



UNIVERSITY OF NIGERIA

VALEDICTORY LECTURE

OF THE UNIVERSITY OF NIGERIA

Topic:

**Challenges of Balancing Work with Life,
Geriatric Otorhinolaryngology
and Living Post - Work Life of Retirement**

*A Discourse of the Experiences
and the Lessons Learnt from the Nigeria University System and
Health Services Sectors Perspectives of an Academic Clinical
Otorhinolaryngologist Head and Neck Surgeon*

Lecturer:

BASIL CHUKWUEMEKA EZEANOLUE



Date: FRIDAY, 10 NOVEMBER, 2023
Venue: CBN Centre for Economic and Finance, University of Nigeria,
Enugu Campus (Opposite University Secondary School UNEC)



University of Nigeria
to restore the dignity of man

Lecture Topic:

Challenges of balancing work with life, Geriatric

Otorhinolaryngology and living post-work life of retirement

- *A discourse of the experiences and the lessons learnt from the Nigeria University System and Health Services Sectors perspectives of an Academic Clinical Otorhinolaryngologist Head and Neck Surgeon*

A Valedictory Lecture of the University of Nigeria (6th)

Delivered on 10 November 2023

By

PROFESSOR BASIL CHUKWUEMEKA EZEANOLUE

B.M., B.Ch., MD, FMCORL, FWACS, FICS, KSM

*Professor of Otorhinolaryngology Head and Neck Surgery,
University of Nigeria*

Lecture Topic:

Challenges Of Balancing Work with Life, Geriatric Otorhinolaryngology and Living Post-Work Life of Retirement

- *A discourse of the experiences and the lessons learnt from the Nigeria University System and Health Services Sectors perspectives of an Academic Clinical Otorhinolaryngologist Head and Neck Surgeon*

**A Valedictory Lecture of the University of Nigeria (6th)
Delivered on 10 November 2023**

By

PROFESSOR BASIL CHUKWUEMEKA EZEANOLUE

B.M., B.Ch., MD, FMCORL, FWACS, FICS, KSM

*Professor of Otorhinolaryngology Head and Neck Surgery
University of Nigeria*

Published by the University of Nigeria
Senate Ceremonials Committee
Chairman: Professor Bennett C. Nwanguma

Printed by the University of Nigeria Press Ltd.
Bookshop/Bank Complex
University of Nigeria, Nsukka.

© University of Nigeria
Senate Ceremonials Committee

First Published 2023

All rights reserved. No part of this publication may be reproduced in any form or means without the prior permission of the publisher.

VISITOR, CHANCELLOR, AND PRINCIPAL OFFICERS OF THE UNIVERSITY

VISITOR

Bola Ahmed Tinubu
*President and Commander-in-Chief of the Armed Forces,
Federal Republic of Nigeria*

CHANCELLOR

His Imperial Majesty
Oba Adeyeye Enitan Babatunde Ogunwusi, Ojaja II
The Ooni of Ife

ACTING PRO-CHANCELLOR

Ambassador Bako Sani
(MFR, mni)

VICE-CHANCELLOR

Professor Charles Arizechukwu Igwe, FAS
B.Agric., M.Sc., Ph.D(Nig), PGD(Norway), Av H Fellow

DEPUTY VICE-CHANCELLOR (ADMINISTRATION)

Professor Patrick Uchenna Okpoko
B.A., M.A., (Ibadan), Ph.D (Nig.)

DEPUTY VICE-CHANCELLOR (ACADEMIC)

Professor Johnson O. Urama
(Ph.D., FASN)

DEPUTY VICE-CHANCELLOR (ENUGU CAMPUS)

Professor Daniel Nwachukwu
B.Sc., MSc.(Lagos), Ph.D(Benin)

REGISTRAR

Dr. (Mrs.) C. N. Nnebedum
B.Sc., FIIA, FCAI, MAIEA, MAUA (UK)

UNIVERSITY LIBRARIAN

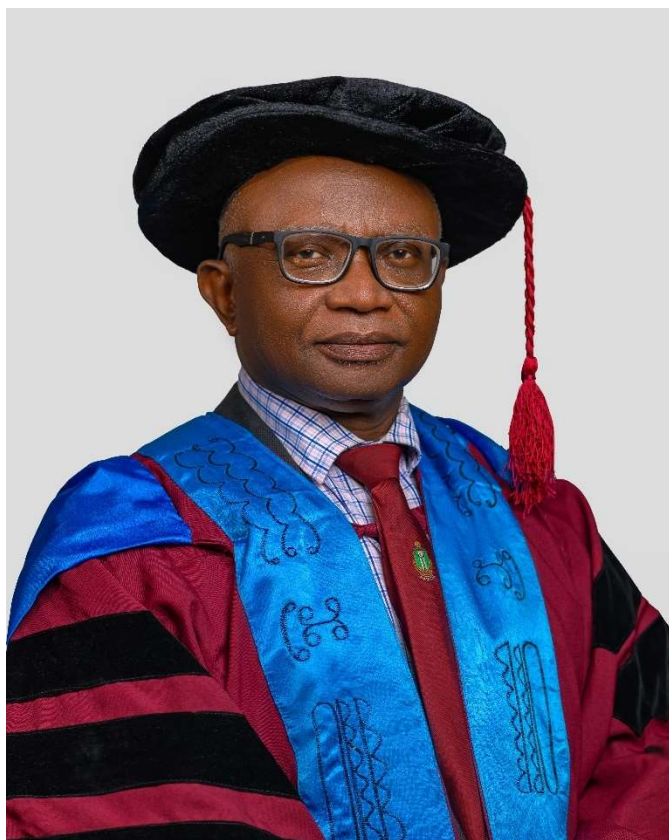
Dr. Promise Ifeoma Ilo
B.A., MLS, Ph.D (Nig), MNLA, CLN

BURSAR

Dr. (Mrs.) Adaobi Ozioma Godwin
FCNA, FCCSA



Professor Charles A. Igwe, FAS
B.Agric; M.Sc.; Ph.D (Nig); PGD (Norway) AvH Fellow
Vice-Chancellor
University of Nigeria



PROFESSOR BASIL CHUKWUEMEKE EZEANOLUE
B.M., B.Ch., MD, FMCORL, FWACS, FICS, KSM
Professor of Otorhinolaryngology Head and Neck Surgery
University of Nigeria

CONTENTS:

Title: Challenges of balancing work with life, geriatric Otorhinolaryngology and living post-work life of retirement.

- *A discourse of the experiences and the lessons learnt in the Nigeria University System and Health Services Sectors, from perspectives of an Academic Clinical Otorhinolaryngologist Head and Neck Surgeon.*

Sections:

- 1. PROTOCOLS**
- 2. PREAMBLE/ INTRODUCTION:**
- 3. TITLE OF THE LECTURE: ITS CONCEPTS, COMPONENTS AND CONTEXTS AS USED IN THIS LECTURE**
- 4. PHASES OF MY LIFE IN RELATION TO WORK**
- 5. HEALTH AND UNIVERSITY PUBLIC SECTOR SERVICES IN NIGERIA**
- 6. WORKING IN THE PUBLIC HEALTH SECTOR AND UNIVERSITY SERVICES**
- 7. WORK-LIFE BALANCE OF THE CLINICAL WORKER AND ACADEMIA IN NIGERIA**
- 8. SOME CHALLENGES OF WORKING IN THE HEALTH SECTOR OF NIGERIA THAT IMPACTS ON LIFE**
- 9. WORK ETHICS and CODE OF CONDUCT OF MEDICAL PROFESSIONAL**
- 10. MEMORABLE CLINICAL CASE PRESENTATIONS AND LESSONS LEARNED**
- 11. SOME CHALLENGES OF WORKING AS AN ACADEMIC STAFF OF NIGERIA UNIVERSITY SYSTEM THAT IMPACT ON QUALITY OF LIFE AND SUGGESTED SOLUTIONS**
- 12. DISEASES THAT CHALLENGED THE BALANCE BETWEEN WORK AND LIFE FROM 1979 TO 2023**
- 13. TECHNOLOGICAL ADVANCES THAT AFFECTED THE WAY CLINICAL MEDICINE WAS PRACTICED AND**

OUR WORK IN THE UNIVERSITY SYSTEM FROM 1979 TO 2023

- 14. THE ROLE OF *BRAIN DRAIN PHENOMENON* IN BALANCING WORK WITH LIFE IN NIGERIA**
- 15. GERIATRIC OTORHINOLARYNGOLOGIC PRACTICE IN NIGERIA**
- 16. PREPARING TO FACE THE CHALLENGES OF LIFE IN RETIREMENT (POST-WORK LIFE)**
- 17. FINANCIAL AND SOCIAL SECURITY CHALLENGES DURING RETIREMENT**
- 18. LIVING RETIREMENT YEARS: SOME QUESTIONS ONE WOULD BE ASKING ABOUT RETIREMENT LIFE (POST-WORK LIFE)**
- 19. HIDDEN HAZARDS OF OUR *WORK AND LIFE - MEMORIALS***
- 20. GRATITUDES**
- 21. ACKNOWLEDGEMENTS**
- 22. CONCLUSIONS**
- 23. REFERENCES**
- 24. APPENDIX 1: Hippocratic Oath**
- 25. APPENDIX 2: The Physician's Pledge**
- 26. APPENDIX 3: Brief Profile of the Valedictory Lecturer**

**Challenges of balancing work with life, geriatric
Otorhinolaryngology and living post-work life of retirement**

- ***A discourse of the experiences and the lessons learnt in the Nigeria University System and Health Services Sectors, from perspectives of an Academic Clinical Otorhinolaryngologist Head and Neck Surgeon***

1. PROTOCOLS

Vice Chancellor Sir, Chairman of this occasion,

Deputy Vice Chancellors,

The Provost, College of Medicine,

The Provost, College of Postgraduate Studies,

Other Principal Officers of the University,

Deans of Faculty here present

Emeriti Professors here present

Directors of Institutes and Centres, here present

Professors and other members of the University of Nigeria Senate,

Heads of Department,

My Lords Spiritual and Temporal,

HRM Igwe C N Okpala, Ezennebo III, of Akwaeze and All Traditional

Rulers here present

Septuagenarians and above present, you are my **Special Guests of Honour,**

Retirees here present, you are my **Guests of Honour,**

My spouse and family members – nuclear and extended,

Professional Colleagues,

Otorhinolaryngologist Head and Neck Surgeons,

Alumni of CKC, Onitsha, and University of Nigeria,

Members of the Press -print, electronic and multimedia

Distinguished Guests,

Great Lions and Lionesses,

Ladies and Gentlemen

2. PREAMBLE/ INTRODUCTION:

It gives me great joy and sense of fulfilment to stand here today to deliver this Valedictory Lecture to formally mark my retirement from the public service on the attainment of 70 years of age (a septuagenarian). I am giving this lecture with a heart filled with gratitude and glory to God Almighty, my creator, who made it possible.

I am retiring from the University of Nigeria, and by extension University of Nigeria Teaching Hospital, after what I may call **elongated service years**, *elongated* more than *normal* for other public servants in Nigeria, because full Professors in the Nigeria University System (NUS) retire *statutorily* at 70 years of age ¹. Recall that the maximum years of work/employment currently allowed in the Nigeria Public Services before retirement are either 35 years of service, or on attainment of age of 60, 65 or 70 years of age, depending on the branch of public service one is employed in ².

My retirement from public service is taking place after over 44 years of working in public services, 33 of which was in the University of Nigeria as an academic staff. I started working at the University of Nigeria Teaching Hospital, Enugu on 1 July 1979, as a House Officer. I worked in other public sectors and lastly became a full-time academic staff of this University in November 1991.

In the University service, I rose through the ranks from Lecturer I to a full Professorial Chair in Otolaryngology in October 2005. I recall giving my Inaugural Lecture on 17 July 2014 titled “**Hear the Voice**”, the 82nd in the series of the University of Nigeria.³

That was the day my elevation to Professorship was formally celebrated, 9 years after being a professor. This valedictory lecture is not delayed, but statutorily elongated by the conditions of service.

As I statutorily retire from the University service, I have the rare honour and privilege to deliver this valedictory lecture of the University of Nigeria. This lecture will also let me give account of the **work** I did and the **life** I lived while serving in the University and health sectors of Nigeria and formally inform the public that I am retiring from active service of the University, having served fully my tour of duty. The retirement did not happen as a surprise to me, it was anticipated, and I looked forward to it.

In this valedictory lecture, I will be sharing the experiences I had over these working years as an academic staff of the University of Nigeria who in addition to teaching held administrative posts, memberships of Committees, Head of Department and as Dean of Faculty. I will also talk as a clinician, who took care of sick people, trained, and mentored other medical practitioners, researched, and lived life in the milieu of these works and the Nigerian and global society. *To God be all the Glory.* Hopefully I will talk on challenges of balancing work of the public service, of medical professions, of Otorhinolaryngology, of University System in Nigeria, with living the life of a Nigerian in Nigeria. I will put forward suggestions that I hope will improve the system on issues of **life** during and after **work** years, with reference to Nigeria.

I thank the Vice Chancellor for giving me approval and the platform to deliver this lecture.

3. TITLE OF THE LECTURE: ITS CONCEPTS, COMPONENTS AND CONTEXTS AS USED IN THIS LECTURE

The title of the lecture is: **Challenges of balancing work with life, geriatric Otorhinolaryngology and living post-work life of retirement.** It was a title that changed several times as I wrote the draft of the lecture. There were many *challenges* of *working* in the public sector of Nigeria. There are even more challenges of *life* as the years go by. How will I capture the essence of these 44 years of working and living life in a single lecture? There are many tales to tell but no unlimited time to do so. At the end of the search for a suitable title, the above title was settled on.

Firstly, two keywords of the title of this lecture are: **Work** and **Life**. Work in this paper is taken in its broadest meaning even though it will focus on the work (labour) of a public servant of a clinical academic in the Nigerian university and health services delivery sectors. These were intellectual work of *service* delivery that provided *services* as its consumable products and moulded humans in character and learning skills, competences to be highly skilled workers (labour forces) for more work in the world. The work (labour) was also to attend to the sick, in a bid to attend to their health challenges and well-being.

We have **work** (labour) of a formal nature, where we are remunerated for our services; be it physical labour or intellectual effort or both. In the same manner, I recognise *work* done in other sectors of the society like to one's family. Traditionally in our society, work was of subsistent agricultural socioeconomic sector at the household. In present day society, scope of work expanded to include household work including child-care, housekeeping, cooking, laundry, etc. We have non- remunerated work (labour)

done for organisations like professional bodies, communities, and society at large.

I appreciate that people experience **work** differently, depending on the work they do, their innate characteristics, their training for the work, their gender and the levels of competence, and skills they possess for the work (labour).

The second component of the lecture is the contextual meaning of **life**. It is broadly to be interpreted as our personal life, our social life, our family life, our home life, our life in the communities we belong to, our religious life and our lifestyle. It is the life of individuals that make the life of the society.

It is universally accepted that any person who could work (labour) and willing to do so has the *right to work* as well as the *right to life* and sustenance. Work and life had always existed together, and at times competitively, but most often to the benefit of the worker and society.

It is this apparent disequilibrium between **work** and **life**, balance needs to be established between them. From the beginning of humanity, *work had always been life and life had always been work*. The issue of work and social life had always been co-factors. Both were combined and finding balance between both will make us examine the concept of **Work-Life Balance** in this discussion.

Work-Life Balance. The dictionary defined **Work-Life Balance** as “the amount of time you spend doing your job compared with the amount of time you spend with your family and doing things you enjoy”⁴

There are varieties of challenging relationships between work and life that made some persons to prefer other terms to **Work-Life balance** such as;

Work-Life Integration

Work-Life Effectiveness

Work-Life Flexibility

Work-Life Interface

This recognises that the work we do and the life we live are related and should be *integrated* in a *balanced* manner to achieve a happier, healthy, and productive life. We must think of balancing work with the life we live in an integrated way. Work-life is the business of everyday living. It could be challenging to balance them.

The work environment plays a major role in work-life balance so also, is the family and community situations. Work brings out the dignity in man. At the same time work (labour) in a degrading set up diminishes man. Here I have in mind slave labour or forced work in the concentration camps. ⁵

The third key words in the title are **Geriatric Otorhinolaryngology**. I worked as a *General Otorhinolaryngologist Head and Neck Surgeon*, which meant that I attended to all population groups. The elderly (geriatric) populations were attended to when such patients turn up for consult. We are discussing my works, life and as a senior citizen Otolaryngologist, it will be appropriate to discuss the branch of *Otorhinolaryngology Head and Neck Surgery* that focused on the care of the elderly population: - **Geriatric Otorhinolaryngology**. Their numbers are increasing, and we need to be focusing on them more than we are currently doing.

Retirement (or post-work life) is the fourth keyword of the title of this lecture. It logically follows that at the end of public service working phase, one enters the *retirement* phase of life and are often referred to as *senior citizen*. So, **life** continues after formal working years and its balancing or integration will need to be adjusted accordingly. One may view **retirement** as the opposite of **work**. Not all will agree to that. One may retire but not tired. One may retire from public service but still is full of strength and skill to work productively. Hence some people prefer to call retirement years **post-work life years**.

Work-Life during pre-retirement years, and post-work life in retirement are viewed differently by different persons. However, either way pre-retirement working life and life in post-retirement working should be balanced. Some understand retirement life as years when the person is just always idling about, as when the elderly and frail person is unable to do any productive work, as a period of decline in cognitive abilities and to sit idly, tell *old people's tales*, to whoever gives them a listening ear.

Even after retirement from the public service or any paid employment, work will continue in organised private sector or informal sector for most people. This implies that a greater, and better part of our lives will be spent in working. If you consider self-employed persons, many work far beyond the statutory retirement ages set for government services. Hence some prefer to use the term **post-work life** to **retirement**.

If our lifetime is divided into phases in relation to work, it could be divided into 3 phases. These would be the **pre-work**, **work**, and **post work** phases. Let us look at the hypothetical situation, of one who lived for one hundred (100) years, this is most likely how the

person will spend the 100 years lifetime in each of these three phases:

- ❖ The first *pre-work phase* of 20 to 25 years of the early lifetime is for birth, growing up, cultural upbringing, being formally trained and educated, and preparing for work (labour) that is remunerated.
- ❖ The second *work phase* that is made up of subsequent 30 to 40 years will be the gainfully employed working years, integrated with further training/education, establishing social connections, marrying, raising own family and involvement in activities in societies, communities.
- ❖ The third *post-work phase* is made up of the last 25 to 40 years of lifetime, will be living in retirement, or post-work life.

From above one will understand that the *third post-work phase* (of retirement years) is significant for a worker, especially one who gets longevity. So how does one face the challenges of balancing or integrating life lived during these three phases of our existence on earth – education/preparatory years, active working years and in the retirement years?

Mr Chairman, Vice Chancellor sir, having worked formally for more than 44 years, many of which were as an academic Otorhinolaryngologist Head and Neck Surgeon, I feel that I spent long enough time to have experienced the challenges of balancing **work** with **life** and having the insight to anticipate living later years of **retirement** and living a **post-work life**. In addition, I had the chance to observe some of my age mates,

for more than a decade, who retired earlier or at 60 or 65 years of age. I had interactions with some who worked in the private or

informal sectors as well as public service. I suppose that these exposures will equip me with the knowledge to discuss the challenges faced by a worker in balancing work with life.

In this discourse, I will be sharing some of my experiences at workplaces from the perspective of an academic Clinical Physician/Surgeon in Nigeria university system and Health Services Sector and the life I lived in Nigeria at those times. I will also engage the audience in the discussions of lessons learnt from matters arising therefrom. Most of what I experienced, and lesson learnt will also be applicable to other cadre or professions working in Nigeria and indeed other parts of the world.

4. PHASES OF MY LIFE IN RELATION TO WORK

Mr Chairman sir, Vice Chancellor, let me introduce myself by stating my **pathways** of *work of life* and *life of work* I did as a medical doctor, a clinical academic Otolaryngologist, and the *life* I will live in post-work (*retirement*) times.

First Phase: - 1953 to 1979, birth, growing up, cultural upbringing, education, and preparation for work.

I was born as a second child to my parents, Fredrick and Margret Ezeanolue Ezepue, in Enugu, Nigeria on 17 November 1953. I started early life in Enugu and completed my childhood in Port Harcourt because my parents relocated to the town a few years after I was born. As the years passed, my parents had other children - my siblings, and we added up to eight.

I started formal primary education in Port Harcourt and in 1963, my parents in their wisdom decided that I should move to my village, Akwaeze, to complete the primary education at St Michael Primary School, Akwaeze. From there I gained

admission to Stella Maris College, Port Harcourt, to start secondary level formal education. By the time the Nigeria Civil War started, I was a student at Stella Maris College, Port Harcourt, but had to take refuge to my hometown of Akwaeze, in present day Anaocha LGA, Anambra State.

At end of the civil war, I could not return to Port Harcourt, so I enrolled at Christ the King College, Onitsha, where I completed secondary education and proceeded to the University of Nigeria, to study Medicine and Surgery. I graduated in June 1979 with Bachelor of Medicine, Bachelor of Surgery (BM, B.Ch.) degrees, thus becoming a medical doctor.

These completed my first phase of life: birth, the years of home upbringing, growing up, family/home informal trainings, formal education, and preparation for formal work. I was ready to start work (labour) in the public service of Nigeria.

Second Phase: - 1979 to 2023. *Work, further formal education (especially Residency Training in Otorhinolaryngology Head and Neck Surgery), skills acquisitions, establishing social connections, marrying, raising a family and active life involvement in communities.*

OUTLINE OF THE PLACES I WORKED IN, 1979 TO 2023

I started public service work as a House Officer (Intern) at the University of Nigeria Teaching Hospital (UNTH) on 1 July 1979. Some months later, I was sent to (volunteered) on secondment for 3 months as House Officer (Gynaecology/Obstetrics) to Mater Hospital, Afikpo, during my 12-month Houseman job in UNTH. (1979 -1980)

After completing my houseman job, I worked in the following places:

- i) NYSC Medical Officer in then Sokoto State (General Hospital, Yelwa, Yauri; present day Kebbi State) {1980 to 1981}
- ii) Benue Health Management Board, General Hospital, Otukpo (Medical Officer, 1981 to 1983)
- iii) Benue Polytechnic, Ugbokolo, (Ag. Director, Health Services, 1983 to 1985)
- iv) University of Nigeria Teaching Hospital (UNTH), (Resident Doctor, 1985 to 1991)
- v) University of Nigeria Teaching Hospital, (Honorary Consultant, (November 1991 to 2023)
- vi) College of Medicine, University of Nigeria. (Academic Staff, November 1991 to 2023)
- vii) Visiting Consultant Otolaryngologist, Nnamdi Azikiwe University Teaching Hospital, Nnewi (July 1996 to 2023)
- viii) Other works I did were part-time in the private sector of clinical health care delivery (Balsam Clinics, 1990 till date) and in subsistent agriculture.

AD HOC, PART TIME AND ASSOCIATED ACTIVITIES THAT AFFECTED WORK-LIFE BALANCE 1979 to 2023

Service to Other Relevant Public Bodies

1. Anambra State Housing Development Corporation Member, Board of Directors, July 1988 to March 1991
2. Nigerian Medical Association, State Secretary, (erstwhile Anambra State Branch, presently made up of Anambra State, Enugu State and part of Ebonyi State.) July 1990 - May 1992.
3. National Postgraduate Medical College of Nigeria: Member, *Faculty Board* 1993 till 2022

4. Faculty of Otorhinolaryngology, National Postgraduate Medical College of Nigeria
3rd Member, Senate 1996 to 2000
5. Primary Fellowship Revision Course Coordinator, National Postgraduate Medical College of Nigeria 1997 till 2016
6. Resource person to Fellowship Revision Courses of the National Postgraduate Medical College of Nigeria and the West African College of Surgeons 1997 till date
7. Faculty of Otorhinolaryngology, National Postgraduate Medical College of Nigeria Faculty Secretary 2000 till Jan 2007
8. Faculty of Otorhinolaryngology, National Postgraduate Medical College of Nigeria Faculty Chairman Feb 2007 - Dec 2010
9. West African College of Surgeons, Faculty *Board Member*, Feb 2003 – till 2023
10. Otorhinolaryngological Society of Nigeria,
Secretary 1999 to 2003
President 2005 to 2009
11. Orient Journal of Medicine, Associate Editor, 2000 till 2010
12. Nigerian Journal of Otorhinolaryngology Editor in Chief (pioneer) 2004 till 2016
13. Medical and Dental Consultant Association of Nigeria, UNTH Chapter, Chairman, August 2006 till December 2008
14. National Postgraduate Medical College of Nigeria: Senate Committees:
 - Chairman, Senate Travel Fellowship Grant Jan 2011 to 2015
 - Chairman, Senate Docimology Jan 2016 to Dec 2019
 - Co Ordinator, Enugu Examination Centre 2000 to 2022
15. Nigerian Postgraduate Medical Journal, Associate Editor Jun 2011 to Dec 2017
16. Chairman, Akwaeze Town Union, Akwaeze , March to Dec 2017
17. Member, Akwaeze Traditional Chieftaincy Council, September 2015 till date

18. Member, Chukwuemeka Odumegwu Ojukwu Teaching Hospital
Governing Board, Awka,, Anambra State, 19 September 2019 till
, July 2022

LIFE ACTIVITIES DURING WORKING YEARS were spent establishing social connections, marrying, raising family and involvement in communities, social and economic life. These are integrated with further formal education (*especially Residency Training in Otorhinolaryngology Head and Neck Surgery*) and skills acquisitions.

The social life we lead may have work (labour) components we render to our community or professional bodies in the process of socialising. These are mostly non-remunerated.

Third Phase: - November 2023 to --- *post-work life or Living Retirement Years*

This is the phase that is about to start. You will notice that I had not indicated the year it will end. I do not know when.

For some persons, retirement years are when to start a second career, to become an entrepreneur, to work part time, to do all things that they wanted to do but were unable to do so because of work schedule constraints, and to shift priorities of living activities. Hence the wide range of appellations are living post-work life, retirement years, or post-retirement working life.

Whatever one does in this phase, will depend on how many more years left to live on earth and their state of health. Personally, I do not know. However, let me use my father as a *template* to predict what will be for me in these years remaining.

Ichie Frederick Ezeanolue Ezepue, my father lived to 95 years. He was in excellent health except, last 2 years of his life,

occasional minor challenges. He was an ex-service man of British colonial army; an old soldier that remained physically fit, agile, and cerebral like a person in prime age up to his last breath. He died of old age. Note that his parents did not give him **Cow and Gate Baby® milk** in his infancy nor in childhood. But he gave me much of it in my infancy and childhood and better nutrition all through my growing up years. In addition, I was fully breast-fed by my mother. I had childhood immunisations which my parents did not have. We came from a lineage known for their longevity, so survival genes were also transmitted and inherited. All these enabled me to survive risks of mortal neonatal conditions, lower respiratory tract infections, tuberculosis, malaria, and diarrhoeal diseases that are major causes of childhood mortality in Nigeria of the 1950s. I even survived the civil war. I have surpassed the Nigeria life expectancy from birth of 62.6 years. ⁶

So, I can say that I was better prepared for longevity than my father and the consequent translation is that I will surpass his 95 years to be a Centenarian. (Do not remind me that I may have more *challenges of balancing work with life* than he had. *I learnt lessons from the experiences*). I will attain to be a centenarian in excellent health of body and mind. Hence, I must plan for these anticipated long years. I will later in this lecture tell you what I plan to do with these long extra post-work years that my creator will give me.

5. HEALTH AND UNIVERSITY PUBLIC SECTOR SERVICES IN NIGERIA

My working years were spent in the public sectors of health and university. The Nigeria civil service sector employed the core

civil servants in the services of Local Governments, State Governments and Federal Government in the various Ministries. Additionally, the extra Ministerial Departments, Agencies, Universities, Teaching Hospitals, and the other organs of Government employ those that are *public servants*. Note that the Police, Paramilitary and Military have their different service conditions, rules, and guidelines.

The conditions of service of civil and public officers are guided by the provisions of Civil Services (public services) Rules and Guidelines ². These rules and guidelines direct not only the conditions of work but also to a large extent, the lifestyles public servants are expected to live. Hence any public servant working in Nigeria is expected to adapt his/her *Work-Life* in accordance with these guidelines and rules. He is to balance and integrate the work with the life he lives. The times spent at work are clearly stated. The types of leaves and duration of absence from work are clearly stated. The remunerations allowances, wages, and pensions to receive are clearly stated.

Considering the above, I assert that the employers, the Governments, determine to a large extent the Work-Life Balance and Retirement Life of their employees. In the case of a medical practitioner in the Teaching hospital or academic staff of the University, the conditions slightly differ from the core civil or public servants. Still the employer will determine how work-life will be integrated.

6. WORKING IN THE PUBLIC HEALTH SECTOR AND UNIVERSITY SERVICES

Health Sector:

At the start of my working life in 1979, most young people like me then thought that we shall live the life we dreamt of, especially when we were starting at enhanced salary entry point of being medically qualified and working in a Federal Government tertiary health institution.

The first rude shock was that as medical interns, our graduate class group were denied the benefit of car loan!!! The first set of medical graduates to be so denied in Nigeria. It was unbelievable!!! Unacceptable!!! Intolerable!!! Offensive!!! We threatened, protested, discussed, negotiated with the Management but all were to no avail. The most painful part of it was that Management told us that funds for the car loans were available in sufficient amounts, but there was then a new directive backed with establishment circular that explicitly stopped granting car loan to all categories of public servants. It was a military Government in mid-1979. To show good faith and *appease/placate* us, UNTH Management bought two brand new Toyota Coaster buses for the specific and exclusive use of House Officers in UNTH. You can imagine how sad we were. The work-life we planned was disrupted as soon as it started. Life was unbalanced from outset.

A year later, off to NYSC we went, to serve the nation, without a car as our earlier colleagues had. A *car-less* Medical Doctor was at that time viewed by the public as a fake one or at best still a medical student. You had a lot of explanations to give because then society did not expect you not to own a car.

Back from completing the NYSC service year, the *automatic* employment we were used to was not available. Government was yet still to decide what they would do with our desire to start working for them. These events adversely affected our self-esteem and the life we lived then. Life was not balanced with work. The challenges were increasing.

For many of us, it was not *funny* anymore. The Teaching Hospitals were delaying employment. They did not restore car loan grants and in addition, official accommodation took months to be allocated. So, other places of work had to be explored. Therefore, off to Benue Health Management Board I went to for employment. My colleagues went to other places too. Some months later, I received appointment letter to resume in Department of Surgery, UNTH as a senior House Officer. Not long after that I received another appointment letter to resume in Department of Surgery, Jos University Teaching Hospital, Jos. Both institutions were not granting car loan, so I did not accept their offers.

Those were the years of starting to climb the career ladder, engaging fully in social and community life. The struggle was to overcome the challenges of balancing work with life. The desire for specialist medical training could not be suppressed in me. Hence in 1985, I started Residency Training in UNTH at a lower salary grade level than I attained outside the UNTH. The lower salary unbalanced my work-life. It did not matter to me since I was doing what I wanted that will give me satisfaction, to have the type of work and life balance I wanted.

These were challenging working years, integrated with further education, establishing social connections, marrying, raising my family and involvement in the community's life activities.

In the beginning of my Residency Training, there were only three centres for training/residency in Otorhinolaryngology accredited by the postgraduate Colleges in Nigeria situated at Enugu, Lagos and Ibadan. All these accredited training centres were facing severe shortage of academic staff to train others because of the brain drain phenomenon of the 80s. Some facilities in other teaching hospitals that were in the verge of starting training were shut down, when they lost qualified persons that should work there to brain drain phenomenon.

I completed the Residency as a pioneer Fellow in Otorhinolaryngology by examinations in all three stages of the Fellowship examinations of the National Postgraduate Medical College of Nigeria and the West African College of Surgeons. There was delay by Management of UNTH and the University to appoint me Consultant/Lecturer, even when there were vacancies in the University and UNTH and in all similar establishments in Nigeria for me. I did not even have a competitor for the positions of Lecturer nor Consultant. Otolaryngologists Head and Neck Surgeons were scarce, and the few available foreign trained ones travelled to the Gulf States where pay packages were irresistible.

University Academic Clinician Appointment.

With the unnecessary delay, it was time for me to move on to find better work-life balance. I completed plans to move to other Institutions. I recall Professor Benson C Okafor *intercepting* me when he heard, from the grapevine, of my plans to leave UNTH. He pleaded with me not to leave because the future of our

department will be in my hands. He said that he was not aware that the recommendations they made months earlier for my consultant rank appointments had not been implemented. You will not blame him for I was working and carrying out job descriptions of a consultant with my substantive rank of post Fellowship Senior Resident I. He promised to investigate the issue. I do not know how he went about it but within a week, he sent words to me to pick up my appointment letter, a letter that had been overdue for 18 months!!! With that, I did not have to implement the *two weeks ultimatum* I privately gave myself to relocate to another institution, two of which had discreetly reached out to me months earlier for appointment. It was some months later, I learnt that the delay in issuing me appointment letter as Lecturer/Consultant by some *conspirators*, was that I *committed the offence* of passing all my examinations at first attempt and in record time. Join me thank Professor Benson C Okafor, who persuaded me not to leave UNTH and ensured that the appointment letters were written.

Despite the challenges, I was eventually “*called to work*”. I voluntarily answered. Hence, I began the work of a clinical Physician/Surgeon and academic. The work was Lecturer I at the University of Nigeria with concurrent consultant appointment at the UNTH. I stood on the shoulders of my trainers viz Professors Benson C. Okafor, Olu Ibekwe, and Michael N. Obiako to *work* as best as I could with passion. The work was to teach medical and dental students, train Resident doctors, render clinical services to all patients that present, serve the Community and University/Teaching hospital as well as conduct research works.

I realised that **teaching** is a profession that needs specialised training in Education, to qualify as a trained teacher/educationist to teach efficiently and professionally. I was learning on the job. When the opportunity presented, I then undertook the online National University Commission (NUC) Virtual Training in Educational Pedagogy. This was an online training for academic staff of Nigerian Universities who did not have formal training background in Education. I completed and certified in 6 modules between October 2003 and April 2004. It was a great practical training where I gained knowledge, skills and competences in Education and its methodologies. With the skills and competences gained in the Virtual Training in Higher Education Pedagogy, teaching, curriculum implementation, curriculum improvements, educational assessment, and evaluation, mentoring and guidance of medical/dental students, junior colleagues/Residents became easier to deliver professionally and efficiently.

Just like the doyen, Professor Benson C Okafor told me that the department will be handed over to me to look after, it was done a few years later. I took up the tasks.

There were *skeletal* ORL services in a few other places in Nigeria. The places close to Enugu you can get the skeletal services were in Park Lane Hospital, Enugu, then General Hospital, Owerri and a private health facility at Ikot-Ekpene. For us in UNTH, Enugu, our ORL catchment areas were extensive covering the present five South-Eastern states, in addition to parts of Benue, Kogi, Plateau, Delta, Edo, Rivers, Bayelsa, Akwa-Ibom, Cross River States and occasionally the western parts of Cameroon Republic. The above situation resulted that we received supernumerary Residents from

across the country, some for full period while others were selected periods of postings. Similarly, patient load was heavy and variety of illnesses diverse. These also made teaching and learning to progress faster than usual.

I went beyond UNTH to pioneer/starting the Department of Otorhinolaryngology at the Nnamdi Azikiwe University Teaching Hospital, (NAUTH) Nnewi, courtesy of emeritus Professor Okechukwu O. Mbonu (then NAUTH *Chief Medical Director*) and Professor Festus Nwako (of blessed memory, then UNIZIK *Vice Chancellor*) who enticed me with better conditions and promotion to *relocate* to Nnamdi Azikiwe University. Thank you for being so proactive and *settling* to accept the part-time services I offered instead of full time with promotion that you offered me at the time. You extended uncommon encouraging cooperation to me in the task of establishing Otorhinolaryngology services at NAUTH. You made it possible.

I rose through the ranks from Lecturer I till I was given the full Chair of Otorhinolaryngology in October 2005 by the University of Nigeria.

Many sets of medical and dental students were trained in our Department because Otolaryngology Head and Neck Surgery, was compulsory requirement module component of degree in Surgery in the medical and dental curriculum of Nigeria Universities. I actively took part in these trainings and assessment for certifications.

During these working *life* years, some Residents training outside my primary assignment training centres had reasons to approach me personally for guidance, mentoring and advice. I answered all

such requests. I assisted them in their training, and research activities by meeting their individual needs, advising, and mentoring. One common factor with them all was that they were intelligent, ambitious, Residents aiming to achieve success with excellence. I am glad, but not surprised that, today they are very successful in their careers, working all over Nigeria and beyond because they possess the characteristics that assure professional success.

Another source of my sense of fulfilment is that alumni of our Department during my watch, are in top posts and in charge today, not only in our centre in UNTH/UNN Enugu, but also in NAUTH/UNIZIK and various centres across Nigeria and abroad. These practitioners we produced are one of my reasons for *bragging*. I am so proud of them.

Our great products are making us proud and occupying leadership positions at:

- i. Ambrose Ali University Teaching Hospital, Irrua
- ii. Bayero University/Aminu Kano Teaching Hospital, Kano
- iii. Chukwuemeka Odumegwu Ojukwu University/
Chukwuemeka Odumegwu Ojukwu University Teaching
Hospital, Awka
- iv. ESUT Teaching Hospital, Park Lane Enugu
- v. Federal Medical Centre, Makurdi,
- vi. Federal Medical Centre, Owerri
- vii. Federal Medical Centre, Umuahia
- viii. Federal Teaching Hospital, Abakaliki
- ix. Imo State University/Imo State University Teaching
Hospital, Orlu Imo State
- x. Kingdom of Saudi Arabia
- xi. National Ear Care Centre, Kaduna

- xii. National Hospital, Abuja
- xiii. National Postgraduate Medical College of Nigeria
- xiv. Niger Delta University/ Niger Delta University Teaching Hospital,
- xv. Niger State Ministry of Health, Minna
- xvi. Nnamdi Azikiwe University/Nnamdi Azikiwe University Teaching Hospital, Nnewi
- xvii. The United Kingdom
- xviii. The United States of America
- xix. University of Abuja Teaching Hospital, Gwagwalada
- xx. University of Benin/University of Benin Teaching Hospital, Benin City
- xxi. University of Health Sciences, Otukpo Benue State
- xxii. University of Ibadan/University College Hospital, Ibadan,
- xxiii. University of Port Harcourt/University of Port Harcourt Teaching Hospital, Port Harcourt
- xxiv. University of Uyo/University of Uyo Teaching Hospital. Uyo
- xxv. Usman Dan Fodio University/Usman Dan Fodio University Teaching Hospital Sokoto
- xxvi. West African College of Surgeons

Many of them are Professors in these Universities or are in Management positions in their tertiary health institutions. Some were pioneer staff in their institutions' departments of Otorhinolaryngology Head and Neck Surgery. Some went further from their primary centres to establish new centres of training and service in Otorhinolaryngology. Many of them today have a long list of their own products/alumni. These are my **academic children**, and the later ones are **academic grandchildren** and **academic great grandchildren**. I am very proud of you all.

Back home, in UNTH/UNN, we have vibrant products who stayed back and are now senior academics and professors. As I happily retire, I will be handing over to many competent products of our Department. *The seeds sowed yesteryears have grown to be big trees, yielding fruits at all seasons. To God be all the Glory.*

As an academic staff, work goes beyond teaching and research. It includes services to communities of geopolitical definitions, of professional bodies and of organisations outside the University. This is in addition to work usually written in the public services job description as ***“any other duties assigned to you”***. This is also the expectation of the Teaching Hospitals. It must be pointed out that University expected these works to be done before promotions in rank. These works are challenging the life the worker lives. It should be factored in the efforts at work-life integration. Some of the ones I did were:

WORK AT THE POSTGRADUATE MEDICAL COLLEGES

My narrative of useful productive works will not be complete without recalling my long years of service to the National Postgraduate Medical College of Nigeria (NPMCN), I served as a member of its Senate in various capacities for a period of 23 years **consecutively** (1996 to December 2019). It is a long service record that will be difficult to equal. This is in addition to other assignments done for the Faculty of Otorhinolaryngology of the NPMCN and the West African college of Surgeons (WACS).

WORK AT SOME OUTSIDE/PROFESSIONAL BODIES, SUCH AS

1. Nigeria Medical Association, (NMA)
2. Otorhinolaryngological Society of Nigeria, (ORLSON)
3. Nigerian Journal of Otorhinolaryngology,

4. Orient Journal of Medicine
5. Anambra State Housing Development Cooperation
6. Medical And Dental Consultants' Association of Nigeria (MDCN)
7. Akwaeze Town Union, Akwaeze, and its affiliates
8. Home Parish at Akwaeze

COMMITTEE WORKS AND GENERAL CONTRIBUTION

Other duties that should be mentioned is the *community* services to the University and the UNTH communities usually through one Committee membership or another. These are usually described in the public services job description as “*any other duties assigned to you*”.

At the UNTH, I served in various Committees that are non-remunerated nor statutory. Some of them are:

- UNTH Mechanical Workshop, Chairman
1998/99
- Committee on Commercialization and Privatization,
Member 2002
- Committee on Reforms Member
2006
- **Committee on Movement to Ituku-Ozalla Chairman**
2006/07
- Board of Survey of UNTH Member
2007
- Committee on Commissioning of the UNTH, Member,
2007

At the University of Nigeria, Committees in the University of Nigeria,

Some non-statutory ones are:

- Faculty Internet/Business Chairman 1999 – 2002
- Impersonation in Anatomy Exams Chairman 2000
- Est. of Health Mgt & Hosp Admin. Chairman 2000
- Review of Exams & Assessment Chairman 2001
- College budget Preparation Chairman 2001
- Review Contract Appointments Member 2001
- Deferment of Annual Leave Member 2001
- Curriculum Committee Member 2005
- Establishment of Faculty of Basic Medical Sciences
Chairman 2006/07
- University Entrance Committee Member 2006
- Committee on Faculty Union Bank Account Chairman 2007
- Others, etc

(I omitted statutory Committees where position/posts gave automatic membership.)

For Work-Life to be balanced and integrated, one must have satisfaction in all aspects of the work. One must be passionate about the job description you are doing. This is even more so when it is in delivering health care services in addition to teaching, research, and Community services. Most often there were administrative duties to the bouquet of duties. One still has a life to live with responsibilities to personal needs, family demands, social engagements, and community obligations. As President Kwame Nkrumah of Ghana said in 1963: **The gown must go to town.** Work and life should be balanced despite of the challenges of doing so.

7. WORK-LIFE BALANCE OF THE CLINICAL WORKER AND ACADEMIA IN NIGERIA

Work and life are inseparable. The search for balance between them remained elusive. Google Inc, as a big corporation, is researching on how to balance work and life of its employees. They have this *Googles' People Innovation Lab* developed a **gDNA study** they hope to run for 100 years starting in 2012. This their study is evaluating Work- Life Balance of its employees.⁸

I agree with statement made in the article which I quote herein:

“For example, much has been written about balancing work and personal life. But the idea that there is a perfect balance is a red herring. For most people work and life are practically inseparable. Technology makes us accessible at all hours (sorry about that!), and friendships and personal connections have always been a part of work.”⁸

Some people believe that work should be separated from personal life (Segmentors) while at the other end of the spectrum are those who believe that work and life should be integrated (Integrators). There are others whose beliefs are between the two ends of the spectrum.⁸

While considering work-life balance, please permit me to ask the following questions:

Why do you work (labour)?

Who are you working for?

What is the essence of working?

What do you expect from the work you do?

What is the purpose of work (labour) in one's life?
How does your work relate to your life?
What impact had your work on your family members
and family life?
Do you live to work or work to live?

These questions are central to challenges of work and life and how they could be balanced. I do not have all the answers to the above questions. I did not pretend to answer them either. Please reflect on them for the answers which I believe will be diverse for different persons.

PAST ATTITUDINAL RE-ORIENTATION TO PUBLIC SERVICE WORK

How do we posit **work** and **life** in our subconscious minds? The why, the who, the what, and the how of work and life. I recall that sometime in the 1970s, the government of East Central State (ECS) had a program to orientate its public servants of the concept of work and who they are working for. They keyed in the Igbo language translation of working for the government (government work; civil or public service) which in Igbo

language, is "*Olu Oyibo*". Literally translated to mean *work of the white man* (our former colonial masters). The ECS government made attempts to change the appellation "*Olu Oyibo*" to "*Olu Obodo*". **Olu Obodo** means **work of community**. This was aimed at re-orientation of the public servants to have attitudinal change that their labours/efforts expended in their places of work as public servants were for the common good and development of their communities not for their erstwhile white colonial masters.

ORAGANISATIONAL MANGEMENT STYLE AND POLICIES

Integrating work and life is another way of considering the issues of balancing work with life.



Figure 1 WORK-LIFE INTEGRATION ⁹

The **Work-Life** situation is a complex one. Often the leadership style in places of work will add to the burden of challenges of work with life. Leadership of an organisation must be **INCLUSIVE** to create enabling environment that will give employees work **flexibility**. Inclusive leadership attributes of *Empowerment, Accountability, Courage, Humility, Empathy, and Avoidance of bias* in managing its employees will increase

productivity.¹⁰ *One size fits all* policy is not sustainable, certainly not in the University nor health sector of any country.

Flexible working conditions enables the academic clinician to attend fully to his primary work schedules, *any other duties assigned to you*, as well as services to relevant professional and public bodies. He needs time to balance the works with his life.

Family-needs challenges could be made lighter by policies of the government and employers of labour. The *work-family conflict* situations should be avoided. The family activities of *school run* of workers who have children to take to school in the mornings or bring them back from school, should be factored into official working hours. Leave from work is adequately provided for in public services rules.² Such leave as maternity, paternity leave, sick leave, compassionate leave and many others are well provided but implementations were defective.

Flexible working hours and working from sites outside the physical office location are desirable policies to be formalised. If you have the necessity to take office work back to the home, ensure that the work does not interfere with home and family prime times. The academic most often cannot avoid working at home. The work is done late at night or early in the morning. This depends on the person's *prime biological clock*. Do not sacrifice the family life for work. Resolve any work-family conflict. An effective time management regimen will help strike a balance between work and family life.

The regular work time of public officers is from 8 am to 4 pm, Mondays to Fridays, but it is not suitable for the health worker nor for the academic

staff of university. The academic staff has flexibility of teaching hours, research, and community services. Some of his work hours will be impacted by the regular office opening hours. I observed some persons sacrificing career progression to have a balanced work- family life and vice versa. Should this be so? I think that a balanced work-life arrangement would allow both work and family commitments to progress concurrently. After all, when work formally ends, the family life will not end.

Work flexibility should consider the contribution to the life of a family where the mother stays at home to educate and care for her child. Should such a mother be given concessions in her place of work or receive specific remuneration for this service to the society?

There is an Igbo language saying “***nwoke ezu ike***” meaning that “***man does not rest***” from work. I beg to disagree, even when I suspected that the saying originated when work and life in the traditional Igbo society were inseparable. The European saying that “***All work and no play makes Jack a dull boy***” is a saying that relates to the work-life balance and was first recorded in 1659. The work life balance is the optimum balance between our working lives and our social and home lives.¹¹ The twist of the phrase is “***All play and no work make Jack a mere toy.***”¹² This is also true.

The follow-up to the original phrase is that “***All work and no play makes Jack a dull boy and Jill a wealthy widow***”. Do I need to say that this too is true? In Igbo language we say “***aghalu ndu kpa aku, oli ekpe eri ya***” (meaning: *When one neglects life in pursuit of wealth, heirs will inherit and enjoy the wealth*).

Do not act as if you are indispensable in your place of work. Do not be a workaholic. *Work does not finish* as the saying goes but at same time give your best honest labour for the pay and make out time to balance work with life when work time permitted.

8. SOME CHALLENGES OF WORKING IN THE HEALTH SECTOR OF NIGERIA THAT IMPACTS ON LIFE

i. OFFICIAL OPENING HOURS FOR WORK

Official working hours in the public service is normally 08:00 hours to 16:00 hours Mondays to Fridays, inclusive. However, official work hours in the health sector for a clinician is not so fixed. He has **shift** as well as **emergency call duties** added to the usual official 08-*to*-16 working periods. Work schedule of health sector worker is at all hours, all days of the week.

For a clinician, the emergency call duties were one of the schedules that disrupt any plans to live a life within the time off routine work hours. Management should have a policy of flexible work hours to accommodate these peculiarities.

The situation presently is that staff hardly report to duty promptly at the designated opening hours. Many reasons were advanced for the habitual lateness. There were challenges of efficient transport services, running personal errands such as taking children to school before setting out to place of work. My suggestion is that the policy of official opening hours of offices could be adjusted to be 09:00 hours to 17:00 hours for those operating the fixed office opening hours. This will allow more time for staff to reach their places of work in the morning even after taking the children to school or going on other important errands.

A former Governor of Imo state approved workers of the state public services to take one day off the official Mondays to Fridays schedule, ostensible to enable them attend to their private farm works. On 7 June 2023, the Governor of Edo State was reported in the news of (<https://punchng.com/fuel-subsidy-edo-increases-minimum-wage-approves-three-days-work-week/>) approving 3-day instead of the present 5-day work week for public servants of the State. Were these actions for increased productivity or for political gains?

ii. UNWILLINGNESS TO PAY FOR SERVICES RECEIVED BY BENEFICIARIES

Interactions in the course of work between health care providers and beneficiaries at times do not go well. There were cases where health care services were rendered either as emergencies or scheduled but at the end of the treatment, the recipients will be unwilling to pay for services received. This attitude was not influenced by the outcome of the treatment because this happened in both excellent outcomes and those that end in mortality. It happened in the public and private health institutions. It happened with the rich and the poor. Some of our populace seem to have the sense of entitlement to receive health care services free of charge. Who pays? This is even more so with people who evade paying their taxes to government but expect the government to provide healthcare free of charges. We must all work towards enjoying and paying for the good things of life.

We know that self-financing of health care services had been a challenge in Nigeria.¹³ The National Health Insurance Scheme was introduced by government to address health care financing. Its impact was still not felt by majority of Nigerians. Its

operations need to be reviewed to deliver on the objectives of setting it up.

iii. DELAYED REFERRALS OF PATIENTS IN THE HEALTH CARE SYSTEMS

Being in specialist or tertiary health care provider, we will encounter cases we wished were referred earlier. Some referrals will come when the condition had deteriorated thereby making its management more challenging. The delays were caused by many factors of poverty, ignorance, misinformation, cultural and social biases. This is most painful when the delay is caused by another professional in the health care sector, including medical doctors. These practitioners are expected to know better than the general populace but for reasons best known to some of them caused the delay in seeking appropriate assistance from the specialists.

Professor BC Okafor captured it in his publication where he pleaded for early referral¹⁴ Sadly, the situations that led to that plea is still subsisting.

iv. IMPROPER TREATMENT OF PATIENTS' DISORDERS

One disorder peculiar to ORL practice is improperly treated impaction of foreign objects in the external ear canal. Not only will there be delay but also more damage inflicted on the patient than the initial disorder being treated. This is done by family, friends, sympathisers, patent medicine dealers and *regrettably* health professionals. A foreign body (FB) in the external ear canal may look as if it could easily be extracted by these group of persons. Please note that no matter how easy it appears to you, special training, skills, competences, and equipment are needed for its safe removal. An attempt improperly made at removing it

will push it deeper in the ear canal rupturing the ear drum and the middle ear structures. A previously minor condition will become exacerbated and in some of these patients may need surgical operation (exploratory tympanotomy) under general anaesthesia to remove it from the middle ear cavity. The lesson was do not do a work you are not adequately prepared, nor trained for.

Another scenario of improper treatment is by alternative practitioners who render treatment that makes the disorder worse or misinform the public of the treatment to receive. In ORL practice we have “**mgbapia**” in Igbo language (tonsillitis and its related disorders). These alternative practitioners will perform *the traditional uvulectomy* in the treatment of sore throat. This practice is common among many tribes in Nigeria and does more harm than good.

v. WAGES AND SALARIES, AND PRIVATE MEDICAL PRACTICE

A young school leaver who is employed to work in the public sector will need the salary and wages he receives to finance his life engagements. The payments received will finance his lifestyle. It is from its savings that he hopes to fund his marriage, child and family supports and contribute meaningfully to the society at large.

Unfortunately, the take home wages presently being paid are not *living wages*. It does not enough to take the worker home. It is not sufficient to pay for the basic cost of living. The work-life balance is not sustained. The result is that even the very senior public servants cannot make ends meet. Many resorted to look for other means of earning extra income to supplement their meager wages. Some may do it illegally through such means as corrupt practices

in their places of work while others did not. Work-Life cannot balance with the poor wages. *A labourer is worthy of his wages.* (1Timothy5:18) Let the wage be a living wage.

Those who do not want to join wrong doings would prefer to set up legitimate means of income to help work-life balance rather than engage in corrupt practices. The medical practitioners and other health workers in Nigeria through entrepreneurship ventures would establish their private health facilities to earn more income for their upkeep. Some will do locum jobs. This was the situation at the time I started work in 1979. Short falls in earnings were being addressed by moonlighting to balance work-life.

The Military government by Decree 34 of 1984, banned all such private practices by doctors, teachers (and all professions in Nigeria) employed in the public services from 12 December 1984. This decree banned all professionals that work in the public sector from working in the private sector at the same time ¹⁵.

Many workers then opted to shut down their practices while some resigned from the public services to do fulltime in their private practices. The ban became a source of trade dispute between the Government and the Nigeria Medical Association (NMA). Much harm was done to the populace and the system. In 1992, the Government exempted and allowed health professionals to set up private practice while still working for the Government by yet another Decree ¹⁶. This exemption was done after the Government realised that the people are worse off for the ban on medical doctors.

The Medical and Dental Council of Nigeria (MDCN) allowed consultants and medical and dental practitioners of up to ten years post registration to operate private health facilities even if they

are fulltime government employees. In October 2017, Government muted the reintroduction of the ban but did not take further action on it ¹⁷. *Members of the NMA are still waiting!!!* This is an example of policy somersaults that overheats the balance that should be between work and life. The other is the much talked about intra mural private practice policy that had not been articulated for full implementation many years after it was supposed to start in our public health institutions.

Considering the importance of the private sector in the health care delivery system in Nigeria, it is important that the sector be strengthened for better services delivery and work-life balance of their workers. The sector has the capacity to play more roles in the health care delivery system of Nigeria ^{18, 19}.

CONCEPT OF *SPECIALIST HEALTH VILLAGES*

The private health practitioners are major contributors to the health care services of Nigeria. Some are solo practice while others are set up in partnership with colleagues. I believe that large group partnership practices will be in a better position to provide better care than small holdings individual practitioners. These individual pursuits often affect the time the practitioner has for social or family life. Their work-life is out of balance.

My considered opinion is that the individual small and medium sized practices and the large partnership practices could still be more valuable to the nation and community if restructured, while giving the practitioners better work-life balance, if they are established in what I will call **Specialist Health Village (SHV)**. SHV will be a geographic location/village such as a layout or an estate where these health facilities are located, side by side of each other, clustered together in the same neighbourhood or estates specifically established for them.

The outcome will be specialists' health facilities such as otorhinolaryngologic, ophthalmology, surgical, paediatric, geriatrics, psychiatrics, internal medicine, gynaecologic obstetrics, radiological etc clustering together with other healthcare businesses such as pharmaceutical industries and outlets, medical diagnostics laboratories, blood banking establishments, medical waste disposal organisations, ambulance services, mortuary, medical employment agencies, restaurants and hospitality businesses, etc. They will share some overhead costs like alternative to grid electric power generators and distribution and security within the neighbourhood that will be jointly setup. Residential accommodations with social housing services in proximate location to this SHV will enhance work-life balance.

We already have such model mono business villages as drug markets at Lagos, Onitsha, and Kano. Another such cluster of business is the electronic market at Alaba Lagos and the computer Villages at Ikeja Lagos or New Haven Enugu. What we commonly call **markets** in Nigeria were different business enterprises locating in the same geographic places.

Patients will appreciate such a cluster location because once in the SHV, they will certainly find the specialist that will attend to their health needs especially where multidisciplinary team are needed to manage their health challenges. The *Specialist Health Village* will be a health services hub. The health workers will be able to have a better work-life balance, for they may easily share working hours that free up time for them to have social and family life in addition to work loads.

9. WORK ETHICS and CODE OF CONDUCT OF MEDICAL PROFESSIONAL

Work Ethics.

“Work ethic refers to a set of moral principles, values, and attitudes around how to act at work. While this may vary depending on your organization and company culture, there are a few universal qualities of both good and poor work ethic.”²⁰.

Work ethics included aspects such as honesty, integrity, responsibility, accountability, respect, teamwork, professionalism, and quality²⁰.

The public servant work ethics as enunciated in the public services rules spelt out ethical standards that encourages diligence and hard work. Many public servants observe the rules. However, the situation on ground is, at times some of these virtues of work are not observed both in the university system and health sectors. Indolence and indiscipline are the bane of the Nigeria public service. Corruption is worsening the situation. We have the appropriate sections of the public service rules to guide us on this, but the rules were not enforced.

The Medical and Dental Council of Nigeria (MDCN) that regulates medical and dental practices in Nigeria had a code of conduct for all registered practitioners to follow²¹.

In addition, there is the Physicians Pledge to subscribe to and observe. This had traditionally been called the Hippocratic Oath (Appendix 1) which came into effect about 2500 years ago. In 1948 it was modified by the World Medical Association (WMA) to be the Declaration of Geneva. It had undergone revisions in 1968, 1983, 1994, 2005, 2006 and the current version was

approved on 14 October 2017 in Chicago USA ²² {also Appendix 2}

I was inducted into the medical profession in 1979, the Oath subscribed to then was the Geneva Declaration of 1968. Since then, five revisions were made to it. Each revision was to bring it at par with changing times and thought but all to maintain the original concept of dignity at workplace and the profession.

One of the major new introductions to the document in 2017 was the phrase:

"I WILL ATTEND TO my own health, wellbeing and abilities in order to provide care of the highest standard;"
²² (Appendix 2)

This tells the physician that his own well-being is also important. That is the work-life balance is important.

Prior to this in 2015, the WMA had issued a policy statement on the physician well-being ²³.

The physician wellbeing was explained thus:

Physician well-being refers to the optimization of all factors affecting biological, psychological and social health and preventing or treating acute or chronic diseases experienced by physicians including mental illness, disabilities and injuries resulting from work hazards, occupational stress and burnout. ²³

These were some aspects of unbalanced work-life that need to be addressed. It is in doing this that one would understand these documents that clearly enjoined physicians to have a **work-life balance**.

The clinician cum academic carries out research involving human participants. There are clearly stated ethical standards and guidelines on any research involving human subjects as stated in the **Helsinki Declaration** ²⁴. This is added responsibility to the academic clinician.

Despite the challenges, the worker should **not** put life on hold to a later date. Do that which you can at the time you can. Do not postpone the life you want to live and bury yourself in work.; receiving praises as *the first to report at the place of work and the last to depart*. If your home is toxic, do detoxify it so that when you finish the day's work, you look forward to rushing back home to family to have happy family life or social life.

The work (labour) we do should be a source of great happiness to all those we render services to. If they should derive the greatest happiness from our work, we too will in turn have our greatest happiness. Our life will feel fulfilled and happiest. **Work-life balance** is guaranteed. This seemed to provide some answers to some questions I asked earlier in Section 7 above but said I will not pretend to answer them.

Taking a holiday to relax from work and unwind is good for a work-life balance. Annual leave periods are provided in the scheme of service of public servants. How many of us utilise leave period to relax? Go on tourism and experience other climes? Remember that no worker is indispensable.

10. MEMORABLE CLINICAL CASE PRESENTATIONS AND LESSONS LEARNED

I recall the many patients I attended to in my many years of medical practice and teaching career. I tried to identify the *most* memorable ones among them. It was a difficult task selecting from the long list. They were many that tasked my knowledge, resources, dedication, time, and competence. Some were so dramatic in outcome, but each was unique. Let me narrate just a few.

Case 1:

I had a case where I performed adenotonsillectomy on a girl of 3 years of age, then 25 years later the mother of my patient insisted that I am the only one she wanted to do the adenotonsillectomy on the child of this initial patient, her grandchild, and made them cancel the bookings confirmed at an Abuja hospital and to travel all the way from Abuja to Enugu for the operation. There were two other situations of child and mother being operated on, at different times by me. Is this a sign that I have been out in the field for long years?

Case 2:

This was a case of a boy of 6 years of age at the time I excised juvenile laryngeal papillomatosis from his larynx. This was after the mother consulted far and wide and was then at the verge of losing her son to airway obstruction. Fast forward to 30 years later, this son who is now married with family residing in Lagos developed similar symptoms and his mother found out of the recurrent signs and symptoms. The son was not aware of his health challenges in childhood. His mother informed him of his childhood health challenges and insisted that the son should come to Enugu. Meanwhile it took her 2 weeks of diligent investigative

search to find my current location and brought the son to me for treatment. I have certainly been out in the field for long years.

Case 3:

May I to recall the case of a boy who aspirated foreign body and was rushed to the children emergency room at NAUTH, in severe respiratory distress on a Sunday afternoon. The officer on duty put a phone call across to me that he has no option than to despatch the child in their ambulance on oxygen inhalation to me in Enugu. I quickly started all arrangements to receive the patient and do emergency bronchoscopy. The anaesthetist was also alerted to prepare. The ambulance arrived with the patient earlier than I projected. Soon on arrival, while child was still in the ambulance, the attending nurse who accompanied the child from NAUTH raised alarm of cessation of breathing and called for help. I rushed outside to the ambulance to find that the child suffered cardiopulmonary arrest. I quickly carried the child and rushed into the prepared theatre, performed the bronchoscopy without benefit of any medication. I removed the obstructing foreign body and did a successful cardiopulmonary resuscitation. The child recovered fully without sequel. My Sunday afternoon was made. We saved a life that was *lost*.

LESSON: Yes, we rescued a life from death's grasp. That had always been the aim of any medical intervention. The work had always been teamwork. The doctor who identified that the life of this child was in grave danger and made the phone call, the hospital authorities who promptly approved that the ambulance and nursing officer shall depart with the child immediately for Enugu, the ambulance driver who safely drove to Enugu at that break neck speed, the accompanying nursing officer who was monitoring vigilantly, the persistent prayers and tearful

supplications of the mother and our full state of preparedness to attend to the emergency were the teamwork that rescued a life that was **lost**. This improved the quality of life of many others who were stakeholders.

We could not have planned it so well. However, everyone doing his little bit of work timely contributed to resecuring this life. Imagin what could had been the outcome if this cardiopulmonary arrest happened while on the highway? Or if we were not fully prepared for the emergency bronchoscopy when the cardiopulmonary arrest occurred? Do not underestimate the power of the mother's prayers either. (cf. Mathew 15: 21 – 28. Story of the Canaanite woman). This reminded me of the common Igbo saying or name CHUKWUKADIBIA.

No matter the work we do, it has effect on the life of someone in the society so let us work hard and well.

This case reminded me of a previous incidence which I narrated in my inaugural lecture ³ In fact, it was a reversal of roles, I was the one to rush the child to Enugu. It was a decisive turning point event that made me opt to specialised in ORLHNS. Let me quote the narrative here:

*“One afternoon a family friend rushed her child to my house. You only need to **hear her voice** cry out to me: “Doctor help, my child is choking, please help”. Then she handed the child over to me. I could not help. I do not have the required expertise. The voiceless child was asphyxiating in my arms. I was about to pull out my car to do the emergency drive to Enugu, more than 100km away, when dramatically, there was Divine intervention, the object choking the child was spontaneously expelled. Life returned, the child cried, and I **heard the voice** of this*

child. That was it. I became fascinated with Otorhinolaryngology-Head and Neck Surgery and started giving it serious consideration as a career choice over Plastic/Reconstructive Surgery. Yes, I will train in Surgery, but it must be Otorhinolaryngology-Head and Neck Surgery. The decision was made”³

Case 4:

As I type this manuscript, I had prepared for a booked thyroidectomy on a woman who resides in Cross River State for the operation, having been referred to me by her mother who had thyroidectomy done on her by me, 9 years ago. My current patient’s mother can only refer her daughter if she was satisfied with the services, she received several years earlier. *The reward for good work is more work.*

There are many more memorable patients to recall. However, let me for now end this recall process with this patient I started attending to when she was a neonate. I will use her case to illustrate more points and lessons learned in the challenges of balancing work with life.

Case 5. ★ ★ ★ ★ ★

Let us call her Baby N. I choose Baby N as my 5-star patient because of the long-term doctor-patient relationship; from neonate, infancy, childhood, and growing to adulthood. In addition, her story has many of work-life balance challenges and lessons to learn. It went beyond the domain of a clinician’s work of not just saving life but in addition improving the *quality of life*.

In 1988, I received a distress call from the Neonatal Intensive Care Unit of UNTH to attend to an emergency. The patient was a week-old baby girl of full gestational age and normal spontaneous vaginal delivery. The emergent health challenge was that she was in severe respiratory distress, among some congenital anomalies. The best option to keep her alive was to perform emergency tracheostomy. The challenges were getting the appropriately mini sized tracheostomy tube to use and the miniature sized structures I needed to dissect in her neck for a successful tracheostomy. I was a newly advanced senior Resident. A few hours before the distress call came, I bided my consultant farewell to one of the Arabian Gulf countries, so I knew that I was on my own that evening. I never did such a procedure on such small sized person and even till date had not the opportunity to repeat it on such a neonate.

With some *luck*, I found a small sized tracheostomy tube after rummaging through the Departmental *junk* cupboard in the theatre and ward. With the patient *in extremis*, I embarked on the emergency surgical procedure and secured the airway. I spent the whole night in the hospital attending to her. The surgery went well. That was the beginning of a doctor-patient relationship that lasted till date – from 1988 till 2023, and most likely will go beyond this day.

Later clinical assessments revealed that Baby N had multiple congenital anomalies. We had regular follow-up appointments. We did multiple surgical procedures in stages to correct congenital anomalies to make room for better body functions. These were scheduled as dictated by her growing body size. The tracheostomy was refashioned at interval of years to accommodate bigger tubes.

She is now Miss N. She attained the school age, but the school authorities were apprehensive to have her in school because of the tracheostomy tube she is wearing. I had to write letters to the school reassuring them that her health condition was not infective, does not pose any health risk to other children and gave some advice on the emergency care of the tracheostomy tube.

When we completed and satisfied that we solved the identified congenital health challenges, we knew that we could not decannulate her. By this time, she was about 11 years old. The tracheostomy she had was affecting her *quality of life*. The final reconstructive surgery was needed to decannulate her and close the tracheostoma. She has acquired tracheal stenosis because the tracheostomy done when she was a neonate impeded growth of her tracheal cartilage at the site of insertion of the tracheostomy tube. She needed tracheal reconstruction. In doing this tracheal reconstructive procedure, I harvested cartilage from one of her ribs and transplanted it on the trachea in the neck. The outcome of this procedure was successful, and we decannulated her. You need to witness the joy everyone displayed in the ward the day we successfully decannulated her. No amount of gold nor silver could buy this level of satisfaction and happiness. Work and life balanced fully for me that day.

We kept in regular contact and monitoring, this time at longer intervals. Secondary education completed and sat for JAMB. She passed well but missed the primary admission score by 1 mark for the competitive course of study she wanted. This time instead of writing letter, I resolved to accompany her to meet the then Vice Chancellor at Awka to plead on her behalf. My schedules were tight, and time was elapsing, hence I once more wrote an

explanatory recommendation appeal letter which she and her mother took to deliver to the Vice Chancellor, Nnamdi Azikiwe University Awka. (VCUNIZIK)

Events at the VCUNIZIK's, office that day were reported by the mother as fast, dramatic, that left her in the state of unbelief, speechless, confusion, and happiness. I will not bother you with the details. Suffice it to say that pressures from *prominent* visitors who wanted to see the VCUNIZIK were much. It was admission season. Visitor's slips were being filled and sent in, while the VCUNIZIK was having a management meeting. She attached the recommendation letter I wrote to the visitor's slip she filled. The VCUNIZIK read the recommendation letter, promptly called them into the office. They were not expecting to be called before the various dignitaries waiting who came before them. She hardly voiced her greeting to the VCUNIZIK, while she was still rehearsing in her mind how best she would plead passionately for her daughter's admission. She had not uttered any word before the VCUNIZIK asked her if this is her daughter. Mother answered in the affirmative. VCUNIZIK glanced at her. He instantly minutes on the letter, approving the admission of Miss N under the University discretionary list. VCUNIZIK handed the letter over to the university Registrar, who incidentally was one of those holding management meeting in the VC's office at the time, and then requested them to go and complete registration formalities. Today Miss N is a graduate of Nnamdi Azikiwe University, Awka.

Challenges and Lessons of work and life from this case illustration:

- i. A clinician must respond promptly to emergencies and calls at any time they arise. The junior professionals are usually the first responders to emergency calls. If the

narrated emergency tracheostomy was delayed that day, Miss N may not have survived to the next day. These emergency duties disrupt work-life balance. Another arrangement of work program that disrupts work-life balance is **shift** duties. The emergency and shift duty hours when combined assures that work-life will be thrown out of balance, especially if it involves prime hours of day or night, when one should be at home with the family.

- ii. I was able to find the size of tracheostomy tube needed. These days it will not be available. It will result in probable costly delay.
- iii. The mother of Miss N. was a specialist Nurse Practitioner residing in Anambra State. Her knowledge and competence were invaluable in decision making of her child's health challenges and helpful in taking care of the child's tracheostomy at the early age and in later years. Her dedication in caring for her baby was awesome and unparalleled. Health education and literacy of the public are helpful in many clinical situations to disabuse the superstitious minds about illnesses being *punishment from the gods*. A knowledgeable populace will be a caring partner with the clinician.
- iv. The point not to be lost here is that medical practitioners need the collaboration of the recipients of their services for better outcomes. The health enlightenment and advocacy of the public on health issues is always as important. This health knowledge of the populace will make one not to give nor take advice that will

adversely affect our health outcomes. It helps in joint decisions of treatment plans of ill persons and in obtaining informed consent.

- v. Mother of Baby N. many years later confided in me that a close friend of hers advised her at that early stage of her baby's life to just neglect attending to the child for a night that she would be dead in the morning and release her from the restricted stressful life she was then living. Note that she had other healthy male and female children before Baby N. Beware of advice from friends!
- vi. The mother of Miss N. sacrificed all comfort of living her life, *gave her all*, to ensure that her child survived. She had to forego her career progression by changing her place of work when the flexibility she needed was not optimised in the original workplace that had better conditions of service. She accepts the challenge, adjusted her **work** and **life** to get balance between them. A sweet great mother!
- vii. Another lesson of this story was to illustrate the work of the clinician and balancing it with living a life. It could be a *work* that is not appreciated and thankless. A practitioner should not bother about this. What should be paramount is to work to achieve the greatest happiness and satisfaction for the patients and their relations and place it above personal gains. Patient – doctor relationship should be cordial but occasionally it will be the contrary. If all went well, you are acknowledged and spoken good of. At times the outcome is not what they expected even when

the practitioner gave the best care. In the state of their dissatisfaction, you may face assault and battery, bullying, and litigations. There are reports of patients' relations physically attacking the doctor in our health facilities ²⁵.

- viii. On the matter of the discretionary admission into our Universities, I assert that *affirmative action* was the purpose it was meant to serve. In this instant case, *affirmative action* considered the challenges Miss N faced in her quest to study in preparation for a working meaningful life. She no doubt was *a minority* that had slim chances of survival at birth, challenges of acquiring formal education in a very competitive setting, but she overcame them despite all odds. The VCUNIZIK action was selfless. He did not ask for any gratification nor expecting any before taking altruistic action. That should be the spirit of work in public service.

11. SOME CHALLENGES OF WORKING AS AN ACADEMIC STAFF OF NIGERIA UNIVERSITY SYSTEM THAT IMPACTED ON QUALITY OF LIFE AND SUGGESTED SOLUTIONS TO THE CHALLENGES

a. INDUSTRIAL LABOUR RELATIONS

The academic calendar had provision for the long vacation, usually 3 consecutive months. However, the incessant industrial actions in the Nigeria University system of the past three decades disrupted the long vacations arrangement such that we are having *short breaks*. For the academic medical clinician, it is more complex than this because his clinical duties do not afford the

luxury of long periods break from work. This is in addition to the work loads of undergraduate medical school curriculum and the Residency Training Programs which did not have long holidays in their calendars. Any industrial strike period will result in automatic elongation of time for the course of study in the medical school.

These incessant industrial actions in the Nigeria University System and the Health sector were manifestations of Government insensitivity even to collective agreements it voluntarily entered in with the different labour unions. These industrial actions disrupt the work-life balance of families and society. They adversely affect the academic calendar. Many of the disputes were refusal to accept policy failures.

From 14 February 2022 to 22 September 2022, the Academic Staff Union of Nigeria Universities (ASUU) members were on industrial action to press their demands for the Federal Government to adequately fund the universities and stem the declining standards of university education. The government response was to withhold their salaries. For eight months academic staff were not paid their salaries. The academics in the clinical departments continued teaching, research and attending to patients yet they were owed salaries. Teaching is not the only duties of an academician, no matter the discipline. The research duties and community services were still done even when teaching was not ongoing.

Withholding wages was a big challenge to balancing the life of these academics. The federal government in addition took ASU to industrial court. On 30 May 2023, at the National Industrial Court of Nigeria (NICN) Hon. Justice B. B. Kanyip, gave rulings

in the case of the Federal Government of Nigeria (FGN) and Federal Ministry of Education (claimants) Vs Academic Staff Union of Universities (ASUU) (defendants) to the case. The claimants made some demands including not to pay the Academic workers for the period of the industrial action using the *no work no pay* mantra. The NICN in its ruling held *inter alia*, that: ²⁶ quote:

“(3) I declare that in the instant case, the claimants are legally permitted, not just by section 43(1)(a) of the TDA, but by ILO Convention No. 87 and its accompanying ILO jurisprudence, to withhold, and so not pay, the salaries of members of the defendant union (ASUU) who partook in the strike that commenced on 14 February 2022 up to the date it was called off.

5) I declare that the claimants acted in error to impose IPPIS on the defendant union (ASUU). The issue of which payment platform is to be used in paying the salaries or wages of staff of the Universities is one that is within the discretion of the individual Councils of the Universities in line with the autonomy granted them by the Universities (Miscellaneous Provisions) (Amendment) Act 2003” ²⁶

Owners of means of production (employers) and their labour organisations had always been in conflict since their origins more than a century and half ago. In Nigeria, those who manage the production centres for the government that owns these educational and health institutions are always disagreeing with labour organisations of these sectors namely the Academic staff Union of Universities (ASUU) and its affiliates and the Nigeria Medical Association (NMA) and its affiliates, in this instance.

We must not see organised labour to be at conflict with those entrusted to manage the means of production for the government and the society. Criticisms of the actions or inactions of such managers and employers must be a call to reflection and improve the working conditions and output of such institutions. The ruling of the NICN above highlights the FGN not keeping to the *rule of law*, by eroding the *autonomy* of the Universities, even when it was pointed out to them by ASUU remained adamant²⁶. Society will be better off for it and development will progress if labour and employers work harmoniously.

b. CRITERIA FOR STUDENT ADMISSIONS AND RECRUITMENT POLICIES OF ACADEMIC STAFF INTO THE UNIVERSITY

The universities had more qualified prospective students than the spaces available to admit undergraduate and post graduate students into its programmes. The consequence was that tests were conducted to determine those to be so admitted. The aim was to admit the best academically qualified while also observing affirmative actions of geographic catchment areas, university discretions and educationally backward geopolitical areas. Excellent policy we have, but what is the reality?

The empirical observations I made were that *at times*.

- i. the highest scoring students at the entrance examinations may find it difficult to cope with the high demands of study in the university.
- ii. the best graded student on admission may not be close to one of the best on graduation.
- iii. The least scoring student on admission grading may turn out to be the graduating member of the class with best grade.

- iv. The best graduating student may not be the most successful of their class member years later in life, even when they practiced the same profession they trained for in the university.
- v. The graduating students with highest GPA or distinctions *do not always* make a good academic staff.

So those entrance examination scores were not a true test of suitable qualification to benefit from university education. Nor were the university courses grading, also the best test of who will be a better academic staff. May I quickly recognise that some who did not merit these admissions or employments received them to the detriment of better candidates. They are not the ones I am talking about here. I am talking about those who received positions on merit based on agreed criteria. I suspect that something was not being tested. Or do I suspect that the tests procedure and results were flawed?

My thoughts are that we are testing only the intelligence quotient (IQ) **not** social quotient (SQ), nor emotional quotient (EQ) nor adaptability quotients (AQ). We are not considering **SOFT SKILLS** in the assessment and evaluation of our potential students' admissions nor employment qualifications and skills of academic staff. These are areas for future scientific research to fill the knowledge gaps.

c. INTRAPRENEUR IN THE UNIVERSITY SYSTEM AND STUDENT WORK EXPERIENCES

The universities did not pay much attention to harnessing the benefits of high skills available among its staff and students. The staff should be supported to set up **intrapreneur** ventures within the university. This will have the advantage of generating revenue

for the university, being a source of extra income for staff, providing part-time employment for its undergraduate and postgraduate students as well as being a training ground for them to be self-employed entrepreneurs in the event of not securing paid employment on graduation. Staff who worked in such ventures will acquire practical skills to be entrepreneurs on retirement from university and easily transit to post-work life of productivity.

The university could go into partnership with industries for this. During the COVID-19 pandemic we saw many government organisations especially the teaching hospitals started manufacturing soaps, disinfectants, and hand sanitizers. What had become of those ventures today? We can still do it.

The university has farm with multiple production units. It could be managed with a *work-life flexibility* arrangement that allows fulltime students at the university to work part time in the farms in their areas of study specialisation for a stipend. I am not talking of their course practical nor the student industrial work scheme but of a *part time employment*. Another example will be students in the medical, dental and health sciences faculties being offered part-time jobs in the medical centre of the university.

If many students do part-time paid work, their life will be better balanced and the need for student loan to pay school fees will be reduced. The students vacation jobs of the 70's readily comes to mind. As a medical student at the University of Nigeria, Enugu campus, I did a one-month vacation job in the Postal Agency at Enugu Campus. I was sorting mails, registering mails, selling postage stamps and money orders. This one-

month vacation job was temporary arrangement that enabled a full-time staff to take his annual leave. I received stipend that I needed badly. It was a beneficial arrangement that was discontinued. We can restart such.

d. UNIVERSITY CURRICULUM WITH PRACTICAL WORK TRAININGS: -

--Example of Medical School Training and Its Graduates

The Faculties in the Colleges of Medicine appear to be doing better than their counterparts in other faculties in the university (there are few exceptions) in terms of their graduates advancing from schooling to working in their special fields of training. This I can attribute to their spending most of their schooling time in their departments in the hospitals where the professional training is done as *apprentices* concurrently with academic studies. The downside is that these are not remunerated works, hence life is not as balanced as it should be for the students and by extension their sponsors.

The point I want to make here is that if the university could collaborate with industries to set up their companies alone or in partnership with the university, these industrial **entrepreneurship** and university **intrapreneurship** will mutually benefit one another. This brings me to the issue of university graduate unemployment.

e. UNIVERSITY GRADUATE UNEMPLOYMENT

When the university graduate unemployment is viewed one must understand that there was something fundamentally wrong with the system we operated. Is it that we did not train people in the appropriate hard and soft skills needed in the workforce?

Some of our graduates after the full preparation and *being found worthy in learning and character* were unable to secure employment. Government will not employ everyone but should create the enabling environment for owners of means of production/employers to flourish and employ those who are willing to work. Those unable to secure employment or unwilling to work for any other person or organisation should use their entrepreneurial skills to create employment for themselves and others. Work gives the individual person dignity.

The constitution of the Federal Republic of Nigeria provided the fundamental rights of its citizens where in Chapter 2 section 16 on Economic objectives statement stated *inter alia* in subsection “2 (d) *that suitable and adequate shelter, suitable and adequate food, reasonable national minimum living wage, old age care and pensions, and unemployment, sick benefits and welfare of the disabled are provided for all citizens.*”²⁷

Similarly, the UN Sustainable Development Goal (SDG) number 8 DECENT WORK AND ECONOMIC GROWTH, envisaged employment for all and development of the society. There should be suitable employment for all that are capable of working. How can a nation attain economic growth where there is unemployment even among its university graduates? I subscribe to the position that our manpower training and practice will make beneficial impact on our citizens if we link the manpower development project to the Global Agenda 2030 especially goals numbers 3 (Good health and Wellbeing), 4 (Quality Education) and 8 (decent work and economic growth) in Nigeria. Manpower training should have in focus the SDG of **economic, social, and environmental** dimensions of development of the country.

f. UNDERSTAFFING ACADEMIC UNITS AND EXCESS ACADEMIC WORKLOAD

The number and quality of academic staff are inadequate in our universities. It calls to mind a passage in the Holy Bible: *“The harvest is plentiful, but the labourers are few; therefore beseech the Lord of the harvest to send out labourers into his harvest”* (cf. Luke 10:2 and Mathew 9:38)

In April 2023, the Faculty of Medical Sciences, University of Nigeria, invited academic staff of the Faculty/College of Medical Sciences to volunteer to take up teaching assignments in the Faculty of Basic Medical Sciences of our College of Medicine. A *call to serve* was issued. This call was necessary because there were not sufficient staff to teach the increasing number of students studying in the various disciplines in the College of Medicine.

What progress had we made over the years? Some of us answered such “call to serve” *pro bono* in the 1990s. I was then doing my full-time academic staff work in the Department of Otolaryngology, and for years, I was also teaching part time in the Department of Anatomy carrying excess academic workload like a full-time staff of Anatomy Department. It was not remunerated but I had the passion. However, the University took the volunteerism for granted. I was the one paying *to serve* the university instead of the University paying me. Let me plead that the Faculties/College/University should treat those who will volunteer this time around better than they did to us in the 1990s. The College must implement conditions that will enhance the Work-Life Balance of those volunteering. It should go beyond financial benefits. They should be engaged in such a way that the

work interfaces with their primary department works in flexible terms. Their engagement in the *secondary* Department should be recognised and rewarded during the promotion /appraisal exercises.

The periods the *dually* appointed staff should do duties in their primary department and time to work in their secondary department should be mutually scheduled. There should be **work-flexibility**. That is a way to balance work with life.

Management of the University and UNTH must jointly, through their two Management Boards articulate mutually beneficial policy of working conditions. Some suitably qualified persons are rejecting the University academic position appointments in preference to full-time hospital appointments because of better conditions of service of the hospital. The grievances should be addressed.

g. DECAY IN UNIVERSITY INFRASTRUCTURES

Infrastructural needs of the Universities are much. The available ones are deteriorating without maintenance nor upgraded when obsolete. New technologies are evolving yet we are not utilising them to work better and smarter. ASUU had been calling for improvement and revamping.

For example, in the 1970s, the Faculty of Medicine then, had a *Medical Illustration Unit*. This unit was shooting clinical photographs of patients when needed and producing educational materials for instructions and publications. It was even then headed by an expatriate. This unit is now moribund. Yet there is still demand for their services. However, photography technology

changed over the years from the cellophane film to digital. We advanced from overhead projector for transparencies and slides to multimedia computer presentations, to internet enabled smart whiteboards. Video presentation progressed from VHS tape on black and white television sets to digital full colour presentations. This digital photo-videography is presently integrated with information communication technology (ICT). Equipment for it is as ubiquitous as our cell phones. What is happening presently is that every clinician is his own medical photographer. This is not bad but why not upgrade the Unit? The upgrading would allow us to do telemedical practice. In addition, courses should be mounted for staff to acquire skills in *medical photography and videography*. Some may even take it further to graphic artistry. With this the production of medical instructional graphics, photographs and videos will be of higher standards for publication and teaching. Our students who had the requisite skills could secure part time work there, while remaining full time students.

12. DISEASES THAT CHALLENGED THE BALANCE BETWEEN WORK AND LIFE FROM 1979 TO 2023

There were diseases that were unknown or of no major concern, in the 70s when I was a medical student, that later became major threat to life of all. From start of my working life in 1979 till date, some of the diseases emerged that gravely challenged our health sector, our university educational system and threatened our lifestyle.

Mankind had been afflicted by viral infections since ages and new ones are emerging as the years go by. Some of the viral infections had impact in the diseases treated primarily by

Otorhinolaryngologist and some specifically affect children in different ways from their effects on adults. Impact of viral infections are vast in Otorhinolaryngology Head and Neck Surgical practice. These ranged from:

- The early effects of the viral infections on the affected anatomic structures,
- The delayed effects of their toxins and body immunological responses.
- Their pathological consequences can be extended to the fetus *in utero* of an infected gravid woman.
- Some are known to have therapeutic benefits in having oncolysis effects.

A few recollections of occupational hazards of viral epidemic infections on health workers and lifestyle in Nigeria will be stated below.

a. HIV AND AIDS ^{28, 29}

The retroviral infection of Human Immunodeficiency Virus (HIV) disease and Acquired Immunodeficiency Diseases (AIDS) A person infected by HIV may remain asymptomatic for years. At this asymptomatic phase, the patient is infective. This situation poses health hazard to other persons who may be exposed to their body fluids. The health practitioner exposure to the blood of the HIV positive patient is an occupational hazard. We encountered some that presented as emergencies that needed immediate operative intervention only for the diagnosis to be made retrospectively, after the exposure.³⁰

The fallout was that clinical practice guidelines of universal precautionary measures were adopted. ^{28 -33}

b. EBOLA VIRUS DISEASE

Ebola virus disease (EVD) is also known as Ebola Haemorrhagic Fever. The largest outbreak to date took place in West Africa between March 2014 to June 2016,

*“The first case of EVD in Nigeria was confirmed in Lagos on 23 July 2014 and spread to involve 20 laboratory confirmed EVD cases. 8 of the confirmed cases of EVD in Nigeria eventually died (case fatality rate of 42.1%) and 12 were nursed back to good health. In Nigeria, the rapid control of the EVD was facilitated by the rapid detection of the index case, the comprehensive contact tracing measures and the isolation and treatment of the secondary cases. On October 20th, 2014, Nigeria was declared free of EVD by the World Health Organization”*³⁴

Health workers were on edge while the epidemic lasted.

c. LASSA VIRUS

This zoonotic disease is associated with high morbidity and mortality. Lassa fever cases and outbreaks continue to be reported in Nigeria and the diseases is increasingly recognised to be endemic in many parts of West Africa, in 2018, Nigeria Centre for Disease Control (NCDC) reported the largest ever number of cases in Nigeria, with over 600 confirmed cases and over 170 deaths^{35,36}

People from non-endemic regions of the world who travelled to the endemic region may get infected before return to their home regions. We need to have a high degree of suspicion for the diagnosis to be made timely and protect other persons from being infected by this deadly disease. These impacted on the medical practice and the international

travels within the period of this review. There was need to balance the travel for work with life.

d. COVID-19³⁷

In December 2019, the world started hearing of a novel viral infection that was causing serious respiratory infection and threat to global health from Wuhan, China. This viral infection spread rapidly globally with lethal consequences to the world population. On March 11, 2020, the World Health Organization (WHO) officially announced that the coronavirus disease 2019 (COVID-19) had reached global pandemic status.

Let me quickly point out that *Corona viruses* had been with us and was indeed first described in the 1960. In 1971, four genera of corona virus were classified and those are what we use today, viz.

- *Alphacoronavirus*
- *Betacoronavirus*
- *Deltacoronavirus* and
- *Gammacoronavirus*

Presently there are hundreds of species identified but only seven coronaviruses are known to sicken humans. The virus that started to cause havoc in December 2019 was initially identified as coronavirus and called a ***novel corona virus*** because it was new and different from all then known species of corona viruses. Through the concerted efforts of Global Scientists, it identified the virus as a β -coronavirus that was known as **Severe Acute Respiratory Syndrome, Corona Virus 2 (SARS-CoV-2)** that causes corona virus disease 2019 (**COVID-19 Disease**)

The practices of medicine and particularly Otorhinolaryngology Head and Neck Surgery globally were affected by this pandemic in several ways. The fallout of this pandemic is still with us, we are not sure how and when it will end. It did not affect only our work but also our life and socio-economic activities. The COVID-19 Disease was of especial threat to Otorhinolaryngologists as an occupational hazard because of its route of spread through the respiratory tract and the positions we take while examining the ear, nose, and throat of our patients.

In a case control study of 46 COVID-19 positive adults and 46 COVID-19 negative adults in Abuja and Ibadan the following symptoms were found among COVID-19 positive participants: **sudden loss of smell, 14 (30.4%), loss of taste, 8 (17.4%) and hearing loss, 5 (10.9%).**³⁸ · The control COVID-19 negative participants did not have any of these symptoms.³⁸ ·

During COVID-19 pandemic period, face-time work was not safe. Virtual work that was underutilised before the pandemic became the norm. Our health facilities became more hazardous to work in than they were previously. Our universities were shut down to teaching and learning. Health care facilities were partially shut down. Elective surgical procedures were stopped. We could not teach nor research the traditional way we had been doing for decades. Society was shut down. Work and life were severely challenged and disrupted.

Our lifestyle changed such that on return home from work at the hospital, most of us health workers will start a ritual of hand washing and undressing, disinfecting, and showering before entering the home to meet family members. Work-life family conflict was becoming rampant. We could not greet nor exchange pleasantries by the traditional handshaking not to mention hugging.

COVID-19 pandemic resulted in more burn-out among health care workers, including clinicians at all levels than previously. Workers were stressed not only by the longer work hours but also by the fear of health safety in the workplaces. One strategy to cope with burnout was to spend quality time with family and friends. The stress acquired in workplaces are known to be relieved by life activities. COVID-19 pandemic denied workers the use of this strategy.

We practiced delivering lectures online, conducting conferences online, and telemedical practice. Some workers were asked not to come to offices physically. Some were asked to work from home to stay safe.

As we jubilate over containment of the still present COVID-19 disease, we need to increase our awareness of consequences of COVID-19. COVID-19 is still present. We are still to return to work *fully* and this is becoming the *new normal*. The challenges presently are that some workers are not returning to the full five-day work schedule despite being directed to do so. Neither were they working remotely nor from home. It is truancy.

When will the next epidemic happen? Are we prepared for it?

13. TECHNOLOGICAL ADVANCES THAT AFFECTED THE WAY CLINICAL MEDICINE WAS PRACTICED AND OUR WORK IN THE UNIVERSITY SYSTEM FROM 1979 TO 2023

This is not the first period in human history that technological progress had affected human work and life for good or for bad. Each advancement had the potential to make progress if managed properly for the benefit of man. Recall the period of industrial revolution when machines were introduced to do the work originally done by man. It was thought that the machines while doing the labour of human would create unemployment. But this was not to be. In fact, it led to the opposite with improvement in the standard of living. What was done was the re-training of humans in the way work was done. The present technological advancement will not be different. On 15 May 1891, POPE LEO XIII issued encyclical *RERUM NOVARUM*, (ENCYCLICAL OF ON CAPITAL AND LABOR ³⁹ . In the document he addressed the disputes between the workers and the owners of means of production.

Achievements in Science and Technology made major impact on how health care was delivered, university teaching done and life we lived. During the period 1979 and 2023, technological feats introduced new things and methods of working that were not available before 1979. In addition, they influenced the way we lived our lives.

Computer Information Technology (ICT).

The advent of the computer was a game changer. Computer Information Technology (ICT) affected all facets of information, communication, education, health care services and lifestyle. We

have the digital libraries that allow us access to information from remote locations and libraries at all times of day and night. This was a game changer in studying, teaching, research, and publications activities.

We can get information on diagnosis and treatment of any disease from the comfort of our consulting rooms instantly. Multimedia was deployed in teaching even to people in remote geographic locations. We now deliver lectures in virtual classrooms from the comfort of our homes. We use Computer Base Test (CBT) methods in assessment and evaluation of students.

Medical imaging:⁴⁰ the plain radiographs we grew up knowing is a different diagnostic and therapeutic setup today. We are having ultrasonography, CT scan, MRI, contrast studies and the soon to be outdated digital radiographs. Body parts and diseases that could not be seen four decades ago are being shown *live* in full colours! You can even use it to navigate to remotes parts of the body even live when performing surgical procedures.

Interpretation of the medical images is being done by AI devices⁴⁰

Telemedicine needs were boosted by the advances in ICT and the fear of the hazards COVID-19 unleashed on the world. Our infrastructures are not up to date for us to fully use these innovations.

ARTIFICIAL INTELLIGENCE (AI)^{41, 42}

Machine learning, Deep learning, and Artificial intelligence. This is the latest progress in the *innovations* that computer brought along to not only medical practice but to the everyday life we live.^{41, 42} It is still evolving and improving in accuracies in all facets of our *work and life*. Its impact is felt in all we do.

Artificial Intelligence: The issue of evaluation of the student knowledge base is being called to question when assignments are done by students using AI. Some of the software are known to perform well in professional examinations. How do we as academicians ensure that the candidates, we are certifying that we *found worthy in learning* earned such?

On the positive, use of these artificial intelligence (AI) software could be deployed in teaching and learning. The introduction of new things in the world had always had their negative and positive characteristics. Artificial Intelligence is not different. It is the responsibility of the society to tap into the beneficial sides of it and checkmate the negatives.

How do we ensure that our students understood what they wrote in assignments or examinations and not generated by Chatbots? Some persons are advocating a return to pen and paper examinations model, in the presence of invigilators to stop answers generated by AI from being submitted.

An example was on 04 July 2023, I delivered online lecture to Residents. I was asked a question at the *interactive questions and answers* period. The question was in a domain my knowledge was not exact, so being unsure of the exact answer and not wanting to give incorrect response, I responded that I do not know the answer, but I advised that the consultant Radiologist who was to join the lecture shortly will give a better answer. At the end of the lecture, I took the question to *Bing App*, an AI of *Microsoft*[®]. The text box below showed the conversation with *Bing*. This is an example of learning using AI. It even provided me references for further reading.

Question posed to **Bing**,

WHAT ARE THE DIFFERENCES BETWEEN T1 AND T2 WEIGHTING IMAGES IN MRI AND CT SCANS?

Answer:

T1 and T2 weighting are two different types of magnetic resonance imaging (MRI) pulse sequences that are used to create images of the body. In CT scans, the terms T1 and T2 weighting are not used. However, in MRI scans, T1-weighted images are best for showing anatomy and structure while T2-weighted images are best for showing fluid and edema²³⁵. T1-weighted images have short repetition time (TR) and short echo time (TE) while T2-weighted images have long TR and long TE⁶.

Source: Conversation with Bing, 04/July/2023

(1) The Basics of MRI Interpretation | Radiology | Geeky Medics.
<https://geekymedics.com/the-basics-of-mri-interpretation/>.

(2) T1-weighted and T2-weighted MRI image synthesis with convolutional
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8086713/>.

(3) T1 weighted image | Radiology Reference Article | Radiopaedia.org. <https://radiopaedia.org/articles/t1-weighted-image>.

(4) Signal weighting (T1, T2, PD) and sequences parameters: TR, TE - IMAIOS. <https://www.imaios.com/en/e-mri/nmr-signal-and-mri-contrast/signal-weighting-and-sequences-parameters>.

(5) Comparison of T1 and T2 weighted images of the lumbar spine.
<https://pubmed.ncbi.nlm.nih.gov/3179982/>.

(6) MRI Basics - Case Western Reserve University.
<https://case.edu/med/neurology/NR/MRI%20Basics.htm>.

Another example was that I used my cell phone to ask **AI Abstracteer** (www.toolbot.ai), an **AI Chat App** to write an academic **abstract** for a paper titled “Work Life Balance and retirement” for me. Below was the text it generated in matter of seconds.



Me:

Work Life Balance and retirement



Ask AI Chat App:

Work-life balance is the concept of balancing the demands of work with the demands of personal life. Achieving a good work-life balance is important for overall well-being, as it can help reduce stress and prevent burnout. It allows individuals to prioritize their personal life and responsibilities, while still being productive and successful in their work.

Retirement is an important aspect of work-life balance, as it marks the end of a career and the beginning of a new phase in life. Retirement can be a time to pursue personal interests, spend more time with family and friends, and enjoy leisure activities. However, retirement can also bring challenges, such as financial uncertainty and loss of social connections.

To achieve a successful retirement, it is important to plan ahead and consider various factors, such as retirement savings, healthcare, and social connections. It is also important to maintain a healthy work-life balance throughout one's career, as this can help ensure a smoother transition into retirement and a more fulfilling retirement experience. By prioritizing personal time and interests outside of work, individuals can develop a sense of purpose and identity that extends beyond their career, which can be beneficial in retirement.

When I reviewed the answer, I felt that I wasted time racking my brain in developing the theme of my writing this paper, when I could have used the **AI Chatbot App** to kick start the main subheadings of this paper. Work and life of the future will be more balanced than presently.

In terms of clinical practice, our patients who use the AI/Chatbots will be better informed on medical conditions that affected them or their relations. Doctors are relying more on the AI/Chatbots for clinical information on managing their patients. They may spend more screen time than bedside times. There is nothing wrong with getting support from Chatbots. However, we must evaluate such information for its appropriateness and accuracy. A doctor who talked more with the patient is likely to develop deeper relationship with the patient than one who did not, to appreciate their health challenges. microcosm

Robotic surgery

At the time I graduated in 1979, there was no practice of robotic surgery. Today we are not only having it but extending its use in intrauterine surgical practices. I do not know how far we shall go with it in the future. It is our obligation to make it improve our work and life.

Age reversal or anti-aging technology or cell reprogramming or ageing retardation

Scientist had been working to understand how humans age. The idea was to restore cells to their youthful functional states. The technology was to turn adult cells to the embryonic like stem cell or directly converting them to other functional forms. Age reversal or anti-aging technology or cell reprogramming or ageing retardation are different names given to the process, but

they differ in the process of doing age reversal or ageing retardation.

There are some publications on the process ⁴³

These had potential for treatment of some diseases such as spinal cord injuries. Other neuronal diseases that had potential for this technology are blindness, presbycusis, etc.

The disadvantage is the potential to transform to cancerous growth. Work in the future will certainly be different from what it is today.

Lifestyle Medicine *“is a medical specialty that uses therapeutic lifestyle interventions as a primary modality to treat chronic conditions including, but not limited to cardiovascular diseases, type 2 diabetes and obesity.”* ⁴⁴

This emerging specialty of medicine is based on the following six pillars for its curriculum: nutrition, physical activity, stress management, restorative sleep, social connection, and avoidance of risky substances. ⁴⁴

14. THE ROLE OF BRAIN DRAIN PHENOMENON IN BALANCING WORK WITH LIFE IN NIGERIA

A major factor driving the brain drain phenomenon is our socio-economic and security situations. Working professionals are not satisfied with their working conditions. Workers are seeking better working and living conditions outside the shores of Nigeria. If work and life are balanced the drive will not be as much as it is now.

Migration rates to outside Nigeria for work is high amongst academic staff, medical doctors, nurses, pharmacists,

physiotherapists, medical lab scientist indeed all health care workers.⁴⁵

Presently, our *unskilled* labours had joined the brain-drain migration train too. It has reached the level to be afraid for Nigeria, but **do not be afraid**.

On 20 September 2018 while delivering the 36 Convocation lecture of the National Postgraduate Medical College of Nigeria at Ijanikin, Lagos, titled: **DO NOT BE AFRAID AND DO NOT FAIL TO RESCUE** I said on that occasion, let me quote verbatim:

*“The brain drain phenomenon is getting worse. For those who have plans of migrating sooner or later, do not feel guilty yet. Let us have a conversation first. I personally have stopped dissuading anyone who wants to migrate. I do not encourage anyone to migrate either. I believe that the conditions in Nigeria offer so many reasons why our trained medical personnel are migrating out of Nigeria. No matter your reason, **DO NOT FAIL TO RESCUE** yourself or the society from the challenges you or they are facing. You can make positive impact on the situation you find yourself.*

The brain drain phenomenon had always been a worldwide issue, including Nigeria. It reached alarming proportions among Nigeria medical experts in the 80's and 90's when highly trained Nigeria medical personnel and other health professionals flew out in their large numbers to the Gulf States in search of greener pastures. The predictions then were that medical education and the health sector in Nigeria will collapse with the mass exodus of our highly trained medical experts. These were the fears in the land. It was the National Postgraduate

*Medical College of Nigeria that took up the challenge of training more highly skilled specialist medical workforce for the nation's health facilities and the Medical Schools to staff our institutions. Our College did **NOT FAIL TO RESCUE** the Nigeria health sector nor the medical Schools. As a matter of fact, there were a lot of positive outcomes for Nigeria from that wave of emigration.*

*The current emigration phenomenon has major differences from what happened in the past. It goes beyond looking for greener pastures outside Nigeria. This time around there are many more reasons and destinations to emigrate to. Hence, we are in for a longer haul. Second, those migrating are the upcoming future leaders of the health sector, as well as the current leaders. The National Postgraduate Medical College of Nigeria is stronger today than it was in the 1980's and 90's. Hence the College is in a better position to train more specialists through its Residency training programmes. However, replacing them may not be that sufficient strategy this time around. Those emigrating to other developed destinations are the ones to do the rescue. So, I tell those emigrating to satisfy their ambition but remember, **DO NOT FAIL TO RESCUE.**'⁴⁶*

Those emigrating are both the trainees and their trainers. Who is staying back at home to be trained or the person to do the training. Are we abandoning the health sector and the academia? Should the ageing clinical academia in the professorial cadre be encouraged not to retire?

The WMA identified 5 key issues for satisfaction in a workplace. These are and I quote: ⁴⁷

1. *“Professional Recognition*
2. *Management Practices*
3. *Support Structures*
4. *Occupational Health and Safety*
5. *Education “*

These five issues are adversely affecting the Nigerian academic medical practitioner.

The Nigerian Health worker and academia are not satisfied with the conditions in their workplaces. The Governments at all levels in Nigeria should re-examine the terms of employment of their health workers and academia especially those that combine academia and health care services. Governments have done too little if anything in this regard. Governments shall address these issues that push professionals out of Nigeria.

We were informed in April 2023 in national news of a piece of legislation in the National Assembly proposing to ban medical doctors from being fully registered to practice Medicine in Nigeria until 5 years post qualification. This is to prevent them from migrating outside the country. We were intimated that similar legislation is coming for the other health workers. What an amazing simplistic solution to such complex problem!!! Is that not forced labour or slavery? This will create more problems than it is to solve. Thank goodness, we were informed later by the then Minister of Labour and Employment that the Federal Government did not support that private member bill. This piece of legislation or any similar thought process is a sure way of **fail to rescue**. Let us hope that those who *flew that kite* had cancelled this agendum.

Management practices need to be re-structured rather than introduce such obnoxious legislation.

'Re-structuring the terms of employment in government services could offer enough flexibility such that those who choose can be employed to work on terms that would still enable them work overseas. The nation would reap the dividends of training them and the benefit of the experiences they had working abroad. India seems to be gaining in the "brain circulation" model without aggressive policy. Each government must compete for this skilled labour by making their country more attractive to employ and retain the services of these skill health labour.'

46

There is no doubt that the academia and health care workers numbers in Nigeria are dwindling at a rate that cannot be sustained. Causes of this are complex. The Association of American Medical Colleges is addressing their peculiar situation about supply and demand of Physicians in its work force and researching on it.⁴⁸

Let us borrow a leaf from them to commission research that assist us proffer solutions and not to enslave a particular set of workers. Addressing the identified root causes of this brain drain phenomenon will help Nigeria stop the migration and will result in *brain circulation* and the *brain gain* phenomena. This is the right way to carry out the rescue mission.

While we are researching, ASUU and NMA with all their affiliated unions should prepare legislative bills for consideration of the National Assembly, instead of waiting for another

obnoxious bill to be introduced. This new bill should address the challenges faced by those migrating out of Nigeria with a view to legally backing up any policies that will help stop the one-way traffic of leaving the country but also constructively provide for them to voluntarily return home through the homecoming route this legislation will provide. That is a way of encouraging *brain circulation*.

The *brain circulation* and the *brain gain* phenomena are the bed rock expected to improve the investments and services rendered in Nigerian health sector and the university system. Brain drain will occur first before brain circulation will be and followed by brain gain. Medical tourism of Nigerians will naturally stop.

We are also having *educational tourism* where young Nigeria migrate out of the country to study courses that are abundantly available in Nigerian universities. Even the doctoral and post-doctoral fellowships of the Universities are not left out of the brain drain phenomenon. Returning home at completion of their courses of study is another gloomy narrative as many failed to return. Government must partner with the various professionals migrating to other climes. This they can do by offering flexible terms of appointment to the highly skilled work force on terms that will allow them *visit* to render their services for short periods.

15. GERIATRIC OTORHINOLARYNGOLOGIC PRACTICE IN NIGERIA

Improvements in the standard of living in Nigeria and worldwide are changing the demographics. We now have more people surviving into old age all around the world, including Nigeria. That also means that since most people retire from service after the age of 60 -70 years, most retirees are geriatrics population. The old age population are increasing in number as they now live longer.

As people age, there are changes of aging which should be viewed as inevitable and physiologic. Our sensory perceptions become weaker. Specifically, we decline in perceptions of smell, taste, hearing, and vision. Arthritis sets in and mobility is affected. Our brain function declines, and mind is dulled. Dementia is knocking on the door. The body systems will decline in function.

Geriatric healthcare providers view the **5Ms** as core principles to be mindful of as their patients age — *mobility, medications, mind, medical complexity, and matters*,⁴⁹

Certainly, the practice of Otorhinolaryngology took note of these, hence the subspecialty of ***Geriatrics Otorhinolaryngology*** emerged and is growing.

“We need to

5. *Raise awareness and act against discrimination of elderly individuals.*
6. *Promote ethical, responsible, effective and efficient practices for treating the elderly.”*⁵⁰

“While many elderly people require medical attention, all elderly people require care”⁵¹

We did a study to determine the Otorhinolaryngological disorders burden of the geriatric population attending a private health facility - Balsam Clinics in Enugu⁵². The study was done for the four years January 2000 to December 2003. We found that of a total of 5096 new patients attended the Clinics during the study period, of these, 294 (5.8%) were aged 65 years and above.

Our findings were that presbycusis, chronic sinusitis and chronic pharyngitis were the leading disorders in the ear, nose, and throat anatomic areas respectively. See Tables 3, 4 and 5 of that publication below⁵².

Table 3: Otological Disorders in 201 cases

Disease/Diagnosis	Frequency	% Age of 201
Presbycusis	71	35.3
Otitis media	41	20.4
Impacted cerumen in external auditory canal	30	14.9
Chronic suppurative otitis media	29	14.4
Otomycosis	10	5.0
Otitis media et externa	8	4.0
Otitis externa only	3	1.5
Foreign body in the external auditory canal	3	1.5
Ototoxicity	3	1.5
Labyrinthitis/Menieres disease	3	1.5
Total	201	100%

Table 4: Rhinological Disorders in 30 cases

Disease/Diagnosis	Frequency	% Age of 30
Chronic Sinusitis	14	46.7
Epistaxis	8	26.7
Hypertrophied turbinates	4	13.3
Carcinoma Maxilla	2	6.7
Inverted papiloma	1	3.3
Rhinoscleroma	1	3.3
Total	30	100

Table 5: Laryngological Disorders in 30 cases

Disease/Diagnosis	Frequency	% Age of 30
Chronic pharyngitis	7	23.3
Carcinoma Larynx	6	20.0
Dysphagia	6	20.0
Laryngitis	3	10.0
Foreign body Oesophagus	2	6.7
Glossitis		
Quincy		
Nasopharyngeal carcinoma		
Foreign body Larynx		
Tonsillar ulcer	1 each	3.3 each
Carcinoma tongue		
Total	30	100

A similar study in University College Hospital, Ibadan of 170 geriatric patients over a 5-year period of 2000 to 2004 constituted 3.6% of the total of 4675 new patients attended to within the study period were aged 65 years and above.⁵³. They reported thus:

'The main presentations in these geriatrics patients were otological presentations 114 (67.1%) followed by rhinological 31(18.2%) and laryngeal presentations 22 (12.9%) respectively. Facio-plastic presentations were of 3 (1.8%) cases. Presbycusis 35 (30.7%) and cerumen auris 30 (26.3%) were the main otological problems encountered.' ⁵³

Age related hearing loss was the main disorder they attended to in their geriatric patients.

Okoye BCC and Onotai LO in their report from Port Harcourt wrote⁵⁴

"In a a ten-year retrospective review of patients aged 60 years and above seen between January 1994 and December 2003 at the ENT Surgery Department of the University of Port Harcourt Teaching Hospital showed Nine hundred and seventy-two patients out of a total patient population of 20,600 were found to be 60 years and above. The geriatric population was thus 4.7% of our total patients. Otological disease predominated with 537 (55.2%), followed by Rhinological disease with 180 (18.5%) before Laryngological pathologies with 154 (16.4%)."

In yet another study in Ado Ekiti, Nigeria, Adegbiyi WA et al wrote on emergency Otolaryngology treatment of geriatric persons: ⁵⁵

"Geriatric otorhinolaryngology, head and neck emergency accounted for 132 (5.3%) of the 2473 patients

seen in our ear, nose and throat department during the study period of October 2016 to September 2018”⁵⁵

From these publications, the main challenges of elderly retiree will be auditory impairment especially presbycusis. When this happens the quality of life is adversely affected because it leads to social isolation, withdrawal, loss of self-confidence, depression, and compromise mobility. Assistive hearing devices will help in their rehabilitation program.

Our Otorhinolaryngology Head and Neck services Departments in the hospitals shall start now to provide facilities aimed at taking care of these increasing numbers of our elderly populations’ otolaryngologic needs. The communities shall also gear up to the needs of our aging population.

All elderly persons need **care** not just medical treatment alone⁴⁷. Our *extended family system* that had been caring for the elderly persons in the communities is breaking down. Children and grandchildren who had been taking care of elderly relations in the past are no more available as they had gone away pursuing their work-life activities. In fact, taking care of their elderly family members fully will throw their work-life out of balance. These elderly persons unfortunately are now being abandoned by their family members. We must make provisions within the societal norms to care for them and stop the decay in our extended family system.

The research ongoing in **ageing retardation** or **age reversal** phenomenon may yield positive results in the future. If this happens, the elderly will be stronger and not afflicted by these sensory declines enumerated above. Shall humans achieve immortality on earth?

16. PREPARING TO FACE THE CHALLENGES OF LIFE IN RETIREMENT (POST-WORK LIFE)

The preparation most workers make for retirement in Nigeria is focused on the financial independence they want to have. They look forward to the gratuities and pension to receive. They believe that the opposite of work is retirement (rest from work). Most do not consider that life continues after retirement. Indeed, retirement life could be great. Retirement life could still be fun, vacations, as well as actively productive. For this to happen one must have the appropriate mindset and prepare for it in advance.

Many people have the attitude that once one is 60 years of age and above, he or she stops working. To me it depends on possessing the skills needed to do post-retirement work. Work needing physical strength is not the same as one that relies on experience nor one that depends on mental intellectual cognitive capacity nor being innovative. Certainly, a younger person in his 20s as an athlete will outperform an older person in his 50s. But this cannot be true for a medical practitioner nor an academic staff. On the other hands, an athlete in his 20s will benefit immensely from a coach that is in his 50s. The experience of the coach is put at the disposal of the younger man and use in making the younger person's performance better. This comparison will be true for an academic staff or a medical practitioner that **collaborates** with a younger professional colleague as mentee in working together. The reason is that they pull together their individual strengths of innovative thinking, experience, and intellectual capacities. The positive effects of **mentoring** are at play too.

Consider the self-employed persons. Many are actively working past the statutory retirement ages set out for the public servants. This could also be applicable to public servants. I am not advocating that public servants should not retire. They shall retire formally from public service according to the public service rules. The current policy on **contract appointments** did not meet the practice I am advocating. The point I want to make is that some of them are **retired but not tired**. Policy should be developed to still get the useful knowledge and skills these retirees have on terms that allow *part time* works with performance output measured objectively with remunerations tied to time spent working and this output measured. The university's system of emeritus professorship should be encouraged, and universities actively seek to appoint those who may not have voluntarily applied for it. Reduced course loads teaching and supervisions of academic projects could specifically be assigned to eligible academicians. The clinician will also have reduced clinical workloads.

A public servant who is retiring from service will certainly have the requisite educational qualifications, in addition to being more experienced in his work with better skills set than a fresh university graduate. Such retiree will most likely have better financial capital to set up a business venture where he could be self-employed to live a better post-retirement work life than the fresh graduate. In essence retirees are a veritable source of socioeconomic assets for development of any country. It is for the government to grant incentives and provide enabling environment for this.

I recall some of my teachers in the medical school and residency program who are still around and the way they go about their

retirement life. Their ways of living their retirement years are impressive in their different patterns. Some are still actively working clinicians while some are into full time *resting* post-work life. I believe both styles are good. One common factor is that they are happy and enjoying life and ageing gracefully and in dignity. They are having **productive aging**. I do not think that it is the earned wages that is driving the zeal of those still working. *When I grow up, I want to be like them.*

Here in Enugu, I observed some academic medical staff retirees who continued to work productively in what should be their retirement years. Their continued working into late old age is a source of inspiration and mentoring to younger colleagues. One common attribute I observed among them was that **the work they continued doing on retirement was an ongoing concern as at the time they retired from public service**. They did not just retire and started new ventures. The **null** hypothesis will be that:

*clinical academic retirees will continue working into advanced elderly age if they do **not** have ongoing professional practice at time of retirement.*

The **alternate** hypothesis will be that:

clinical academic retirees will continue working into advanced elderly age if they have ongoing professional practice at time of retirement.

Every worker must be intentional about what to do after retirement. If one will start a new type of work, fill the gaps in knowledge before venturing in as entrepreneur. Do internship or apprenticeship in the trade or venture you want to embark upon retirement. Career success will depend on having the objective, set the target, plan, and act.

The *Second half of work-life* starts on retirement from public service, which is post-work life. These days people start a second career for various reasons not because they failed in the first one nor because they did not make a fortune there, nor are they seeking a fortune in the new career. The time to prepare for it is, while still in public service. You train for the future. You start the career while still on the first one either as part time or moonlighting, or volunteer. Let the preparation not adversely affect the work you are already doing.

In early 2023, my attention was caught of a news item of Professor Calyampudi Radhakrishna Rao, born 10 September 1920, an Indian American Statistician who was awarded the [International Prize in Statistics](#), the award is judged to be the equivalent of a Nobel Prize in Statistics. He had been winning different awards all his career. He was 103 years old in 2023. Professor CR Rao retired in Indian at the age of 60 years as a professor. He then migrated to USA where at 62 became a professor of statistics at the University of Pittsburgh. He became a USA citizen at age of 75 years. He continued working and had a second retirement at 80 years. Not done yet he continued as Emeritus Professor.⁵⁶

His story is an uncommon one. The essence of this narrative above is to show that one can still work and achieve much at later life in any form of retirement and to inspire someone.

17. FINANCIAL AND SOCIAL SECURITY CHALLENGES DURING YEARS IN RETIREMENT

I observed that for some people their work defines their identity. Separate them from that work, they will not have any identity.

These were people who have work-life *unbalanced*. The ideal situation is to have identities from different aspects of work and life. With these multiple identities, separation from work can only result in partial removal of work identity while other identities remain.

It is usual for workers to be saving funds towards their retirement years. After starting a family one of the things most workers do to have a balanced retirement life is to plan to build a home (acquire property) of their own. The Government supports this with the National Housing contributory scheme. It is left for us to see how this scheme was implemented and the number of workers that benefited from it. Not much impact was noticed.

One can reason that home ownership is beneficial for all workers, but more for the lower income workers than for the higher income group. Yet these lower income group are most times are those who fail in building a home while in service because they have less disposable income to use in building. Maybe we shall strategize on when to start and the design of the home or acquisition of property to embark on. Payment of a living wage will help.

As Pope John Paul II stated, “*property is acquired first of all through work in order that it may serve work*”⁵. If I may say it in this narrow way the property you acquired from the wages of work, you are doing while in service will serve you in the post-work period and may be part of the capital entrepreneur venture you will establish later to create work.

We often hear stories of people who migrated out of Nigeria in search of a better life. They labour for years, living frugally and remitting every kobo saved to relatives in Nigeria to invest for

them, often in building homes. False deceptive tales and pictures were sent to them about their projects. Unfortunately, some will return after many years at retirement, to realise that no investment was there for them, and the money remitted home were misappropriated and not invested. *Life did not balance with work.* Retirement life will be in deprivation for this class of people. This is a form of exploitation of the worker's planned post-work life.

A less dramatic version of the scenario above is where even when the worker resides in urban area in Nigeria will remit money to relations in the rural abode with instructions to solve identified and specifically named family problems and or economically empower other members of the family (often extended family members). The project was not carried out as agreed. He was not even informed that the funds were misappropriated. The financial burden of these beneficiaries that failed to get the benefits will still be heaped on him. He suffered double jeopardy!!! The worker was exploited. The cautionary tale here is for one to find a way of monitoring those trusted with spending your hard-earned money to ensure that the investment purpose you had for setting the fund aside is achieved.

18. LIVING RETIREMENT YEARS: SOME QUESTIONS ONE WOULD BE ASKING ABOUT RETIREMENT LIFE (POST-WORK LIFE)

- Where would you like to retire to? Or do I ask *dream* of retiring to?
- What factors do you consider in planning where to live your retirement years?
- How do you want life in retirement (post-work life) to be?

As I approached my retirement from service in the University and the Hospital, I asked myself these questions. I have only held superficial discussion on my post-work life with my significant persons - spouse and children. The pros and cons of choice available are there and everyone has his or her own preferences. I notice that my views and opinion on these differ with those they held in some important respects and agreed in others. I avoided disposal decision of this topic. Not that I do not want to be advised. We cross the bridge when we reach it. We have reached the bridge now. One certain thing is that I am going to shift priorities in this post-work phase from what it was in my working years.

I know that I am setting out on the *second missionary journey*. Post-work life is going to be a long marathon. I had *extended* time to prepare for the days and years, and I eagerly look forward to *hitting the ground running*.

In this country, we are approaching a situation where our retirees and elderly people will **not** have their children and grandchildren reside in Nigeria or near them. Our demographics are fast changing. Loneliness and isolation will confront retirees squarely. The big homes built while working will be so empty that the retiree will wonder what all the struggle of acquisitions of the house *was all about*. This is beyond the much talked about ‘*empty nest*’ phenomenon. We do not even have adequate retirement homes in this country to accommodate those who are eligible. Our elderly populations are on the increase with increased life expectancy. Extended family system is getting weaker, especially in supporting the elderly.

Specific Answers to the questions:

➤ **Where would you like to retire to? Or do I ask *dream* of retiring to?**

I did like to retire from public services work and do the things that give me happiness, satisfaction, and fulfilment of purpose of life. I will be retiring to Enugu and Akwaeze, where I had nested and spent the greater part of my working life in. I will occasionally take trips to visit children and grandchildren wherever they may reside.

➤ **What factors do you consider in planning where to live your retirement years?**

I chose Enugu and Akwaeze, because I want to remain with the people, that I spent the greater part of my active working years with. I do not want social isolation nor loneliness. Those were the major reasons. If I remain in Enugu, I will still be able to teach the younger ones. I could still practice my profession in a scaled down collaborative way, to devote more time for volunteer works in the communities. I will continue to learn new things for I believe that learning is a lifelong process.

➤ **How do you want life in retirement (post-work life) to be?**

‘Then I heard the voice of the Lord saying, “Whom shall I send? And who will go for us? And I said, “Here am I. Send me!”’ (Isaiah 6:8)

Lord, you will show us the path of life. (Psalm 16:11)

The voice was calling. **Hear the Voice** ³. I volunteered and answered the ***call to work***, I will rely on God to show me the *path of life* to follow. I plan as stated herein but will still follow the *path of life* to do the Will of God. *Thy Will be done O, Lord.*

Life will be fun, balanced, integrated, purposeful making impact in the society. It will be a contented life for I did things as shown in the *path of life*. My retirement years will be post-Work-Life that is effective, it will be Work-Life that is flexible; it will be Work-Life that will continue to interface well with the communities. It will be doing the *Will of God*. It will be post-work life.

I will be the *do-it-yourself* (D-I-Y) person practicing the vocational crafts I learnt over these years: carpentry, welding and metal fabrication, agriculture, masonry, electrician, auto mechanic. To maintain my home.

I shall do more charity works. I shall work better and work smarter. I shall be working in the Lord's vineyard (Mathew 20:1-16)

I will continue to work and live according to the message of the **Opus Dei** (*Opus Die* Latin phrase translated to English language is "Work of God".) that says "*Work, family life, and the ordinary events of each day are opportunities for drawing close to Christ and making Him known to others*".⁵⁷ For those who may not know it, **Opus Dei** is a Catholic organization that promotes holiness in daily life and work founded in 1928 in Spain⁵⁸

If I have the resources, I will establish a retirement home/hospice for elderly persons at the site I had secured, and we shall all happily reside there. I want to leave both working life and post-work life **legacies**.

I shall not be a burden on anyone. I shall continue to glorify my creator, who did so much favour for me. I remain forever grateful.

After all work and life is done what next? Will work or life continue forever? NO. Will retirement years be forever? NO. What is the ultimate plan? And destination? Despite their ageing reversal efforts, life must one day come to an end. **THE ORDER OF THE KNIGHTS OF ST MULUMBA NIGERIA** of which I am a member has as its motto: TEMPUS FUGIT MEMENTO MORI (**time flies remember death**). The final resting place of my earthly body is marked. I discussed that with my parents many years ago when they were alive. They had taken their plots of rest and I will take mine years after becoming a centenarian, and

Almighty creator calls me to the heavenly home. Then my spirit will go to heaven. I look forward to the resurrection to **life** everlasting.

19. HIDDEN HAZARDS OF OUR *WORK AND LIFE* - *MEMORIALS*

There are people who could have been present at this Lecture but were unable to make it. I am not talking of people who should have been or were invited. I am talking of people who I worked closely with but were not invited because they did not live long enough to retire from service and to be alive today. There are many. May their souls rest in peace.

Let me tell the **untold story of only three** of them. This will illustrate the hidden hazards in this work and Life. I begin with Dr Benjamin C.C. Okoye. We started and completed Residency training as the pioneer Residents in Otolaryngology Department, UNTH. The second person is Professor Mrs Nnennia Mgbor who was a colleague in the Department. On this evening in early October 2006 at Ibadan, Prof Mrs Mgbor was the Faculty Chairman, presiding over the assignments as to who and where

the faculty members of Otorhinolaryngology, of the West African College of Surgeons, will pay accreditation visits to. Dr Okoye was seated beside me. Towards the end of this *shuffling* and *juggling* of giving assignment meeting, Mgbor spoke to me from across the table and offered me to choose to lead the accreditation team either to UDUTH Sokoto or UMTH Maiduguri so that she will take the other slot. I had the *approach-avoidance conflict* of choosing going to Sokoto where I last visited during my NYSC in 1981 or going to Maiduguri that I last visited in 1989. I opted to go to UMTH Maiduguri, more out of curiosity to go and see the changes that had occurred there since my 1989 one-month locum appointment with them. Dr Okoye was assigned to be in the UDUTH Sokoto accreditation team. My choosing UMTH, Maiduguri, meant that Nnennia Mgbor was to lead the UDUTH Sokoto accreditation team.

On Sunday 29 October 2006, Dr BCC Okoye and Professor N Mgbor were *enroute* to Sokoto for the accreditation visit on board the ADC airlines flight 053 (ADK053) that crashed soon after take-off from Nnamdi Azikiwe International Airport, Abuja. (see also reference 59 <https://thenationonlineng.net/facing-death-taught-me-to-live-esther-omojafor-survivor-of-2006-adc-airline-plane-crash/> for a recollections of a survivor five years later, in 2021)

About the same time of the air crash, I was airborne from Enugu to Lagos, in company of Prof Humphrey A. Ezike to conduct Fellowship examinations for the National Postgraduate Medical College of Nigeria. We landed safely in Lagos oblivious of the catastrophic disaster that happened at Abuja while we were airborne. While waiting to claim our baggage, I received the first

in the series of phone calls from a colleague in Enugu asking in an uncharacteristic, agitated tone of voice, where I was? Are you safe? Before I could reply she asked me *where is Nnennia Mgbor*? I did not understand the questions. At same time, Prof HA Ezike received phone call from another person enquiring if he travelled as planned or still in Enugu. The person quickly added that since he was answering the call it reassured him that he (Ezike) was safe for there was a plane crash at Abuja. It did not take long before we confirmed that ADC flight crashed at Abuja and may have some of our colleagues on board. From that afternoon we were constantly on the phone calling and answering calls especially when news filtered that our colleagues may be many in that flight. Within an hour we established that Dr Okoye and Prof Mgbor were in that flight among other persons. Their cell phones were not connecting. Did they survive? We prayed that they did. As the afternoon wore out the impending sad reality was weighing us down. Later that night, a mutual friend of Dr Okoye and I, a high-ranking military consultant surgeon, confirmed to me that he recovered Okoye's body from the wreckage. In fact, he drove him to the airport to board the flight. Our worst fears were confirmed. We were devastated.

Although Professor Ezike and I checked into our separate rooms at the same hotel, but we kept awake, mourning together in one of the rooms till daybreak. To say that we were having nightmares while awake will be an understatement. We later confirmed the demise of Prof Nnennia Mgbor, along with some other medical colleagues/passengers who also died in the crash. Phone calls revibrated from Lagos to Enugu, to Port Harcourt, to Ibadan, to Abuja, to Accra, to Monrovia, to Sokoto, to Maiduguri, to Freetown, to all towns, and to Europe and Americas. Unlimited

bereavement enveloped us. They died in active service. This was work that was non-remunerated. Not even life insurance was in place for such calamity. May their souls rest in peace. Amen.

One hundred and five persons were on board, ninety-six died and nine survived. One *untold story* was that seven farmers who were tending their crops in the farm were killed by the plane crashing on them on the ground. They died in the course of their **work**, from an accident that apparently, they had no business with. May their souls rest in peace. Amen.

How we took safe travels for granted! What a tragedy from the **work** we *do*! So, hazard at work could come in different ways. Even for events that one was **not** obviously concerned with, like those farmers in their crop fields. What a narrow escape for me, because of the choice of going to Maiduguri. I could have been on that flight to Sokoto. Another perspective was that it could have been our afternoon flight that day from Enugu to Lagos that crashed. This was evident from the number of enquiries I received from acquaintances who suspected that I might be on that flight.

Such is the uncertainty of life. Work the hardest every day, but at same time live life every day to the fullest. This is a work-life balance formula.

Professor Humphrey A Ezike is the third person in this my memorials. Prof Ezike was a hard working energetic and competent Anaesthesiologist. We worked together, lived life together, mourned together, confided together, enjoyed together, suffered together. I presumed that we had our *work-life* balanced. Many years after the ADC plane crash that I narrated sharing the grief with him above, he took ill, and I was like wondering how

could a man so full of **work** and **life** suddenly could not **work** again nor live **life** again? He struggled for a long time to regain his good health but unsuccessfully. Almighty God called him back when the time was up. May his soul rest in peace. Amen

20. GRATITUDES

Having lived to my retirement at 70 years of age, I have every reason to be grateful to God my creator for preserving me till now. It can only be by His grace. My redeemer God protected me from the hazards of the **work** I did and that of **life** lived. The Holy Spirit gave me knowledge, courage and wisdom to do all work-life activities I had been able to do. I pray that the Holy Trinity of God the Creator, God the Redeemer, and God the Holy Spirit will continue to protect and show me the *pathway of life* in the post-work life. Amen.

I am grateful to God for giving me the types of parents who brought me up. Their sacrificial care for me was unparallel. They prepared me physically, mentally, and spiritually for the works I did, for the life I lived. They encouraged me to continue formal education at the end of the civil war even when the resources to continue were no more available. Papa and Mama, your disciplinary standards were excellent. Your parenting skills were unparallel. Your admonitions on ethical behaviours and conducts were not lost on me. Thank you, Papa, and Mama.

My special thanks to those who taught me the art and sciences of medicine, especially the Otorhinolaryngology Head and Neck Surgery specialty. Professor BC Okafor was outstanding among them. I thank late Professor Olu Ibekwe and late Professor M. N. Obiako. The late Rev Sr Dr D Twomey, FRCOG, MMM, was my *Mother Superior General* who laid solid foundation for my professional practice from 1980. You were all wonderful.

I want to thank all persons who worked with me in these long years in public service; when I worked as a clinician, academician, in committees and/or an administrator – my mentors, superiors, supervisors, colleagues, and the people who worked under me. It was because of you that work was worth doing and life worth living. I shall always cherish your contributions to my work and life.

I thank in a distinct way the following colleagues from all over Nigeria and in diaspora, who volunteered to be in the Planning Committee of this Valedictory events. To mention just a few of them are: Dr James O Akpeh, (*Chairman*), Dr Patrick Okundia, Dr. Mrs Nsebong Undie, Dr Everistus Afiadigwe, Dr Ethel Chime, Dr Chinelo Nze, Dr Job Amodu Enema, Dr Ogechi Akpalaba, Dr Ibora Ekukumana, Dr Peter Nnadede, Dr Enoch Dahilo, Dr Kenneth Nwankwo, Dr Chike Ofoegbu, Dr Newman Ilechukwu, Rev. Sr. Dr Ngozi Onyeagwara, Professor Kolo, Professor Amali Adekwu, Professor FT Orji, Professor AD Salisu, Professor Titus Ibekwe, Professor JN Nwosu, *et al.* You are all wonderful.

21. ACKNOWLEDGEMENTS

I have a large **family** of *academic, biological*, children in-law and *home* children and grandchildren. I equally have many siblings and parental relations. God is great and faithful to us as a **family**. We continue to strive for *work-life* balance.

To my **mentees** and **academic** children, - led by Professor OGB Nwaorgu , *et al*, continue to uphold the tenets of our profession. I understandably, have even more **academic grandchildren**, and

academic great grandchildren than the number of academic children - products of my academic children. Thank you for accepting the mentorships and trainings that I offered you. Thank you for training and mentoring the academic grandchildren and great grandchildren.

Thanks to my academic children, namely, Professor OGB Nwaorgu, Professor K R Iseh, and Professor A D Salisu for finding time to speak today at the *Valedictory Symposium* held in my honour. I express regret to other academic children who were eager but could not get a slot to speak today. Hopefully, there will be opportunities in the future to do so.

I urge all to practice the profession, ethically, with the fear of God. Note the contents of the updated WMA **Physician's Pledge** (Appendix 2) and abide by its provisions. Do not forget to attend to your "*own health, well-being, and abilities in order to provide care of the highest standard*". Check out the MDCN Code of Medical Professions Ethics. Touch as many lives as you can. Remember that it is usually the father's wish that the children will be greater than him. That is also my wish for you. I wish you *work-life* that is balanced. I am still always available for mentoring and collaborations.

To my **biological** children, it had not been possible staying with you all the time as I wanted to and when you want Dad at home because work takes him physically out of the home. My loving wife, Ngozi, your mother, had always done her part and filled the gap for me when I am away from home working. We ensured that your *home-life* was balanced. You did not lack parenting. To this I am so grateful to Ngozi. I expect you to continue to be true to your upbringings. Continue to strive for excellence and live a

balanced *work-life*. I see my grandchildren procreated by you with joy. I am proud of you.

To my **grandchildren**, you are all welcome to this world. The family welcome those that were born and those yet to be born. Whether you came as singletons, twins, or triplets, we thank God for your lives. Great gifts you are. I have no doubt that your parents are equal to the task of parenting you for a *work-life* that will be balanced. Grandpa is proud of you.

To my **children in-law**, welcome to the household. The bonds that hold us together as family are not different from those of biological children. The grandchildren are joy to behold. Bring them up in the fear of the Lord and love. Do not forget to balance your *work-life*. Plan well for your retirement's years too.

To my **home children**, it is God that brought us together. It takes a village to bring up a child. Together we shall prosper and grow from strength to strength. Do not forget the parenting and teachings we gave. Learning is a lifelong process that never stops. Be faithful to the will of God. Live a *work-life* that is balanced and integrated.

To my siblings, Caro, Fr Joe, Chuba, Felix, Nnabuike, and Getrude we grew up together balancing work with life. I believe that we shall also age into retirements in a balanced way of work and life. To Kizito and Chuks you departed this world when your work and life were still ascending the heights of your professions. God knows the best. We accepted the will of God. Continue to rest with the Lord till the day of resurrection when we shall meet to part no more.

I have a divinely finished beautiful **work** of creation that God breathed **life** into and gave me to be a life partner. To my bosom friend, my energetic home co-worker, my efficient home manager, my trusted confidant, my wise adviser, my everlasting love, my beautiful life partner, my dear wife; Ngozi, thank you for helping me balance my work and life. The saying is that *life begins at 70*, so life is starting *afresh* for me. I will have more time to be a loving *stay-at-home* husband, especially now that our nest is almost empty. Our toast on our wedding was “OH LORD, *LET US BEGIN EACH NEW DAY TOGETHER AND SHARE OUR LIVES FOR EVER, TO THE GREATER GLORY OF THY NAME. AMEN*” We shall continue to share our post *work-life* that is balanced and in mutual love.

22. CONCLUSIONS:

I thank the University of Nigeria Teaching Hospital for the opportunity to serve. It was ‘**Service to humanity**’. There were no dull moments. It was services that cannot be quantified in silver nor gold terms.

To the patients I had a duty of cared for, healing is from God. I give all glory to God. We do what we know to the best of our abilities, but God is the ultimate healer. My patients are to attest to if I treated them ethically, to the best available care, and my best ability. May you have good health of body, soul, and spirit to balance your work with life.

At Christ the King College Onitsha, our motto was *Bonitas, Disciplina, Sciencia*” meaning *Goodness, Discipline, Knowledge*. These virtues were inculcated in us. It was with these virtuous principles and mantra that I left CKC and proceeded to the University of Nigeria. Thanks to my teachers at CKC Onitsha. ‘*May the fame of our College last forever*’. Thanks to my

classmates. Efflux of time did not diminish our comradeships. We shall continue to age gracefully.

To the class of 1979 medical graduates of the University of Nigeria, we passed triumphantly through thick and thin in our work and life at every stage. You were pacesetters in many ways. Keep it up and let us continue to relate more in our retirements.

My study at the University of Nigeria as a student was **to seek truth**. Many years after my basic medical degree, I was given the rare privilege to be an academic staff of this citadel of learning in addition to serving in many of its committees and other capacities including, Head of Department of Otolaryngology, and Dean of Faculty of Medical Sciences, at different times. The university found my work and I worthy to be elevated to full Professorial rank,

The University allowed me the **work-life flexibility** to offer services to the Nigeria Medical Association, the Medical and Dental Consultants Association of Nigeria, The National Postgraduate Medical College of Nigeria, the West African College of Surgeons, the Otorhinolaryngological Society of Nigeria (ORLSON), my local Church, my hometown of Akwaeze through its kindreds, Village Unions, Age Grade, the general Akwaeze Town Union and the Traditional Chieftaincy Cabinet. I took *the gown to town*. ***Work-life interface was effective, integrated, and balanced.*** I thank all of you individually and collectively for the good work done and happy life.

The work and life while doing these were in addition ***to seek truth***, to **teach truth**. I had additionally worked **to preserve truth**. Mr Vice Chancellor, Sir, distinguished audience, I will say

that by so doing I played my roles *and thereby* “**To Restore the Dignity of Man**”.

It is my hope that those still formally working in our institutions will continue to give quality education to all, provide efficient medical care while balancing work with life. If they do these then, I will view my work and life in these 44 years, from my retirement observatory station, as accomplishments.

What legacies will I be leaving behind? I do not know the extent. I leave it for those who will in future scrutinise the **work** I did. I leave it to prosperity to analyse the **life** I live while in public service. Let history judge how these were balanced and integrated. One aspect I know is that these legacies will continue to grow and yielding fruits because the people I touched their lives, in whom I invested my time, talent, and treasure on are successfully making their own impacts already because they accepted the teachings, imbibed the high quality of mentoring and training they were offered. My foray into **medical education** was helpful in the teaching assignments. In Igbo language we say: “*madu ka eji aaka*” (*It is the people you have /made that make you a great person*)

Thanks for being present at this lecture and for your listening attention. I am so honoured.

May your **work-life balance** perfectly.

May your **post-work life** be fun.

Basil Chukwuemeka Ezeanolue,

BM, BCh, MD, FMCORL, FWACS, FICS, KSM

Professor of Otolaryngology Head and Neck Surgery

Ichie Ezeani Ugommata of Akwaeze

10 November 2023.

Benedictions

- As I move on to post-work life in retirement, I still have the best interest of all it pleased God to be my students, trainees, or mentees; of those who are still in formal training, those I mentored and taught over these years and those who, in turn, mentored and trained others.
- I invoke my professional blessings, derived from Divine authority and powers, on all my academic children/mentees, grand academic children, great grand academic children and generations of them to come.
- May the Lord bless and prosper you all.

I pray that

- God grant them success in all aspects of their lives, bless the works of their minds and hands. Make them to excel and be fruitful in their works and life,
- Let them overcome all challenges, balance their works and life.
- Let them have abundant **time**, **talent** and **treasures** to work and enjoy balanced life to the fullest.
- Grant them mercy, grace, compassion, protection, and longevity in excellent health.
- I make these declaratory prayers to be irrevocable, to the glory of God our creator, our redeemer and the holy paraclete - the advocate, the counsellor and our helper. Amen.

23 REFERENCES

1. Universities (Miscellaneous Provisions) Amendment Act 2012
2. Nigeria Public Services Rules 2021
3. Ezeanolue BC **“Hear the Voice”**, the 82nd inaugural lecture of the University of Nigeria, 17 July 2014.
4. [WORK-LIFE BALANCE definition | Cambridge English Dictionary](https://dictionary.cambridge.org/us/dictionary/English/work-life-balance)
<https://dictionary.cambridge.org/us/dictionary/English/work-life-balance>
5. Pope John Paul II Encyclical, LABOREM EXERCENS (Human Work) 14 September 1981)
6. <https://data.who.int/countries/566> accessed 21 April 2023) or 61.33 years (male 59.51)
7. <https://www.statista.com/statistics/1122851/life-expectancy-in-nigeria-by-gender/> accessed 29 April 2023
8. Laszlo Bock Google’s Scientific Approach to Work-Life Balance (and Much More) , HUMAN RESOURCE MANAGEMENT Harvard business Review MARCH 27, 2014 <https://hbr.org/2014/03/googles-scientific-approach-to-work-life-balance-and-much-more>
9. [Work-Life Balance: What It Is and 5 Ways to Improve It | Coursera](https://www.coursera.org/articles/work_life_balance)
https://www.coursera.org/articles/work_life_balance 2023a
10. Bourke Juliet and Titus Andrea. The Key to Inclusive leadership Harvard Business Review. <https://hbr.org/2020/03/the-key-to-inclusive-leadership>.
11. <https://importantindia.com/21867/all-work-and-no-play-makes-jack-a-dull-boy-meaning-explanation/>

12. <https://screenrant.com/shining-movie-all-work-no-play-phrase-jack-character-meaning-origin/>
13. Ezeanolue BC Self-Financing of Government hospitals in Nigeria. **Nigerian Medical Journal** 1997; 32 (2):64-66
14. Okafor BC Foreign bodies in the Larynx: A plea for early referral Nigeria Medical Journal
15. Supplement to Official Gazette Extraordinary, No. 70, Vol.71, 19th December 1984—Part A REGULATED AND OTHER PROFESSIONS (PRIVATE PRACTICE PROHIBITION) DECREE 1984)
16. “Regulated and Other Professions (Private Practice Prohibition) Decree No 1 of 1992”
17. <https://dailypost.ng/2017/10/11/nigerian-govt-bans-private-practice-medical-doctors/> (accessed on 05 June 2023)
18. Joshua N. T. Ofoli, Timi Ashau-Oladipo , Stephen S. Hati, Lile Ati and Victor Ede. Preventive healthcare uptake in private hospitals in Nigeria: a cross-sectional survey (Nisa premier hospital) . BMC Health Services Research 2020; 20:273 <https://doi.org/10.1186/s12913-020-05117-5>)
19. Uchendu O.C., Ilesanmi O.S. and Olumide A.E. Factors Influencing the Choice of Health Care Providing Facility Among Workers in A Local Government Secretariat In South Western Nigeria. Annals of Ibadan Postgraduate Medicine. Vol. 11 No. 2 December 2013 p87 95
20. Tutti Taygerly. How to Develop a Strong Work Ethic Harvard Business Review. <https://hbr.org/2022/09/how-to-develop-a-strong-work-ethic> (Accessed 16 Aug. 2023).
21. Rules of Professional conduct for Medical and Dental Practitioners in Nigeria CODE OF MEDICAL ETHICS IN NIGERIA

22. <https://www.wma.net/policies-post/wma-declaration-of-geneva/> accessed 22 May 2023 {also Appendix 2}
23. World Medical Association WMA STATEMENT ON PHYSICIANS WELL-BEING
<https://www.wma.net/policies-post/wma-statement-on-physicians-well-being/> accessed 22 May 2023
24. World Medical Association <https://www.med.or.jp/dl-med/wma/helsinki2013e.pdf>
25. Agboh Alphonsus. Delta hospital shuts, patients flee as policeman attacks doctor. The Nigerian Tribune June 4, 2023. <https://tribuneonlineng.com/delta-hospital-shuts-patients-flee-as-policeman-attacks-doctor/>
26. National Industrial Court of Nigeria, Abuja division SUIT NO. NICN/ABJ/270/2022
27. Constitution of the Federal Republic of Nigeria 1999
28. Bakari A., Ahmad B.M., Imogu A.O. Aids Associated Head and Neck Presentation In Kaduna, Nigeria – An Update . Nigeria Journal of ORL 2:2 2005
29. Nwaorgu OGB and O.S. Osowole Otorhinolaryngological HIV – Related Problems: A Private Practice Experience. Nigeria Journal of ORL 2:2 2005
30. Ezeanolue BC Otolaryngological presentation of HIV infection. Nigerian **Journal of Surgical Sciences** 1999;9:30-33
31. Ezeanolue BC. Results of screening a group of Otolaryngologic patients for HIV infection International Journal of Medicine and Health Development (formerly Journal of College of Medicine University of Nigeria) Nigeria 2001; 6(1):17-19.

32. Obasikene G, Amadi IF, Ibekwe TS, Ezeanolue BC, Ogisi FO The Effect of CD4 Count Level on the Middle Ear Dynamics of HIV Infected Patients East African medical journal 2014; 91 (1), 29-32
33. Obasikene, G. , Afiadigwe, EE , Adobamen,PROC ,Ibiam F.A , Ibekwe TS , Ezeanolue, BC Impact of Human Immunodeficiency Virus (HIV) infection on Pure tone Hearing Threshold in Young Adults Aged 21-45years. Nigeria Journal of Otorhinolaryngology 16: 2 October 2019
34. <https://www.ncdc.gov.ng/diseases/info/E>
35. <https://www.ncdc.gov.ng/diseases/info/L>
36. Chime, E.N., Chime, P.E. and Ezeanolue, B.C. Clinical Presentations of Lassa Fever in Non-Endemic Parts of the World: A Systematic Review. International Journal of Clinical Medicine, 2022 13, 415-427. <https://doi.org/10.4236/ijcm.2022.139029>
37. Ezeanolue BC Nexus Between Covid-19 And Major Salivary Glands Disorders. A paper Presentation of **OTORHINOLARYNGOLOGICAL SOCIETY (ORLSON) Masterclass** on 30 June 2021
38. Fasunla A.J., Thairu Y., Salami H. and Ibekwe T.S. Self-reported olfactory, gustatory and otologic dysfunctions among covid-19 positive adults in Nigeria- a preliminary report Ann Ibadan. postgraduate. Med 2021. Vol.19 (COVID-19 Supplement S16)
39. POPE LEO XIII Encyclical RERUM *NOVARUM*, (ENCYCLICAL OF ON CAPITAL AND LABOR 15 May 1891.

40. Hosny A, Parmar C, Quackenbush J, Schwartz LH, Aerts HJWL. Artificial intelligence in radiology. *Nat.Rev. Cancer*. 2018Aug;18(8):500-510. Doi:10.1038/s41568-018-0016-5
41. https://en.wikipedia.org/wiki/Deep_learning,
42. https://en.wikipedia.org/wiki/Artificial_intelligence
43. João Pedro de Magalhães. Ageing as a software design flaw. *Genome Biology*. <https://doi.org/10.1186/s13059-023-02888-y> accessed on 20 May 2023
44. Lifestyle Medicine <https://lifestylemedicine.org>
45. Drivers of health workers migration ...*BMJ Global health* 2023
46. Ezeanolue BC Do not be afraid and do not fail to rescue. – a discourse on the challenges confronting Nigeria Health Sector 36 th Convocation lecture of National Postgraduate Medical College of Nigeria. Thursday, 20 September 2018
47. <https://www.wma.net/what-we-do/education/workplace-wellness/> 22 May 2023
48. IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. *Washington, DC: Association of American Medical Colleges (AAMC); June 2021. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)*
<https://www.aamc.org/media/54681/download>
49. Medscape Preventing Breaks and Falls in Older Adults by Kathleen Doheny May 15, 2023
50. <https://www.wma.net/policies-post/wma-declaration-on-discrimination-against-elderly-individuals-within-healthcare-settings/>

51. Oloruntoba Sam. Care of the elderly: socio-cultural and medical perspectives. *Nigerian Journal of Otorhinolaryngology* vol. 2 no. 1 March 2005
52. Ezeanolue BC and Obasikene G. Pattern of Otorhinolaryngological disorders seen in geriatric patients in a private Otorhinolaryngologic Clinic. *Nigerian Journal of Otorhinolaryngology* Vol.2(1) 2005,
53. Ogunleye AOA, Ibekwe TS, Ijaduola GTA Otorhinolaryngology and Geriatrics in Ibadan, Nigeria. *Nigerian Journal of Otorhinolaryngology* Vol.2(1) 2005: 7-12
54. Okoye BCC., Onotai LO. Pattern Of Geriatric Otolaryngological Diseases in Port Harcourt. *Nigerian Journal of Medicine*, Vol. 16, No. 3, July- September 2007 239 – 241)
55. Adegbiji, W.A., Aremu, S.K. and Aluko, A.-A.A. (2019) Geriatric Otorhinolaryngology, Head and Neck Emergency in a Nigerian Teaching Hospital, Ado Ekiti. *International Journal of Otolaryngology and Head & Neck Surgery*, 8, 81-90. <https://doi.org/10.4236/ijohns.2019.83009>)
56. Professor Rao <https://mathematics.ceu.edu/rao>
57. <https://opusdei.org/en-ng/article/message/> accessed on 16 June 2023
58. https://en.wikipedia.org/wiki/Opus_Dei
59. <https://thenationonlineng.net/facing-death-taught-me-to-live-esther-omojafor-survivor-of-2006-adc-airline-plane-crash/>

APPENDIX 1

Hippocratic Oath *

I swear by [Apollo](#) Healer, by [Asclepius](#), by [Hygieia](#), by [Panacea](#), and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture.

To hold my teacher in this art equal to my own parents.

to make him partner in my livelihood; when he is in need of money to share mine with him;

to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture;

to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the Healer's oath, but to nobody else.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and

I will do no harm or injustice to them.

Similarly I will not give to a woman a [pessary](#) to cause abortion.

But I will keep pure and holy both my life and my art.

I will not use the knife, not even, verily, on sufferers from [stone](#), but I will give place to such as are craftsmen therein.

Into whatsoever houses I enter,

I will enter to help the sick, and

I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of [man or woman](#), [bond or free](#).

And whatsoever I shall see or hear during my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad,

I will never divulge, holding such things to be holy secrets.

Now if I carry out this oath, and break it not,

may I gain for ever reputation among all men for my life and for my art;
but if I break it and forswear myself, may the opposite befall me.

(Translation by W.H.S. Jones. *Hippocrates of Cos* (1923). "[The Oath](#)". *Loeb Classical Library*. 147: 298–299. doi:[10.4159/DLCL.hippocrates_cos-oath.1923](#). Retrieved 6 October 2015.)

*https://en.wikipedia.org/wiki/Hippocratic_Oath accessed 24 May 2023.

APPENDIX 2

WMA DECLARATION OF GENEVA (www.wma.net/policies-post)

***Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017***

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

APPENDIX 3

Brief Profile of

**6th VALEDICTORY LECTURER OF THE
UNIVERSITY OF NIGERIA**

Professor Basil Chukwuemeka Ezeanolue

B.M., B.Ch.(Nig), MD, FMCORL, FWACS, FICS, KSM

**Professor/Consultant Otorhinolaryngology Head and
Neck Surgeon**

Ichie Ezeani Ugommuta, Akwaeze.

Email : basil.ezeanolue@unn.edu.ng balseze@yahoo.com ,
basilezeanolue70@gmail.com

Basil Chukwuemeka Ezeanolue, is a Professor/Consultant Otorhinolaryngology-Head and Neck Surgeon, an academic Medical Practitioner with additional interest in Medical Education, a Community Leader with a zeal for sustainable Community Development and a subsistence farmer.

2. Formal Education:

He had his primary education at St Michael Catholic School, Akwaeze and secondary education at Stella Maris College, Port Harcourt and Christ the King College, Onitsha. He attended the University of Nigeria from 1973 graduating Bachelor of Medicine (BM) and Bachelor of Surgery (B.Ch) in June 1979. He did his postgraduate Residency training at the Department of Otolaryngology, University of Nigeria Teaching Hospital, (UNTH) Enugu and obtained the Fellowship of the National Postgraduate Medical College of Nigeria (FMCORL) and that of the West African College of Surgeons (FWACS) in Otorhinolaryngology in the year 1990. He later was awarded the

Doctor of Medicine (MD) by the National Postgraduate Medical College of Nigeria.

His interest in Medical Education and Research led him to study and hold many online micro credential certifications from different Institutions, some of which are:

1. National Universities Commission: Virtual Institute for Higher Education Pedagogy: 2003/2004
2. University of Osaka, Japan **Bioethics** May 2017
3. CATALYST INC **Applied Biostatistics** May 2017
4. *FutureLearn Online Program* in collaboration with University of East Anglia
 - a. Clinical Supervision with Confidence
August 2018.
 - b. Clinical Supervision: Assessing and Providing Feedback Septe 2018
 - c. Clinical Supervision: Planning your Professional Development Septe 2018
 - d. Clinical Supervision: Teaching and Facilitating Learning October 2018
5. University of Auckland, **Academic Integrity: Values, Skills, Action** August 2018
6. The University of Glasgow. **Research Impact: Making A Difference** Dec 2018

3. Work Experiences:

He started as House Officer, UNTH (1979 to 1980) and NYSC Medical Officer at Yauri, then Sokoto State (1980 to 1981). Prof Ezeanolue worked at various times as a medical practitioner at the Benue Health Management Board (1981 to 1983), Ag, Director Health Services, Benue Polytechnic, Ugbokolo, Benue

State (1983 to 1986) and, Resident, University of Nigeria Teaching Hospital, Enugu (1986 to 1991). He was part-time lecturer in the Department of Anatomy, University of Nigeria (1991 to 2005)

He became an academic staff of the University of Nigeria in November 1991 and rose through the ranks to become a full Professor of Otorhinolaryngology on 01 October 2005. Since then, he had been a member of the University of Nigeria Senate.

He is also Honorary Consultant Otorhinolaryngologist to the University of Nigeria Teaching Hospital, Enugu, (1991 till date) and the Nnamdi Azikiwe University Teaching Hospital, Nnewi (1996 to 2023). He is the *Founder and Surgeon-in-Chief* of Balsam Clinics, Enugu, Nigeria.

He was **Head of Department** of Otolaryngology, University of Nigeria and UNTH for several years (4 different tenures). He headed many Committees of the College of Medicine, University of Nigeria and UNTH. He was the **Dean** of the Faculty of Medical Sciences of the University of Nigeria, Enugu Campus (2012 to 2014) He served on many Committees of the University of Nigeria and the University of Nigeria Teaching Hospital Enugu at various times. Some of them were, the Chairman of the **UNTH Mechanical Workshop** (1998/99) and UNTH **Movement to Ituku Ozalla Committee** (2006/07)

He was a long-term examiner to the National Postgraduate Medical College of Nigeria (NPMCN) and the West African College of Surgeons Fellowship examinations till date. He served as the Enugu Center examinations Co-Ordinator for the

NPMCN. He was the Chief examiner of the Faculty of Otorhinolaryngology of the NPMCN (2006 to 2010).

He was a member of Senate of the National Postgraduate Medical College of Nigeria (NPMCN) spanning over a period of 23 years continuously (1996 to December 2019), where he at various times served as the third member of Senate, Faculty Secretary and later Chairman, Faculty of Otorhinolaryngology. He was also Senate Committee Chairman for **Travel Fellowship Committee** and later **Docimology and Evaluation Committee** of the NPMCN.

Professor Ezeanolue is resource person to the various revision courses and workshops of the National Postgraduate Medical College of Nigeria and the West African College of Surgeons from 1997 till date. He was the Primary Fellowship Revision Course Coordinator of the Faculty of Otorhinolaryngology, NPMCN (1997 till 2016). He was appointed **Quality Control Officer** of the Faculty of ORLHNS of the NPMCN in October 2023.

He is a reviewer to many scientific journals, nationally and internationally. He was the pioneer Editor in Chief of the Nigeria Journal of Otorhinolaryngological (2004 to 2016) He served in many editorial Boards such as Orient Journal of Medicine, Nigeria Postgraduate Medical Journal, Journal of the American Academy of Otorhinolaryngology Head and Neck Surgery

He has more than 60 publications in international and local peer reviewed scientific journals and *officially* supervised 29 successfully completed Fellowship dissertations of the National

Postgraduate Medical College of Nigeria and the West African College of Surgeons. Some dissertations are still ongoing.

A multichapter textbook titled: **A PRACTICAL GUIDE TO CLINICAL RESEARCH THESIS/DISSERTATION FOR POSTGRADUATE DEGREES IN THE MEDICAL SCIENCES AND DENTISTRY** that was an incidental product of an online training/workshop program he personally organised *pro bono* for Residents nationwide doing research for their postgraduate thesis and dissertation from July to October 2021 will be launched during this valedictory event.

4. Clinical Trial Done for Outside Bodies:

Efficacy of Augmentin BD in the treatment of acute otitis media in children

for SmithKline Beecham, Principal Investigator, 1997

5. Some Invited /Special/Public/Guest Lectures delivered by Basil Chukwuemeka EZEANOLUE

5.1 ‘The Running Nose’.

College Lecture organized by the Directorate of Research and Publications, College of Medicine, University of Nigeria, Enugu Campus 09 March 1999

5.2 ‘Hearing Loss in Children’,

Guest Lecture at National Ear Care Center, Kaduna Nigeria on 05 September 2007

5.3 ‘Management of Hearing Loss in Children’

an invited paper at the 50th West African College of Surgeons Conference in Tinapa Calabar, Nigeria 10 February 2010

5.4 ‘Current Challenges of Medical Education in Nigeria’.

Public Lecture organised by the 1979 Graduating Class of Faculty of Medicine, University of Nigeria at Enugu Nigeria on 04 June 2011

5.5 ‘Audio vestibular deficits related to armed conflicts - the *HIDDEN INJURY*’.

An invited presentation at the 52nd West African College of Surgeons Conference in Monrovia, Liberia 29 February 2012

5.6 ‘Hear the Voice’

82nd Inaugural Lecture of University of Nigeria, at Enugu Nigeria on 17 July 2014

5.7 ‘Secondary Parotid Gland Tumors: Pitfalls, Challenges and Controversies in their Management’.
Keynote Lecture at 9th University of Ilorin/University of Ilorin Teaching Hospital Head and Neck Course at Ilorin Nigeria. 09 November 2017

5.8. ‘Part Two Dissertation program’,

Pre-Conference Workshop Lecture, ASCAF, National Postgraduate Medical College of Nigeria, Owerri Nigeria, 14 August 2018.

5.9. ‘Do Not Be Afraid And Do Not Fail To Rescue – a discourse on the challenges confronting Nigeria Health Sector’

The 36th Convocation Lecture of the National Postgraduate Medical College of Nigeria, Ijanikin, Lagos on 20 September 2018.

5.10. “Time for Sub-Specialist Training of Manpower for Otorhinolaryngology Practice in Nigeria”.

Guest Lecture presented to the 26th Otorhinolaryngological Society of Nigeria {ORLSON} Annual Conference and Scientific Meeting held at Port Harcourt 15 November 2018

5.11. “Maintaining Good Hearing Thresholds through all ages” (with Dr Basil E Nwankwo)

Invited presentation to the 39th Annual Supreme Convention of the Order of Knights of St Mulumba Nigeria, at Awka Anambra State on Saturday 01 December 2018

5.12.’ Nexus Between Covid-19 And Major Salivary Glands Disorders’.

A paper Presentation of OTORHINOLARYNGOLOGICAL SOCIETY (ORLSON) Master Class on 30 June 2021

5.13. ‘Hearing Care for All Nigerians: Prospects and Challenges’.

Keynote Address Presented at the 29th Otorhinolaryngological Society of Nigeria {ORLSON} Annual Conference and Scientific Meeting held at Nnewi 25 November 2021

5.14 ‘Overview of The Role of Surgery in The Management of Head And Neck Malignancies’ An invited paper to the 6th Association of Radiation and Clinical Oncologists in Nigeria (ARCON) Conference at Enugu, 10 September 2023

5.15. ‘Managing your Lifestyle to achieve optimum good health and longevity’ A invited lecture presented to *Anyi Bu Ofu Age Grade Members (1956 to 1960) of Akwaeze, Anaocha LGA*, on 16 September 2023 at Co-operative Hall, Akwaeze.

6. Service to Other Relevant Public Bodies

AD HOC, PART TIME AND ASSOCIATED ACTIVITIES THAT AFFECTED WORK-LIFE BALANCE 1979 to 2023

1. Anambra State Housing Development Corporation Member,
Board of Directors, July 1988 to March 1991
2. Nigerian Medical Association, State Secretary, (erstwhile
Anambra State Branch, presently made up of Anambra State,
Enugu State and part of Ebonyi State.) July 1990 - May
1992.
3. National Postgraduate Medical College of Nigeria: Member,
Faculty Board 1993 till 2022
4. Faculty of Otorhinolaryngology, National Postgraduate
Medical College of Nigeria
3rd Member, Senate 1996 to 2000
5. Primary Fellowship Revision Course Coordinator, National
Postgraduate Medical College of Nigeria 1997 till 2016
6. Resource person to Fellowship Revision Courses of the
National Postgraduate Medical College of Nigeria and the
West African College of Surgeons 1997 till date
7. Faculty of Otorhinolaryngology, National Postgraduate
Medical College of Nigeria Faculty Secretary 2000 till
Jan 2007
8. Faculty of Otorhinolaryngology, National Postgraduate
Medical College of Nigeria Faculty Chairman Feb
2007 - Dec 2010
9. West African College of Surgeons, *Faculty Board Member*,
Feb 2003 – till 2023
10. Otorhinolaryngological Society of Nigeria,
Secretary 1999 to 2003
President 2005 to 2009

11. Orient Journal of Medicine, Associate Editor, 2000 till 2010
12. Nigerian Journal of Otorhinolaryngology Editor in Chief (pioneer) 2004 till 2016
13. Medical and Dental Consultant Association of Nigeria, UNTH Chapter, Chairman, August 2006 till December 2008
14. National Postgraduate Medical College of Nigeria:
Senate Committees:
 - Chairman, Senate Travel Fellowship Grant Jan 2011 to 2015
 - Chairman, Senate Docimology Jan 2016 to Dec 2019
 - Co Ordinator, Enugu Examination Centre 2000 to 2022
15. Nigerian Postgraduate Medical Journal, Associate Editor Jun 2011 to Dec 2017
16. Chairman, Akwaeze Town Union, Akwaeze, March to Dec 2017
17. Member, Akwaeze Traditional Chieftaincy Council, September 2015 till date
18. Member, Chukwuemeka Odumegwu Ojukwu Teaching Hospital Governing Board, Awka,, Anambra State, 19 September 2019 till

7. Resource Person to

- a. Faculty of Otorhinolaryngology, National Postgraduate Medical College of Nigeria,
Primary Fellowship Revision Course Coordinator 1997 till 2016

b. Fellowship Revision Courses of the National Postgraduate Medical College of Nigeria and the West African College of Surgeons 1997 till date

c. External Examinership / Assessment

	Examination	Institution	Date
i.	Primary	National Postgraduate Medical College of Nigeria	2000 till 2010 (Otorhinolaryngology)
ii.	Parts I and II Fellowship	National Postgraduate Medical College of Nigeria	(Otorhinolaryngology) 1997 till date
iii.	Parts I and II Fellowship	West African College of Surgeons	(Otorhinolaryngology) 1998 till date
iv.	Professorial, External Assessor to some Nigerian Universities		

8. Membership of Learned Societies

Member	Nigeria Medical Association	since	1979
Member	Medical and Dental Consultant Association Nigeria	since	1991
Fellow,	National Postgraduate Medical College of Nigeria		1990
Fellow	West African College of Surgeons		1990
Fellow	International College of Surgeons (Nigeria Section)		1998
Member	Nigeria Surgical Research Society		1999
Member	Otorhinolaryngological Society of Nigeria		1990

International Fellow, American Academy of Otorhinolaryngology Head and Neck Surgery 2006

9. **Family Life:** Professor Ezeanolue is married to Bibian Ngozi and they are blessed with children and grandchildren.

10. Others:

- ✓ Cabinet Chieftaincy title: *Ichie Ezeani Ugommuta*, Akwaeze 2015 till date
- ✓ Member of the Order of Knights of Saint Mulumba Nigeria (KSM), Stella Maris Sub Council, Awka 2006 till date.
- ✓ Patron to many Community and religious organizations.

11. His hobbies are **photography, farming, and skills development in craftsmanship.**

BASIL CHUKWUEMEKA EZEANOLUE

Professor of Otorhinolaryngology Head and Neck Surgery