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Medical Elective Report

Objectives

1. To understand the challenges faced in private practice in a low economic setting
2. To create documents to assist in the provision of standardized obstetric and gynecology care
3. To assist the hospital in the creation of a safety culture
4. To provide simulation training for the staff
5. To improve my practical clinical skills in the fields of obstetrics and gynecology and paediatrics

Lagos is a densely populated city with complex economic and social dynamics. There is a great deal of wealth alongside extreme poverty and many essential services such as healthcare, electricity and security and are in a poor state. Although the country has a wealth of natural resources providing a potential source of income due to government corruption a fraction of the income generated is used by the state to provide services to the masses.

Outreach children's hospital is providing high quality, low cost healthcare for women and children filling a gap in the health care sector. The hospital maintains a very high quality of care investing in the most up to date equipment and medical practices. The hospital provides intensive care treatment for around $80 a day, around 5% of the cost of other hospitals in Lagos.

The hospital is engaged in a private public partnership with the state government to provide care for children when the government is unable. In addition to this the hospital accepts patients from some health insurance companies and out of pocket health purchasers. I was extremely interested in witnessing how a hospital could function in such a challenging environment, at such a low cost whilst providing high quality care.

Amongst the challenges face by the hospital, energy provision is one of the greatest. The hospital is provided with around 4 hours of electricity daily and the rest of the electricity sourced from generators run by the hospital. These generators are expensive to run and maintain and around 12% of the hospital income is spent on electricity provision. During my stay I suggested to the management of the hospital the use of solar energy to provide a cheaper source of electricity.

The hospital also has a problem with the late presentation of patients. This is due to multiple factors including poor health education, difficulties with transportation, lack of money and lack of access to quality primary care. There is also a lack of cooperation between local doctors and many of the private hospitals see each other as rivals. The hospital focuses a lot of energy on creating partnerships with other hospitals and creating a network to improve relationships and communication. These efforts have been met with a lot of resistance however channels of communication and cooperation are improving.

I assisted the hospital in the creation of a standardized proformas for antenatal, intrapartum and postnatal care. I hope that these forms will help to improve patient safety and make it easier for staff to document information correctly. In order to create the forms I had to hold meeting with the obstetrician

and the midwives to ensure that all important aspects of care were included on the forms. During the meetings I learnt about certain aspects of antenatal care that are specific to Nigeria such as genotype screening for sickle cell anaemia and prophylactic anti-malarials.

During my time at the hospital there was a drive towards patient safety. I created a form for a pre caesarean section safety checklist based on the WHO safety checklist and provided training for the nurses on the use of the checklist. I also observed that sharps safety could be improved. As sharps bins are scarce and expensive in Nigeria there are not enough sharps bin to carry to the bedside. At times used sharps were placed in a kidney dish containing swabs and blood bottles. I suggested carrying a separate kidney dish to place sharps in whilst at the bedside in order the avoid incurring sharps injuring.

I worked with the facility manager to improve the fire safety in the hospital by increasing the number of fire alarms, signage in the hospital and placement of electrical wires.

It was an exciting time to be in the hospital as many changes were being instituted to improve patient and staff safety, and to create systems that make to easier to have a safe practice. In the past the hospital had a greater drive towards efficiency, cost effectiveness and innovation, but like many hospitals in developed countries the hospital was pushing for patient safety and risk management.

I decided to create a simulation training course for the doctors and the nurses in the hospital on the management of severe asthma. One evening a doctor from another hospital came to the hospital to borrow an ambulance to transport a patient with acute severe asthma from his clinic to the university hospital. The doctor had not thought of the use of nebulised bronchodilators, magnesium sulphate or intubation. I found out later that the patient died and had not received many of the necessary treatments for the management of asthma. This incident spurred me on to create s simulation course that would address this topic.

The simulation course had a low fidelity format with a resuscitation doll as the patient and myself and a consultant paediatrician as the facilitators. Most of the staff had never experienced simulation training before and the training received good feedback. The training revealed that some of the newly employed staff were not up to date on some on some of the treatments for acute asthma. Delivering the simulation training was good revision for me on the recognition of acute asthma and the management. I hope that as a result of the simulation course doctors will be able to deliver better care to patient with acute asthma.

The doctors and nurses at the hospital had very good practical clinical skills. There were very skilled in particular at cannulation on neonates and I was able to observe their technique and eventually I was able to insert a cannular on a neonatal baby. I was allowed to performed an exchange blood transfusion on a baby with jaundice. I observed umbilical cannulation, intubation and resuscitation. I received training on the insertion of central lines using the seldinger technique and ultrasonography. During ward round I learnt about sepsis, respiratory distress, shock and jaundice.

In the obstetric department I performed antenatal assessments, ultrasounds. I observed several vaginal deliveries, caesarean sections and the management of post partum haemorrhage. I attended ward rounds in the pre-natal and post natal ward.

I spent a short period of time in a local government hospital in the antenatal department. In this hospital many of the women were from low socio economic groups and had not received adequate antenatal care prior to delivery. Intrauterine fetal deaths were quite high as were post date deliveries. Medication and medical consumables such as gloves, syringes and canullas were bought by the patients. When a patient did run out of a drug or a consumable friend or relatives had to be called to purchase more. This meant that the patients and hospital staff were highly reliant on the assistance of friend and relatives and at times medical care was delayed due to absent relatives.

The doctors at the government hospital did not have access to a lot of the equipment that we commonly use in the UK an strongly relied on their history and examination to make a clinical judgment.

I feel fortunate to have been involved with a hospital that is going though a lot of positive changes and is striving to provide low cost, high quality care. I was able to work with staff at the hospital to make some changed that will hopefully improve staff and patient safety. I also observed some of the challenges faced by the doctors in Nigerian doctors such as poor funding and poor energy provision. I worked with many doctors and healthcare staff that are striving to improve healthcare provision for patients in Nigeria.