ABSTRACT

Background: The death of Folake Oduyoye at the Lagos University Teaching Hospital (LUTH), Nigeria on 13th December 2014 triggered a protest march against the hospital, by a coalition of civil society organizations and human rights activists, and a legal suit was instituted against the government. Although a Federal High Court ruled in 2018 to overturn Oduyoye's case on a technicality, this ruling is currently being appealed.

Objective: To perform a sociological analysis of the Oduyoye/LUTH case and another managed in OAUTHC Ile-Ife; as a means of providing insight into the current state of patient safety in maternity, in Nigeria.

Methodology: This sociological analysis was conducted using secondary data, sourced from a combination of detailed online searches of published literature, news items, and social media posts; along with personal observations and reviews of patient’s records.

Results: Patient safety issues in maternity are prevalent in Nigeria. Responsible macrosociological factors include lack of clarity regarding the political economy of healthcare in Nigeria, dubious justiciability of citizens’ right to healthcare, poor resource allocation to healthcare, and dismal coverage of national health insurance, along with poor regulation of health services, and nonintegration of healthcare with partner social institutions. At the mesosociological and microsociological levels are lack of public confidence in Nigerian healthcare, gross infrastructural decay from chronic neglect, understaffing and inadequate training of personnel, lack of institutional risk management and clinical governance.

Conclusion: The state of patient safety in maternity in Nigeria is quite worrisome. Various sociological factors were identified and viable solutions proffered.

Key words: Clinical governance; patient safety; quality healthcare; risk management.

Case 1

The death of Folake Oduyoye at the Lagos University Teaching Hospital (LUTH), Lagos, Nigeria on the 13th of December 2014 is a rallying point in the renewed public discourse around patient safety in maternity in Nigeria. Folake was a 35-year-old Para 4 (4A), who according to LUTH management, was admitted in extremis and managed for complications arising from a cesarean delivery which she had had in a private hospital in Lagos. At LUTH, she underwent a laparotomy and drainage of a septic abdominal collection; and was managed in intensive care unit (ICU), where she was on mechanical ventilation for 1 month. She had also developed renal failure for which she had to undergo four sessions of hemodialysis.[1]

According to her husband, Folake eventually recovered and was transferred out of the ICU, for possible discharge home. By this time, however, she had accumulated a hospital bill...
of almost 1.4 million Naira (approximately $4000), a sum which the family did not have the means to pay. Folake was then allegedly moved to a guarded ward, where she was denied any further treatment and held “in detention” pending the settlement of her bill. She eventually developed a chest infection and died after spending over 40 days “in detention”. This unfortunate incident led to intense public outrage. A protest march against the hospital was organized by a coalition of civil society organizations and human rights activists, and a legal suit was instituted against the government. A Federal High Court, however, ruled in 2018 to overturn Oduyoye’s case on a technicality. This ruling is currently being appealed at a Federal Court of Appeal.\textsuperscript{[2,3]}

**Case 2**

On the 23\textsuperscript{rd} of September 2019, a 35-year-old P5 (4A) was admitted at the Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC), Ile-Ife, Nigeria 7 days post-caesarean delivery of a stillbirth in a private hospital. She was said to have bled heavily during the Cesarean section and, therefore, had one unit of blood transfused intraoperatively. Postoperatively, she was noticed not passing urine, hence the private hospital referred her to a state-owned general hospital on the third postoperative day. At the state hospital, her admission packed cell volume (PCV) was 16\%, serum urea 15.2 mmol/L and serum creatinine 530 µmol/L. She was transfused with two units of blood and given frusemide and intravenous fluid to challenge her kidneys. She, however, remained anuric and her urea and creatinine continued to rise, on account of which she was referred to OAUTHC on the sixth postoperative day. Upon presentation at OAUTHC, she was diagnosed with severe puerperal sepsis and acute kidney injury (AKI). Her admission PCV was 29\%, serum urea 29.8 mmol/L, creatinine 1260 µmol/L and she was indeed anuric. She was, therefore, commenced on hemodialysis.

Upon the removal of the skin stitches from her midline infraumbilical wound on the eighth postoperative day, she developed a burst abdomen. She consequently had an emergency laparotomy, with drainage of a septic abdominal collection, insertion of a peritoneal drain, and repair of the burst abdomen. The intraoperative findings included about 500 ml. of seropurulent intra-abdominal collection, a healing midline vertical (classical) wound on the uterus, and apparent nonclosure of the rectus sheath from her primary surgery. She started producing increasing quantities of urine postoperatively. However, the peritoneal drain was also actively returning a straw-colored effluent which was tested and confirmed to be urine. In all, she had four sessions of hemodialysis. The peritoneal drain eventually stopped functioning after about 3 weeks postoperatively and the bladder catheter was discontinued after 5 weeks of continuous bladder drainage.

She was discharged home a week prior to this report but was yet to leave the hospital due to financial constraints. Her husband was still trying to raise the funds to settle her hospital bill at the time of submitting this manuscript.

**Definition and Conceptualization of Patient Safety**

Patient safety is a paramount indicator of the quality of care, where healthcare is concerned. According to the World Health Organization (WHO), patient safety can be defined as “the absence of preventable harm to a patient during the process of healthcare and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum”.\textsuperscript{[4]} This definition implies that patient safety is not a rigid construct with absolute criteria, but rather, one that is amenable to collective setting and resetting of the reference standards. This is evidently an attestation to the fact that it is impossible to eliminate the risk of unintended harm in healthcare, despite our best wishes. An acceptable minimum risk of unnecessary harm, therefore, is used by the WHO to refer to “the collective notions of given current knowledge, resources available, and the context in which care was delivered weighed against the risk of nontreatment or other treatment”.\textsuperscript{[4]}

Another very useful definition of patient safety is provided by the Institute of Medicine (IOM), an organization of the American Academy of Science. The IOM defines patient safety as “the prevention of harm to patients.”\textsuperscript{[5]} Great emphasis is placed on the development of a system of healthcare delivery that (1) prevents errors; (2) learns from the errors that do occur; and (3) is built on a culture of safety that involves healthcare professionals, organizations, and patients.\textsuperscript{[5,6]} In this context, an error is defined as “failure of a planned action to be completed as intended (i.e., the error of execution) or the use of a wrong plan to achieve an aim (i.e., the error of planning). An error may be an act of commission or an act of omission.”\textsuperscript{[6]}

Errors in healthcare sometimes result in adverse events or near misses. An adverse event is said to occur when a patient suffers unintended harm by an act of commission or omission rather than by the underlying disease or condition.\textsuperscript{[6]} Adverse events may be in the form of any of the 5Ds - death, disease, disability, discomfort, and dissatisfaction.\textsuperscript{[7]} A near miss, on the other hand, is defined as “an act of commission or omission that could have harmed the patient but did not do so as a result of chance (e.g., the patient received a contraindicated drug but did not experience an adverse
drug reaction), prevention (e.g., a potentially lethal overdose was prescribed, but a nurse identified the error before administering the medication), or mitigation (e.g., a lethal drug overdose was administered but discovered early and countered with an antidote)."[6]

All the foregoing are variables or indicators arising from the conceptualization of a major construct, which is the quality of healthcare. The IOM defines healthcare quality as “the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” To attain a desirable standard of quality, healthcare has to be safe, effective, timely, efficient, equitable, and people-centered.[8]

Nigerian Maternity in Context

Macrosociological analysis

Nigeria is a sub-Saharan African country on the Atlantic coast of West Africa. It is the most populous nation in Africa and the seventh most populous in the world. The nation has a largely young population, with a median age of 18.4 years and a life expectancy of 53.8 years.[9] This relatively low life expectancy reflects the general state of Nigeria’s health indices. The country still has one of the highest maternal mortality ratios in the world (814 per 100,000 live births) with 58,000 maternal deaths in 2015 representing 19% of the world total, for a country which makes up less than 3% of the world’s population.[10] This goes along with a low rate of skilled birth attendance at delivery (43%), high total fertility rate (with the average Nigerian woman still having 5–6 children in her reproductive life), low contraceptive prevalence rate (12%; modern methods), and high rate of unmet need for contraception (19%).[11] In the same vein, Nigeria’s under-five, infant and neonatal mortality rates are all unacceptably high. This can be attributed to the high burden of infectious and communicable diseases, coupled with a suboptimal immunization coverage and weak preventive health framework. This added to the widespread inaccessibility and unaffordability of healthcare to a population more than 60% of whom live below the poverty line, with about 50% in extreme poverty, completes the Nigerian health conundrum.[10]

Economically, Nigeria belongs to the low-middle income band of countries but is the world’s 27th largest economy.[9] The Nigerian economy has embedded in it, various elements of the capitalist and socialist systems; hence the country is often described as operating a mixed economy. This mixed pattern is also reflected in the structure and organization (or lack thereof) of the nation’s healthcare system. There are three arms of government in Nigeria, each working independently and yet in concert with the others. These are respectively the executive, legislative, and judiciary arms of government. This tripartite structure of government is replicated at each of Nigeria’s three tiers of government i.e., federal, state, and local governments. At the federal level, Nigeria operates a Presidential system of government with the executive seat of power in Abuja, the country’s political capital. The rest of the country is divided into 36 States, and each State is further divided into local government areas (LGAs) resulting in a total of 774 LGAs in the country. Health care is on what is called the concurrent legislative list in Nigeria. This means that all three tiers of government are simultaneously responsible for the provision of healthcare. The local governments are to provide primary healthcare, while the state and federal governments are to be responsible for the secondary and tertiary levels of healthcare, respectively.

Healthcare in Nigeria was only recently elevated to the status of a right, with the launch of the Patients’ Bill of Rights in 2018.12 This right to health is enshrined in the National Health Act of 2014 as well as in the Nigerian Constitution.13,14 However, the justiciability of this right remains to be tested in the Nigerian legal system, although this is beginning to happen with the “Oduyoye case” presented in case 1 above. It is a generally known fact that the Nigerian healthcare system falls short in delivering the rights of the Nigerian populace to quality healthcare. In a 2016 Nigerian survey, Price Waterhouse Cooper reported that over 90% of respondents each associated the Nigerian healthcare system with the words low quality and disorganized. Between 70 and 80% of participants, each used the words rude, amateur and fear in connection with Nigeria’s healthcare system. On the other hand, positive words such as polite, trustworthy, value for money, professional, and reliable were only used by less than 10% of the respondents.[15]

Universal healthcare is the very foundation upon which the entire superstructure of any population’s right to healthcare can be built. Nigeria unfortunately still scores poorly where this is concerned.[16,17] The country is currently struggling with problems of inaccessibility and the unaffordability of quality healthcare for the most part. Although Nigeria has a National Health Insurance Scheme (NHIS) which was flagged off in 2005, the scheme is still largely limited to the formal sector which is made up mostly of government employees, and thus covers less than 5% of the Nigerian population. Consequently, between them, the government and the NHIS are actually responsible for only 17.2% of total health spending in Nigeria, while 75.2% comes from direct individual and family expenditure in the form of out of pocket payment for healthcare. In fact, over 25% of households in...
Nigeria expend more than 10% of their household expenses on healthcare.\[16\]

In an effort to address these numerous challenges, the Nigerian government developed a revised National Health Policy in 2016 with the theme of promoting the health of Nigerians to accelerate socioeconomic development.\[18\] The findings of the situational analysis, referenced in the policy state as follows: “the Nigerian health system is weak and, hence, underperforming across all building blocks. Health system governance is weak. There is an almost total absence of financial risk protection and the health system is largely unresponsive. There is inequity in access to services due to variations in socioeconomic status and geographic location. For instance, 11% of births to uneducated mothers occur in health facilities while 91% of births to mothers with more than secondary education occurs in health facilities; 86% of mothers in urban areas receive ANC from skilled providers, compared to only 48% of mothers in rural areas; and ANC coverage in the northwest is 41% compared to 91% in the southeast.”\[18\] This analysis further states the presence of “low confidence of consumers in the services provided, especially in public health facilities; absence of a minimum package of health services; lack of proper coordination between the public and private sectors; and poor referral systems.”

**Meso and microsociological analyses**

A close look at the two cases presented in this review will raise a few questions, top among which will perhaps be: why do these women present in extremis, and where do they come from? It is quite ironic that in both cases, the patients had, in fact, been managed in hospitals from the outset, although private hospitals. Considering the fact that facility-based delivery conducted by a skilled birth attendant is the advocated standard of intrapartum care to combat the high rate of maternal morbidity and mortality in Nigeria, these women should be commended for having taken the right decisions.

It is not at all out of place to expect that patients would be able to enjoy quality healthcare, or at the very least, safe maternity care from hospitals, be they public or private. Unfortunately, this is not always the case. The patient in case 2, for example, had apparently received extremely unsafe care and suffered multiple life-threatening complications which led to her presenting to the referral facility in extremis. Experiences like this reinforces the public’s mistrust of hospitals and promotes the pursuit of alternative maternity care in mission homes and traditional birth attendants, both of which options are patently unsafe. Both cases also evoke the question; how are the practices of private hospitals in Nigeria regulated to ensure patient safety, and by extension, public safety? In case 2 for instance, the managing team at the referral center, in fact, deemed it necessary to report this serious incident and escalate it appropriately, to enable necessary interventions geared towards preventing future re-occurrence. However, it was quickly realized that there was a team-wide lack of awareness of any existing framework for this. To which office or officer, in which ministry, department or agency should such a report be directed? This was a question that no one in the whole obstetrics and gynecology department of a teaching hospital had a ready answer to, and this situation was probably not peculiar to the index center.

The quality of healthcare available to patients in referral hospitals in Nigeria, most of which are government-owned, quite often still leaves a lot to be desired. In fact, after managing to overcome enormous phase 1 and phase 2 delays, for which the practitioners are usually happy to blame the patient and the government, patients still almost invariably go on to suffer varying degrees of phase 3 delays, with sometimes catastrophic consequences.\[19\] It is absolutely undeniable that phase 3 delays remain one of the biggest impediments to patient safety in maternity, in Nigeria.

Cesarean decision-delivery interval (DDI) is an excellent indicator of phase 3 delay in maternity. The reference standard DDI for emergency (category 1) Cesarean section worldwide is 30 min. In Nigeria however, studies have reported DDI ranging from 4.4 h in 1999 to 3.2 h in 2010 and about 2 h in 2015.\[20-22\] Although on the surface this might suggest an improving trend, this observation is not quite generalizable, as many centers in Nigeria still struggle with DDIs of over 4 h even in present-day practice.

Various factors have been blamed for long DDI in Nigerian public hospitals and it is saddening to note that these have not changed over the years. These perennial factors include waiting for the anesthetist, a problem which has long been solved in the UK by having dedicated obstetric anesthesiologists on the labor ward floor at all times; waiting for blood, a problem already solved in the UK by having a dedicated blood fridge in the labor ward which constantly holds a few units of O Rh-negative blood; and maintaining an efficient blood bank. Another major factor is the theatre being engaged at the time a decision was taken for cesarean section, a problem whose obvious solution is to have at least two fully operational theatre suites in the labor ward.

Other factors implicated in prolonged DDI include the nonavailability of some necessary drugs and supplies for
surgery. In fact, in some centers where the pack system has been successfully introduced to overcome this problem, it is not uncommon to still find that the packs are sometimes missing some contents which will need eventually to be procured before surgery, thereby causing delays. Problems in the CSSD (central sterile supplies department) leading to lack of prompt availability of sterile supplies and instrument packs for surgery are also not uncommon. Though the use of disposable surgical gowns and drapes may be an obvious alternative, this is often unaffordable and therefore unsustainable in the Nigerian context. Also, various infrastructural challenges such as shortage of electricity, water, and oxygen are all still far too common.

There are frequent problems of understaffing in the labor wards, affecting the different cadres of maternity personnel in Nigeria. For instance, the widely recommended 1:1 ratio of midwives to patients is seldom attained.[23] Moreover, worse still, this insufficient personnel is often also under-skilled due to persistent lack of vital training and retraining to maintain proficiency in critical skills. For example, unlike what obtains in the UK and other developed countries, there is no mandatory requirement of up to date BLS (basic life support) training for all healthcare personnel in Nigeria. This clearly has grave implications for patient survival in situations where cardiopulmonary resuscitation is required. The various other obstetric practical training courses and skills drills such as MOET (medical obstetric emergencies and trauma) and PROMPT (practical obstetric multi-professional training), and ALSO (advanced life support in obstetrics) are not requirements either.[24-26] It is therefore not surprising that interprofessional rivalry and conflicts still abound, especially between midwives and doctors on the labor ward floor, hindering teamwork, and further compromising patient safety.

The automated electronic defibrillator (AED) which is a standard requirement in every ward in developed countries like the UK will be an extraordinary sight in a Nigerian labor ward. Even basic emergency trays, where present, are often inadequately stocked. In close similarity to the PPH (postpartum hemorrhage) box in the UK, some emergency packs have been developed and tried in some public hospital labor wards in Nigeria including the author’s center, but this initiative keeps failing because of inability to replenish these packs after use, most times as a result of failure of the patients to pay for the replacement due to financial constraints (unpublished). While this is happening, many a residency-training institution in Nigeria is busy “window dressing”—a term used to describe the artful portrayal (falsely of course) of the attainment of ideal standards of infrastructure, equipment and staffing, to the accreditation teams during accreditation visits by the National Postgraduate Medical College or West African College of Surgeons. Many hospitals virtually become movie sets to secure accreditation.

The impact of the lack of a realistic funding mechanism for healthcare for most Nigerians is being felt daily on the shop floor of the labor ward. With a population of almost 200 million people, out of which 60% are famed to be living below the poverty line and less than 5% are covered by the NHIS, hospitals are bound to have a hard time recovering healthcare bills from the countless poor Nigerians who literally have no pockets out of which to pay for their own healthcare. Although it has recently become possible for individuals outside the formal sector to self-subscribe to the NHIS, there is still a 3-month latency period after registration, before they can begin to enjoy the insurance coverage. This latency period is currently a causal factor for late booking for ANC, as most women wait it out before booking for ANC, to avoid out of pocket payment of their booking fees. Should these patients have emergencies during this latency period, the NHIS would not cover them, and quite unlike in developed countries, emergency healthcare is not free in Nigeria. Also, payments for expensive interventions such as CT scan or MRI which are often provided through PPP (public-private partnership) arrangements in public hospitals are not covered by NHIS.

In government-owned hospitals in Nigeria, the hospital management must generate revenue internally from patient fees to keep the hospitals running, as the government is only responsible for the payment of employee wages. This expectedly drives hospital managements to sometimes resort to extreme measures such as “detention” of indebted patients in guarded wards or security posts, to extract their bills. This practice has been a ticking litigation time bomb waiting to go off, the first detonation of which is perhaps the Oduyoye case (case 1). There is no government social support or benefits system in place to cater to the needs of poor Nigerian patients. Some good Samaritans and public-spirited individuals do help these patients during festive periods such as the Christmas and New Year celebrations and on other sporadic occasions. Politicians and their wives have also been known to provide such assistance occasionally, although for political gains. Healthcare is a social institution that intersects with many others such as family, education, economy, security, and the law. Its delivery in Nigeria is, however, still very fragmented and poorly integrated with other interdependent services such as social support and safeguarding.
The Way Forward

To begin to address the widespread patient safety issues in maternity in Nigeria, the country needs urgently to determine its priority areas and set standards. These then need to be translated into action which will be assiduously implemented. A very good example of this can be found in the now-defunct “Abiye Program” of the Ondo State government under the leadership of former Governor Olusegun Mimiko.\textsuperscript{[27-29]} In the words of a junior doctor who worked in Ondo State during the program “The governor invested a palpably huge amount of political will in advancing a fantastic template for public healthcare. Besides making health free for pregnant women and under-5 children, there were resources both human and material to execute the necessary tasked.” He summarized the interventions as follows: “(1) Rapid construction of new medical facilities in an expansive Medical Village on Laje Road; (2) Concurrent construction of residential facilities for the medical staff; (3) Timely and regular payment of salaries commensurate with the level of energy devoted to improving the health indices of the state; (4) Sustained provision of medical consumables and modern equipment, especially in the medical village; (5) Massive employment of medical practitioners AT ALL LEVELS to ensure optimal staffing levels; and (6) Partnership with multinational corporations who rewarded the proactive system with massive investments.”\textsuperscript{[30]} Unfortunately, this program succumbed to the inevitable change in the political leadership of the State.

Moreover, in need of urgent change, is the prevalent culture of “scapegoating” i.e., naming, blaming, and shaming of individuals for adverse events in healthcare in Nigerian hospitals, without addressing the contribution of the dysfunctional system to the problem. The priority should rather always be to learn as much as possible from such incidents in a respectful and nonjudgmental atmosphere. This can best be achieved by performing root-cause analysis (RCA) of all serious incidents. An RCA is “a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. Typically, the analysis focuses primarily on systems and processes, not individual performance.”\textsuperscript{[31]}

Institution of effective risk management and clinical governance in all labor wards, and indeed everywhere else, in every healthcare institution in Nigeria, should be an urgent priority. According to the WHO, clinical risk management specifically is concerned with improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks. The following simple four-step process which is commonly used to manage clinical risks should be deployed in all healthcare facilities in Nigeria: (1) Identify the risk; (2) Assess the frequency and severity of the risk; (3) Reduce or eliminate the risk; and (4) Assess the costs saved by reducing the risk or the costs if the risk eventuates. Clinical governance, on the other hand, is a practice-based, value-driven approach that has the goal of delivering the highest possible quality care and ensuring the safety of patients. Striving for high quality and safe healthcare is underpinned by continuous learning, shared responsibility and good relationships and collaboration between healthcare professionals, managers, and patients.\textsuperscript{[32-34]}

Another very crucial intervention needed in the Nigerian healthcare landscape is a patient safety reporting system. As illustrated in case 2, such a system is either not yet in existence in Nigeria or if it already is, the awareness of it is terribly lacking. At present, in the United States, there are many types of patient safety reporting systems in operation or under development in the public and private sectors.\textsuperscript{[35]} Australia and the United Kingdom are also implementing strong nationwide patient safety reporting systems.\textsuperscript{[36,37]} The UK, in particular, has in addition, the CQC (care quality commission),\textsuperscript{[38]} which functions to ensure that quality healthcare is being delivered in every healthcare facility across the UK. The CQC has been known to shut down whole maternity units of hospital trusts which were unable to maintain the required standards of quality healthcare and merged them with good performing centers. Nigeria urgently needs to set up its own local equivalent of the CQC, to periodically accredit or discredit hospitals, based on their performance with respect to patient safety and quality healthcare.

The dedicated collection and maintenance of truthful patient safety data is the foundation upon which every other effort will stand. In the NHS for example, Datix\textsuperscript{[39]} a computer software is used for reporting, collating, and analyzing patient safety incidents, be they minor or serious, across the UK. This provides the CQC with reliable information about patient safety in the various centers. Based on their results, hospitals are rated using a traffic light (red, amber, or green) system and flagged appropriately based on their performance in the various patient safety and healthcare quality indicators, in comparison to the adopted national benchmarks. In maternity, this is well encapsulated in the maternity dashboard.\textsuperscript{[40]} Using the traffic light system, the dashboard displays the unit’s performance status regarding key indicators such as maternal mortality rate, cesarean section, assisted vaginal delivery, 3rd and 4th degree perineal tear, PPH, and eclampsia rates. Others include the preterm delivery rate, stillbirth, neonatal, and perinatal mortality rates.
Obviously, information technology including comprehensive internet coverage is cardinal in the development of a nationwide database such as Datix in the UK, and these remain real challenges in Nigeria at the present time, owing to the existing massive infrastructure deficit. Initial steps towards the future attainment of this goal in Nigeria must, however, begin now, by increasing the quantum of investment in healthcare by the government and empowering the populace either by promoting universal coverage of health insurance or adopting a policy of state-funded universal healthcare as with the NHS in the UK. In the interim though, there is an abundance of low-cost but high impact patient safety interventions which Nigeria will have no excuse for not adopting immediately. Examples of these include the maternity dashboard, which has been successfully used in Zimbabwe,[41] as well as the WHO safety checklists, some of which have been specifically designed for use in maternity.[42,43]

In conclusion, a tsunami of healthcare-related lawsuits targeting individual healthcare workers and organizations as well as the Nigerian government is on its way here, if the recent deliberations of the Nigerian Bar Association are anything to go by. Worldwide, maternity services are known to be the hotbed of litigation. It is therefore, high time for the health sector in Nigeria to wake up from its slumber and start living up to its life-saving responsibilities, by ensuring that the highest possible standards of patient safety and quality healthcare are faithfully upheld at all times. Our patients are watching! Their lawyers are waiting!

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

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