ANAESTHESIA REPORT - HOIMA HOSPITAL

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Anaesthetic Staffing

There did not appear to be adequate anaesthetic cover for Hoima Hospital. We were informed of an emergency case where the hospital had been unable to find an anaesthetist to attend. It was unclear if this was because an individual had refused to come in when they should have done or if there are not enough anaesthetic officers to provide round the clock cover.

The anaesthetic officers did not receive much if any CME or support from medically trained anaesthetists. This will make it difficult for any of them to make changes to improve practice.

The anaesthetic officer I worked with was thorough and was doing his best in difficult circumstances. He had a sound knowledge base but was severely limited by the lack of drugs and equipment.

Anaesthetic Technique

I was surprised that so many of the patients having sections in Hoima had general anaesthesia in preference to regional, which I would have thought was not only safer, but provided better analgesia post-op.

The anaesthetic officer I asked about this said that he found regional anaesthesia difficult as he was also required to resuscitate the baby on delivery. He found that when he was using regional techniques the women became hypotensive (a common side effect of regional anaesthesia), and that he could not manage this and be resuscitating the baby. He found it easier to give a general anaesthetic. Whilst I understood his problems, this did seem to expose women to greater than necessary risks, especially considering the lack of adequate monitoring.

Equipment and Drugs

The anaesthetic machine in Hoima is an old very simple machine, which serves its purpose. They had been given a complex machine which has never worked, illustrating that there is little point in donating out of date equipment which cannot be maintained.

There was very little monitoring in theatre. There was an oxygen saturation monitor, which the anaesthetic officer thought did not work very well as it did not pick up saturations in patients who were hypotensive. In fact, this is true of all oxygen saturation probes and perhaps indicates the condition of most of the patients during anaesthesia. We tactfully discussed this with the anaesthetic officer.

There was an old manual sphygmomanometer, which again the anaesthetic officer was prompted to use. There was no means of monitoring the amount of anaesthetic delivered to the patient, ECG or end tidal carbon dioxide. My overall impression is that after induction for a Caesarean section the anaesthetic officer sits back and hopes for the best!

There was a very limited range of drugs in theatre. I saw no analgesic drugs at all, and only a few vials of the vital drugs like Thiopentone and Suxamethonium. I understand that there is a problem with stock disappearing from the hospital, but not supplying in the first place does not seem a sensible solution to this problem.

We had a supply of IV fluids available, but were informed that these had been ordered especially for our visit. Blood was sometimes available, but on a limited basis. It was transported over from Kampala, which would have taken at least 2-3 hours. It seems likely that some people will be operated upon with very limited fluids available and no blood.

We visited a neighbouring hospital which had run out of Suxamethonium. It was sending all its patients that required an operation to Hoima and Kampala while it waited for a supply of Suxamethonium to arrive from the central drug ordering service. Hoima had Suxamethonium, so it seemed markedly illogical for them to receive the extra workload rather than provide a loan of an inexpensive drug.

Recovery and post op monitoring

There was no recovery area and patients were not monitored as they recovered from their operation. When went to the theatres for a Caesarean section, the previous patient was on a trolley, unmonitored and without oxygen in the theatre corridor. She had had a Caesarean section a few days ago and had come back to theatre with an infected abdomen and had a laparotomy. In the UK a patient with this kind of complication would be managed in Critical Care, and the contrast was striking. In Hoima she was transferred straight back to the ward, where again there was little monitoring

At the conference, after my lecture on obstetric haemorrhage, one of the delegates asked why sometimes when they have treated haemorrhage the patient later deteriorates and dies. It seemed very obvious that better post-op monitoring would pick up some of these patients earlier in this process and allow time for appropriate management. There seemed a real lack in post operative care for women post operatively, so that complications of childbirth which would be detected and managed appropriately in the UK actually led to maternal mortality which in many cases would be preventable.