Introspection and Intervention

Group Process as an Intervention for Resocialization in The Bahamas

D Allen

In the 1980s, The Bahamas faced a country-wide crack cocaine epidemic. Crack cocaine was the first drug to feminize drug addiction. Mothers were ejected from the homes, leaving children to fend for themselves. This produced a powerful social fragmentation which included drug trafficking with overt executions, a proliferation of chronic addicts with severe cognitive impairment and rampant gun smuggling. Moreover, the crack epidemic led to the breakdown of socio-cultural values throughout The Bahamas. The following became prevalent: life became cheap (burgeoning murder rates), property was not respected, work ethic diminished, families and communities disintegrated, youth unemployment rates increased and violent youth gangs were formed. In 2004, I found that the social fragmentation had deepened, leading to the marginalization of many once stable communities. An initiative to repair social fragmentation was needed. Several group processes were established in 2008, where people would tell their stories in a contemplative environment of silence, love, acceptance and non-judgmental listening. There was testimonial evidence of people who had a reduced desire for revenge, increased anger management and conflict resolution, reduced abusive relationships, reduced loneliness, increased self-esteem, increased forgiveness and a desire for healing the community. With the use of nine psychological instruments (*ie*, the Beck Depression Inventory, Buss-Durkee Hostility-Guilt Inventory, Gratitude Questionnaire, Hope Scale, Self-Deception Questionnaire, Internalized Shame Scale, Satisfaction with life scale, Spiritual Well-Being Scale and Transgression-Related Interpersonal Motivations Inventory (TRIM-18), we were able to demonstrate reductions in violence, revenge, anger, shame and abusive relationships. We also found an increased sense of benevolence and being in a meaningful community.

A Retrospective Study Evaluating the Effects of Misoprostol *versus* Non-misoprostol Agents on Cardiotocography and its Correlation with Maternal and Fetal outcome at the Princess Margaret Hospital

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Objectives: To assess maternal, neonatal outcome and Cardiotocography (CTG) patterns of patients undergoing induction of labour.
Methods: This retrospective cross-sectional analytical study included 270 patients. Infant and maternal demographics, types of induction agents, indications for induction, partograms, CTG patterns, mode of delivery, maternal and fetal complications were abstracted from the patient files. IBM SPSS statistical software facilitated data analysis.
Results: The median age of participants was 26 (IQR: 21–25, 26–30) years. One hundred and twenty-eight patients laboured spontaneously. For those induced, 89 had misoprostol 30 Foley's, 19 oxytocin. The main reason for induction was postdatism (47.6%). The highest incidence of precipitous labour, abnormal and tachysystolic CGT patterns was seen with misoprostol (both $p < 0.001$). Approximately, 76.5% had vaginal delivery, 19.0% Caesarean sections and 4.5% assisted vaginal delivery. For those who were induced, the use of misoprostol resulted in higher rates of Caesarean delivery (31.8%, Cramer's V = 0.200, $p = 0.002$) and meconium exposure (44.3%, Cramer's V = 0.349, $p < 0.001$). When spontaneous deliver and the various induction methods were compared, perinatal lacerations and postpartum haemorrhage (PPH) were more common in the misoprostol group (Cramer's V = 0.284, $p < 0.001$ and Cramer's V = 0.192, $p = 0.021$, respectively).

When the various groups were compared APGAR score rates were slightly lower in the misoprostol group ($p = 0.035$). Despite this, whether or not labour was spontaneous or inducted, the rates of neonatal intensive care unit (NICU) admissions did seem to be affected. (Cramer's V = 0.085, $p = 0.59$)
Conclusions: Misoprostol is associated with higher rates of abnormal labour, perineal lacerations, operative vaginal delivery, Caesarean section and PPH. Although there

is a trend to lower APGAR scores, there was no difference in NICU admission rates in this review. Further study is needed to confirm these findings.

Knowledge, Understanding and Recall of Informed Consent for Patients Undergoing Caesarean Sections at the Princess Margaret Hospital

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Objectives: To determine the knowledge, understanding and recall of informed consent on day one postoperatively. To assess patient satisfaction of the consent process

Methods: A voluntary self-administered questionnaire was used to obtain patients' demographics and to determine recall of different aspects of their informed consent from the medical procedure, and risks and benefits. Their level of understanding and satisfaction of the dissemination of information pertaining to their diagnosis and care were also explored. The patient responses were cross-referenced with the consenting physician's documentation. IBM SPSS statistical software facilitated data analysis.

Results: There were 141 participants. The mean age was 27.42 (± 6.37) and the majority 84 (60.9%) had a secondary education. Approximately, 89.7% recalled that their diagnosis was explained to them, 93.9% the procedure and 76.5% the alternatives explained, 60.3% were satisfied with the explanations. The most frequent rates of discussed risk recalled were 81.6% bleeding, 54.6% blood transfusion, 48.2% wound infection, 39% bladder injury, 39% death, 30.5% bowel trauma, 26.2% wound dehiscence, 23.4% endometritis, 22.7% possible hysterectomy 21.3% ICU admission and 21.3% fetal trauma. In contrast, the most frequent documented by physicians included excessive bleeding 47.5%, wound infection 42.6%, hysterectomy 35.5%, bowel trauma 17%, bladder injury 17%, possible blood transfusion 16.3% and death 9.9%

Conclusion: Overall, despite the fluctuation in patients recall, they claimed to have understood most of the information shared and they were satisfied with their informed consent experience. Measures such as written handouts, repetition and a more detailed consent form itemizing specific risks may result in better correlation between medical records and patient recall.

Knowledge, Attitudes and Practices regarding Vector-Borne Diseases among Public Healthcare Workers in The Bahamas

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Objectives: The study aimed to determine public healthcare workers levels of knowledge, attitudes, and practices (KAP) regarding Dengue, Chikungunya, Zika and Malaria in The Bahamas.

Methods: This was a cross-sectional study utilizing a self-administered questionnaire. The IBM SPSS Statistical Analysis Software (v.24) was used for statistical analysis.

Results: There were 331 public healthcare workers with 251 (75.8%) females and 80 (24.2%) males. The median age group of participants was 31–40 (IQR: 21–30, 41–50) years including physicians, nurses and ancillary healthcare workers. Mean percentages scored correctly for participant's knowledge of vector-borne diseases (VBDs) were: Chikungunya 58.16% (± 1.46%), Zika 53.2% (± 1.17%), Dengue 45.6% (± 1.17%) and Malaria 42.9% (± 1.24%). The most used source of knowledge by the participants was the Internet (84.6%), and the least used was the Medical Journal (56.8%). Positive attitudinal responses regarding the vector-borne diseases were universally shared among the healthcare workers. Low mean percentages for practices (< 50%) and low self-reported practices (< 40%) were typical for the four VBDs. Multivariate linear regression analysis showed factors associated with correct VBD knowledge level to be VBD practices, nationality, Zika diagnosis and work region. Multivariate linear regression analysis showed that the factors associated with level of correct VBD practices were VBD knowledge, profession, age and medical training.

Conclusion: Healthcare workers are the first responders and a main-line of defense against outbreaks of VBDs. It is essential to put in place strategies for training and education of more healthcare professionals to heighten the awareness of the public regarding the threat to human life posed by VBDs.

Knee Osteoarthritis and its Impact on the Quality of Life of Adults Actively Utilizing the Government Clinic Services in Exuma, The Bahamas

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Objectives: To assess the impact of knee osteoarthritis (OA) on the quality of life of patients utilizing the Exuma Government Clinic.

Methods: Over a five-month period, 374 participants were recruited by convenience sampling and enrolled in a cross-sectional study. Information pertaining to sociodemographic variables, body mass index (BMI) and Western Ontario and McMaster Universities Arthritis Index (WOMAC) and short form-36 (SF-36) health-related quality of life (HRQoL) questionnaires were ascertained either through a self-administered or face-to-face interview completion of the questionnaires. Participants were divided into OA and no-OA groups using the American College of Rheumatology diagnostic criteria for knee OA and analysed statistically.

Results: Of 374 questionnaires, 97.6% responded. There were 123 (35.1%) adults with knee OA. The median age was 60 years for those with knee OA. Two hundred and

twenty-three (63.7%) females enrolled. Mean BMI for the OA group was 31.8 kg/m^2 and 29.6 kg/m^2 for no OA participants ($p < 0.028$). Scores from WOMAC scales for participants with OA were: pain 0.6 (IQR: 0.0, 1.6), stiffness 1.00 (IQR: 0.0, 2.0) and degree of difficulty with movement 0.53 (IQR: 0.0, 1.44). Regarding the 10 parameters of the 36-item HRQoL questionnaire, participants with knee OA's median physical function score was 60.00 (IQR: 40.00, 92.50), general health 41.40 (IQR: 32.00, 46.6.00), energy levels 55.00 (IQR: 50.00, 70.00), pain 70.00 (IQR: 45.00, 80.00) and for physical component summary score 64.73 (IQR: 39.80, 77.85) domains.
Conclusion: Knee OA negatively affected persons in the Exuma primary healthcare system. A targeted approach is needed to develop OA prevention strategies targeting modifiable risk factors.

Determining Associations between the Occurrence of Depression and Socio-demographic Factors in Persons 65 years and Older Presenting to the Accident and Emergency Department of the Princess Margaret Hospital
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Objective: To determine the associations between the occurrence of depression and socio-demographic factors (*eg* age and family support) in persons greater than 65 years old who present to the Accident and Emergency Department (AED) at the Princess Margaret Hospital (PMH) in Nassau, The Bahamas.
Methods: A prospective, cross-sectional observational study employed a questionnaire interview format to persons over 65 years old in the AED during a six-month period. Measurements included patient demographics, a six-item screener (SIS) determining persons' cognitive impairment, and the Geriatric Depression Scale-short form (GDS-15/GDS-S).
Results: A total of 251 participants attempted the questionnaire. Forty-six persons did not progress to completing the GDS-15 due to scoring ≤ 2 on the SIS. However, their socio-medico-demographics were still analysed. The mean (± 1 SD) age of the participants was 75.18 (± 7.80) years, 123 (49%) were males and 128 (51%) females. Most persons were either widowed (89; 35.5%) or married (84; 33.5%) and lived with their children or relatives (102; 40.6%). The most common co-morbidity in the participants was hypertension 202 (80%). The most common presenting complaint was shortness of breath (51; 20.3%) and 158 (62.9%) persons were admitted. Of the 205 persons completing the GDS-15, 20 (9.76%; 95% confidence level (CI): 8.56, 10.97) had a score ≥ 6 and were assessed as depressed. Eight (7.34%; 95% CI: 6.41, 8.27) of the 109 males were depressed and 12 of the 96 females (12.46; 95% CI: 10.97, 13.95) were depressed.
Conclusion: Once cognitive impairment was excluded, most elderly AED patients were not depressed. Marriage, the use of paracetamol, levothyroxine and Daflon™ were found to be protective against depression in this subpopulation.

Confronting the Illusion of People-centred Care: The Case for Integration
G Mery

People-centred care will remain an illusion unless we achieve real health system integration. People-centred care means that the person and their environment are placed at the centre of the healthcare system. This simple statement has several challenging implications. One is that healthcare services need to undergo a deep transformation if they are to be re-built around the person. Another is that while today's healthcare services work with different aspects of the person, they are not prepared to work with the person as a whole. Also, healthcare systems usually focus on the person, but not on their environment. To provide effective people-centred care, they will need to learn a whole new set of skills and build different capacity. This presentation explores the implications of people-centred care in healthcare systems and reviews some of the international efforts and experience in building people-centred integrated healthcare systems.