OBS + GYNAE

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Learning Objectives:

1. How are the health services provided in Mauritius different to those provided in the UK?
2. What are the prevalent gynaecological conditions in Mauritius and how do they differ from the UK?
3. How are obstetric cases managed and how is care to the pregnant provided?
4. To be able to reflect on the differences and similarities seen in care as well as unusual presentation of conditions

Elective Report

Being Mauritian, I wanted to experience a little bit of what the health system is like in the country in which I was born, which is why my choice for electives was not a difficult decision. It was a privilege to shadow the obstetric & gynaecology team at Victoria hospital, the hospital that saw my birth.

Mauritius has a system of free health care for all, however, resources are limited. There is also private health care for those who can afford it. There is a system similar to primary care where the first port of call for patients should be to go to their local 'dispensary'. There, they can have a consultation with either a nurse or a doctor, if available, and they can be prescribed necessary medications if needed without having to go to hospital. This system should, in theory, take pressure off the Accident & Emergency department. Unfortunately, the attitude in Mauritius is that better care is given in hospital, so patients will just go there instead.

During my time on electives, I attended gynaecology clinics where the patients mostly complained of menorrhagia. This was due to fibroids. The gynaecology clinic would be set up in such a way where a junior doctor would clerk the patient and present to the consultant. The consultant would then ask any other relevant questions and decide whether the patient needs an ultrasound scan. The scan would then be carried out straight away by the junior doctors. All this would happen in a circuit, with the consultant seeing other patients as well.

This was a big difference in care. The pace at which the clinic ran was amazing. Patients had to be clerked, examined, scanned and booked in for surgery in one visit. There were approximately 60 to 100 patients to see in one clinic which ran for three hours. The clinic room would hold a consultant and about ten junior doctors. It was a hectic environment to be in but the pace kept things interesting.

In these clinics I was able to learn and practice doing ultrasound scans on both pregnant and non pregnant patients. The junior doctors were very helpful in teaching me as they themselves had to self teach.

A ward round happens in the prenatal ward every morning where the consultant or Sp (specialist) decides who needs ultrasound scans or PV examinations. These are then performed at the end of the ward round by the consultant. This is also very fast paced.

The way conditions are dealt with in Mauritius is very different to the UK. For example, these patients suffering from fibroids were all offered total abdominal hysterectomies. These were open surgeries as vaginal hysterectomy was a very new procedure and not frequently performed.

The most interesting and somewhat shocking case during my time with the Obs&Gyn team was to witness a high risk patient undergo an elective caesarian section. The patient was from Rodrigues, at 39+5, Gravida 6 Para 5. She had a history of aortic stenosis and mitral stenosis as well as a degree of mitral regurgitation. She was consented for DOT (death on table) prior to surgery. Both the surgeons and anaesthetists dealt with this case calmly and in the end the lady had a baby boy and survived.

Obstetric cases are managed in a similar way to the UK. They have different protocols of course when it comes to the time of delivery. In Mauritius, when a woman comes into hospital with labour pains, she is admitted on the 'prenatal ward' and given an enema to clear her bowels. She will then stay on the ward until the doctors decide she needs to be transferred to the labour ward. Births happen very quickly as doctors want to avoid caput on the baby. Episiotomies are also very common.

Junior doctors have a lot more to do than us in the UK. They have to be very fast at gaining competency in what can be regarded as complicated procedures. For example, junior doctors are always present on labour ward and take care of deliveries and episiotomies. They are sometimes under very little supervision. They always have help if needed but are mostly alone.

If a patient reaches 40 weeks gestation, she is automatically offered a caesarian section as the risk of maternal and fetal death increases. These women are then offered elective caesarian sections for any subsequent pregnancies to avoid rupture. Caesarian sections were generally performed in a separate obstetrics theatre where the fast paced pattern continued. Surgeons were gowned and scrubbed as patients were being anaesthetised. The theatre was also crowded with junior doctors and medical students. In the space of an hour and a half 3 caesarian sections were completed. I never thought I'd a scene like this.

My experience, overall, was very enlightening. The pace of work and volume patients was a shock at the beginning of the placement. However, after accepting the way things were, I was able to look at learning opportunities. I was made to feel welcome by all the junior doctors (pre-registration house officers) which made this experience all the more enriching.