The British Association of Urological Surgeons

The College of Medicine & Health Sciences School of Medicine, Hawassa, Ethiopia

3 to 9 December 2016
Report on UROLINK visit

UROLINK
PROMOTING UROLOGICAL CARE AND EDUCATION WORLDWIDE

Funding: BJUI

Visiting faculty

Ms Suzie Venn (SV) (Co-Chair, UROLINK)
Mr Paul Anderson (PA)
Mr David Dickerson (DD)
Mr Steve Payne (SP)
Mr Shekhar Biyani (SB) (Hawassa UK coordinator)

Background

In 2015, Urolink received funding from the BJUI to develop management of urethral strictures in Hawassa. Our objective was to deliver two training sessions for the local urology team on urethroplasty and urethral stricture management. Due to unavoidable circumstances, the first visit for urethroplasty was planned in December 2016.

Dr Aberra (Local coordinator) was informed about the visit and was requested to select cases. In addition, we requested extended operating times and 2 theatres to run the training sessions.

Objectives

1. To understand urethral stricture pattern and management in Hawassa.
2. To assess infrastructure to support a satisfactory management of urethral stricture.
3. To assess progress on TURP

Activities (3rd December to 9th December 2016)

The team arrived on Saturday late afternoon. All cases were reviewed on Sunday during the ward round and a list was prepared for 2 theatres on Monday. On Monday morning, SV introduced the Urolink Team to the theatre staff and we had a “group huddle”. SP, DD and PA started operating in both theatres mainly dealing with complex urethral strictures. Dr Aberra performed a small TURP and this was observed by the team. Dr Aberra scrubbed with team members for complex stricture cases to understand and learn different techniques.

On Tuesday, the team attended a surgical handover meeting. We felt that it was very well conducted with the on-call resident presenting the history, x-rays and emergency care. Trauma cases dominated the meeting. Both theatres were used by DD, SV and PA for a variety of cases. SV and SB went down to meet Dr Henok Tadele (Asst. Professor), College Chief Executive Director, Hawassa Referral Hospital. We had a good discussion with Dr Tadele regarding Urolink plans and also discussed possibility of an MOU between Urolink and Hawassa University. SB managed to speak to the IT Coordinator Mr Betsegaw Lukas Zula and requested to develop Wi-Fi in theatre as this would help in tele-mentoring. Follow up mails have suggested some progress on this front.

SB and SV left for Addis to attend the COSECSA meeting in Mombasa. In Addis Ababa, we had a dinner with Dr Gataneh. Dr Gataneh outlined his vision for Hawassa and was looking forward to starting his job. SP, DD and PA performed multiple complex procedure (appx 17) in the next 3 days. DD and SP have summarised their thoughts (Appendix 1 and 2).

Dr Getaneh has joined the Hawassa Referral Hospital in January 2017 and mailed a short update to the Urolink office.

What went well?

- A very experienced team in urethral surgery visited Hawassa for the first time and had a first-hand experience of the place.
- We had 2 theatres and extended working hours till 5 pm.
- Our accommodation was supported by Hawassa University.
- Meeting the hospital manager allowed us to understand their vision.
- Theatre staff were very supportive.

What could have been better?

- Dr Aberra struggled with the workload and lacked regular junior support in theatre.
- Last minute alterations in the theatre list were very disruptive and unsafe.
- We failed to get any data from the unit on prostatectomy and urethral stricture.

Recommendations

- Cases for surgery should be discussed along with x-rays with the visiting team in a structured way, if possible, before the visit or on arrival.
- To ensure a designated junior doctor for the visit to support a safe pathway for patients and smooth working in theatre. In addition, the designated doctor should present cases to the visiting faculty. This would allow us to improve “soft skills” in a junior trainee.
- To facilitate Wi-Fi facilities in theatre for tele-mentoring
- To improve data collection to assess outcomes.

Group “huddle”

Deep in thoughts!!

Appendix 1

Hawassa visit - initial thoughts (David Dickerson)

Firstly, there is a large population dependent on the service the hospital provides. There appears to be a significant number of patients being admitted with urological conditions. A high proportion of these have significant complications resulting from delayed or poor management, or a failure to recognise/diagnose relatively common problems. (eg bladder outlet obstruction, obstructive uropathy). Assessment of basic urological conditions is poor for several reasons (mainly education and training, but also due to a lack of access to investigations). Transvesical prostatectomy would appear to be a common urological procedure often carried out by general surgeons and, in our experience on this trip, is associated with a high complication rate. Complex stone disease is common as is urethral stricture. Treatment options are limited.

Although training in endoscopic resection, and urethroplasty is already taking place, the basics are not being performed well and addressing this is a priority.

There is clearly a strong need for a dedicated, trained urology service, with the resources (staff and equipment) to back this up.

This service is currently managed by a single consultant general surgeon with an interest in urology, with a rotating general surgical resident changing every three months. There are no dedicated urology wards or theatres and these are shared with general surgery. There are no dedicated urology ward or theatre nursing staff.

The existing consultant is in his late 50's and approaching retirement and is probably not suitable to be trained up. There are however several positives:

A new consultant is expected to take up post in the coming months. He is young, enthusiastic, and would be ideal to train up, and support to develop the service. I addition the existing consultant has been the primary driving force behind the acquisition and development of the referral hospital and has a high profile within the hospital, the city of Hawassa and has received national recognition as well. His remaining ambition is to create a urology service and ultimately create a second urology training centre in Ethiopia. He is therefore well placed to drive and support development of urology training.

There are no dedicated urology wards, theatres or nursing staff, and theatres are very inefficient for a multitude of reasons including poor communication between medical staff and theatres. There are however some very capable, enthusiastic individuals currently working in theatres and efficiency and safety could be relatively easily improved with training and education

At present the hospital has just 3 operating theatres shared by all specialties, but three new theatres are nearing completion.

Appendix 2

UROLINK visit to Hawassa – December 2016 (Mr S Payne)

SWOT analysis of Hawassa referral hospital

Strengths

- Enthusiasm
    - Dr. Aberra
    - Theatre staff
    - Anaesthetists
- Support from the hospital administration
    - Want better/more durable services
    - Want external help that will help provide the above
- Urological need
    - Massive mismatch between incident workload and personnel to handle it
    - Large intrinsic workload of a general urological nature
    - Apparently large secondary and tertiary workloads from the rest of the Rift Valley
- The volume of patients requiring general urological management
    - Large population with bladder outlet obstruction, stone disease and infection
    - Very large local intake of patients with poly-trauma
    - Cancer presents late, so much less of a problem
- The volume, and complexity of patients requiring highly specialist reconstructive management
    - Pelvic fracture
    - Urban violence
    - Hypospadias
    - Previous surgery elsewhere, especially following open prostatic surgery for benign disease
- The reconstructive workload
    - Opportunity for advanced level surgery in difficult circumstances
- Equipment
    - Some endoscopic equipment with video ability
    - Flexible cystoscope
    - Functioning diathermy – mono and bipolar

Weaknesses

- Communication
    - Language difficulties with staff/patients
    - Communications such as operating lists
- Basic clinical organisation and documentation
    - Lack of personnel
    - Haphazard ward rounds
    - No apparent documentation of management dictated by rounds
    - Nobody to carry through ward round decisions
    - Patient stays longer as a consequence
    - No community-based follow-up or management
- Dedicated trainees, lack of time in urology
    - One-month rotation far too short to be useful
    - Organisational issues do not promote education
- Lack of clinical prioritization
    - Priority not always given to most clinically urgent cases
- The need for basic urological knowledge/teaching/training
    - Poor Consultant level CPD or up-to-date knowledge acquisition
    - Frequency of junior rotation thwarts knowledge acquisition

    - Seniors clinically managing incumbent workload with little time to teach
    - Juniors organising theatre ‘chaos’ rather than spending time operating
- The need for basic urological investigation
    - Uroflowmetry
    - post void scans
    - I-PSS
    - frequency/volume charting
    - Very poor quality urethrography
- Risks associated with chaotic list organisation
    - WHO check infrequently applied
    - Appropriate equipment not always ready or available
- The lack of general and specialist urological surgical expertise
    - Basic standard of surgical training
    - Failure to understand principles of endoscopy and reconstruction
    - Lack of familiarity with equipment
- Lack of equipment
    - Appropriate antibiotics
    - Poor quality stirrups
    - No VTE prophylaxis (but not sure it’s important)
    - Disposables such as sutures and scalpel blades
    - No backup for ‘basic’ endoscopic equipment or video endoscopy
    - Lack of available lighting for taking grafts during reconstruction
- IT issues
    - No functional WiFi throughout the hospital
    - Consequent limited ability to video-network

Opportunities

- Willingness to engage
- Willingness to improve quality of service provision
- New personnel and ways of using them
    - Dr Getch
    - Possibility of altering the length of trainee’s rotation
    - Developing core urological skills in nursing and theatre staff by increased exposure to urological problems
- Political experience of Dr Aberra
    - Negotiating skills for resources locally and possibly nationally

Threats

- Established staff
    - Lack of knowledge leading to less than optimal clinical management
    - Limited surgical ability
    - Limited insight
    - Desire to bring something new to the institution but which may not be the community’s greatest need
- Lack of appropriate pre-op urological assessment to optimise management
- No concerted management stream to optimise patient care
- Lack of equipment
- Willingness of the local management, and surgical community, to continue to support development in urology
- Cost of bringing external expertise to Ethiopia
- Ability to maintain skills without mentoring

- Ability to maintain endoscopic equipment