

## COMMENTARY

### MY EXPERIENCE IN CLINICAL PRACTICE AS A MEDICAL REGISTRAR IN THE UNITED KINGDOM (UK)

#### Summary

My experience working in the UK National Health Service (NHS) has been largely positive. Reflecting on my previous experiences makes me aware of the need for a standardised structure of practice to be put in place to guide the care of patients in Ghana as well as to ensure patient safety. There is still a lot that needs to be done in terms of the legal framework that guides medical practice in Ghana. Civil society groups and other medical groups should champion the enactment of laws on emergency care, patient safety, patient communication and patient involvement in their own care. Most of what I've discussed in this essay can be implemented with little to no resources

#### Introduction

I have been working at the Elderly Medicine Department of the Harrogate District Hospital since May 2017 with the Medical Training Initiative (MTI) Scheme. It has been a very good experience and it has exposed me to new and modern ways of taking care of patients. I was initially apprehensive as I was going to work in a totally new environment with a different culture and was wondering how I was going to settle in. The gradual introduction into clinical work at the Harrogate Hospital helped me to settle in. I initially observed patients being seen by different grades of doctors and then reviewed patients under supervision

me for the course and also allowed me to familiarise myself with the equipment and processes in my Hospital. In the UK, there are even defibrillators at particular areas outside health facilities which can be accessed when needed. People outside the health facilities are also trained in resuscitation.

The bleep/pager systems, emergency alarms, critical care outreach teams which are part of the British system all help to build the excellent emergency response system which they operate. However, the bleep system used in the UK can be improved as it causes a lot of distractions during on-calls especially as a registrar. The bleeps also do not show the urgency of the case for which the Doctor has been summoned. Without this, it is impossible to rationalise one's response and distraction is a norm. The NHS has been told to stop using pagers for communications by 2021, in order to save money. Health Secretary Matt Hancock called them "outdated" and said he wanted to rid the NHS of "archaic technology like pagers and fax machines" (2).

The UK's bleep system needs to be reviewed (2) and I have worked on a quality improvement project that has contributed to changes on how the bleep system is used at the Harrogate District Hospital.

before independently seeing patients. I also worked as a foundation doctor (house officer), then shadowed registrars (residents) before I eventually got on to the rota as a registrar.

#### Discussions

I will classify my experiences under these four headings:

#### Emergency care

One of the key tasks I had to complete before getting on to the rota was an Advanced Life Support (A.L.S) Course (1). For someone who thought his knowledge on A.L.S was good and had previously taught other professionals on the subject, I soon realised how intensive and well-organised resuscitation was in the UK (1). I also realised that my knowledge on the subject was not as adequate, thorough and standardized as I thought. The UK has a Resuscitation Council that supervises certification of A.L.S providers and ensures standard practice (1). The local hospitals also have their own Resuscitation teams that train all health professionals in the various hospitals. The local Resuscitation teams also audit resuscitation or crash calls to ensure standards are adhered to. Before participating in the UK A.L.S course, I had the opportunity to attend briefings organised by my host Hospital's Resuscitation team. This prepared

These systems are largely non-existent in Ghana. Some of these emergency responses like the critical care outreach services can be implemented in Ghana with little to no resources. The Critical Outreach Team consists of a team of nurses trained in resuscitation, how to review critically ill patients and liaise with on-call doctors and the High Dependency Unit (HDU)/Intensive Care Unit (ITU). One of the key things I have learnt working in the UK is making decisions about escalation and the level of care when seeing patients. This involves making a decision on whether to admit patients to HDUs/ITUs or to be managed on the ward (3). Critical decisions with respect to Do-Not-Attempt-Cardiopulmonary-Resuscitation (DNACPR) and escalation and having these difficult discussions with patients and family (4, 5) are made. Without many functioning HDUs/ITUs in Ghana, escalation to HDU/ITUs is not common practice and most patients are treated at ward level care. We need to teach our doctors and nurses on the levels of care i.e. Ward/ Level 0 or 1 care, HDU/Level 2 care and ITU/Level 3 care and how decisions are made regarding appropriate level of care when seeing patients especially unwell patients (6). These decisions involve good clinical judgement taking into consideration

patients' medical and social circumstances as well as their wishes (4, 5). Communication is one of the key differences between

the practice in the UK and what I had experienced in Ghana.

I can recall several discussions between the Management of the Hospital I that I worked for back home in Ghana and other colleagues on decongesting the Emergency Department. To begin with, the referral system in Ghana is not good as most patients simply show up at the various health facilities without any appointment. It is imperative that service providers efficiently use their bed space by ensuring seamless flow of patients through the various departments when they get to the hospitals and ensure that the available beds are efficiently used. There must be good bed management systems in place to ensure patients in emergency beds are quickly moved to the various wards to make space for new admissions. This will also ensure all sufficiently improved patients are quickly discharged to free bed space. Having a set time to discharge patients from the E.D which is set at four hours here in the UK avoids delays and frees up beds for emergency cases (7). However, my experience in the UK is that, there are times more emphasis is placed on avoiding a breach of the time than actually getting the patients in a better state before transfer to the various wards (7). The idea of a Bed Manager to liaise between the various wards and the emergency units is good and can easily be implemented in Ghana to ensure emergency beds are freed up. As a Medical Registrar in a UK hospital, I liaise with the E.D, Bed Manager, Nurse-in-charges and other team members to facilitate this. This system can be implemented in Ghana to address bed management issues. The National Health Insurance Authority together with other relevant stakeholders in the health sector in Ghana can set this four-hour window to move patients out of the E.D and incentivise health facilities that meet the target(s).

Due to a heavy load of patients and a significantly lower doctor-to-patient ratio, communication with patients is very poor in Ghana. This doesn't allow patients to actively partake in decisions regarding their own health (3). Research shows that patient participation in decisions regarding their care ensures better patient care (3).

### **Patient safety**

Though there are legal and professional Guidelines or protocols to ensure patient safety, adequate supervision and teamwork is important to achieve this. Consultants in the UK make sure they see almost all cases under their care and have well laid out plans for them. There is a clear structure of responsibility and greater support for junior doctors. The Consultants are more actively involved in the management of patients under their care. This is a practice that I have learnt in the UK and will incorporate into my future practice to ensure that I take full responsibility for patients under my care and make sure that junior doctors working under me get the required support. In the UK, all team

members (including non-clinical staff) contribute towards patient safety by ensuring everybody supports each other. The working of a Multidisciplinary team (MDT) is integral in the practice in the UK (8). An MDT meeting is, for instance, organised every morning on the Elderly care wards here at the Harrogate District Hospital. During this meeting, different specialties like doctors, nurses, physiotherapists, occupational therapists and discharge coordinators discuss the various cases and what actions are needed for the day. During these meetings, expected dates of discharges are set and this puts the whole team on its toes to ensure speedy discharges and efficient care and use of bed space.

The use of the Datix tool (software to report clinical incidents) to ensure patient safety and quality standard of care is another useful experience especially when it operates in an environment of openness, accountability and improvement. Datix is an electronic tool to report issues that compromise patient safety and care. A culture to encourage learning from mistakes and reflection on events must be encouraged (9) in Ghana. I remember having to respond to a Datix query because I requested a Magnetic Resonance Imaging (MRI) for the wrong patient. This happened on a busy day when I was shuffling between wards and multi-tasking. My initial thoughts were: "this is harsh; after all this was detected early and the patient wasn't even sent for the MRI". But on reflection, I realized the waste of time and resources to identify and rectify this mistake plus the potential and risks to have imaged the wrong patient. The checks and balances in the system ensured that the wrong patient wasn't imaged. This has made me more careful when requesting investigations; I now double-check and make sure my requests are for the right patients (9). Audit and quality improvement projects are useful ways of contributing to patient safety and improving quality of care. I was involved in the audit of a post-falls pro-forma form which is currently being rolled out throughout the Harrogate and District NHS Foundation Trust here in the UK.

We need to implement the MDT culture in Ghana and ensure more efficient use of our human resources and ensure quicker discharges. A culture of audit and quality improvement must be inculcated and must be a requirement across the health system. All trainees should be expected to draft and implement an audit or quality improvement project during their training.

### **Legal framework to guide practice**

During my orientation both by the Trust and the Department of Elderly Medicine, I got exposed to the various legal frameworks for practice in the UK. Being an elderly care registrar has been extremely helpful in my ability to work on the rota in the U.K as it allowed almost daily exposure and learning about some of these concepts, i.e. safeguarding, Deprivation Of Liberty Safeguarding (DOLS), capacity assessment, end of life/palliative care, DNACPR, escalation decisions and so on (5, 10). The absence of these concepts backed by explicit laws back home in Ghana compromises our

health care since these are “grey” areas. Those of us in the medical profession must partner civil society groups in Ghana to fight for a proper legal framework to back some of these issues or concepts.

### **Standardized care and training**

Another issue that I have really appreciated whilst working in the UK as a Medical Registrar has been the standardisation of patient care and the training of caregivers. The National Institute for Health and Care Excellence (NICE) guidelines allow for a more standardized care across the whole of the UK. The protocols in the NICE guidelines are used for training and set the standard of care required for various conditions across the UK. Exams questions at the various stages of undergraduate and postgraduate training are also based on these guidelines. My host Hospital in the UK also has locally generated protocols on many conditions online and this also allows for easy referencing and standardises the care. In the UK, the use of an electronic e-portfolio (electronic logbook) that is easy to verify and monitor is an excellent way of ensuring trainees receive adequate training and acquire the competencies needed. I've found the e-portfolio extremely useful as it allows me to know where I am with respect to my Personal Development Plans (PDPs) as discussed with my supervisors. Through the use of a multisource feedback form in the e-portfolio, I have received feedback from the different people that I have worked with in both clinical and non-clinical areas. I have also received feedback from some patients that I have seen (11).

Whereas Ghana has the Standard Treatment Guidelines that seek to guide the work of doctors and the National Health Insurance Authority, the information is sparse and the information is not reviewed regularly (12). The protocols in the Standard Treatment Guidelines are not reviewed frequently in line with changing practice and local guidelines.

The protocols of the Standard Treatment Guidelines should be used to teach medical students and residents and should be the standard of care expected for patients seen in Ghana. This will standardise care across the country and ensure all patients no matter where they are in the country are given a certain expected care with clear indications for referrals. A patient with a heart attack in Techiman should receive the same care as one in Kumasi.

In Ghana, most hospitals have mainly paper-based protocols pasted somewhere in the hospital in the various departments. However, these are not exhaustive and mostly, for lack of space, cover few conditions. This means that care basically depends on the knowledge of the doctor who sees the patient at that time of reporting with various doctors choosing to treat similar conditions in different ways. Hospitals should digitise and develop local online treatment protocols to allow ease of access. The Government of Ghana's plans to use more computer based technology in hospitals should help facilities to implement this. We

should also take advantage of technology to synchronize the medical records of patients to allow ease of access anywhere in the country.

The Government can set up Foundation Trusts as is done in the UK and have all health facilities in a particular area put under one Trust (13). This will allow efficient use of resources, human and equipment, with laid down referral systems between facilities in the same Trust and those outside it. This will allow the Government to save on provision of equipment and human resource. It will also allow patients to have access to specialist services and equipment within a Trust with ease of movement in between health facilities within a Trust.

In Ghana, a physical log book is used to record the practical training of residents but this lacks all the advantages of an electronic system. The log book of trainees in Ghana must allow feedback from various people working in the hospital even those in non-clinical areas so that trainees receive a comprehensive feedback from everyone they work with and not just from doctors, as the case is now. This will allow overall growth and better team working.

Furthermore, the log book doesn't allow for a more personalized development plan. I've found reflection(s) on incidents, meetings and clinical cases useful (9). Medical trainees need to reflect on events, mistakes and attachments to various units in order to build a spectrum of useful experiences. We should also encourage trainees to agree on PDPs with their supervisors/teachers and work towards them.

I will in future make quality improvement projects or audits mandatory for all trainees under my care back home. This allows health facilities to improve and also build other non-clinical competencies in trainees like leadership, management and research.

### **List of abbreviations**

1. ALS- Advanced life support
2. DNACPR- Do not attempt cardiopulmonary resuscitation
3. DOLS- Deprivation of liberty safeguards
4. ED-Emergency department
5. HDU-High dependency unit
6. ITU- Intensive care unit
7. MDT- Multi-disciplinary team
8. MRI- Magnetic resonance imaging
9. MTI- Medical training initiative
10. NHS- National Health Service
11. NICE- National institute for health and care excellence
12. PDP-Personal development plan
13. Resus- Resuscitation area

### **Definition of terms**

1. DNACPR-A do-not-resuscitate order, or DNR order, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's

- breathing stops or if the patient's heart stops beating (4, 5).
2. Deprivation of liberty safeguards-Deprivation of Liberty Safeguards (DoLS) Provides protection for vulnerable people who are accommodated in hospitals or care homes in circumstances that amount to a deprivation of their liberty and who lack the capacity to consent to the care or treatment they need (10).
  3. Advanced life support-a set of life-saving protocols and skills that extend Basic Life Support to further support the circulation and provide an open airway and adequate ventilation (breathing) (1).
  4. Capacity assessment-The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over (10).
  5. Multidisciplinary team-A multidisciplinary team is a group of health care members in different disciplines, each providing specific services to the patient with the aim of ensuring that the patient receives optimum care and support (8).
  6. Foundation trust- An NHS foundation trust is a semi-autonomous organisational unit within the National Health Service in England. They have a degree of independence from the Department of Health (and, until the abolition of SHAs in 2013, their local strategic health authority (13).
5. *Goldman-Cecil Medicine*. 25th ed. Philadelphia, PA: Elsevier Saunders; 2016:chap 3.
  5. <https://www.bfwh.nhs.uk/our-services/> group on cancer to the Chief Medical Officers of England and Wales hospital-services/critical-care/levels-of-care.
  6. Agoritas T, Heen AF, Brandt L, Alonso-Coello P, Kristiansen A, AkIEA, et al. Decisionaidsthatreallypromotesshareddecisionmaking: thepacequicknessBMJ2015; 350:g7624.
  7. Fabiny A, Sabatino C. Living Wills: A Guide to Advance Directives, the Health Care Power of Attorney, and Other Key Documents. Cambridge, MA: Harvard Health Publications; 2013.
  8. Jones P, Schimanski K. The four hour target to reduce emergency department 'waiting time': a systematic review of clinical outcomes. *Emergency Medicine Australasia* 2010; 22:391-398. The Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales. A report by the expert advisory. London: Department of Health; 1995. [[Google Scholar](#)].
  9. <http://careers.bmj.com/careers/advice/Reflective-writing-as-an-agent-for-change>
  10. Mental Capacity Act 2005. United Kingdom (c 9).
  11. General Medical Council. Colleague and patient feedback for revalidation. <https://www.gmc.uk.org/dpctors/revalidation/colleague-patient-feedback.asp>.
  12. [www.moh.gov.gh/wp-content/uploads/2016/02/Standard-Treatment-Guideline-](http://www.moh.gov.gh/wp-content/uploads/2016/02/Standard-Treatment-Guideline-)
  13. Butler, Patrick; Parker, Simon (14 November 2002). "O&A: foundation trusts". *The Guardian*. London.

**Competing interests:** None

#### References

1. Resuscitation Guidelines 2015. Resuscitation Council (UK). <http://www.resus.org.uk/resuscitation-guidelines/>.
2. BBC Technology page 23<sup>RD</sup> FEBRUARY 2019.
3. Arnold R. Care of dying patients and their families.
4. In: Goldman L, Schafer AI, eds.

**Dr. Dartel Norman**  
 Specialty Doctor in Geriatrics  
 Harrogate District Hospital  
 Lancaster Park Road  
 Harrogate  
 HG2 7SX  
 United Kingdom