Editorial

Health Service, Teaching medical students and Training of Residents in Khartoum as applied to the Surgical Specialty

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The triangle of integrated health services with teaching of students and training of future consultants:

a) Teaching medical students

The number of medical students in Khartoum is huge and catering for their teaching and training is an integral part that have to be addressed at a national level. They are the future registrars who will ultimately be consultants that man the service. Medical students need in addition to primary health care, both acute and elective medicine. The term: teaching hospitals, as being named now all over the country, must fulfill the criteria for offering these functions. The presence of general medicine and general surgery with emergency service is the minimal requirement for teaching. Both obstetrical and paediatric services must be met within or in a separate hospital setting but within the vicinity to economize the multidisciplinary needs for medical consultation. The presence of students within the hospital or nearby is essential to augment clinical apprenticeship. Students are currently being more examination oriented. The sole introduction of OSCE as the only means of clinical evaluation in several medical schools led to exam solving approach as the learning method. Presence of many specialties in a general hospital is the ideal setting for teaching undergraduates.
The surgical curriculum entails the rotation of the residents within the training facilities in a way to satisfy the training program. The hospitals must have the general pattern in both acute intake and elective general surgery. Rotational slots are made to satisfy the requirements of the curriculum rotation. The number and types of surgical units as well as the selection and distribution of training consultants are important functions that the council of surgery in Sudan Board must be part of the administrative body. Young promising consultants satisfaction is the cornerstone for both teaching and service. The current state of dissatisfaction on both work, pay and unclear pathway of self-promotion in a sub-specialty abroad. This leads to frustration currently noticeable and hence hasten migration to where these justifiable aspirations can be satisfied. Those young consultants are the future leaders and the second generation that will shoulder the responsibility of training. This process needs time and must be addressed now. To keep them within the system is possible and these ways can be spelled in another memorandum.

**b) Training of registrars**

The quality of health service offered is more important than availability. The burden now of misdiagnosis leading to delay in management both in acute and neoplastic conditions, over investigation that is being repeated, over prescription and un-necessary use of antibiotics are major issues. We, as clinicians are living with these issues on daily basis. Too many health facilities in itself should not be the only objective. We commend the various hospitals and health centers being established but the picture will not be complete without addressing other essential parallel issues. The HUMAN factor is more important. Health services is based in well trained health professionals paramedics and nursing staff. Hence the inclusion of both deans of medical schools and the training specialty councils should be part of a joint body that plans for health service.

**A) Hospital function and hospital grade**

Based on the above concept the hospital functions and grades must address those concerns

a) Acute and emergency services: Emergency intake should be an integral part of as many hospitals as can be. Acute admission is the most important part in the hospital. The acute patient has no choice but to have care at the nearest casualty. Participation of experienced senior colleagues working in elective surgery can help in acute patient care as well as teaching registrars and medical students within the casualty as being done in in Khartoum Teaching Hospital and Jaffar Ibn Oaf Hospital. The omission of the casualty service from some hospitals made senior consultants redundant. It is inconceivable to loose willing and free (minimal pay) available services offered by senior colleagues. The change of function, to sole tertiary hospitals without co-ordination with concerned beneficial bodies like medical schools and postgraduate council .

b) Multidisciplinary Hospitals The presence of multidisciplinary hospitals is an international concept. The patient needs for specialists in various fields is becoming even more urgent. The concept of a multidisciplinary approach is now prevailing in various specialties: cancer management, GI diseases etc. with all the relevant specialists present to plan management.
The three main hospitals (Khartoum, Omdurman and Khartoum North) should be in this context as top grade. The multidisciplinary approach is now the modern way of patient management. This can only be achieved in those settings where various disciplines are present. The three main hospitals should act as National Centers as they had been in the past. More than 40% of the admissions are from outside Khartoum. Referral from all regional hospitals is a daily event in both acute and elective medicine. The under staffing of regional hospitals entails that the three main reference hospitals should be kept, upgraded and staffed with senior reference consultants. This era will continue until the general development of those regional hospitals reach a level to keep all sector professionals satisfied with education and health services to their families and ultimately settle there. The recent experiment whereby some fragmentation of specialty services happened led to a situation whereby patients being moved around to various hospitals seeking specialty service that can be easily catered in the multidisciplinary hospitals.

c) The General Hospital: This is the most common hospital setting that would be available within the vicinity but how far distance should not be the main issue. The posting of young surgeons can be boosted by a weekly visiting senior consultant. The senior fellow helps both in upgrade of services, patient care and training and supervision of major surgeries performed. This practice is being applied in many countries and it maximizes the utilization of senior consultants.

d) Specialty hospitals: The allocation of some hospitals for specific function has to be addressed with the specialty concerned. The balance between being integrated in a large multidisciplinary hospital or have their own is a matter to be discussed with the specialty concerned. The Cardiac and renal transplant recent allocation in Ahmed Gasim is a step in the right direction. A liver centre within Ibn Sinna could be ideal within a GI hospital.

e) Private hospitals: The current dissatisfaction in the public hospitals lead to loss of trust by the middle class and ordinary low income patients who can not afford the costly service offered in private hospitals. Faced with long waiting time for elective surgery and substandard emergency service, those patients are compelled to sacrifice basic needs to have private service. Many patients will ultimately find themselves unable to continue if the needs rose to extend the hospital stay to manage postoperative complications. Some private hospitals are offering reasonable price to help this category. Many public hospitals are now offering paid service which is matching the private hospitals bill. The idea being to attract extra funds to serve the poor patients on free basis. However, free service entails patients have to purchase many other items. Patients are suffering from repeated and unnecessary investigations and over prescription especially of antibiotics. Junior doctors without clear guidelines are steering this dilemma.

Those complex problems cannot be solved by a single institution. The involvement of all sectors to plan and share in the decision making is the only approach that paves the way forward.