INAUGURAL LECTURE SERIES 20

LADOKE AKINTOLA UNIVERSITY OF TECHNOLOGY

OGBOMOSO, NIGERIA

CUTTING WITH COMPASSION: INCLUDING THE EXCLUDED

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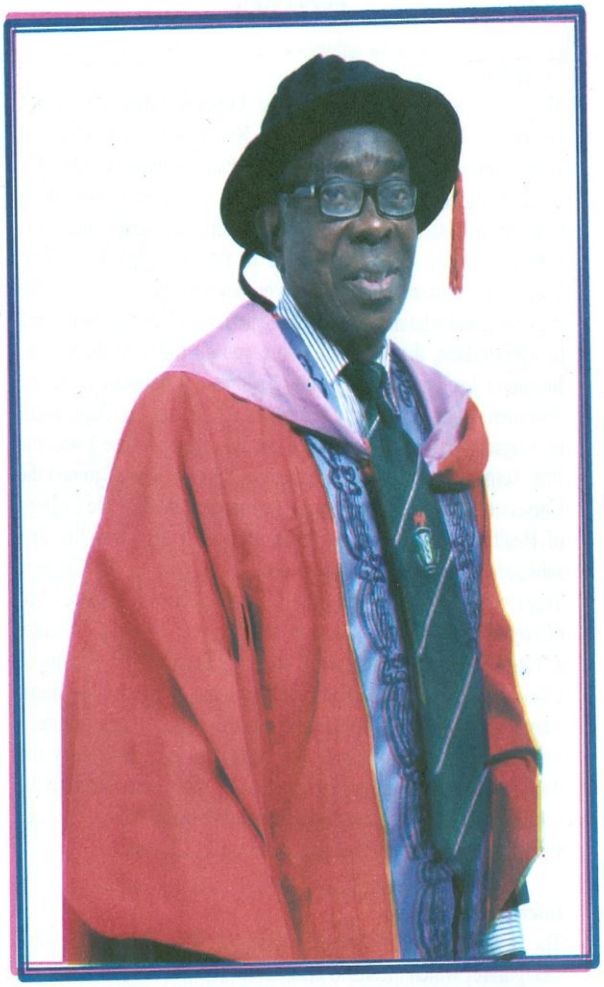

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Preamble

Mr. Vice-Chancellor, Sir, Principal Officers, Members of the Governing Council, Academic and Non-Teaching members of staff, Professional Colleagues, Royal Fathers here present, My Lords Spiritual and Temporal, Students of this great Institution, Gentlemen of the Press, distinguished ladies and gentlemen, it is with a heart of absolute gratitude to the Almighty God - the Creator of Heaven and Earth who knows the end from the beginning and who makes everything perfect and beautiful in His own time - and to many others, that I stand before you all today to deliver my Inaugural Lecture cum valedictory address. It happens to be the Twentieth of the University series and the first in the Department of Surgery. Perhaps it has turned out this way because I was the first Acting Head of the Department of Surgery when I joined the University about 20 years ago as a permanent staff of the College of Health Sciences. By the grace of God, I also was the first substantive Head of the Department of Surgery of the College. Three other Professors from the College of Health Sciences had delivered their Inaugural Lectures ahead of me; 2 from the Faculty of Basic Medical Sciences and 1 from my Faculty - the Faculty of Clinical Sciences. To God be the Glory; great things He had done. Ahead of my detailed appreciation at the close of this lecture, I wish to sincerely welcome all who made time to be here today and thank everyone who has in one way or the other contributed to the success of this occasion and made it worthwhile, memorable and significantly etched in the annals of this great University.

Introduction

The word "Inaugural" takes its origin from the Latin word 'inaugurare', which means to inaugurate. The first known Inaugural Lecture was in 1689. History however recorded that it was Prof John Wood, a Fellow of the Royal College of Surgeons of England, who on October 4th, 1870, delivered the first Inaugural Lecture in Surgery at the highly prestigious King's College, London.[1] Prof. Wood was a specialist in Hernia and antisepsis after Joseph Lister.

An Inaugural Lecture marks the beginning of a new venture or series. It is an occasion of significance in an Academic Staff member's career. Academicians refer to it as a Lecture during which Professors profess the thoughts of their minds and the works of their hands. Academic Inaugural Lectures are supposed to be given by those recently promoted to the Chair of Professor so as to showcase their achievements in the course of their work as Academicians and Researchers. Obviously this is a far cry from what currently obtains.

In the course of my Lecture titled, **"Cutting with Compassion: Including the Excluded",** as a "bloody" Surgeon, I intend to present a synopsis of how and what I have

been **'cutting'** for over four decades, of which over twenty five years has been as a Consultant Surgeon. In the process of doing so, I will define the key words of "Cutting", "Compassion", "Including" and "Excluded". I intend to briefly take us through the Echoes of my Early Life, the strenuous training period as an undergraduate and later, postgraduate student of Medicine, my Practice - Past and Present - including my adventure into "surgical 'herbology'" and, the Future. I will also touch on the struggle for the Clinical accreditation of the College of Health Sciences in the early years of the College and highlight some troubling policies and practices with adverse consequences on the Future of the Health Care System and its Practitioners. This will include the omissions and commissions of Medical Practitioners, Policy makers and the Governments of our funding states. Lastly, I will make some recommendations, as I bow out, Mr. Vice-Chancellor, sir

Echoes of Early Childhood:

Born into a simple family of a successful Transporter as Father and Kolanut trader as mother, I learnt very fast and had an early start in talking. My late father sent me to an Arabic school in a popular compound (Ile besin, Pakoyi compound) in Oyo town. I was fortunate and privileged to have been termed "gifted" and fast in learning. I was able to learn and finish the Quran within the shortest time possible, even ahead of my senior brother. I enjoyed so much attention, pampering and love of my Arabic teacher, Alhaji Jimoh, (whose name my father insisted I should be bearing when I started western education) and the Muslim community in general. I represented a particular denomination (the A.U.D Society) in long quranic recitations as far a place as Ikoyi town near Ogbomoso, that I decided to go full scale in leaning the nitty-gritty of Islam in Cairo, Egypt, and other Arab countries as a big Imam with a big turban that would intimidate other Muslim Scholars. I was virtually not interested in western education. However, as destiny would have it, my senior brother, Engineer Adeniyi Olayiwola Aderounmu and my Arabic teacher felt that I should have western education in addition to the quranic one as a result of my Arabic teacher's experience when he was sick of prostate disease and treated at the Ogbomoso Baptist Hospital, now Bowen University Teaching Hospital, Ogbomoso. I agreed with the hope that this would not interfere with my long term ambition. I had no problem in my primary school education. I also did not have to go through the Modern school, which was common then, before gaining admission to Government College, Ibadan, in the early sixties.

I was expelled from Government College, Ibadan, in Form III for failure to pay my school fees consequent upon the drastic downturn in my father's transport business. Due to some unexpected and unexplained misfortune, my father lost all his six big Bedford Lorries, one after the other, within my first year in School and I was one of the nine students that were

sent packing for inability to pay our school fees in the first term of the third year. It was indeed a trying period which threatened to dash any hope of successfully completing my educational pursuits. I want to, at this juncture, acknowledge those classmates of mine who took it upon themselves to share their notes and food with me when the School authorities first stopped us from attending classes and stopped providing food for us. Some of them are here today to honor God and me.

The expected help from sources such as my father's friends (who initially assured my father that they would contribute money to pay my debt), elites of my home town and the local government did not materialize in loan, scholarship or sponsorship. However, by what I termed a stroke of good luck then, which I later realized as Divine Providence, I completed the secondary school as a day student at the then Baptist High school, now Olivet Baptist High school, Oyo and gained admission to study Medicine at the University of Lagos, after I had taught for one year as a pupil teacher at Iseyin Grammar school, Iseyin where I first met Professor 'Dibu Ojerinde (a.k.a "Iya ku ariwo ta"). Prof. Dibu Ojerinde is the immediate past JAMB Registrar who through ICT revolutionized the examination Process such that results can be viewed on the same day of the Examination instead of the prolonged wait, sometimes up to months, that subsisted. He has been a very close friend since then.

My Professional voyage – the Past, Present and Future: In defining and discussing the title of this lecture, we need to look back on how it all started in the very beginning and how every challenge along the way has contributed to making the 'whole' of me.

My first contact with a "Physician" was when I was at the age of about five years. I had some abdominal pain and my father took me to his friend "doctor". I was impressed by his snow-white laboratory coat with 'gators' sharp enough to 'cut' like a razor blade. He had his stethoscope around his neck. I loved the way he was palpating my abdomen, looking at my face and asking if I felt any pain in any part of the abdomen. After examining me, he assured my dad that there was no problem and gave me some syrup to take after my evening meal that day. The following morning, I passed so many coiled round worms along with faeces. This frightened me and made me to cry out "my mother's head o!" running in fear to her. I never experienced the abdominal pain thereafter. I later learnt that the "doctor" friend of my father's was actually a male nurse working for the government at the General Hospital but practicing on a small scale in his house.

My undergraduate training at the College of Medicine, University of Lagos was not without hiccups. I lost my Father a few months to my first professional Examinations and had to re-sit some Examinations but to the Glory of God I finished with my colleagues

without repeating any year. In those days there was palpable fear that you could be sent out of the Medical school if you fail any of the pre-clinical subjects of Anatomy, Physiology and Biochemistry after a re-sit. There were usually many casualties in Biochemistry because our teacher then, who later became a Professor of Biochemistry, was always drumming it into our ears that a "tripod cannot stand on two legs"- meaning that even if one passes Anatomy and Physiology with distinction, without Biochemistry, one will still not be able to cross to the Faculty of Clinical sciences.

Though I was encouraged to specialize in either Internal Medicine or Surgery during my Internship rotations, my interest shifted towards Obstetrics and Gynaecology (O&G) during my Youth Corps Service year at a Christian Hospital in Onitcha-Ngwa, near Aba in the then Imo (now Abia) state. This American Missionary run 40-bedded hospital provided more than Primary Health Care. My motive for wanting to specialize in O & G was pecuniary because I thought there was good money in that specialty. I later opted for Surgery because each time I made an acute abdominal diagnosis at the hospital's outpatient clinic and the patient got operated on in the theater, the surgical findings would just confirm my clinical diagnosis. The matron of the hospital, an elderly retired Seventh Day Adventist (SDA) nurse, then told me frankly – "Dr. 'Bimpe, it is not good enough for you to diagnose a problem for others to treat; follow it up by doing the surgery yourself". So began my love and desire for Surgery as a Specialty. Today Forty years down the road we shall be reviewing how the romance has fared.

My "present" spans over 30 years as a Senior Registrar and Consultant Surgeon, and covers the spectrum of my clinical, academic and research work so far. My desire to train in Urology as a subspecialty did not quite materialize. The farthest I went was a few months' stint in Endo-Urology at the Academic University of Pretoria in South Africa.

The College of Health Sciences, Osogbo, and the struggle for Clinical Accreditation

A major part of my "present" would include my work at the Ladoke Akintola University of Technology (LAUTECH), Ogbomoso, where I have been privileged to be promoted to the Chair of Surgery. With the benefit of hindsight, I believe the Medical School of LAUTECH was prematurely started (a year after the main University) without adequately planning for it from admission to graduation. This might have been largely responsible for the initial challenges we experienced. Late Emeritus Professor Toriola Solanke was the foundation Provost. A Surgeon of no mean repute- The Hon. Justice Kayode Eso CON- who chaired "T.F.S @70: A celebration of Values" said this of him and I quote "Tori is a gentleman. As a friend, Tori is reliable. As a husband and family man, Tori is loving and totally committed. As a leader, he plays the role model; and though an Aristocrat, which he might deny he is, Tori is meek, gentle and humble"-(Page 9). I was really fortunate to have met him early in my Residency. He was one of my Role models in the discipline of

Surgery. He loved singing a song which I would crave the indulgence of the Vice-Chancellor, Sir and the audience to sing, even if my voice will not be as sonorous as his - "Oni dodo oni moinmoin, nigbati kota o gbegba kale, e wa woja ni Lafiaji". I clearly regarded myself as his son and mentee; he loved me passionately and assisted in advancing my career as a Surgeon. His efforts with those of succeeding Provosts delivered the Preclinical accreditation to train Medical Students in the Basic Medical Sciences. Professor C.O Adeoti in her Inaugural Lecture (Series 13 Page 05) mentioned the Pioneering College Staff (Academic and non-teaching) but did not state that most or virtually all of those Academicians she mentioned were Civil servants with the State Ministry of Health (or Directors of private hospitals such as Abake, Bicket, and Onward) that were temporarily seconded to the College to assist in teaching the students and in building the Faculty of Clinical Sciences from the scratch. Many of them that are still in the system transferred their services later. Without ambiguity and being immodest, I think I qualify to be listed as a pioneer staff of the College because I was employed directly as Lecturer I in 1998, twenty years ago, when the students moved to Osogbo. I joined from my Private Hospital - the Oil of Joy Specialist Hospital and Surgical Centre - that had to close down after some years of operation due to the Ife-Modakeke war that adversely affected virtually every part of the city, especially the environment in which the hospital was located – the war zone. I became the Acting Head of Department, Deputy Dean, Acting Dean and Acting Provost in quick succession because we were "bottom heavy".

The First Clinical Accreditation Visit:

It was while I served as the Acting Dean of the Faculty of Clinical Sciences that we made the first attempt to invite the Medical and Dental Council of Nigeria (MDCN) to come and accredit our Clinical section. Our first set of medical students had spent nine to ten years for a course of six years.

Although I had my reservation on our readiness, based on my experience on accreditation matters and as a former Chairman of the Osun State Branch of the Nigeria Medical Association, (No clinical laboratory, no animal house, the students were too many - 300 in a class where only 50 was approved, inadequate wards and clinics and lack of equipment- these factors among others contributed to our dis-accreditation later), I was prevailed upon to keep my fears to myself and to support the invitation. Even then, I had to speak with Professor T. F. Solanke of blessed memory when we knew that the leader of the accreditation team was Prof Okey O. Mbonu, an Emeritus Professor of Urology and a friend of the College. We invited him severally as our external examiner. He is still a respected Mentor of mine – himself being a Mentee of Professor Solanke, hoping that the

connection would "magically" confer on us the accreditation. Another advantage I assumed we had was that the Registrar of the Medical and Dental Council of Nigeria (MDCN) then - Dr. Celestine O Ezeani, was a friend and former classmate of mine in the Medical school. Suffice to say, and painfully so, that after all the labour and sweat in "preparation" we failed woefully. **I wept**. It was then that the Vice-Chancellor in the person of Late Professor Muritala Akinola Salawu, a Charismatic achiever and hardworking Vice-Chancellor, listened to my advice. Since our problems were poor funding, lack of equipment and inadequate space, we advised him to set up an Accreditation Task Force with the then Governor of Osun State, Chief 'Bisi Akande, or his representative as Chairman (he was represented by the Secretary to the Government at our meetings), Other members of the Task Force were the Vice-Chancellor. himself, the Chief Medical Director, Provost, Dean of Clinical Science (my humble self), the Chairman, Medical Advisory committee (CMAC), the Honorable Commissioner for Health and the Commissioners for Finance of both Oyo and Osun States.

Our mandate was to do all that was humanly possible, through the relevant Government agencies to make a repeat accreditation successful. We were meeting almost every two weeks to review what we needed to do or buy and how far we had gone in our preparations. By then, I had been made the Acting Provost and Dr. (now Professor) (Mrs.) 'Yinka Akinwusi was my Acting Dean. I still vividly remember her speech during the pre-accreditation dinner we hosted for the accreditors titled "The siege is over". Truly, accreditation is a siege, and we need to understand this. We happily ticked each goal that we succeeded in achieving, including the Medical Students' hostel. This was initially refused because the University was not supposed to be residential for students. Fortuitously, we had the full cooperation of the Governing Council chaired by late Barrister Sir Dele Ige who made funds available for the purchase of equipment, building of "Animal house" and others as recommended by us. By the time the accreditation team came back six months later, they were flabbergasted at what they met and **we passed with Credit**. The Oyo and Osun State Governments then realized that Medical Education was truly Capital-intensive at both the College and the Teaching Hospital levels. (However, I am no longer so sure that this understanding still subsists among our Governments). Glory be to God in the Highest, Great things he had done.

We give Kudos to Professor O. Ogunbode, a hardworking, jovial, sociable and easy going Professor of Obstetrics and Gynaecology, who initially combined the position of Provost with that of the Chief Medical Director, and to Professor D. A. Olatubosun, who later became the Provost before our first attempt at accreditation. Our students could then continue their Clinical Postings and qualified after about 11/12 years due to no fault of theirs. Even these days, incessant strikes prevent the timely graduation of our Medical students. The Medical students are doubly jeopardized when a strike action ensues in the

University and / or the hospital and it is worse when it occurs at different times. The students have to repeat the postings from where they stopped. This is the very reason why we continuously appeal to our Academic Staff Union of Universities (ASUU) friends and colleagues to see these children as their own and assist them to graduate on time by allowing us to continue our teachings, not because we are special but for the sake of the students and their parents. No lecturer among us, especially among the executive, would want his child or ward to spend extra years to qualify. I honestly hope ASUU and our executive will understand the reason behind our appeals during well thought out unavoidable strikes. It is not to compromise the collective desire of the Union or to sabotage it. It is purely for the sake of the students.

This is why, Mr. Vice-Chancellor, Sir, we felt with you and for you when we lost that accreditation we had suffered so much to get. No matter what, Sir, we should do all within our power and the ambits of our jurisdiction, including the regularization of our Associate staff before we lose them all to near and far places. Mr. Vice–Chancellor, Sir, I know you have the ears, hearts and the support of the Governing Council, headed by Professor Oladapo Afolabi- an Academician to the core as well as an astute Administrator in his days as a former Head of Service (HOS) of the Federal Government of Nigeria. Undoubtedly, his new Board brought LAUTECH back to life when some people had already given up on the Institution. Our strength is weakening because the Associate Lecturers are leaving in droves while regular staffs are retiring without being replaced. Even unlike 1984 when Doctors left the shores of Nigeria for Saudi Arabia through foreign adverts, advertisements are now locally and readily available for foreign recruitments. We should prevent another brain drain of yesteryears through our acts of omission. We probably still feel that we lack the financial capacity to do the needful by fully employing these ones. With all humility Sir, I do believe that we, with the present caliber of the members of our Governing Council and the favor the Vice-Chancellor shares with them and the funding states, we should be able to regularize their appointments NOW as permanent staff, at least to replace many that have left our system and are yet to be replaced. If the will to do so is there, there will be a way out, Mr. Vice Chancellor, Sir.

Mr. Vice-Chancellor Sir, knowing fully well that accreditation is the bed rock of any University and Teaching hospital program for the maintenance of high standards of education, we appreciate your success Sir, in shifting the University and College of Health Sciences' accreditation to May. I just hope that the shift would not make us go to sleep because before we know it, the month of May would be here. It would be helpful to know what progress has been made by the accreditation committee since the postponement. Let us therefore continue to work assiduously towards its success of ALL accreditations in the pipeline (College of Health Sciences and other Faculties of the University). Accreditation these days sir, is through a prepared check-list of what we have or do not have, and not

who we know. I therefore advise that our "Mock Accreditation" teams do the needful. I thank you and the members of the Governing Council in advance for making the coming accreditation a big success.

My work:

While I would not be able to list the surgical operations I performed chronologically, the number of prostatectomies that I had done, made a senior orthopedic colleague who used to operate on the same day with us say they were more than 4000 - and he could be correct.

Definition of Key Terms: Cutting, Compassion, Including, Excluded

Cutting: means making a long narrow incision using something sharp like a knife or Scalpel

Compassion: sympathy, pity or concern for the suffering or misfortune of someone.

Including:-allowing someone to share in a privilege

Excluded:-denied access or privilege, to remove from being considered, rule out or keep out

Cutting with compassion: Surgery is about "cutting". According to Wikipedia, it is a procedure involving cutting of a patient's tissues or closure of a previously sustained wound. It is a science and an art where one uses his brain and eyes by working with the hands to bring about cure, relieve a patient of an infected abscess (lancing), cut to implant and to transplant organs, cut to correct a birth defect, cut to sew damaged tissues resulting from trauma and to do other incredible things in saving the lives of our patients. [Fig 1]

Fig 1-A Surgeon's hand prepared for cutting…

In "cutting", one may also have recourse to physical manipulation (in the setting of

fractures and dislocations) to the external application of a wide variety of medication, for bleeding, infection, cleansing of wounds and pain management.

Compassion: means to be sympathetic or have pity or concern for the suffering or misfortunes of someone. It motivates people to go out of their way to help the physical, spiritual or emotional pains of another. The etymology of "compassion" is Latin, meaning "co-suffering". It involves allowing yourself to be moved by the suffering of someone and to help in alleviating or preventing it. Compassion has some qualities which include: patience, wisdom, kindness, perseverance, warmth and resolve. Its perspective is based on the finding that people sometimes emulate and feel the emotions of people around them. It has the ability to induce a feeling of kindness by identifying with another person. Mostly, it is an evolved function from the harmony of a three-grid internal system:

i. Contentment and peace system;

ii. Goal and driver system;

iii. Threat and Safety system.

Compassion in Medicine is one of the most important attributes of physicians practicing Medicine. Felt compassion brings about the desire to do something to help the sufferer. It was Dalai Lama who said “if you want others to be happy, practice compassion, I you want to be happy, practice compassion”.

Compassion consists of three major requirements:

1) People must feel the troubles of others that evoke their feelings as serious
2) The understanding that sufferers' troubles are not mostly self- inflicted and
3) The ability to picture oneself with the same problems in a non-blaming manner.

Monk Bhikku Bodhi states thus and I quote "Compassion supplies the complement to loving kindness, whereas loving kindness has the characteristics of wishing that others are made to be free from pain and suffering"

Religious outlook on compassion

Islam: In the Moslem tradition, the foremost among God's attributes are Mercy and Compassion. In the Canonical Arabic language Rahman and Rahim, each of 114 chapters of the quran except one, begins with the verse "In the name of Allah, the Compassionate and the Merciful"

Christianity: Jesus Christ embodies for Christians, the very essence of compassion and

relational care. Many of His healing Miracles, including the bringing back to life of the only son of a widow at Nain[2] and the raising of Lazarus[3], were born out of compassion that he was even reported to have wept in the later instance. Christ challenges Christians (and others I believe) to demonstrate selfless love and act compassionately towards others, particularly those in need or in distress. Christ himself demonstrated compassion to those the society had condemned through healing, provision and forgiveness of sins[4]. Paul Gilbert (2010)[5]-in a write up stated "The Compassionate mind-A new approach to Life's changes"

The role of Anaesthesia in Cutting with Compassion:

Anaesthesia is derived from the Greek words "an" meaning "without" and "aesthesia"meaning "sensation" In other words, "anaesthesia" means "without sensation or insensibility." [Fig 2]

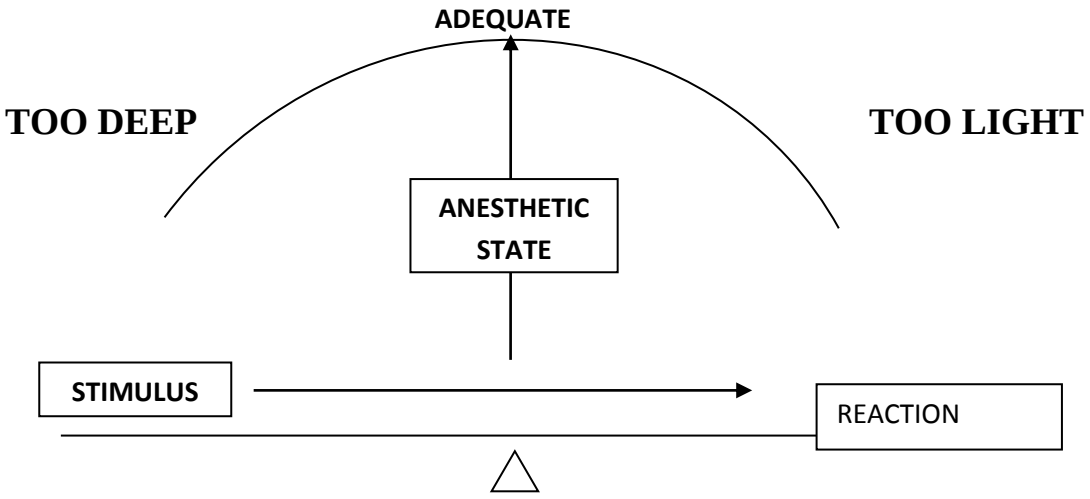


Fig 2: The Relationship between Patients' Pain Stimulus and Reaction in Equilibrium

Before the advent of modern anaesthesia in the mid-19th Century in Britain and United States of America, control of Pain, bleeding and infection, surgery was at best very dangerous. Surgical procedures were largely by restraint, carotid compression, mesmerism, hypnosis and later the use of alcohol brewed extracts such as mandrake plants, opium, coca leaves, chloroform and ether. Dr. William Morten first gave a Public demonstration of Ether inhalation at the Massachusetts General Hospital, USA on the 16th of October 1846[6][Fig 3]. Local/Regional Anaesthesia and General Anaesthesia have evolved fully to now make "cutting with compassion" an interesting and stress-free procedure.

Fig. 3: Demonstration of Ether Inhalation by Dr. Morten (1846)

My Contributions to Knowledge and Research

As young medical students over forty years ago (early 1970s), we thought there was

nothing more to discover in the basic and clinical aspects of Medicine. Virtually out of over 66 foramina that were located at the base of human skull over 44 had been named after someone or another. Even in the simple anatomy of the inguinal region, hernia being the commonest surgical procedure in the groin all over the world, the triangle through which hernia protrudes is named after Hesselbach. We have discovered over the years however, that the statement that says "there is nothing new under the sun" may not be absolutely true in Medicine. Technology has far advanced Medicine and Research that one can humbly mention some areas where we contributed to knowledge, teaching and research. For instance, these days, a Surgeon no longer needs to make a long incision from upper abdomen to pubis just in the name of "Exploratory Laparotomy". This is made possible with the advent of Minimal Access Surgery or Laparoscopy (MAS) for diagnosis and treatment intervention. For this lecture, I shall categorize our contributions under the following sub-titles:

(a) Trauma and Emergency Surgery[6-16]
(b) Breast [17-25]
(C) Hepato-biliary[26-28]
(d) Superficial and deep Infections[29-35]
(e) Medical Education [36-37]
(f) Rural Surgery [38]
(g) "Surgical herbology" [39-40]
(h) Surgical Audit[41-42]
(i) Others[43]

For lack of time, I may not be able to discuss all of them in into details but will choose a few examples of relevance to our situation/environment and highlight some of their importance for the purpose of this eminent gathering.

TRAUMA

Fractured Penis: Penile fracture is a rupture of one or both of the tunica albuginea - the fibrous coverings that envelope the penis's corpora cavenousa. It is caused by rapid blunt force to an erect penis, usually during vaginal intercourse or aggressive masturbation. It could be complete or partial. In complete Penile fracture there are associated injury to the urethra, dorsal penile nerves, veins and arteries of the penis with possible permanent damage that will prevent the individual having good erections again unless surgical intervention is sought immediately. This, most of the time is not possible because young men are afraid to come out in the middle of the night (when it mostly occurs) to "expose" themselves and to complain about it until the complications set in. It is therefore an under

reported problem among the sexually active young adults in an undergraduate environment like ours. It occurs in 90% of cases when a couple uses the reversed Missionary Method (the lady is on top) in sexual act. The man will experience a popping sound or "cracking sign", severe pain tumescence (the penis will suddenly lose erection), leading to flaccidity and skin haematoma [Fig 4] In a sexually active environment like ours, we need to let our students and young colleagues know about the problem and that emergency surgery, as soon as it occurs, can prevent future complications, including the possibility of not been able to "perform" when they get married.

Fig 4: Fractured Penis: Note the haematoma, the flaccidity and the "bend"

EMERGENCY SURGERY:

Of the series of Emergency surgeries published by us, I will briefly discuss the following: Pattern of Gunshot injury as presented in a communal clash in two Nigerian teaching hospitals (OAUTHC, Ife and LAUTECH, Osogbo), published by the Journal of Injury and Infections[11]; Pattern of Emergency operations seen in a new Nigerian teaching hospital, published by the Nigerian Postgraduate Medical Journal[12] and Non-trauma surgical emergencies in Adults: Spectrum, Challenges and Outcome of care, published by the Annals of Medicine and Surgery[16]

In the paper on communal clash, the gunshot injuries came as a result of a fratricidal war between two communities that had been living together for centuries. One hundred and eighty five cases from both communities were treated. Almost 50% were youths whose ages ranged between 22 and 30 years. It could best be described as a carnage that wasted away the lives of able youths. Injuries to the lower limbs were common; however the greatest causes of death were those from the head and colon. The sad part of the war was that only 57.5% of the victims were combatants, the remaining 42.5% were passersby who had nothing to do with the war. It is hoped that such a war between people of the same stalk will not come up again as discussion and dialogue should always be a better pursued

option. The economic loss of the war is better imagined with many houses burnt down, thriving estates left in ruins and sources of livelihood of several residents of the communities cut off abruptly.

In the paper titled "Pattern of Emergency surgery in a new Nigerian Teaching Hospital, LAUTECH Osogbo Experience, 2070 operations were performed in a five year retrospective study out of which 726 were done as emergencies. Obstetrics and Gynaecology cases accounted for 66.6% of the lot, while 33.4 % (including 6 cases of perforated uterus and gangrenous bowels from unsafe/criminal abortion) belonged to general surgery and specialty emergencies. Mean waiting time was 39.5hours, which was unduly prolonged. The high mortality of 10.3% observed could be reduced through prompt surgical interventions, education, contraceptive awareness and legislation against unsafe abortion.

In the paper on Non-surgical emergencies that I co-authored in Lagos during my Sabbatical leave, 7122 adults were prospectively reviewed, representing 29% of the emergency cases seen. It is important to note in the table below (Table 1) that acute abdomen (from Peritonitis secondary to perforated appendicitis or malignant large bowel perforation) carries the highest percentage of 29.6. The Urological conditions were mainly acute urinary retention from enlarged Prostate in elderly males. The malignancies were from Colon and rectum and they were commoner in females (7.5%F: 2.7%M) Mortality was 24%

Diagnosis	Males Number (%)	Females Number (%)	Total (%)
Acute abdomen	386 (18.7)	226 (10.9)	612 (29.6)
Urological conditions	362 (17.5)	12 (0.6)	374 (18.1)
Malignancies	55 (2.7)	156 (7.5)	211 (10.2)
Joint/bone pains	81 (3.9)	74 (3.6)	155 (7.5)
Limb/soft tissue swellings	71 (3.4)	65 (3.2)	136 (6.6)
Medical conditions	77 (3.7)	54 (2.6)	131 (6.3)
ENT/Eye conditions	48 (2.3)	53 (2.6)	101 (4.9)
Gastro-intestinal bleeding	54 (2.6)	21 (1.0)	75 (3.6)
Skin ulcers	39 (1.9)	20 (1.0)	59 (2.9)
Peri-anal conditions	34 (1.6)	16 (0.8)	50 (2.4)
Neurosurgical conditions	26 (1.3)	11 (0.5)	37 (1.8)
Gynaecological conditions	0 (0.0)	26 (1.3)	26 (1.3)
Thoracic conditions	17 (0.8)	8 (0.4)	25 (1.2)
Dental conditions	8 (0.4)	16 (0.8)	24 (1.2)
Sepsis/fever	14 (0.7)	6 (0.3)	20 (1.0)
Complicated goiters	1 (0.05)	6 (0.3)	7 (0.35)
Enterocutaneous fistula	3 (0.14)	1 (0.05)	4 (0.19)
Colostomy prolapse	2 (0.09)	1 (0.05)	3 (0.14)
Other conditions	10 (0.48)	5 (0.24)	15 (0.72)
Total	1288 (62.4)	777 (37.6)	2065 (100)

Table 1: Spectrum of Non-trauma Emergency Surgery

BREAST DISEASES:

The Breast or the Mammary gland is what distinguishes Mammals from other lower animals. The rudiments of Human breasts develop along a "milk line" which starts from the region of axilla and runs along the trunk to the middle of inner thigh. Hence, a woman is capable of having as many "breasts" as a dog. However before birth, these potential extra breasts disappear, leaving only two except on rare occasions where some fail to disappear, and the woman is sometimes referred to as having "accessory breasts or nipple" which may occasionally be physiologically functional [Fig. 5]. Only men with such wives among the audience will understand what we are saying.

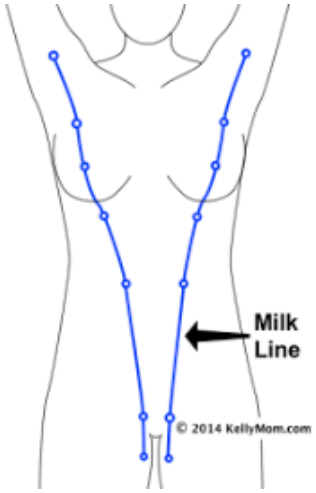


Fig. 5: Breast development and possible Locations of Accessory Breasts

Diseases of the Breast can be classified into Benign (BBD - Benign Breast Disease) or Malignant (MBD - Malignant Breast Disease). It is however the Malignant Breast Disease that bothers not just the patient but also the doctor because of our experience in this part of the world where patients present late by which time not much can be done for them. It is the challenge of this late presentation that brought out our Paper on Knowledge of educated and non-educated women in Breast cancer[18]. One of our most distressing finding is that education did not prevent late presentation of Cancer of the breast by our women. The "fear factor" and the alternative method (particularly prayer houses) of treatment were found to be responsible for this. The paper made a strong case for promoting Self Breast Examination through Radio jingles. Also the Association of Women Journalists made a successful effort to make Breast screening through Mammography possible at LAUTECH, Osogbo, by influencing the purchase of a mammography machine which makes early detection and early surgery possible with concomitant improvement in

prognosis. Thanks to Professor 'Wale Akinsola - our indefatigable and highly cerebral Chief Medical Director at that time, who purchased many sate of art equipments that set LAUTECH Osogbo apart as a teaching hospital destined for greatness.

Male Breast Cancer: It is erroneous to believe that only women suffer from Breast Cancer. [Fig 6] In fact recent studies show that the incidence has risen from 1% to about 3.2%.[39] We looked at the ones we have seen at Osogbo studying their Socio-demographic factors, treatment and outcome of treatment[21]. The take-home point here is to be aware that the male breast is of small volume and cancer, when it occurs, is locally advanced by the time it is noticed. We therefore enjoin men to be careful and watchful

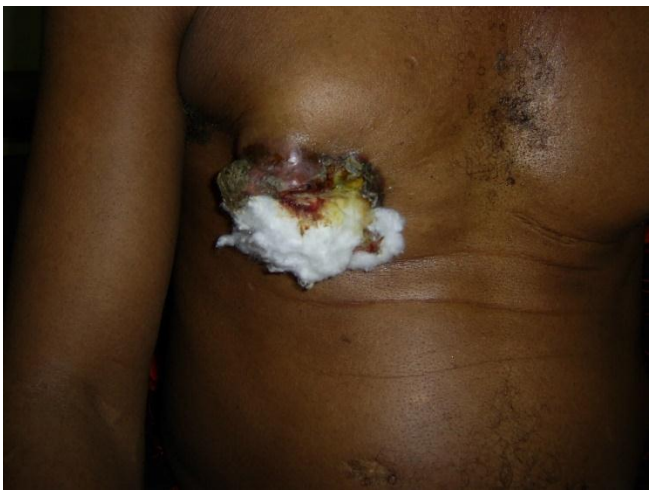


Fig. 6: Male Breast Cancer in advanced stage - note ulceration and bleeding

Bilateral Breast Cancer: Bilateral Breast Cancer occurs in about 4.6% of women who had had Mastectomy for Breast Malignancy where a contralateral breast was found involved. It could be found synchronously at the time of presentation or later during follow up clinic appointments. In a review of 256 cases by Oguntola et al, between 2001 and 2008, 11 cases had bilateral breast cancer with close to 50% of them being symmetrically located[22]. One of our papers also recommended the role of men (husbands) in early detection of Breast Cancer[23] There is usually a high genetic outlay (less than 5% familiar-the gene can be passed from mothers to daughters) to the extent that young women in developing countries who have such risk factors or predisposition for developing cancer of the breast opt for what we call "prophylactic" bilateral mastectomy, have breast implants and move on with their lives.

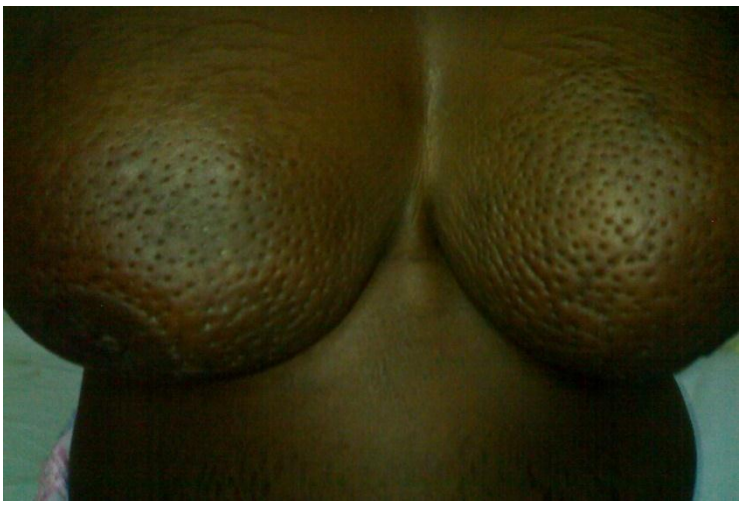


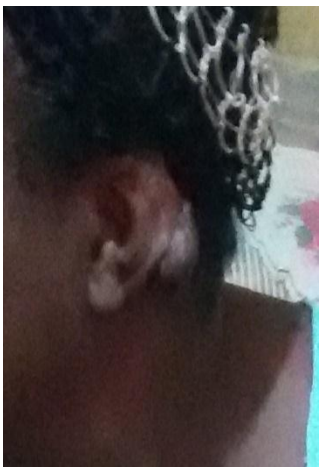
Fig 7: Bilateral Breast cancer in a middle aged woman: Note the "peu d'orange" on both breasts-a sign of advanced breast cancer

Medical Education: When Examination malpractice became the order of the day in our country and some other African countries, we felt it was good to look at this malady in our Medical Schools and see if our doctors of tomorrow were involved. It was a multi-institutional study involving some medical schools in the Northern and Southern parts of Nigeria. We researched on Preclinical and Clinical students (200-600L students) and the findings were shocking! We discovered that Examination Malpractice was a National malady that tomorrow's doctors were not exempted from. We felt this would be dangerous for people's health as such doctors would not mind "cooking up diagnosis and treatment" with lives being unsafe in their hands. We looked at why some students decided to study Medicine which they were not primarily interested in and for which they were not psychologically prepared in terms of discipline and rigors of training. Some of them were forced to read the course by their parents who want Doctors in their family which, by the way, is a good intention but done in the wrong way. This made me to look at the **Exam Process** generally and note the various ways examination questions could leak as well as propose measures to block these potential leakage pathways. The exam process includes teaching the appropriate courses, submission of questions by Lecturers to the Head of Department who creates a "pool" from where questions are taken intermittently. Usually this pool is known only to the Head of Department (HOD) and the questions to be given to the medical students are solely at his discretion. Where you have an HOD who can compromise his position by leaking questions to his Favorites/ "girl-friend," or could be induced to do so by whatever means, the unimaginable becomes highly probable. Where the Secretary to the Department knows the password to the pool, he or she can compromise the examination process for monetary gains in this era of unsure salaries. Students themselves can smuggle information into the exam hall through phones and other modern ways of communication. [Video] Invigilators must therefore be very vigilant all the time. I

first gave a Lecture on the Examination process during the Education week at the Lagos University College of Medicine (LASUCOM), as the Vice-Chairman of the Education Committee. We have since incorporated the lecture into our annual orientation week of interaction between students and lecturers for our 400L students during their week of Faculty of Clinical Sciences clinical orientation in Osogbo. This paper[36] so caught the attention of an International body known as "Medical Education in crisis" that they still write to us to update our paper. I sincerely hope my younger colleagues who co-authored the article would rise to the challenge.

Surgical "herbology": This is an unusual or emerging terminology coined for the use of herbs to perform surgery. Those of us trained in Western medicine find it difficult to readily believe in Eastern Medicine and use of herbs to treat diseases. My adventure into this was quite accidental and propelled by the story of a young lady whom I will call O.O. who happened to be a member of my church. I noticed a big Keloid on her left ear lobe and advised surgery. She declined, saying that she had tried on two occasions to remove it but it got worse each time. About 6-8 months after, I noticed that the keloid was smaller in size and asked for where she went to remove it without informing or involving me again. She told me that she did not remove it surgically and that on the recommendations of someone she had been applying the juice of "bomubomu" with resultant gradual shrinkage. She told me the story of how she developed it as a teenager. She had flippantly replied her mother one morning, and the mother, in a fit of anger threw a padlock she was holding at her. This hit her left ear lobe and created a wound that bled freely. The mother took her to a clinic where the wound was sutured and they both thought all ended well until a few months after, when the keloid started developing. As a researcher, many research questions that needed answers started to flood into my mind on account of this experience.





A. Before management B. Early stage C. present stage

What in this plant juice was responsible for reducing the size of the Keloid?; Is there any

danger associated with its use?; Could the content be developed and patented for treating keloid and hypertrophic scars whose treatment, despite advancement in drug technology research is still evolving? These and many other such research questions bombarded my mind. I then sought the help of Professor A. A. Elujoba, a former Head of Department, Dean of the Faculty of Pharmacy and Acting Vice-Chancellor of the Obafemi Awolowo University, Ile-Ife. He did the taxonomy, classification and proper naming of "Bomubomu" for me as Callotropis Procera (CP). Literature review showed that the plant was not as innocuous as I thought.

Fig 9: Calotropis Procera plant at Edunabon, Osun State

Fig. 10: Calotropis Procera plant in my frontyard showing its fruits/pods

Calotropis procera belongs to the Family *Asclepiadaecae* which is an important plant with medicinal properties and a popular remedy among Ayurvedic and traditional practitioners for the treatment of a range of ailments[43]. It is known by various synonyms in English(calotrope, calotropis, Dead Sea fruit, giant milkweed, swallow- wort, mudar fibre, sodom apple) and French (pomme de Sodome, algodón de seda, arbre á soie, coton soie, arbre a soie du Senegal). In Nigeria, it is known by various names e.g., in Hausa (TUMFAFIA), Kanuri (KAYÔU), Igbo (KAUSU), and Yoruba (BOMUBOMU). It also goes by the following names in other languages of the world Hindi (madar, akada, akdo, aak); Italian (calotropo); Mandinka (kipapa); Sanskrit (alarka); Somali (boah, bo'ah); Spanish (bomba, algodón extranjero, cazuela); Swahili (mpamba mwitu); Tamil (vellerukku); Tigrigna (dinda, ghindae, akalo); Wolof (faftan), Commonly found in many parts of the world, it is believed that every part of it - leaf, bark, fruit, juice has one medicinal value or another [Table 3].

Phytochemical Screening of CP Leaf		
1.	Phytochemical	Alcohol Extract
2.	Alkaloids	-
3.	Carbohydrates	+
4.	Reducing Sugar	-
5.	Flanoids	+
6.	Glycoside	+
7.	Tannin and Phenolic	+
8.	Saponin	-
9.	Protein & Amino Acid	+
10	Fats & Oils	-
11	STEROIDS & Interpenoids	+

Table 2: Phytochemical Screening of CP Leaf

Therefore, with the first research questions needing answer(s) I discussed with Mr. Wakil of the Department of Pharmacology, LAUTECH, to know if we could analyze the contents of parts of this plant. In an unpublished work by us (Aderounmu, Elujoba, Wakil, Eziyi) we did an alcohol extract of the dry leaves and discovered that one of the contents, apart from others, contained the presence of steroids in some quantities and concluded that if it could be that much in the extract, then the raw juice was likely to contain more.

S/No.	Part Used	Medicinal Utility
1.	Whole Plant	To treat common diseases such as fever, rheumatism, indigestion, cold, eczema and diarrhoea. In boils and also to remove thorn from body for the treatment of jaundice
2.	Root	Eczema, leprosy, elephantiasis, asthma, cough and rheumatism. In the treatment of Diarrhoea and dysentery. In case of diarrhoea it changes the faecal matter into a semisolid mass with in the first day of treatment
3.	Stem	For the treatment of skin diseases, enlargements of abdominal viscera and intestinal worms. To people suffering from leprosy. To cure Leucoderma.
4.	Leaves	To prompt healing, used for joints and waist pain, for asthma. To cure malarial fever. Eczema, leprosy, elephantiasis, asthma, cough and rheumatism. In rheumatism, gout and to relieve pains. To apply on ulcers. To cure flatulence, anorexia, indigestion and intestinal worm infestation.
5.	Buds and Latex	Anti-tumour activity
6	Latex	Wound healing properties, Powder latex for the treatment of early symptoms of dementia of Alzheimer's disease(Neuro-protective)

Table 3: Medicinal Utility of different parts of CP

We concluded that it could be the steroid content that might have been responsible in reducing the size of the keloid (Table 2). The next stage of the research was to look at its effect at the cellular level. We compared its effect with some known anti-keloid drugs using rats[38]. At this stage, I knew we may not be able to do this locally at LAUTECH. God, by divine arrangement (through my long term friend in the Medical school, Dr. Basola Adebayo) brought me in contact with a Professor of Pharmacology in Obafemi Awolowo University in person of Professor Lara Orafidiya. I first knew her over 40 years ago when she was the Chief Bride's Maid to her friend and classmate - Yinka Adebayo - and I was the Best man to this my classmate and friend when they were wedding. I showed some of the pictures to her and we then started working together by bringing on board other young and brilliant researchers in other relevant faculties and departments including Morbid Anatomy and Histopathology, Pharmacy, Pharmaceutics, Haematology and Biochemistry. The findings were almost comparable [Figs 11&12]

Fig 11: Section of the wound treated with triamicinolone on Day 3, Note the scanty granulation tissue. (H&E Stain. Medium power magnification)

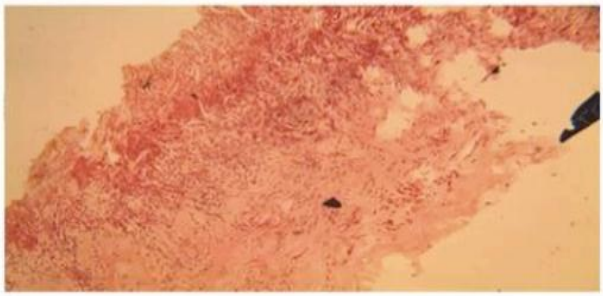


Fig. 12: Section of the wound treated with Calotropis procera on Day 21, showed marked reduction in thickness of the collagen fibres (H&E Stain. Medium power magnification)

The third stage of the research was to find its toxicity in animals before we could extrapolate to humans and this was the most challenging as well as time-consuming aspect. We looked at the effect of different doses on different organs of the body and concluded that, by and large, the latex is safe to use at reasonable doses as many of the organs, except the testis, still showed normal architecture after its application.

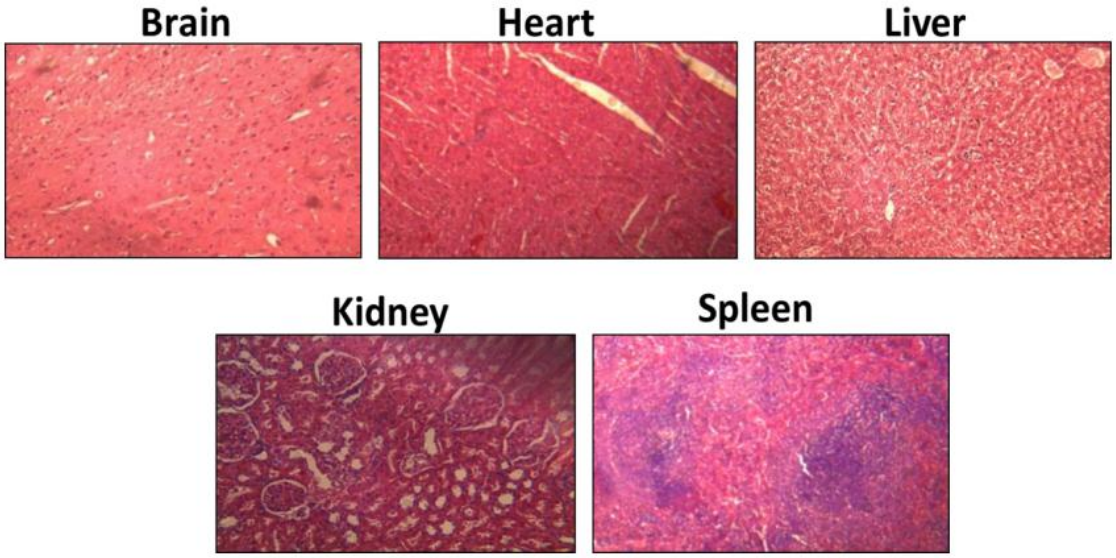


Fig 13: Photomicrographs of the brain showing viable brain tissue, the heart showing bundles of cardiac muscles separated by thin myocardial fibres, the liver showing a well preserved portal tract, parenchyma and central vein of the liver. Photomicrograph of the kidney showing numerous glomeruli with preserved Bowman's space, unremarkable interstitum, tubules and blood vessels. Photomicrograph of the section of the spleen showing the red pulp consisting of thin walled vascular channel and white pulp consisting of aggregates of lymphocytes. (H&E staining (400x).

I presented these findings at an International 3rd Asian Clinical Conference held in Tokyo, Japan in 2014, through the sponsorship of the Education Trust Fund (ETF) and by courtesy of the recommendation of the Vice-Chancellor and the Director of ETF then - Professor Jekayinfa. This resulted in the paper published by the World Journal of Pharmaceutical Research - a highly rated Journal of high impact factor of about 8.04 and an ICV of 95.07 in 2017[40]. Further research in this regard will subsequently depend on my younger colleagues in the Department by seeking funding from any willing organization - Pharmaceutical, Governmental and Non-governmental - to isolate the active ingredients in the latex.

Further contributions to Knowledge and Professional Accomplishments:

Fellow of Surgery:

The Fellow of Surgery awarded to me by the National Postgraduate Medical College enabled me to have a Recognition Nationally and World Wide;

Through my Publications:

My publication on **Mirrizi** Syndrome[28] highlighted a cause that had hitherto not been considered in World Literature, subsequently giving rise to a 5th classification of Causes.

Similarly, my publication on the knowledge, attitude and practices of the Educated and Non-Educated Women to Cancer of the Breast gave the window to review articles in some International Journals like the Indian Journal of Cancer and the Mediterranean Journal of Medical Sciences;

Membership of International College of Surgeons

As an active/Council member of International bodies such as International College of Surgeons-(FICS) Nigerian National Section, American Association of Science and Technology(AASCIT)

In collaboration with the Osun State Government and others, we were able to spearhead the Rotational Surgery for the poor in developing nations[37], led and participated in the free surgical procedures given to the rural dwellers of Osun State in all the Nine Zones of the state (GOWN to TOWN)

As a Member of the Association of Academic Surgeons (AAS)

Many workshops had been organized in Nigeria (LASUCOM, Lagos) and some West African Countries, Liberia, a West African Sub-region, where we collaborated with our American colleagues of Nigerian Origin/Root. This afforded Cross-pollination of Research.

Justice of Peace (JP), Osun State (1996)

Specific examples of "cutting with compassion" done by me:

With all sense of deep humility and gratitude to God, I want to mention some clinical scenario of cutting with compassion-

(i) The first case of "cutting with compassion" that I did was as a Youth Corper in Imo State. It was on a 36 year old G8P7+3 woman, I.O. She was a farmer. She presented in the hospital with ante-partum haemorrhage at 38 weeks gestation. She bled once at home and again when she got to the hospital. Even though her vital signs were stable, I envisaged that another bleeding episode would be precarious for her and her baby. I immediately opted to do emergency Caesarean Section for her before she became unstable clinically which could jeopardize her life and that of her baby. Our problem was that she needed her blood to be cross-matched. Her husband was not around when she took ill. Fortunately for her and for me, we shared the same blood group. I therefore donated a pint of blood for her after which I performed her surgery. To the Glory of God, she made it with her baby - a practical

example of cutting with compassion.

(ii) Mrs. B. A. was a 48 year old lady who presented with Surgical Jaundice. She was admitted following a 3 month history of progressive jaundice, severe itching of the body, loss of appetite, vomiting recently taken meals, marked weight loss and passage of clay colored stool. LAUTECH teaching Hospital, Osogbo was just starting and there was minimal investigation that could be done. Diagnosis was therefore mainly Clinical. The lady, on clinical examination, was deeply jaundiced and very pale with scratch marks all over her body, more on the arms. Serum bilirubin confirmed Obstructive jaundice secondary to Carcinoma of the head of Pancreas. More importantly, she had lost all hope of living, being very depressed. Two of her children based in the United States of America (USA) and who were nurses wanted her to travel over, but she refused because she thought she was too ill to undertake any journey. We talked to her to allow us to intervene with the help of God. After some counseling, she agreed. We prepared her for surgery knowing that the cancer must have advanced but that we would still do our best. At operation, we confirmed Cancer of head of the pancreas with some nodes in the hilar region. We took one of the nodes and biopsied the pancreas and then did double bypass- Gastro-jejunostomy (for her to be able to eat without vomiting) and cholecysto-jejunostomy (to divert the bile-reduce the conjugated bilirubin, reduce itching and give her a sense of well-being). She had two units of blood transfused. The histology came back as "well differentiated adenocarcinoma of the pancreas with lymph node metastasis". After about a week of recovery we started her on 5-Fluouracil and she had 6 courses of chemotherapy. She later travelled to the USA with our referral letter and documentation of findings, including histology. She had comprehensive investigations including those we could not do in our setting, such as CT. They were no longer able to trace any cancer. By the time we saw her a year after her surgery for follow up she had blossomed into middle aged beautiful, grateful lady. This was a lady who had even excluded herself from care, but, who because we showed her compassion, concern and love, accepted 'cutting' and got healed by divine intervention (We care, but God cures/heals)

(iii) Mr. I.O was six years old when he was brought to our Private Clinic – the Oil of Joy Specialist Hospital and Surgical Centre. He was brought to us because the two Government Tertiary Hospitals in town were on strike. He had Peritonitis from perforated Typhoid enteritis - a very common and lethal abdominal emergency among the young in those days. The mother who was

estranged from her husband then had only money for Card registration, none for investigation and none for surgery. Since there was no functioning government hospital, we had to take him and do our "cutting" to save his life. By the time we discharged him about two weeks after, now hale and hearty, the mother was unable to pay the remaining bill. She offered to deposit her radio, television or fridge (as most doctors would insist on) but we refused and allowed her to go with her child.

One afternoon many years later, a middle-aged lady met us around the OAU campus gate, greeted me familiarly and asked to visit our place since she would not want to discuss why she wanted to see us by the road side. We described where we were living in Ife to her. Later she came with the young man who was with her to our residence. The young man, now a handsome 24 year old was the one operated on about 18 years earlier. She had been trying for months to locate us and the hospital, which closed down during the Ife-Modakeke war. The most surprising part of the story is that she brought the discharged bill with what was still outstanding to pay. It remained about 570 naira to balance and she dropped the money. I just thanked her for her honesty, took 50 naira and asked her to keep the rest (I took part of the money so that she would not feel that I was unhappy with her). We glorified the name of God that God used us to have saved the life of that young boy then, now a graduate and promising young man through "Cutting with Compassion". This was actually a demonstration of the vision of the hospital based on Isaiah 61:1-3….”Oil of Joy for the Spirit of mourning, garment of Praise for the spirit of heaviness….”. The mother came with the spirit of heaviness and God exchanged this with a garment of Praise

The future of Medical Practice

This enables us to flow easily into looking at the fate of medical profession in this age where many of us no longer show compassion with and in our practice. I make bold to say that the medical profession is presently a "hated" profession from attacks coming from all sides-there are enemies within and enemies without. Gone were the days of Socratic teaching from "Known to Unknown" when a Consultant's ward round would bring everybody together from the student nurses, student doctors, interns, residents, nurses, senior nurses, matrons and even junior consultants. We were all ready to learn from ourselves to make the treatment of a patient better. “We knew then that Iron sharpeneth iron.” The most senior doctor was always in charge. The medical student who was allotted the patient to clerk

would have presented the patient from presenting symptoms to examination findings, results of investigations and like a detective, bring all these together to arrive at the diagnosis. The Socratic method of teaching and interrogation is to put the learners, starting from student nurses and moving up the ladder gradually till you even get to the younger consultants on their toes by the Professor. With this method, one-particularly the medical student would be questioned to the point of embarrassment that "he does not know anything". He will be fortunate if the student nurse he is "eyeing" is not part of the ward round to see the hollowness of his knowledge. The advantage however was that he would have prepared by thoroughly reading up the case so that he can "shine", as the fear of being de-shined in front of your "lover" is real. Today everybody is his or her own master. Now, every profession in the hospital - Nursing, laboratory Science, Pharmacy, etc. have "Consultants" and has the right (given by courts not necessarily by schedule of training), to conduct their own ward rounds separately from Medical Consults on patients admitted under the Consultants' names. The result of this is chaos with patient care fast deteriorating.

It may be pertinent to ask why the doctor is now an endangered species, an enemy to other health workers and colleagues within the same profession. In the University, ASUU perceives us as cocky privileged members who should not benefit from what other teachers are benefitting from because it is assumed that we are on "double salary". I remember vividly an incidence when a former Acting Dean of Basic Medical Sciences, who was even supposed to represent the interest of the College in the University, tore my form for Excess work load claim with the statement "this one wants to collect excess work load allowance too". His main reason was that he does not like his medically qualified colleagues and considered them unfit and over privileged. He probably might, like the Professor of Biochemistry I earlier referred to, have loved to read Medicine during his time but fell short of the pre-requisites. He forgot that I wake up and teach students in the night when we have emergency cases to do. It is worse in the teaching hospital where 90% of the Health care team would gang up against doctors and say that their own is "too much". Negotiating with the government of the day is no longer based on work schedule / performance but on the "strengths" of one's Union and who they are connected with. Things continue to slide down. Perhaps we should do some critical thinking, look backwards and find out the causes so that if possible, appropriate remedies can be proffered.

My blame however, goes first to the Medical Profession because Charity begins at home. There is no gainsaying that Physicians who are practicing Medicine and the

specialties are all relatively intelligent and resilient people, otherwise they would never have gotten to the level of MB.BS, MB.ChB, MD or OD first degrees, not to talk of attaining the Postgraduate chain of other degrees.. I believe this has so registered in their subconscious that they allow Ego -one of the terrible triads to be avoided - to creep in their relationship with other Professions. We agree you have to be a bit above average to score high marks and to have your cut-off marks much higher [Table 4) than others, but are we saying somebody in the arts with a first class in History or Geography or even French or Mathematics is not equally intelligent or brilliant? Should we say because of certain circumstances like JAMB cut-off point, the student that was denied reading Medicine and ended up with reading Microbiology or Biochemistry or Nursing or Medical Rehabilitation or Medical laboratory sciences and still finished with a first class or a second class upper is not intelligent? It is an "Inflated Ego Syndrome" that makes one have a bloated sense of self-esteem. It may be that we made fun of our classmates who could not meet up with the type of our grades then, but now, because of their relatively shorter period of training or because they are in the administrative or political class, are now the ones bossing, oppressing and suppressing us

LADOKE AKINTOLA UNIVERSITY OF TECHNOLOGY, OGBOMOSO
CUT OFF MARK FOR DEPARTMENTS
2017/2018 ADMISSION EXERCISE

S/N	FACULTY	DEPT/COURSE	Cut off mark	
1.	FAGS	(a)Agric. Economics • Agric. Extension and Rural Development • Animal Production and Health • Animal Nutrition and Biotechnology • Crop Production and Soil Science • Crop and Environmental Protection	35% 30% 35% 35% 30% 30%	**All courses required PHY, CHM and BIO**
2.	FBMS	• Medicine • Anatomy • Biochemistry • Physiology • Nursing • Medical Laboratory Sciences	69% 45% 50% 45% 64% 60%	
3.	FES	• Architecture • Fine and Applied Arts • Urban and Regional Planning	55% 30% 33%	

Table 4-Coutesy of LAUTECH Admission Committee

As we all know it, this is even worse in the teaching hospitals where the hydra headed (octopus) union called JOHESU regards it as a thing of joy to always antagonize the Medical doctors and query their negotiated allowances backed by law.

Greed and fear of being subjugated to the background by any of the unions are the two other components of the triad. This should not be. Though greed is found in every profession, it is unethical to practice medicine with a greedy mind/attitude. When a doctor is motivated by greed, many times his judgment is clouded or warped, and the result will most likely not benefit those it should. He would carry

out unnecessary procedures, order unrelated investigations and persuade the patient to comply; the most likely reason being money. The government on her own has failed woefully in supervising Health care according to law. Let us humble ourselves and relate with each other as if the other is better than us. [Video clip]. Our constant quarrels and strikes only make the medical students and the patients we swore oaths to take care of losers. The end result being course prolongation of our students and suffering or even death of our patients. Let us also note that the Medical students are doubly jeopardized. They suffer when ASSU is on strike and when the Teaching hospital is not functioning. This means we are not practicing our Profession with Compassion. "The purpose of human life is to serve and to show compassion and the will to help others" [Albert Schweitzer]

Health Insurance - a way of including the excluded:

"Patient autonomy is paramount to the oath that we take when we enter the Profession of Medicine. That is why I am appalled when the federal government gets between my patients and their right to the full range of medical information and complete access to health care" Ami Bera The Health Insurance scheme as being practiced presently gives the HMOs (Health Maintenance Organizations) the power to dictate the way a Physician should treat his/her patient by dictating the type of drugs to be given or surgery to be performed-all in an attempt to cut down on claims for treating the patient. This is both unfair and unethical.

Although the Nigerian Medical Association has been calling on our governments to establish the Nigerian Health Insurance scheme since 1976, our political leaders did nothing till 1999 when the Nigerian Health Insurance Scheme was enacted as a Perpetual Act of Parliament. It however did not become operational until June 2005. Its main thrust is the provision of needed Health Care for all from pooled funds, released for the care of those needing it at any point in time as a type of Social Health Insurance. The National Health Insurance Scheme (NHIS) offers financial security to the Citizens against unanticipated ill health. The scheme was meant to cover the formal sector workers, the informal sector workers and the vulnerable groups-persons to start with but is intended to cover every strata of the society after some years. Provision of affordable and accessible health care in our country is highly parlous. The NHIS coverage as of today is only about 5% while the Health care system is on the verge of collapse as we wake up to the news of suspensions and re-instatements of corrupt executive officers. Corruption, the dreaded disease that is killing our beloved country has not spared the Health sector and there seems to be no respite in sight as our Politicians/ elites continue to access care from U.K, Germany, France, India, Dubai and America even for an illness as common as common cold!. Majority of the Citizens are not that lucky. Like the

Clinical scenario cited above (Case 3), majority of them are unable to provide adequate funds for their healthcare needs. This prevents them from coming to the hospital on time until it's almost too late. To decrease the morbidity and mortality associated with this, the less than 5% coverage that is presently attained in the formal sector has to be increased while the informal sector workers and other non-governmental workers like artisans should be included in the scheme, else we would still not be able to take care of the less privileged. To include the excluded and cut with compassion, we should provide sound health care for those with little or no means of paying for it. The National Health Insurance scheme must be made to work and the University should key into it by enabling members of the University Community (staff and students) to be registered for affordable premiums negotiated with experienced and forthright HMOs. It would also make good economic sense among other advantages for the University Medical Center to be positioned to be accreditable as Primary and secondary care providers within the Scheme. The fund realized could be used to upgrade the Health Centre facilities.

The Legal System - anti "cutting with compassion"

There is a potential ticking "bomb" in the field of Medicine and Nursing right now. This is the Lawyer-driven insistence that no matter the condition of the patient accepted for care, the prescribed standard has to be rigidly adhered to, whereas, a good and experienced doctor sometimes needs to weigh the pros and cons of interventions vis-a-vis the total situation of a patient before embarking on a particular course of treatment which may not necessarily follow what the "books say", but based on experience.

You may know that if you do nothing to a patient that is clinically bad, he or she would certainly die, but if you do something, no matter how small, the patient might live. Let's look at the scenario of a 40 year old farmer who came to the hospital with a bad peritonitis secondary to neglected perforated duodenal ulcer. The surgical intervention that would be needed will be to open the abdomen, clean the peritoneum and just close the perforation and run out to do a more definitive Ulcer surgery later, for "he who fights and runs away lives to fight another day". Otherwise, even with the best antibiotics, the clinical condition would progress to sepsis, multiple organ failure and sure death. For such a patient with possible derangement of serum potassium, urea and creatinine, he will be a "bad" candidate for surgery and the anaesthetist will most likely refuse to give anesthesia. The option will be to give the patient only oxygen and open the patient under local anaesthesia, clean/irrigate the peritoneum of pus and defer the definitive surgery. If however something unpleasant occurs along the line, the lawyer may call you to

question and ask for damages.
There is the true story of a young business man who travelled to China on business. The wife was about 8 months pregnant and he left her care to his bosom friend who happened to be a surgeon with a private clinic. Not long after the man travelled, the lady developed Ante-partum haemorrhage (bleeding before delivery). The doctor called a specialist Obstetrician to handle the case. When the lady needed two pints of blood during the surgery in the night, the friend doctor went round town. He was harassed by vigilante and regular police for moving around in the night. The lady and her baby's lives were saved - all expenses were born by the friend doctor. The sad part of the story is that when the young business man came back and was given the bill, he was very angry that the bill was too much and he was ready to inform his lawyer about it, after writing a cheque as part payment. The doctor also got infuriated and tore the cheque he gave him. Could any amount of money substitute for two precious lives? But this is how most of us would react, get a lawyer and charge the poor doctor for negligence if he had not risked his own life in the night to save the woman and her baby. This however is not saying that Medical Negligence should be tolerated. I believe however that our controlling bodies like the MDCN should use the inbuilt disciplinary system to punish such doctors.

Conclusion and Recommendation:
This lecture has basically highlighted the need to practice Medicine and Surgery with Compassion by being aware that we are called to care. I have also made effort to call us back to the old practice of working together as a team. I have ventured into Government policies that should help in “cutting with compassion to include the excluded”. Lastly, I want to encourage my younger colleagues to seek funding to continue our research on "surgical herbology”. I will always make myself available to provide the appropriate guidance if and when required.

Acknowledgements
I want at this material time to acknowledge my teachers and mentors, many of whom are still alive, although some have transited into the Life beyond. The latter group includes Drs. Alabi, Baba Bamgboye (both Orthopedic Surgeons) Prof. Badejo and Dr. Omole (General Surgeons) and Professor Adebayo Adeyemo, a Cardio-thoracic Surgeon. May their souls continue to rest in perfect peace. My living teachers and mentors include the following giants and colossus in surgery. Professor (Baba) M A Bankole who stands out prominently as a meticulous teacher with the baritone voice. Strict but loving, you would always enjoy his contributions

at clinical meetings, and at Senate meetings as well. He, till date, has zero-tolerance for laziness. Prof. Olu Arigbabu is in a class of his own - generous, hard-working and very bold when he handles the surgical knife. He is the type that would include on the surgery list what others would have excluded. Prof. Sanmi Esho, an Urologist, was the one who fired my interest in urology, when as a House Officer he allowed me to scrub with him for a nephrectomy; Prof. Soji Oluwole is a very brilliant, bold, humorous 'young' surgeon and a National Award Winner whose background training made him to see his trainees as friends. He believes in the principle of "showing one (a surgical procedure) doing one together and encouraging you to take charge hence forth without breathing on your neck." The nick name he gave me was "Sekere Alafin" because back then, I used to have a rickety car that made so much noise on motion such that if the car is at Taki in Ogbomoso here, you would know that I am on my way to LAUTECH because you could not miss the noise of the car! Prof O G Ajao is a father and mentor that I could discuss any case with, anytime and anywhere and who is always ready to guide. Professors 'Sanya Adejuyigbe and Yinka Akinola were teachers who also taught me many procedures and encouraged me into Academics through joint paper writing as we had several research collaborations together. Professor Adejuyigbe supervised my dissertation for my Part II Fellowship. Other contemporaries include Professors O.O. Lawal, A.R.K. Adesunkanmi, Agbakwuru Oginni Lawrence and Dr. Segun Fashakin-a bold and fast operator. Professor Dunni Kehinde of blessed memory and my other contemporaries at LAUTECH (HOD O Olakulehin, SO Fadiora (the first Professor of Surgery in the Department), PB Olaitan, Adeoti M L, AS Oguntola, SO Akanbi, DA Onilede, SA Olatoke, SO Agodirin from Ilorin, and NA Ibrahim, B Oludara and F Omodele from LASUTH with whom we did joint publications. Dr. Bade Akintan is a Consultant Urologist who also fired my interest in Urology. When he resigned from Government service to establish the MOS Medical center, he trusted the running of the Urology clinic and unit to me for over three years but was always coming over to assist in major cases that I lacked experience in handling. He also trusted me to supervise his clinic when he had to "run" to Saudi Arabia and United States of America for greener pasture when things were tough like today. Rev. Dr. and Mrs. Funso Omowo contributed immensely in prayers and hospitality to my work and making. The family accommodated me each time I was in Lagos. I acknowledge my Research colleagues on surgical herbology - Professors L Orafidiya, K Adelusola, PB Olaitan and Drs. J Akingbasote, AA Omonisi, R Bolarinwa, Adegoke, Bejide, D Onilede and the Pharmacy students-Makanjuola and Adedigba. I wholeheartedly acknowledge Emeritus Professor 'Wale Akinsola who has been a friend and mentor since our Government College, Ibadan days

even though we did not meet in school till several years later.

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when they are part of the team that managed the patients and participated in the research / study that led to the publication. Some of them are here today to honour God. I am also exceptionally grateful to all my patients over the years who entrusted themselves to my knife to cut with compassion.

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REFERENCES

1. Inaugural Lecture Prof. John Wood: Lancet Vol. 96 No 2460 Pages 534-562
2. Luke 7:11-15
3. John 11:42-44
4. John 6:3-11
5. New Harbinger Publications ISBN 978-1-57224-236-6.
6. Oludara MA, Nwariaku F, Ibrahim NA, Pursnni K, Omodele F, Osuoji R, Ikuerowo S and **Aderounmu AOA** (2013) Pathway to Independence: Implications for developing a sustainable MIS programme in low resource settings. Nigerian Quarterly Journal of Hospital Medicine(2013) Oct-Dec; Vol. 23(4) 309-313
7. History of Anaesthesia www.en.Acupuncture
8. Adejuyigbe O, **Aderounmu AOA. (1992**) Adelusola KO. Abdominal Injuries in Nigerian Children. Journal of Royal College of Surgeons of Edinb. Vol. 37 29-33s
9. Oboro VO, Dare FO, Fadiora SO, **Aderounmu AOA** Adeoti ML and Ajadi AM. **(2002**) Ureteric Injuries following Pelvic Operations: East African Journal of Medicine, Nov. 2002, Vol. 79(2): 611-613.
10. **Aderounmu AOA**, Fadiora SO, Adesunkanmi ARK., Agbakwuru EA, Oluwadiya, KS., Adetunji OS.: **(2003)** The Pattern of Gunshot Injuries in a Communal Clash as seen in Two Nigerian Teaching Hospitals. The Journal of Trauma: Injury, Infection, and Critical Care, Vol. 55(4), .626-630.
11. **Aderounmu AOA**, Adeoti ML., Fadiora SO., Oboro VO., Oguntola AS., Akanbi O, Bello TO. **(2006)** Pattern and Outcome of Emergency Surgery in a New Nigerian Teaching Hospital, LAUTECH Teaching Hospital Osogbo Experience. The Nigerian Postgraduate Medical Journal, Vol. 13 (3): 172-175.
12. Oguntola AS, **Aderounmu AOA,** Adeoti ML, Olatoke SA, Bello RO, and Rabiu TB **(2008)** Splenic Operations in a teaching hospital, South-Western Nigeria. Sahel Medical Journal Vol. 11 No (1): 15-19
13. Salako AA, **Aderounmu AOA**, Olatoke SA and Oyedeji ASA **(2008)** Fractured Penis While Turning Over In Bed-A Case Report The Journal of Surgery and Surgical Sciences Vol. 1 (3): 11-13.
14. **Aderounmu AOA**, Salako AA, Olatoke SA., Eziyi AK and Agodirin SO. **(2009)** Penile Fracture at LAUTECH Teaching Hospital, Osogbo - Challenges in the Management of late Presentation: Nigerian Journal of

Clinical Practice Vol. 12(3): 330-332
15. TA Badmus, ARK Adesunkanmi, AO Ogunrombi (2006) Penile Fracture in a patient with stuttering Priapism WAJM Vol. 23(3) July-Sept 2006 Pp 270-272
16. Ibrahim NA, Oludara MA, Ajani, Mustafa I, Balogun R, Idowu O Osuoji R, Omodele FO **Aderounmu AOA**, Solagberu BA (2015) Non-Trauma Surgical Emergencies In Adults: Spectrum, Challenges and Outcome Of Care. Annals of Medicine and Surgery
17. Fadiora SO, Mabayoje VO, **Aderounmu AOA,** Adeoti ML, Olatoke SA and Oguntola AS. **(2005)** Generalised Burkitt's lymphoma involving both Breasts – A Case Report West African Journal of Medicine, Vol. 24(3): 280-282.
18. **Aderounmu AOA**, Egbewale B.E, Ojofeitimi EO, Oguntola AS, Fadiora SO, Asekun-Olarinmoye EO, Adeoti ML, Akanbi O. **(2006)** Knowledge, Attitude and Practices of the Educated and Non-Educated Women to Cancer of the Breast in Semi-Urban Areas of South West Nigeria. The Nigerian Postgraduate Medical Journal, Vol. 13, (3): 182-188.
19. Adeoti ML, Oguntola AS, **Aderounmu AOA** and Agodirin OS **(2008)** Influence of Socio-Cultural, Political, Economic Status and Environment on the outcome of Surgical Practice in a Developing Tropical Country-Using Breast Cancer as Case Study Surgery Journal 3 (2): 21-23
20. **Aderounmu AOA**, Olaitan PB, Ojemakinde KO, Olatoke SA, Bello TO, and Agodirin SO. **(2008)** Primary Angiosarcoma of the breast: A case report and review of literature. Western Nigeria Journal of Medical Sciences Vol. (1): 55-57
21. Oguntola AS, **Aderounmu AOA**, Adeoti ML, Olatoke SA, Akanbi O and Agodirin SO **(2009)** Male Breast Cancer in LAUTECH Teaching Hospital Osogbo, South Western Nigeria The Nigerian Postgraduate Medical Journal, Vol. 16, (2): 166-170
22. Oguntola AS, Agodirin SO, Adeoti ML **Aderounmu AOA** (**2010**) Bilateral Breast Cancer: experience in a poor resource black African setting. East and Central African Journal of Surgery 2010; 15 (1)28-34
23. Adeoti Moses, Agodirin Olayide, Odu Olusola, Oguntola Adetunji, Bello Temitope, and **Aderounmu Atilola**. The role of Men in early detection of their spouses Breast lump(s)/Cancer. Nigerian Journal of Clinical Practice
24. Akanbi OO, Oguntola AS, Adeoti ML, Aderounmu AOA, Idris OL, Abayomi OO (August 2015) Delay Presentation of Breast Cancer: A study among South Western Nigerian women. International Journal of Current Research Vol. 7 Issue 07 Pages 2-8

25. Adisa AO, OA Arowolo, OI Alatise, OO Lawal and ARK Adesunkanmi CLINICAL PATTERN OF MALE BREAST CANCER IN ILE-IFE, NIGERIA. Sahel Medical Journal Vol. 11 No.1 January – March, 2008 (17 – 20)
26. Lawal OO, Adejuyigbe O, Ojo GO and **Aderounmu AOA**. **(1992**) Brunner Gland Adenoma of Ampulla of Vater-Case Report Nigerian Medical Journal, (22), 32-34.
27. Lawal OO, Oluwole OS, **Aderounmu** A**OA** and Ndububa DN. **(1993**) Cholecysti- Choledocal-Fistula-Mirrizi Syndrome (type II) in a Nigerian Central African Journal of Medicine, 39(6), 126-128.
28. **Aderounmu AOA**, Oguntola AS., Lawal OO, Eziyi AK, Bello TO, Osinaike BB and Agodirin SO. **(2007)** Mirrizi Syndrome caused by a Bile Pseudocyst West African Journal of Medicine 26(2): 148-151
29. Agbakwuru EO, Adesunkanmi ARK, Fadiora SO, Olayinka SO, **Aderounmu AOA** and Ogundoyin OO. **(2002**) A Review of Typhoid Perforation in Rural African Hospital: West African Journal of Medicine, Vol., 21 (3) 22-25
30. **Aderounmu AOA**, Adeoti ML, Oguntola SA. Fadiora SO, Oluniran OO. **(2003)** Lupus Vulgaris: Manifestation of Systemic Tuberculosis Nigerian Journal of Surgical Sciences, Vol., 13(1) 7-9.
31. Adeoti M. L., Adisa S., Oguntola A. S., Fadiora S. O., **Aderounmu A. O. A.** (**2003**). Recurrent typhoid ileal perforation after 2 months – a case report. *Nigerian Clinical Review*. 7(4): 18-19. Nigeria
32. Fadiora SO, **Aderounmu AOA,** Oboro VO, Dare FO, Komolafe JO and Bello TO. **(2005)** Surgical Complications of Unsafe Abortion: A 10-year Review in South Western Nigeria. Nigerian Medical Journal, Vol. 46, (3): 75-79
33. Taiwo S. S and **Aderounmu A.O.A** (**2006**) Catheter Associated Urinary Tract Infection: Aetiologic agents and antimicrobial susceptibility Pattern in Ladoke Akintola University Teaching Hospital, Osogbo African Journal of Biomedical Research Vol.9 no 3 (141-148)
34. Oguntola A S, Akanbi O O, Adeoti ML, Aderounmu AOA, Idris OL. Repeat Laparotomy in Typhoid Intestinal perforation Patients-Experience from a Developing Nation (2015) Scholars Journal of Applied Medical Sciences (SJAMS) 2015 3(IB) 85-91.
35. Adeyemo AO, **Aderounmu AOA**: **(1984**) Intra-thoracic Complications of Amoebic Liver Abscess Journal of the Royal Society of Medicine, Vol. 77, 17-21
36. Eziyi AK, Ademuyiwa SO, Eziyi JAE, Salako AA, **Aderounmu AOA** and

Oyedeji ASA **(2010)** Knowledge and Experience of Medical Students with Male Urethral Catheterization. East and Central African Journal of Surgery-Volume (2): 18-24

37. **Aderounmu AOA**, Olaitan PB, Kolawole IK, Dairo MD, Oluwadiya KS, Okeke LI and Salako AA **(2011)** Examination Malpractice among Students in our Medical Colleges-Prevalence and Import on Tomorrow's doctors The Nigerian Postgraduate Medical Journal, vol. 18, (3): 191-196.
38. **Aderounmu AOA,** Afolayan SA, Nasiru TA, Olaore JA Adeoti ML and Adelasoye M **(2008)** Rotational Rural Surgery for the poor in developing countries. Tropical Doctor 38 141-144
39. **Aderounmu AOA**, Omonisi AE[2], Akingbasote JA[3], Makanjuola M[4], Bejide RA[5], Orafidiya LO[4], Adelusola KA[2] (**2013)** Wound-Healing And Potential Anti-Keloidal Properties Of The Latex Of Calotropis Procera (Aiton) Asclepiadaceae In Rabbits.
African Journal of traditional Alternate Med (2013) 10 (3)
40. Omonisi AE, A Adedigba, RA Bolarinwa, JA Akingbasote, OA Adegoke, RA Bejide, DA Onilede, PB Olaitan, **AOA Aderounmu**, KA Adelusola and LO Orafidiya; *An Experimental study of the Toxicity of Calotropis Procera (Aiton) Ascelepiadaceae in Sprague-Dawley rats* (2017) World Journal of Pharmaceutical Research Vol. 6 Issue 11:42-55
41. Fadiora SO, Oluwadiya KS, Kolawole IK and **Aderounmu AOA**: **(2003)** Audit of Day Case Surgery in LAUTECH Teaching Hospital, Osogbo, Nigeria. Nigerian Journal of Surgical Research, Vol. 5, (1-2)43-49.
42. Akanbi OO, Adeoti ML, Oguntola AS, Onilede DA, Aderounmu AOA, Idris OL. Audit of Surgical Operation Notes in a teaching Hospital, South Western Nigeria (March 2016) International Journal of Development Research Vol. 16 Issue 03 Pages 7119-7121
43
43. Preeti Chaudhary, Shamim Ahamad, Najam Ali Khan. A review of Medicinal Utility of Calotropis Procera. WJPMR (2017) 3(1): 335-342

CITATION

The Citation of Professor Adebimpe Oyebisi Atilola Aderounmu, MB.BS (Lagos), AASCIT (American Association of Science and Technology), FMCS, FICS, FWACS, B.Th., JP

Professor Adebimpe Oyebisi Atilola Aderounmu was born close to seven decades ago at Molaba Compound, Jabata Quarters, Oyo Alafin. He had his Primary Education at the Divisional Council Town School Idi-ope, Oyo, before progressing to the highly prestigious Government College, Ibadan, and later Olivet Baptist High School, Oyo, to complete his secondary school education. He was admitted into the University of Lagos, College of Medicine and obtained his Bachelor of Medicine & Bachelor of Surgery (MB.BS) degree in April 1976. His Postgraduate (Residency Training) was at the Obafemi Awolowo University Teaching Hospital Ile-Ife, from where he became a Fellow of the National Postgraduate Medical College, Faculty of Surgery in 1991 after which he left for Private Medical Practice for a period of about eight years.

He was Consultant Surgeon, MOS Medical Clinic Ile-Ife (1991-1994) and Consultant Surgeon, Oil of Joy Specialist Hospital and Surgical Center, Urban Day, Ile-Ife up till 1998.

He joined the Staff of Ladoke Akintola University of Technology, College of Health Sciences, Osogbo in 1998 and rose in rank from Lecturer I to Professor of Surgery in 2011. He has been an Honorary Consultant Surgeon, Department of Surgery, LAUTECH Teaching Hospital Osogbo, Osun State Hospital since 1998, and LAUTECH Teaching Hospital Ogbomoso since 2011.

He served as Acting HOD and Chief Examiner, Department of Surgery (1998-2000) and the first substantive Head of Department many years after. He was also a Member of the LAUTECH Teaching Hospital (Osogbo) Management Board (2000-2001) and was Deputy Dean, Faculty of Clinical Science, College of Health Sciences, Osogbo (1998-1999).

He was Chairman, Theatre Users' Committee of the LAUTECH TH, Osogbo from 1998-2000; Chairman, Oncology Group from 2000-2002 and Chairman, Residency Training Program from1998-2000.

He was Acting Dean, Faculty of Clinical Science, College of Health Sciences, Osogbo 1999-2000; Chairman, Faculty of Clinical Science, 2000-2001 and Acting Provost, College of Health Sciences 2001-2002. As Acting Provost, he was a Member of the University Governing Council 2001-2002 and served as Member of the Appointments and Promotion Committee of the University Governing Council during the period. The clinical accreditation came to be when he was the acting Provost.

Between 2011 and 2012, He served as Associate Professor of Surgery LASUCOM, Ikeja Lagos on sabbatical; there he also served as Vice-Chairman, Education Committee.

He is presently the Chairman of the College of H/Sciences Historical and Prospectus Committee

He is a member of many Professional bodies including the Nigeria Medical Association where he served as Chairman of the Osun State branch in 1994, Member, Medical Consultants of Nigeria from1991 till date and was the Chairman of Lautech Osogbo branch for some years, Nigerian Surgical Research Society where he served as the Immediate Past President, Association of Academic Surgeons, ResearchGate (2015-2017), International College of Surgeons where he served as a member of Council and several others. He holds a large retinue of Awards including the High Flier's Award, Heroes Award and Legacy (Global Achievement) Award.
He has endowed an annual Book and Cash gift to the student with the best result in Surgery in honour of his late parents

Professor Aderounmu has over 60 Publications in Local and International Journals and over 680 Citations (Source-Academia Edu. ResearchGate). He co-authored "Illustrated Clinical Surgery" edited by JO Esho. He has taught many undergraduate students here at the Ladoke Akintola University of Technology and elsewhere. Many of these have found their feet (by themselves) in good positions all over the world. His Postgraduate students over the years have grown to become Consultants, creating waves where they are practicing all over the world.

As a leader, he has supervised about ten Dissertations for Fellowship of both the National and West African Colleges of Surgery two of whom are now in the Professorial cadre.

He is reviewer to some Peer reviewed International Journals such as

i) **Lancet**,
ii) International Journal of Quality Health Care,
iii) Indian Journal of Cancer,
iv) **Mediterranean Journal of Medical Sciences** and to some Internationally acclaimed Nigerian Journals with good Impact factors such as
v) Nigerian Journal of Clinical Practice,
vi) Nigerian Journal of Surgery (also Member of Editorial Committee of both) and
vii) Nigerian Postgraduate Medical Journal.

He has assisted in reviewing and assessing many colleagues within and outside the University in the Professorial Cadre and has served as External Examiner to some sister Medical Schools. He has also served as Examiner for both the West African College of Surgeons and National Post graduate Medical College of Nigeria for several years.
He is widely travelled and is an avid attender of Professional Conferences, Workshops and training programs locally and internationally

He and his wife are blessed with loving children and grandchildren.
He is an Ordained Minister of God.