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11th E. Latunde Odeku Memorial Lecture given on 27 October 1987 by Professor R. G. Hendrickse

Introduction by Professor A. O. FALASE, *Provost*
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Introduction

All of us in this Medical School and Teaching Hospital felt a great sense of loss when the news arrived of the death on Tuesday 20 August 1974, at the Hammersmith Hospital in London, of Professor E. Latunde Odeku. He was 47 years old.

Professor Odeku was a much liked person who devoted most of his life entirely to the practice of medicine, particularly neurosurgery, which he practised here for 12 years. Professor Odeku received his basic medical education in the United States of America, where he also received his specialist training in neurosurgery.

He was appointed as Lecturer/Consultant in neurosurgery in Ibadan in October 1962, and was promoted to Senior Lecturer in October 1963. In November 1965, he was appointed here as Professor in Neurosurgery.

Professor Odeku was Head of the Department of Surgery from January 1969 to September 1971, and was Dean of the then Faculty of Medicine for the period 1968–1970.

He was Visiting Professor of Neurosurgery at the University of Michigan in October 1979, and won the prestigious Alumni Award of Howard University, U.S.A. in 1973. By the time Professor Odeku died, he had established a fully functional Neurosurgery Unit at Ibadan, the first in Black Africa, and thus carved for himself a permanent niche in the history of the University of Ibadan, the Ibadan Medical School, and neurosurgery in Africa.

In appreciation of his contribution to the neurosciences, his colleagues and friends at home and abroad launched a Memorial Fund with the objectives of endowing a Memorial Lecture and a prize in neurosurgery in his memory. The Council of this University, apart from contributing to the Endowment Fund, also approved the naming of the Medical Library as the E. Latunde Odeku Library, in recognition of his outstanding academic contributions to the University.

There have been 10 previous Memorial Lectures, given by distinguished scholars from Nigeria and abroad. These previous lecturers included Professor R. C. Schneider of Michigan University (U.S.A.), Professor A. O. Adesola of the University of Lagos, Professor Marion Mann of Howard University, Professor F. A. O. Udekwu of the University of Nigeria, Professor F. D. Martinson of our own Department of Otorhinolaryngology, Professor Charles Easmon of the University of Ghana, Professor B. O. Osuntokun (presently Chief Medical Director of UCH, and former Dean of our Faculty of Medicine), and Professor L. F. Levy of the University of Zimbabwe. The ninth lecture was delivered by Professor Ojetunji Aboyade, one-time Head of the Department of Economics in Ibadan, and later Vice-Chancellor of the University of Ife; the 10th by Professor A. Adeloye, perhaps his closest associate, a Professor of Neurosurgery in this College of Medicine.

Tonight, we have, as our Eleventh Memorial Lecturer, Professor Ralph G. Hendrickse, Professor of Paediatrics at the University of Liverpool. Professor Hendrickse was a former Professor of Paediatrics of this University's Department of Paediatrics, and was Head of that Department between 1962 and 1969. Professor Hendrickse, a world-renowned scholar specializing mostly in disease affecting tropical communities, is at present the Professor and Director of the Department of Tropical Paediatrics at the University of Liverpool and Liverpool School of Tropical Medicine. He is familiar with the life history of late Professor Odeku, having been his colleague and collaborator in many clinical research projects. He is a worthy friend of this College in that he has

assisted many of our young men and women in their quest for knowledge and postgraduate training in institutions in the United Kingdom. We are eternally grateful to him for this assistance.

I now have great pleasure in calling on Professor Hendrickse to deliver the 11th E. Latunde Odeku Memorial Lecture, which he has titled 'Poetry in Medical Education'.

The Lecture

I Do Not Ask

I do not ask,
Why should I ask? No diadems I seek;
I do not ask for a Hall of Fame,
Not for the Sanction of men . . .
I do not ask.

Not for power to molest, to indulge;
I seek no throne, no eulogy;
I do not ask to be chosen, nor be served.
Not for honours . . .
I do not ask.

Give me strength to walk erect,
To place each footstep straight, on the road;
When the journey nears its stretch
Keep the weary old man's steps from waving much

I ask this much . . . only to be myself,
To fulfil my own
All else I do not ask

LATUNDE ODEKU
University College,
Ibadan, Nigeria,
December, 1962.

Introduction

To pay tribute to a man like Latunde Odeku, within an institution in which he contributed so much and loved so well, is an honourable pursuit that presents no great difficulty for almost every aspect of his many faceted life reflected something of merit. However, to pay a tribute that is worthy of the man is a much more daunting task for Lat Odeku combined the bard with the scientist, the visionary with the pragmatist, the perpetual student with the eternal teacher and the common touch with the magic of Midas.

Neurosurgery, medical education and poetry were the fields in which Latunde Odeku displayed particular excellence and are those that have been designated for the themes on which these lectures must be based. In respect of neurosurgery, of which I know little, I must admit to have been tempted to explore some thoughts about similarities between the surgeon's skill in exposing the brain and the teaching talent for opening minds. The final nail in the coffin of this idea was a colleague's comment that 'there is a vast difference between having an open mind and having a hole in the head'. My choice of subject was, therefore, limited to medical education or poetry. I decided, probably rashly, to attempt to combine these, knowing full well that my poetry will not transport you into paroxysms of literary delight, but in the hope that my use of verse may amuse, possibly instruct, and hopefully stimulate those of you with latent talent to use poetry and verse to promote medical education. A more appropriate title for this lecture might be: 'Poetry portraying personal peculiarities pertaining to pedagogic pursuits, persistent problems plaguing paediatric practice and pernicious politics.'

A glimpse at the past

The men and women who laid the foundations of theory and practice in this great institution were inspired by: the concept of a medical school, steeped in the best traditions of international medicine, that displayed excellence in health care delivery; teaching and research relevant to the real needs of Nigeria in particular and Africa in general; and consistent with plans for overall national development within the constraints of available resources.

Among the problems which confronted the pioneers of this medical school were; lack of information about such basic matters as physiological norms in haematology, biochemistry etc., against which to assess disorders in the local population; genetic and environmental hazards to which the population are exposed and the pattern of disease which these engendered; and serious constraints on the facilities and services, which we now take for granted, for the diagnosis and management of disease in the individual and in the community.

There was dedication and conviction, there-

fore, in prosecuting research to elucidate the physiological and pathological basis of local clinical practice and urgency in developing diagnostic and therapeutic facilities to improve patient care and facilitate further research.

Innumerable papers, now gathering dust on the shelves of libraries, attest the industry and success of past staff in building up the corpus of knowledge which today underpins teaching and practice, but I doubt if many here today are aware of some little verses that pay tribute (through poking a little fun) to people like Patrick Collard and David Montefiore who laid the foundations of the now extensive knowledge of Salmonellosis in Nigeria, or the late Derrick Abrahams and others who established the foundations of clinical cardiology; or Richard Batten who crusaded for a blood transfusion service; or the nurses who took the first faltering steps on the road to a Department of Nutrition. These efforts are affectionately, but somewhat irreverently, acknowledged in these limericks taken from 'Harmattan', the very first journal produced in this medical school, which lies buried somewhere in the library.

Re Salmonella:
A bacteriological wizard,
Investigated a lizard,
The dear little fella
Was all Salmonella
From his sinuous tail to his gizzard.

Re Cardiology:
A medical gent from Barts,
Took an interest in feminine hearts,
His technique was to rest
With his head on their breast
Collecting murmurs and thrills from these parts.

Re Blood Transfusion:
Quoth the surgeon 'Young man you're a dud
Don't you know your patient needs blood,
Not in drops or mills,
Nor cups or gills,
But a stream . . . a river . . . a flood . . .'

Re Nutrition:
There once was a sister named Ellen,
Whose charges were always a yellin'
For some peace and quiet
She increased their diet
Now instead of yellin' they're swellin'.

When I arrived at UCH, Ibadan in 1955, Paediatrics was the Cinderella of the Medical Faculty and was generally regarded as an unglamorous and somewhat indecent appendage to adult medicine. Clinical facilities in the old Adeoyo Hospital were basic and totally inadequate to cope with the thousands of sick children who daily besieged the out-patient department. In the children's ward, chickens and sometimes goats competed with the sick for the limited space! Activities were perforce mainly directed at clinical salvage of the sick and the dying. We were unable to do more than pay lip service to preventive paediatrics and promotion of child health. Neonates asphyxiated or infected at birth presented with brain damage and neonatal tetanus, toddlers were decimated by preventable infections like pertussis, measles, tuberculosis and poliomyelitis acting in concert with malnutrition, and innumerable school-aged children, survivors of the battle for life in infancy and early childhood, were afflicted by disorders of sight and hearing while struggling to acquire education in schools with poor staff and in a political atmosphere that was unsettling and confusing!

It seemed to me then, that for most children in Nigeria divine rather than human intervention offered greater hope for a brighter future and it might not surprise you, therefore, that I incorporated into my teaching the following 'prayers' for children with hope and intent to raise awareness of the need to expand Paediatric activities to include prevention of disease and promotion of health in the community.

Prayers for children

The Neonate
At birth help me to breathe with speed,
Protect my cord from stick and reed,
Please grant me breasts on which to suck
Not feeding bottles filled with muck.

The Infant
Grant my parents sense to know
What food I need to help me grow,
And a doctor whose intention
Is to guard me by prevention.

The Child
Protect my hearing, speech and sight
And my mind from noxious blight,

Give me teachers willing and wise
And men of state I won't despise.

It would appear that the neonate's plea for protection from neonatal tetanus, which we have confidently taught results mainly from unhygienic, traditional methods of cutting the cord at birth, requires some modification. The latest edition of the *Journal of the Nigerian Paediatric Association* to arrive on my desk contains a paper on neonatal tetanus which reports that 44% of cases, from whom adequate histories were obtained, indicated that the disease had been acquired in a hospital or maternity home. I am sure that you must share my surprise and dismay by this disclosure which implies breaches of conduct in the delivery of medical care that offered the long established, basic principles of modern medicine. It is to be hoped and anticipated that, should further enquiry confirm that newborns delivered in some medical establishments are at risk from tetanus, the Nigerian Medical Council will take swift action to ensure that these establishments either meet the standards that the public deserves and is entitled to expect, or be closed down as unsafe and unworthy of recognition.

One of the corner stones of child survival and health in Africa and other areas of the Third World has been breast-feeding and the close mother–child relationship associated with the practice in traditional societies. I wish I could comment that the neonate's prayer for breast-feeding has been answered, but sadly that is not so. The decline in the number of women now breast-feeding their babies and in the length of time babies are breast-fed, by those who still use this method of feeding, has occasioned increasing concern in recent years. There is abundant evidence that abandoning or curtailing the practice is accompanied by a great increase in gastroenteritis and early infantile marasmus and its complications. There is evidence too of a rapid increase in disorders like infantile eczema and gastrointestinal cow's milk protein intolerance in communities which traditionally were not afflicted by these problems. And, sadly, there has also been an increase in social problems affecting children and parents who have not experienced the close and intimate relationships that are an integral part of successful breast-feeding.

The causes for the change in infant feeding practices are many and varied and include some that reflect poorly on our profession. Many doctors have qualified and many paediatric specialists have been accredited who, though oozing the finer points of modern concepts of molecular biology from every orifice, are singularly ill-informed about the qualities of the milk that oozes from the breasts of women. Indeed, breast-feeding is given such scant professional or scientific regard by some that I have been criticised, by a co-examiner, for expecting candidates in the Paediatric Membership examination to know some of the basic differences between breast- and artificial feeding. In the so-called 'advanced' countries of the world, breast-feeding in any public places is forbidden or discouraged even though newspapers daily display female breasts for the delight of their readers, and a great industry exists for live display of female breasts in private! I grew up in a world where breasts were for babies and bottles for drunken old men. It seems that I now live in a world where bottles are for babies and breasts for dirty old men!

The infant food companies have been singled out as the principal villains in the decline of breast-feeding in Africa and elsewhere because of their vigorous and sometimes unscrupulous promotion of their baby milks. I cannot, and will not, defend the indefensible, but I am certain that the milk companies should not stand alone in the dock accused of promoting artificial feeding. Every employer, including governments, universities and teaching hospitals, who employs mothers, but denies them rights, privileges and facilities to breast-feed their young — compound the problem. Health professionals who preach breast-feeding while using a different method of feeding for their own offspring cannot convince the public that what they preach is preferable to what they practise.

Some breast-feeding 'activists', appalled by the consequences of bottle feeding, now seriously advocate that doctors should in no circumstances prescribe or condone any form of artificial feeding to babies in their care! From a baby's point of view the question of how it will be fed must be a cause for considerable alarm, and the little poem that follows reflects the reality that confronts babies in many countries today.

Cried the newborn babe, 'I am in need!
Who will give me a breast-feed?'
'Not I' said its mother,
'I can't afford the bother.'
'Not I' said the Dad,
'I would if breasts I had.'

'Not I,' said the midwife, a lass of ample girth,
'I did my job quite well I think, helping with your birth.'
'Not I,' said the GP waving a prescription,
'Treating, not feeding, is my job description.'
'Not I,' said the consultant, rather ill at ease,
'You can take your feeds any way you please.'

'Not I,' said the person who is the mother's boss,
'Feeding babes in my time causes me some loss.'
'Not I,' said the restaurateur, a lecherous old cad,
'Exposing breasts in public is very, very bad.'
Cried the baby 'I will die, if you do not feed me now,'
'Then have some of my milk,' said a passing friendly cow!

The subject of breast-feeding is worthy of greater scientific study and attention than has been accorded to it in the past. It is not generally appreciated that the change from breast- to bottle-feeding that we have observed in this century is arguably the most significant biological revolution that has ever occurred. We are mammals whose species' survival depends on suckling their young. *Homo sapiens* has somehow contrived to perpetuate itself though abandoning a survival characteristic and we have stupidly and arrogantly assumed that this change in behaviour has no biological implications. It is my firm belief that the immediate and direct ill-effects of bottle-feeding, seen today in poor, illiterate communities, is only the tip of the iceberg of the biological consequences of abandoning breast-feeding. We have no idea of what the delayed consequences may be, because the subject has never been considered worthy of serious, systematic, scientific enquiry.

I have long conceived the possibility that coronary thrombosis, which has reached epidemic proportions in the western world in this century, but was virtually unrecorded in previous ones, may be associated with the change in infant feeding that has characterized the 20th century. There is incontrovertable evidence that the vascular pathology that strikes the heart in middle age can be demonstrated in the blood vessels of many children who die accidentally in the first 5 years of life in Europe and America. We all know that coronary vascular disease was virtually unknown in most African communities in the past — can we assume it will continue to be so in the future? I doubt it, and wonder to what extent the feeding bottle teat in babies mouths today may increase the frequency with which catheters find their way into coronary arteries in the future! Perhaps it is not yet too late, in a country like Nigeria, to initiate the long-term studies that will prove whether such thoughts are worthy or merely foolish.

In the 'good old days' in Nigeria it was safe to assume that almost all dehydrated children were also electrolyte depleted, i.e. dehydration was isotonic or hypotonic. In consequence, rehydration therapy could be reasonably standardized though few medical students would have believed this possible, after enduring the tortures inflicted on them by their teachers while exploring the mysteries and complexities of acid–base balance and fluid and electrolyte homeostasis.

The increasing use of artificial formulae in infant feeding has seen the emergence of a new type of dehydration in paediatric practice, namely, hypertonic or hyperosmolar dehydration, which was first documented in Nigeria some years ago by our colleagues in Lagos who found 20% of children, presenting in the emergency service at LUTH, to have this type of dehydration. The practical significance of this discovery is that the time-honoured, standardized approach to rehydration is not applicable to these children. Indeed, it is dangerous, for rapid rehydration of these sodium-loaded children leads to cerebral oedema, convulsions and coma, and cardiac and respiratory arrest.

Our teaching on fluid and electrolyte disturbances and their management, in childhood, already difficult and complex — became more so. Indeed our teaching became so complicated that most doctors became terrified of contemplating rehydration without the support of a

laboratory staffed by competent biochemists. As these are not available in many hospitals and other centres to which dehydrated children present, they suffer and die because the mysteries of science have paralysed doctors into inactivity.

I have found that although most students quickly forget their biochemistry, they tend to remember verse, and for many years past I have used the following to summarize a rational and practical approach to the management of different types of dehydration in childhood:

Dehydration:
Babies who have D & V,
Shrivel up and fail to wee,
When this happens, then we oughta,
Give them sugar, salt and water.

Shock:
If they're shocked they'll only last,
If you give them plasma fast,
Following this you must proceed,
According to your patient's need.

Hypernatraemia:
If sodium's high and water low,
Keep your IV weak and slow,
Play it cool, don't lose your wits,
For, rushing things may bring on fits.

Hyponatraemia:
But when sodium's rather low,
Then its time to have a go,
With stronger stuff, at greater speed,
To make up loss and daily need.

Medical education today — some dilemmas

The failure of curative medicine to make any significant impact on medical problems has led to emphasis on preventive medicine. A logical extension of preventive medicine has been the concept of community medicine rather than personal medicine, and this in turn has led to the concept that health promotion should take precedence over direct medical care. In some quarters, thinking along these lines has created an atmosphere in which curative medicine is seen as an immoral use of time and facilities. Unfortunately, there is an element of hypocrisy in this, for different standards seem to apply depending on whether they refer to 'them' or 'us', as illustrated by the following:

When a native gets typhoid in Zunguru
You must tell the poor fellow what to do,
About cooking his food and boiling his water
And no defaecating where he hadn't oughta,
For health education will save the nation
While curative medicine leads to damnation,
But, when British get typhoid in Zanzibar,
And the NHS seems very far,
They look for a fella
Who can treat Salmonella.

Doctors whose training has traditionally been oriented to the diagnosis and management of disease in the individual, now often find themselves in the invidious position of being equipped for a job it seems they are no longer required to do, and prevailed upon to do a job for which they are inadequately trained; for which there is no clear job description and which requires the mobilization and coordination of resources to which they have no direct access and over which they have no control.

There is clearly a need to review and modify medical curricula and training to take account of the new functions expected of doctors which are crucial to the implementation of national plans to achieve better health for all. But I venture to predict that changes in medical training and practice that are not paralleled by similar changes in the orientation of training and practice of other professionals, such as agriculturalists, civil engineers, lawyers, architects, etc., will lead to disillusionment, frustration and conflict because a community's potential for good health is crucially determined by their access to land, clean water, food, housing, transport, communication and education and fair participation in commerce and industry, and these are matters over which doctors have little control. I believe that Nigeria may be poised for genuine reform in its medical services and general improvement in its population's health because there is currently evidence of political will to affect these changes. Essentially, improved health care is crucially dependent on political will without which it would be foolish to anticipate genuine and lasting change.

In contrast to the problems of meeting basic health needs at the grass roots of society, medical schools have to grapple with the scientific explosion of recent years that has pushed back the frontiers of knowledge and added undreamed of sophistication to the science of

medicine. People in the western world now demand and expect to benefit from the miracles of modern science in matters related to their health, but sadly improved science has not been accompanied by improved care of the sick and there is growing discontent with the services rendered to the public by the medical profession. In some countries, like the U.S.A., doctors today dare not practice without very substantial insurance cover to protect them from hostile patients who will sue for any error of commission or omission, real or imagined, with the aid of lawyers who share in the spoils of any dispute. The modern 'scientific' doctor has lost his place as a respected figure in the community involved in the care of the sick and trusted in his efforts to do so. The following little poem illustrates this dilemma and gives warning of what may happen to our profession if we fail to reconcile the dictates of science with the perceived needs of our patients.

The doctor was once a community figure
Who practised his art with more or less vigour
He knew his patients in health and disease
And, did very much as he pleased
With provision, I hasten to add
If his actions were suspect, his income was bad.

But, then from his patients he was forced to retreat
With his mantle of care lying loose at his feet
For science took over his medical art
Ignoring the whole, while it studied the part
First systems, then organs and finally the cell
Surplanted the patients, though they still paid him well.

The increasing cost of diminishing care
Soon occasioned loud cries of despair
And lawyers grew fat as they litigated
For patients and doctors who mutually hated
Themselves and each other, I'm sorry to tell
For they both were poorer, but the lawyers did well.

As protest mounted science lost its vigour
And there arose a new community figure
Not the doctor of old, as you might have expected
But, community health councils newly elected
Who dictated to doctors, I'm sorry to say
Just how to behave and on rather low pay.

This may seem a dreary note on which to conclude a tribute to Latunde Odeku, but I believe that he, who was so successful in combining science with humanity, would endorse the thoughts I have shared with you and join me in exhorting you to close the gap that now separates the science of medicine from delivery of medical care that satisfies felt needs at all levels in society, and promotes the health and well being of the least privileged at the grass roots of society. Let us remind ourselves and our students that in our profession we are seldom privileged to be the instruments of cure, but can in most circumstances afford relief of pain and suffering and can, if we are willing, always provide guidance and comfort to those who seek our help. Perhaps above all we should not forget that to deserve the title of doctor — we must, like the late Latunde Odeku, be good men or women.

Epitaph for a last page

When a man dies
Drawing the mysterious curtain over his life,
Flash from his birth, the narration quickens
And the book is closed.
On the last page . . .
Not his noble birth,
Or his illustrious sires;
Neither his trophies nor his fame;
Not his dynasty, not his might,
Not his knowledge, or his wits,
Not the Social Register;
The wreathes may cluster on the bier,
Empty mansion for a piece of Earth;
Not his gold, not his name,
But his simple way . . .
All what he has been to his fellowmen:
His highest note, perhaps unnoticed,
His glory, unpretentious;
His purest testimony . . .
That '*he was a good man*'

LATUNDE ODEKU
University College
Ibadan, Nigeria
November 1962