University. The journey to getting the program approved by the Senate of the University was a tortuous one. The course was designed to be delivered via a distance learning platform so that the teachers could continue to render services in their various institutions and countries while enrolled as students in the program.

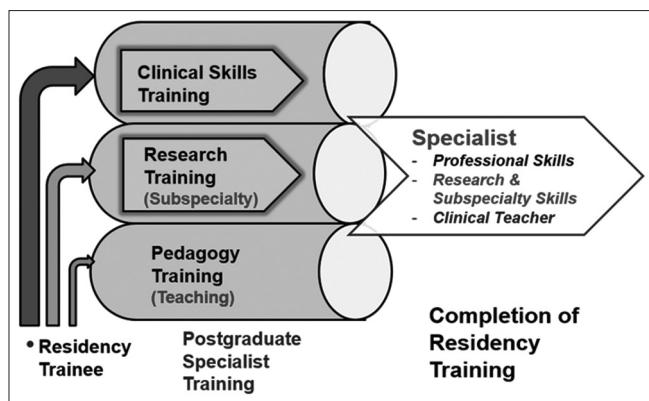


Figure 5: “Triple-Barrel” Training of Clinician-Researcher-Teachers



Figure 6: Professor Linus and Mrs. Christy Ajabor



Figure 7: Professor and Mrs. Ajabor with Children and Grandchildren

The taught elements of the course were to be delivered from Ibadan over three semesters, and would incorporate three distance learning modules. The fourth semester would be occupied by a teaching project to be undertaken and supervised at the students’ host institution. The only period to be spent at Ibadan was the week of project defense at the end of the course. No distance learning postgraduate program had ever been approved at the University of Ibadan.

All manner of objections were raised from different quarters because of the novelty of the idea.

Eventually, after a couple of re-presentations of the proposal, it was approved by UI Senate on 27th April, 2009, with the first set of 24 students commencing studies in August 2009. Twelve of the original twenty-four students from four West African countries completed their studies on 14th July 2011 by defending their projects. The pioneer Course Director was Professor Ayo Oluwatosin, a plastic surgeon. He was succeeded by Dr. Akin-Tunde Odukogbe, an obstetrician colleague, after the first set had graduated. The External Examiner at that first project defense was none other than Professor Uche Onwudiegwu, a renowned obstetrician/gynecologist with special interest in medical education from Obafemi Awolowo University, Ile-Ife. The findings from some of those projects were subsequently published in reputable journals.^[22,23] A member of that pioneer set is now the Dean of the Faculty of Clinical Sciences, my very own Faculty, at the University of Ibadan.

In evaluating their experiences, all the students affirmed that the course had improved their ability to teach their students while also sharpening their research skills. All of the graduates believed that the pedagogical skills they had acquired in the course of taking the modules would make them more effective as teachers and this cut across the different professions represented—medicine, dentistry, nursing, physiotherapy, and public health. There were some communication difficulties in terms of gaining access to the distance learning materials, but these were temporary and all the students were able to get all the materials needed for their studies. The biggest constraint was the bureaucracy in the Postgraduate School of the University which became so difficult to navigate that the program had to be suspended. Efforts are ongoing to resume the program. The most important lesson, however, is that there had been a clear demonstration of the proof of concept. The academic skills of clinical teachers and other teachers of students of the various health professions could be significantly enhanced through a distance learning program while they remained at their duty posts. If this could be widely adopted, it should significantly enhance the quality of the learning experience of medical students in Nigeria.

Insight into the Past

Placing the phrase “insight into the past” in the title for this lecture was a deliberate act to convey the message that determining our next course of action in improving medical education in our nation requires an insightful re-examination of what had transpired in the past. Dictionary.com^[24]

describes insight as “appreciating the true nature of a thing” and “seeing into inner character or underlying truth.” Insight is also described as “an understanding of relationships that sheds light on or helps solve a problem.” The whole purpose of going on the historical journey we just undertook can be found in a summation of those three descriptions. We can all relate to the expression from the world of psychiatry that the moment a mentally ill person gains an insight into the nature of his/her illness, the journey to recovery begins. Appreciating the true nature of medical education in Nigeria and understanding the relationships that had shaped it can shed light on how to prepare for a better future.

Looking through the lens of past events, some of the lessons I feel could be learnt in preparing for the future are:

1. Medical education should be geared toward meeting perceived national needs. The French needed Assistant Medical Officers (AMOs) in their West African territories after the First World War and they designed their system to produce that cadre of personnel. As perceived French national needs evolved and circumstances changed in the colonies, their methods changed and they permitted Africans to train in France and become internationally recognized doctors. The same happened with the British. Due to the agitations of Nigerians trained under the licentiate system and because doctors were needed for the National Health Service in the UK, a university medical school was established in Ibadan. Nigeria needs to articulate her national health needs and set appropriate goals and targets concerning training the personnel to meet those needs. This includes planning for internship and postgraduate specialist training so that medical graduates do not spend two anxious years after graduation still looking for where to do a compulsory program without which they cannot be fully registered to practice. Asking Universities to suddenly increase intake without a commensurate increase in the physical facilities and the number of trainers is a recipe for lowering standards and destroying quality. Such an approach is ultimately counter-productive.
2. The Asquith and Elliot Commissions provide an insight into the virtue of doing a needs assessment, followed by planning and implementation. Contemporary undergraduate medical education in Nigeria can benefit from such an approach, whether it is in planning the establishment of new medical schools or in curriculum development and review in already established schools. The University of Ibadan followed such an approach in developing its current curriculum with salutary results.
3. We should be candid and forthright with policymakers and other stakeholders when what is available for training is simply unsuitable. This is the only way to guarantee quality medical education in Nigeria. The Hunt Visitation Panel from London came to inspect the Native Administration Hospital in Adeoyo and the Jericho Hospital and rejected them for clinical training for the London degree, in spite of the fact that a lot of funds had been committed to improving those two facilities for the accreditation exercise. One can only imagine how Sir Samuel Manuwa must have felt after the efforts he had led to upgrade facilities at those hospitals, only for accreditation to be denied. The nation was, however, much better off for the decision of the Hunt Panel in the long run.
4. We should not adopt a one-size-fits-all approach to the issue of undergraduate medical education. After the Yaba Medical School and its licentiate program was abolished in 1948 because of all the indignities visited on her graduates and their determination to practice according to international standards, the Northern Regional Government still felt the need to establish another licentiate school in Kano, presumably to meet the peculiar needs of that region at that time. Certainly, the slow pace at which the new University College Ibadan was training doctors would not allow sufficient numbers to be trained in good time to meet the huge needs of the Northern Region where virtually all the doctors were expatriate, many of them missionaries. Eventually that licentiate program in Kano was phased out when the medical school in Zaria was established, but a stop-gap palliative effect had been achieved in meeting the healthcare needs of the population in the period before the university medical school came on stream.
5. Setting minimum standards and enforcing the same through accreditation visits is a time-honored method of quality assurance.^{116]} With the publication of the Guidelines on Minimum Standards—setting objective parameters—and by being proactive in providing guidance before the commitment of resources, the MDCN is increasing efficiency and reducing waste when it comes to establishing new medical schools. What is next is to further reduce waste by harmonizing the disparate standards set by MDCN and NUC, and conduct of joint accreditations by the two agencies for greater efficiency.

What Lies Ahead?

How can we apply the lessons to the task of improving undergraduate medical training in Nigeria? That question could best be answered by addressing the issues that are driving medical education today. Virtually all of these

issues have been around for a long time, but emerging circumstances have given them new prominence.

Curriculum review

Curriculum review should not be an afterthought or something that is done after glaring deficiencies in the products of medical education have surfaced. It should be a planned activity conforming to the cycle shown earlier so that as evaluation of a previous exercise is being done, the needs assessment of the next cycle is beginning. This will ensure that the graduates being produced are prepared to meet the emerging healthcare needs of the population. Ideally, curricula should be reviewed in five-year cycles so that sudden shocks are not introduced into the system as is bound to be the case if things are allowed to fester for decades before change. Systems do not often react well to shocks and this may make implementation of new curricula more onerous.

Simulation in medical education

Imagine a situation where pilots are trained to fly passenger jets by just putting them in the cockpit and having an instructor sitting beside them as they lift off in a jumbo jet with 250 passengers. Unthinkable, we will all say. I am sure most people would not want to be passengers in such an aircraft. The same goes for the military. They do not train for combat missions by exposing soldiers to live ammunition. Medical education can no longer depend solely on medical students having access to living patients to learn the basic skills of physical examination. The same goes for training residents in the complex skills of carrying out investigative or therapeutic procedures. Simulation in medical training has undergone tremendous advances in the last twenty years and Nigerian institutions must embrace it. Fortunately, both the NUC and the MDCN have included the provision of functional simulation laboratories as part of the minimum standards for accreditation.

Training Physician-Scientists

Many institutions all over the world are exploring ways and means to produce the corps of clinical and translational researchers who will produce the answers to local and global health problems. In the United States where students obtain first degrees before embarking on medical education, elite institutions offer combined MD-PhD programs for talented students who would like to pursue advanced research while remaining clinicians. In the United Kingdom, the approach has been the introduction of intercalated degrees, bachelors, masters, and doctorates even as the student pursues medical education. It is now possible for a student to enter medical school and emerge nine years later with five degrees—BSc, MSc, MB, BS, and PhD. Of course, such students must be very talented and

highly motivated but it is possible. An attempt was made to include this in the current curriculum at UI, but those efforts were frustrated by those who were invested in the status quo.

Role of professional societies

The final point I wish to make about the future is about the role of professional specialist societies such as SOGON. I believe that our educational responsibilities as a society of specialists should go beyond providing continuing professional development for our members. The culture of producing practice guidelines that SOGON has now embraced is a laudable one but those practice guidelines should not just be for the use of specialists. They should be designed in such a way that they can be tools for teaching undergraduates. That should also make them useful for non-specialists providing services in underserved areas.

Recommendations for the Future

The title of this lecture makes it clear that its purpose is to make suggestions on how to improve undergraduate medical education in Nigeria. It is therefore appropriate, as I conclude, to make a few recommendations for this:

- There should be a harmonization of the guidelines on minimum standards published by the MDCN and the minimum academic standards published by the NUC so that institutions have a clear picture of what is required to run a program for training doctors. The two agencies should also conduct joint accreditation visits to maximize efficiency and reduce waste
- There should be mandatory training in educational methods for all preclinical and clinical teachers so that they are proficient in issues such as curriculum development, curriculum delivery, instructional methods, and pedagogy. This will contribute immensely to improving the quality of the educational experience of medical students
- Curriculum reviews at specific intervals should be mandatory for all training institutions and should be one of the criteria for renewal of accreditation. Curriculum review should not be just by accretion of new topics because of new diseases, but by deliberate needs assessment and evaluation of what had been done in the past so that the overall needs of the population are met.
- Intercalated degrees should be introduced (or re-introduced) for talented students so that a corps of physician-scientists who will spearhead high quality clinical and translational research that would address the nation's specific health needs can be built up.

- All medical schools in the country must invest in simulation laboratories and equipment to enhance the training of medical students in physical examination and basic clinical procedures such as venepuncture, cut-downs, lumbar punctures, and other similar procedures. The era of students learning such skills using live patients is approaching an end.
- Specialist societies such as SOGON should develop a template for the preparation of practice guidelines that would be useful for clinical teachers as well as medical students. Such guidelines may also be useful to generalists serving in remote or underserved areas.

Linus Ajabor and Medical Education

I had touched upon Professor Ajabor's passion for medical education in my opening statement but I believe his real impact is in his diligence and patience in teaching generation after generation of medical students and residents over the past 52 years since he returned to Nigeria after obtaining the MRCOG. Many of those that were taught by him have gone on to become great teachers themselves. This includes many of those who are the brains and donors of the resources for the endowment of this series of lectures such as Professor Michael F.E. Diejomaoh, Professor Mutairu Ezimokhai, Professor Eugene Okpere, Professor Paul Waboso, Professor John Ikimalo, and Professor Polite Onwuhafua. Others who have committed resources to this cause are Dr. Peter Odili (former Governor of Rivers State), Dr. James Nwabine, Dr. Emeka Oloto, Dr. Sonny Okojie, and Dr. Abu Alasa.

Professor Ajabor has played key roles in the establishment of new medical schools, notably those of Ambrose Alli University, Ekpoma and Delta State University, Abraka where he served as Chairman of the planning committee of each of them in 1983 and from 1999–2002, respectively. It is incomprehensible that none of those two institutions had deemed it fit thus far to confer honorary degrees on him for his contributions to their establishment. His contributions to developing the discipline of Obstetrics and Gynecology at UBTH were fundamental to the phenomenal success of that hospital in training many obstetricians over the past 40 years. It is gratifying that the authorities of the hospital thought it fit to recognize his contributions by changing the name of Maternity M1 Ward to LN AJABOR MATERNITY WARD.

Professor Ajabor is a devoted husband of Mrs. Christy Aba Ajabor [Figure 6], a nurturing father of three sons and a lovely daughter, a doting grandfather [Figure 7], an accomplished obstetrician and gynecologist, an outstanding clinical teacher, a motivator and mentor to many, and

a patriot who has had the good fortune of having his contributions recognized by being conferred with the high national honor of Officer of the Order of the Niger (OON). He is held in very high regard in the community of his nativity, Umunede where he is a titled chief and member of the Obi-in Council. I am glad that those who had benefitted from his tutelage recognized the sterling qualities in him, his enormous contributions to medical education in Nigeria and elsewhere, and endowed this lecture in his honor.

Acknowledgements

In concluding this oration, I wish to acknowledge the Grace of God upon my life for in Him I live and move and have my being. He has inserted people into my life from the onset and all along the way to shape the contours of my life. The aggregate of those contributions is the person standing before you to deliver this lecture.

I acknowledge my beloved parents who have both made the transition to eternity, the Venerable Julius Ladunjoye Omigbodun and Chief Regina Olatide Omigbodun. They were my first teachers and without the foundation they laid, there would have been nothing for the other teachers to build upon. I am grateful to all my siblings, three brothers and three sisters, who have all contributed to making me who I am.

My beloved wife and partner of the past 32 years, Professor Olayinka Olusola Omigbodun, is indeed the bone of my bone and flesh of my flesh that God Almighty has provided to complement me in this walk. I thank God for her life and the positive influence she has been as we have continued this pilgrimage together. She is my pillar of support. I thank God for our son, Dr. Akinyinka OreOluwa Omigbodun, and our daughter Mrs. Iyeyinka Kusi-Mensah. They have been a tremendous source of joy for us and their insight and counsel at various times have been invaluable for me. And we have a wonderful addition in our son-in-law, Dr. Kwabena Kusi-Mensah. I am blessed to have family across West Africa, with my mother-in-law hailing from Sierra-Leone and my son-in-law from Ghana.

I am grateful to all my teachers, particularly in the discipline of Obstetrics and Gynecology, many of whom are here, including the honoree of this lecture. I appreciate all my colleagues in UCH and all others with whom I have worked in SOGON, the West African College of Surgeons and the National Postgraduate Medical College of Nigeria. I thank the mentees of Professor Ajabor for considering me worthy to deliver this lecture and I thank all who have found the time to attend.

To God be the Glory for the great things He hath done!

God bless you all and thank you for the audience.

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Conflicts of interest

There are no conflicts of interest.

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