The Hospital Authority Commissioned Training 2008-Obstetrics

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Many of us would recall we had a wonderful week in January this year in the Pamela Youde Nethersole Eastern Hospital. The theme of this Commissioned Training was on Obstetrics.

We had very distinguished speakers from overseas, Dr Kim Hinshaw who was no stranger for most of us for he had been our main instructor in many of the ALSO Courses in the past years. We also met Dr Tracey Johnston who is the consultant in Foetal Maternal Medicine, Birmingham Women's Hospital, United Kingdom. Not the least, we had very renowned local speakers who are obstetricians, neonatologists, anaesthetists and midwives!

Different from the previous commissioned trainings where we listened to lectures and a minority of us observed procedures, operations or had short experience on some new skills, this time we had 2 whole days of workshop where many frontline staff, medical and nursing, joined in discussions and drills where some of the ideas are new to us. But are they useful and how many Obstetric Units have applied the ideas and knowledge learned?

I am blaming globalisation again, many of the problems faced by obstetrical practices in UK mentioned by Dr Johnston are very similar to ours. Concerns she mentioned included high Caesarean Section Rate, or interfered too much, juniors are not well trained, consultants are de-skilling and midwives are extremely short with low morale. And what do we mean when we say we wish to 'improve outcome'? Do we mean reduction in maternal and perinatal morbidity and mortality, reducing unnecessary interventions, improving birth experience of our pregnant clients and family or improving job satisfaction for obstetricians, trainees, midwives and other health care workers? We have tried very hard to decrease perinatal and maternal mortality and morbidity figures and we used to measure our performance by these figures, meticulously compared ours with other units' and previous years'! Ways to improve our performance would include doing audits, both local and international. Teaching and training to trainees need more refinement particularly when the enforcement of limited workhour is going to be in place very soon. Clinical protocol has to be updated and evidence-based. And we have to adopt a positive and open view and mood in handling complaints, incidents and special events with careful review, suggestions of improvement and proper reflection to all staff. An area that we did very little is on clients' satisfaction. 'Healthy mum with healthy baby at the end' may not mean our job well done! We seldom ask what our service users want or what they think of our service. When standing on our side and looking at our own constraints, we dare not ask what else should we provide and whether their needs are met by our service! It is known that one to one care in labour will reduce intervention and increase satisfaction. User satisfaction will also be enhanced when they are given choices in management, there is continuity of care, they are being listened to, kept informed and being treated with respect and dignity. To achieve this, there may need a rather fundamental change in strategic planning with our funding authority regarding models of care and staffing. Staffing needs need to be recalculated with regard to workload in striving for a less stressed workplace, better communication and improved patient and staff job satisfaction.

Dr Kim HInshaw presented a relatively new concept in Intrauterine Foetal Resuscitation (IUR). He gave us a very clear concept in foetal physiology. He advocated systematic interpretation of CTG in one's own clinical scenario with support of foetal pH. IUR may be considered when there is borderline or established foetal acidaemia. IUR may improve foetal environment prior to urgent delivery and IUR may alter the mode of delivery. When there is suspected foetal comprise, institute conservative measures like maternal fell lateral tilt, oxygen and IV fluid bolus and continue monitoring. Candidates suitable for IUR are foetuses with borderline or established acidaemia, when general anaesthesia can be avoided for Caesarean Section, and when there is oligohydramnios and recurrent decelerations on CTG. Active IUR includes tocolysis for those with foetal acidaemia before Caesarean Section and amnioinfusion for those with oligohydramnios and borderline acidaemia.

Other very interesting topics include training of Delivery Suite Staff, High Dependency and Critical Care in Delivery Suite and many updates in Obstetrics Emergnecy Management. Most of the slides and valuable presentations are in CDs compiled after the training and have been distributed to all training units.