Eleanor Bradley Fellowship Final Report

August 2009 – September 2010

Dr Sarah Kate Alldred

It has taken me a significant amount of time to sit down and be able to write this report. Since returning from Kampala, I have had much time for reflection on my year in Uganda. It is very difficult to do justice to the professional and life experience that I gained during my year there. First and foremost, I would like to sincerely thank the trustees of the Alan and Cyril Body Trust for affording me such a fantastic opportunity and for their generous financial support. There are so many different aspects to the fellowship, and so many different ways in which it has shaped me that it is difficult to know quite where to start. I will try not to duplicate information provided in the monthly reports, but rather, will try to present a summary overview of how my time was spent. I will then report on several specific aspects of the fellowship, and also my views on the strengths and weaknesses of the fellowship post, the opportunities that the fellowship provides, and the threats that are posed to the fellowship's success and long term future. It may help to read this report in conjunction with the monthly reports and I have attached this as an appendix.

SETTING THE SCENE

Mulago National Referral and Teaching Hospital delivers approximately 33000 babies per year. In 1999 there were 186 maternal deaths in pregnancy and childbirth. 6-7% of the babies delivered are either stillborn, or die within a few days of birth. The labour ward handles huge volumes of women every day, with around 60-70 deliveries occurring on the main labour ward daily, and a further 20-30 on the midwifery led unit. The labour ward is staffed on each shift with between 3 and 8 midwives per shift. At any given time, one midwife could be looking after up to 20 high risk women. There is one operating theatre on the labour ward, and there is usually a queue of women waiting to go to theatre for delivery by emergency caesarean section. The average decision to delivery interval between a doctor deciding that a woman needs delivery by caesarean section, and the baby being delivered is 7.5 hours, and priorisation of women is poor. There is a lack of privacy due to overcrowding, and it is difficult to maintain patient dignity. The labour ward is dark and difficult to keep clean. Infection risk is high. The midwifery led unit (ward 14) is staffed by a dedicated team of midwives, who run the ward without the presence of medical staff. While suffering from shortages of staff and equipment, the ward does not suffer from the same problems of overcrowding, and they have the capacity to transfer women who are developing problems to the main labour ward.

There is a gynaecology theatre suite with two operating table, but usually only the capacity to run one. Due to the number of emergency cases on labour ward, the elective operating lists for both oncology and benign gynaecology are often cancelled, meaning that patients may wait for weeks and weeks on end for procedures. Often, the stage of cancer in a woman progresses during this time, from being operable, to being palliative, or a woman will sit in hospital waiting for a hysterectomy for menorrhagia (heavy bleeding) for months, leading to significant loss of earnings. There is a dedicated urogynaecology theatre, with two tables, for fistula repair, vaginal surgery and family planning procedures. This theatre suite functions well and they have a good record of successful fistula repairs, performing several each week. We rarely had a full majors set. It was common to perform caesarean section with a knife, two clamps, a retractor and nothing else. Swabs were washed, autoclaved and re-used.

The wards frequently run to 200% capacity, with patients sleeping on mats on the floor. Clinics are overwhelmed, with several hundred attending for antenatal appointments each day. Unfortunately, antenatal care doesn't seem to present problems in labour for many of the women coming through the labour ward. Mulago runs a very successful PMTCT (prevention of mother to child transmission) programme, testing all pregnant women for HIV and ensuring newborn babies receive antiretroviral medication within a specified time after birth.

As the National Referral and Teaching Hospital, Mulago receives many women who are referred from clinics too late in the labour process, after they have developed significant complications, such as severely obstructed labour and massive haemorrhage. Often there is little that can be done for these women. Mulago Labour Ward has a reputation amongst Ugandan women for being a place that people never leave.

The staff, both midwives and doctors work in these conditions day in day out, for poor salaries and with little reward or praise. They do a remarkable job in these circumstances.

Mulago was undoubtedly the most challenging environment I have ever worked in, and the Fellowship was the most rewarding thing I have ever done.

CLINICAL TIME

My clinical time was divided between different subspecialty areas, with the bulk of my time spent on the labour ward and in urogynaecology. My time was divided as listed below, and was interspersed with project work and teaching. On average I estimate that I spent 3 and a half days carrying out clinical work, although there were some weeks where no clinical work was done due to deadlines and targets for other work.

- Labour ward - I spent a total of 15 weeks on labour ward. I have always had a natural leaning towards labour ward obstetrics, and although the labour ward at Mulago is an extremely harsh clinical environment, it was my work in this area which was most rewarding. I gained huge amounts of experience with obstetric emergencies which are relatively uncommon in the UK - eclamptic fits, uterine rupture, vaginal breech delivery, HIV complications, malaria in pregnancy, twin deliveries - an other complications of pregnancy and labour - APH, PPH, shoulder dystocia. This experience is immeasurable.
- Urogynaecology - I spent a total of 7 weeks working with the urogynaecologists. The team at Mulago are phenomenal. Extremely skilled surgeons and dedicated theatre staff. I spent 4 weeks working with them at Mulago, and 3 weeks on fistula outreach camps in poorly equipped hospitals, in various parts of rural Uganda. I would travel with a one or two gynaecologists, a scrub nurse and a land rover full of equipment to each hospital. We would perform up to 10 repairs a day, for 5 days in hospitals. The operating theatres were often ramshackle, one having dead insects in the theatre light, and plants growing through the windows. I gained clinical experience that would be impossible to gain in the UK and am grateful for the learning opportunities that the specialists created for me.
- Oncology - I spent 5 weeks with the gynae oncology team, which mostly involved ward work and doing examinations under anaesthetic. For the 5 week period I worked with the oncology team there were no functioning gynaecology theatres and so no operating was carried out in this period. I found oncology a very upsetting attachment, as many women presented with advanced cervical carcinoma, and we were unable to do much for many of them. I learned a huge amount about cancer of the cervix and about staging by examination.
- I spent 3 weeks working on the maternal fetal medicine wards and in antenatal clinic to get an idea about what antenatal care in Uganda involves. This was very useful in terms of working out why the levels of pathology seen on labour ward were so high, and what journey the women go through in pregnancy prior to arriving on the labour ward itself. Many of the project work I did concerned the MFM department - triage and HDU for example - and I worked most closely with the specialists in this sub-specialty. I learned a lot about tropical medicine in these three weeks. The MFM teams have overarching responsibility for the labour ward.
- Emergency and general gynaecology - I did very little emergency gynaecology. I felt that I could learn and achieve much more on the labour ward than in the emergency gynae admissions area. I spent three days here and was involved in a handful of laparoscopies for pelvic abscess and ruptured ectopic. A fellow with a significant interest in gynaecology would potentially gain a lot from this area. I spent a week and a half in general gynaecology. Teaching and learning opportunities were limited by the fact that cold benign gynaecology operating lists were frequently cancelled due to the demand for

theatre space from labour ward. Women sitting in beds for weeks on end awaiting hysterectomy for benign pathology such as hemorrhagic frustrated me immensely, and I got to a point where I personally felt my time would be better spent in the labour ward. This will hopefully improve now that the labour ward has been moved and there will be two theatre tables in the labour ward, reducing the need for theatre space in general gynaecology.

- The Liverpool Mulago Partnership - I spent 4 clinical weeks working with the two sets of visitors from Liverpool Women's Hospital. Most of this time was spent on labour ward with them - see separate section.

I thoroughly enjoyed the clinical work, although it was often bittersweet, and have seen and experienced conditions and situations that I would never have gained otherwise, and may never see again. I won't expand any further on the clinical side of things as this was described in detail in each of the monthly reports I sent back. I don't feel like I did enough, often due to the sheer volume of patients coming through the doors, but also due to other non-clinical commitments. This is the one thing that I would have changed about the job, although I suspect over the next few years, as the fellowship becomes more established, and the role is perhaps more defined, that the balance of work will favour the clinical side of things more.

TEACHING

This was my favourite aspect of the job. Over the course of the year, through regular Thursday afternoon sessions, I built up a good working relationship with the midwifery staff. Together, through interactive and practical sessions we managed to cover a lot of obstetric emergency topics, dispel urban myths about certain aspects of midwifery, and I tried to introduce the concept of multi-disciplinary team working and attempted to empower them to have the confidence to do what they are trained to do. The teaching sessions were a huge amount of fun, and the participants were always enthusiastic. In particular the staff from ward 14, the midwifery led area, always attended in good numbers, and they would feed back to me about clinical cases where they had used the skills and knowledge that we had worked through together, often successfully.

In addition to the weekly informal teaching sessions, I set up and delivered a number of additional formal courses. When I first went out, Kate Lightly and I ran a one day neonatal resuscitation training course for 103 midwives. I followed this up by raising around £1400 and refreshing those that we had trained, and trying to capture those that we had missed. Over a total period of just under 2 weeks in May and June, we trained a total of 71 midwives on 2 day courses. A paediatric colleague went out a few weeks ago and spent some of the remaining money on 2 more courses and they trained a further 39 midwives, bringing the total to 110.

I also ran a couple of emergency skills drills days which were very well received by the staff. We opened them up to all healthcare cadres, but unfortunately, only the midwives came. We carried out the training while the teams from Liverpool were over and they were great fun and very well received. I think this is the way forward with the teaching, and making it mandatory and multi-disciplinary, while difficult to achieve, would be fantastic for morale and team working. Mr Byamugisha seemed keen for this sort of training to continue. We trained around 40 staff on these courses.

I was also involved in 4 days of midwife training on partograph use and safe motherhood.

GUIDELINES

The head of department was extremely keen to get some clinical guidelines in place and I completed a sizeable number. While they are time consuming, I learned a lot from writing them about adaptation of evidence based medicine for different settings. It was challenging to incorporate the best available evidence into a system of limited resources. The difficulty, however, is not in writing the guidelines, but in getting the staff to accept and use the guidelines, and also in monitoring their implementation. A good example of this is the guideline for pre-labour rupture of membranes, and trying to get doctors to comply

with certain aspects of it, most notably, avoiding unnecessary vaginal examination. Two Liverpool medical students audited the adherence to the post-operative recovery guideline which Kate Lightly wrote, and found 0% compliance. There are currently no plans in place to audit many of the guidelines produced, which is a shame as the records department are extremely good at pulling records. My feeling is that if the fellow continues to be heavily involved in writing guidelines, it has to be an effective use of their time. The department needs to take responsibility for ensuring the guidelines are introduced into the clinical areas and enforcing compliance as much as possible through random spot checks and more formal, thorough audits. This needs to be carried out by the Ugandan staff, so that it's not seen as something created by the fellow, and therefore something that can be considered optional as it's not locally driven.

PROJECTS

Consumed a lot of my time and energy, some of which were successful, and others not. They will hopefully become an intrinsic part of the fellowship and continue with each successive fellow.

- Triage - I spent time on the triage project which was commenced at the request of the head of department. The aim was to improve the flow of patients through the labour ward from the admissions area and to identify and treat the sickest women first. There were a number of issues and barriers to implementation of the triage system, despite a lot of publicity and training. The main issues were of space and staffing, and were contributed to by staff attitudes to carrying out the triage process. After long discussions with the head of department, it was decided to abandon the project until after the labour ward move which has a much larger area for admissions. I hope that my successor will consider trying to revive the triage process, but this will only work if it is driven by the senior clinical doctors and midwives.
- AMEWS - was set up with the help of the Liverpool Mulago Partnership. We attempted to run an evaluation project, however we were unable to get ethical approval for it. This is being incorporated in the HDU project so hopefully it will be evaluated, and if it works put into routine use.
- Painting - I managed to con some of my friends into helping paint the labour ward and the area that will be used for the HDU. It made the place look a bit brighter and a lot cleaner.
- HDU - was probably the most successful thing to come out of my year, and despite a big hiccup that prevented me from completing it before I left, we then found out that the grant application I helped write with the team from LMP was successful, giving £30,000 a year for 2 years to get it set up. Paul is using the foundations which were created while I was there to build on and complete what I believe is a very necessary and hopefully very successful initiative.
- Maternal death audit - I collected the data for 2009. I am still trying to find a weekend to analyse the data.

LIVERPOOL MULAGO PARTNERSHIP

I had significant involvement in this project, mostly because I had spent a number of years at Liverpool Women's Hospital. It is inevitable that the fellow will become involved in the project as they are essential to the functioning of the partnership from an administrative point of view. I thoroughly enjoyed being involved in what is a very young, but I believe worthwhile partnership. Unfortunately, the team at Mulago have become dependent on the Eleanor Bradley Fellow in terms of looking after the Liverpool contingent. This may have in part been due to the fact that I knew all 4 of the LWH visitors, either through through work, or socially, and felt very strongly that their 2 weeks should be as structured, useful and memorable as possible. It is difficult to know how the partnership would function without the Eleanor Bradley Fellow, and I think it is important that the fellow has some involvement, particularly from the point of view of logistical and pastoral support.

I found the visits very beneficial for me, as the timing of the visits coincided with points in time where I was particularly frustrated and low. It was very cathartic to have colleagues around from a similar clinical background, to bounce off. It also helped me get my head in check regarding preparedness for coming back to the NHS.

I had a lot of involvement with the management/evaluation team, and thoroughly enjoyed working with them, particularly on the HDU project. I did find it difficult and frustrating knowing that I would be leaving before the money came in to see the project through, at least to opening. I hope to continue my involvement with LMP long term, particularly in helping prepare prospective visitors from Liverpool prior to arriving at Mulago.

I have given feedback to Andrew Weeks regarding the level of involvement the fellow has in LMP, especially regarding the admin side of things. It is important that the Ugandan members of the team take more responsibility for ensuring that their side of the partnership functions.

MY PERSONAL FEELINGS ABOUT MULAGO

My time at Mulago was by far the most difficult, frustrating, at times heartbreaking year of my life, and yet in many respects it was also the most rewarding and educational time too, and ultimately, I left a significant part of my heart at the hospital. I have learned more about myself as a person and as a doctor than anything else, gained huge clinical experience, but perhaps more importantly, and more transferable, life experience. It has, without doubt, changed me and shaped me into what I hope is a better person. It was a huge privilege to be accepted into the department of obstetrics and gynaecology, and I am grateful to all those who I worked with, both midwives and doctors, who supported me and taught me.

I believe that the fellowship is an excellent opportunity for any trainee in obstetrics and gynaecology. I do feel that I would have gained more, and been able to offer more if I had been two or three years further on in my training. The opportunities afforded to me were excellent, and there were many experiences gained, that would not have been possible in the UK. The fellowship succeeds because of a longstanding relationship with Andrew Weeks in Liverpool, and is built on mutual respect between the fellow and the department. In particular, the head of department, Mr Byamugisha, was keen to see me succeed and was supportive. I do think that the role of the fellow needs to be better defined, so that their personal learning objectives can be realised. There is potential for the fellow to be used to complete tasks and projects that they may not be interested in. I also think that the fellow's involvement in LMP needs to be better defined, particularly if future fellows have no active involvement with Liverpool Women's Hospital.

The Eleanor Bradley Fellow occupies a unique position in the department. The fellow is neither an SHO or a specialist, falling somewhere in between, and has a set of skills that are very different to most others working within the department. There is a huge challenge for the fellow on first arriving at the hospital, to work out exactly how they will use and shape their time to meet both their own personal objectives and those of the department. I feel that for future fellows, there should be a more open dialogue before their arrival, between themselves, the trust and the department to set realistic objectives and to fully understand what will be expected from the various interested parties during their time there. The job that I did while out in Kampala, was very, very different to what I thought I was going to be doing.

There are huge learning opportunities at Mulago and there is the potential for a huge amount of experience to be gained. One disadvantage of being a British trainee at Mulago is that the two systems are very different. It is assumed that there is a certain amount of clinical experience and expertise, which is currently difficult to achieve in a British system. The ethos at Mulago is to muck in and get on with it, to a certain degree. Many of the SHOs at Mulago have worked as medical officers in rural hospitals, often on a 1 in 2 rota, covering all specialities, and cut their teeth in these posts as far as surgery is concerned. In this respect, the vast majority of junior British trainees are at a huge disadvantage, with the opportunities to gain experience and carry out major operating at home being fairly low due to service commitments, and the changing attitude towards training and assessment. With this in mind, I found it very difficult to adapt easily to the sort of working environment where, to a certain extent, you are expected to get on with it and deal with whatever confronts you on the operating table. By the end of my time at Mulago I was comfortable with being in the operating theatre on labour ward by myself. I was always able to get help when needed but felt I had to be a little strategic in choosing who I did my shifts with, so that I was confident that there was always someone around who could bail me out of trouble.

British trainees are at an advantage where theoretical evidence based clinical practice is concerned, as it is very easy to access evidence, and also because British hospitals are very evidence driven. Additionally due to robust systems of accountability and clinical governance being in place, it is important to keep up to date and be able to defend one's practice. Such robust systems do not currently exist at Mulago. It can be very difficult to change the mindset of the majority and continue to practice evidence based obstetrics and gynaecology where it goes against the grain of local practice, or is restricted due to supplies and equipment. Accountability does not exist to the extent that it does in the UK, and often there is no system for tackling and reducing the number of poor outcomes. I believe that there is a general malaise due to this lack of accountability, and this is coupled with the lack of an incentive to improve practice. This almost certainly leads to an apparent attitude that 'life is cheap'. As an outsider entering this system, it is extremely frustrating and upsetting that there is an apparent lack of desire to improve conditions and outcomes, even where positive change can be achieved very easily with a minimum amount of additional time or money.

I adored the time I spent working with the midwifery staff , particularly the teaching aspect and I think we developed a good working relationship, which is uncommon between doctors and midwives at the hospital. It was disheartening to note that when we opened training sessions up to medical and midwifery staff, only midwives attended. I think this is a crucial barrier to break down in order to get people working together as a multidisciplinary team, and I believe that the fellow could be instrumental in realising this.

On returning to the UK, I do feel de-skilled in many aspects of obstetrics and gynaecology, and the culture shock of returning back to work in the NHS is more significant than when I initially went out to Kampala.
I have to try not to make comparisons between the two systems, as first of all there is very little that can actually be compared, and secondly, it makes me very emotional.

The healthcare system is very different to the British system, and is certainly shocking at first. You then find yourself developing strategies for coping with the differences, and eventually you are able to approach Mulago as 'normal'. It is strange when visitors from overseas, with whom you have worked in the NHS setting, arrive and spend time there. You see their reactions, and discuss the things that they have seen and experienced, and you wonder how you ever came to see it as normal. You feel hard, cold and numb, to a degree. But you have to change your perception of the hospital in your mindset, otherwise you wouldn't survive.

SUPERVISION

My feeling is that supervision of the Fellow could be improved. This is particularly important in theatre, and on the labour ward. It is possible to do whatever you feel like, whether it is right or wrong, and this seems to go unchecked. It is important for the safety of the fellow, and the patients that they receive good clinical support. The fellow is potentially vulnerable, and visitors often find themselves in situations where it is assumed that they are confident and competent, often being left on labour ward while the local staff disappear. This is a dangerous practice. I was lucky to have few maternal deaths during the shifts I worked on labour ward, but I believe that this was as much about luck regarding the case mix, as anything else.

The head of department was always accessible, usually in person. I felt that there were specialists who I could contact if I needed to, but think that a more formal educational supervisor should be on hand. Dr Sarah Nakabulwa was the person who kept an eye on my day to day activities but has many other responsibilities, such as co-ordinating the junior doctors. I would suggest somebody like Mark Muyingo, who is very approachable, and who deals with the overseas elective students would be an appropriate person.

It would be helpful if there was more direct dialogue between the trust and the head of department about expectations of the fellow, and feedback on performance.

PASTORAL SUPPORT

I would like to thank Ruth Groves and Andrew Weeks for being there when I needed to talk to them. Most communication was via email. I was fortunate to make some very good friends in Uganda, who I could talk to. I kept a regular blog, and also sent emails to close friends about particularly difficult cases. I am somebody who does offload by writing and this tactic worked very well from the point of view of coping. Since I have returned home, however, I have found it difficult to talk openly and honestly about my time at Mulago. I am still struggling to work out how I feel about my year there, and how it has affected me emotionally. I saw Andrew Weeks to discuss things, at his suggestion, but am not sure how useful it was. Friends have expressed concern about how the experience might affect me. I think there is the potential for the fellow to be significantly affected by their experiences. In the future it may be worth offering some sort of debriefing for the fellow on return, perhaps by someone who doesn't have any previous experience of Mulago/similar environments.

CONTINUITY OF THE FELLOWSHIP

The fellowship should undoubtedly continue. I was fortunate to be handing over to someone I know from medical school, and with whom I communicated via email, and was able to hand over to quite easily.

I had a good handover from Kate Lightly when I arrived, as she was still in Uganda at the time. I was able to hand over to Paul in Liverpool. Potentially there will be no overlap or physical handover for future fellows which is important.

Paul has moved into the house where I was living, which has worked quite well. I found that in moving to Uganda on my own, finding a place to live was the most stressful aspect of the first few weeks.

I think it is important for the outgoing fellow to make the move as easy as possible for their successor. Housing etc can be difficult to sort out without knowing someone who has been in Kampala for a while. Equally, work visas are a pain in the neck and can only be sorted out in Uganda. The medical registration can be sorted out prior to arrival, with a bit of careful planning. I would be happy to write an information pack prior to the next round of applications for the job, if you feel it would be useful. I'm sure that between the 3 fellows, we could come up with a useful document.

CONTINUED WORK

My school are presenting me with an alumnus award for the work I did while out in Uganda, which is humbling. They are also raising money for emergency skills training, and Paul and I are in discussions about delivering this at the hospital. The school have asked me to deliver a series of talks to the sixth form about my time in Uganda.

I have a number of talks lined up, including a plenary session at an annual national conference for Obstetrics and Gynaecology trainees, which will hopefully raise the profile of the fellowship in the minds of UK trainees. I am considering doing something with my blog, and photos. At the moment I have a number of commitments, including revising for an exam, so can't devote any time to this at the moment.

Mulago is in my blood now, and the women of Uganda hold a very special place in my heart. I will go back in the future, and hope to be involved from afar.

Dr Sarah Kate Alldred
Eleanor Bradley Fellow 2009-2010
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