

ENHANCEMENT OF CLINICAL PRACTICE AND SCHOLARSHIP: POSSIBLE ROLE OF APPLICATION OF POSITIVE DEVIANCE CONCEPT IN A RESOURCE CONSTRAINED ENVIRONMENT.

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The concept of scholarship which had been traditionally viewed as the *Discovery of new knowledge* has been expanded by Boyer's definition¹ to also accommodate, *Scholarship of Integration, Scholarship of Application and Scholarship of Teaching*. In this presentation, the concept of scholarship shall be viewed as any product of a faculty member that utilizes his/her expertise and meets the three *P* requirements of having been *Peer* reviewed, placed in the *Public* domain (print and/or electronic media) and providing a *Platform* for others to build on – to learn from, to use or to adapt².

Positive Deviance (PD) concept is based on the belief that in every society there are certain individuals or entities whose Special Practices or Strategies enable them to find a better solution to particularly disturbing problem than their neighbours who have *access to exactly the same resources*. Such identified individuals are called '*Positive Deviants*'.

The concept of PD was successfully used to solve the problem of malnutrition in Vietnam in the 1990s³ as well as other health related problems in different parts of the world. In the words of one of the greatest contributors to the body of knowledge on PD, Jerry Sternin(2003):

'PD provides a demonstrably successful approach to solving Problems while Valuing the wisdom that already exists within Your community. In that sense, It is an unusually empowering and respectful approach. Look no further than Your community. And when faced with near insoluble problem – think donkey'

In a resource constrained environment a number of unusual practices may have to be adopted to ensure improved patient care. In the case of kidney biopsy, which is an invaluable diagnostic procedure for many patients with kidney diseases, the basic tools needed (Biopsy needles), were not readily available in the country in the 80's and early 90's. The health institutions took no step to include them in their shopping list, partly because the demand for them was low, as there were not many available hands skilled in the art of successfully performing kidney biopsies then. The biopsy needles in production then were manually operated (Tru-Cut needles) and required very high

manual dexterity for successful usage. In order to ensure that the skill was put into effective use for both the benefit of our patients and the need to pass on the skill to younger generation of renal physicians, we (LIO & EO) sourced for the needles abroad at our expense. As a cost saving measure, the panel of routine pre-biopsy investigations had to be prioritized to include only the most essential ones. The kidney localizing technique to us until early 1990's, was intravenous urography (IVU), which a number of patients could not even afford, and so in carefully selected cases, a blind approach had to be adopted, using only surface markings as a guide. Much attention was paid to close post-biopsy monitoring,

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with direct personal involvement and this may partly account for the rather low complication rate recorded in our practice as well as published series^{4,5}.

Considering the effort and resources put into carrying out kidney biopsy in the early period, it was not surprising that I closely monitored biopsy specimens from tissue procurement stage through the processing stages. I also insisted on pre-viewing the slides before official reporting by the pathologists. This approach enabled me to assess the adequacy of the tissue to be reported on. I was also able to see if the sections were cut thin enough (~2 microns), as much thicker sections could appear as hypercellular, giving a false diagnosis if so reported. This particular situation arose during a period when the microtome for cutting tissue sections became faulty, but quick remedial steps were taken. The laboratory scientists and pathologists were quite accommodating of my rather unusual practice towards kidney biopsy tissue specimens as they very well appreciated the passion I had towards ensuring adequate pathological evaluation of kidney biopsy tissue specimens.

A number of interesting clinical observations in the course of practice could lead to structured clinical studies, outcome of which, need to be shared with peers at academic conferences. The normal progression is to move from National to International Conferences. The peer review process for presentations intended for most International Conferences could be intense and it is therefore not surprising that such presentations, in one form or the other, get published shortly after. This was well recognized much earlier in my academic career development. I had developed an avid appetite for International Conference attendance. One in particular I resolved not to miss was the Biennial International Congress of Nephrology (ICN, now World Congresses), organized by the International Society of Nephrology, of which I have been a member since 1989. The cost of maintaining my membership over the years and attending Congresses has been huge but it can be said to

be worth it. Although some competitive national travel fellowship grants were available along the line, they were usually inadequate and the buck of the funding came from personal savings, which took a minimum of 2 years to put together. All presentations made at these Congresses were subsequently published in reputable journals. The most gratifying experience was at the ICN in Jerusalem, 1993. I was still then a junior academic (Lecturer 1) and 2 of my papers were accepted for oral presentation. Interestingly, there was no multimedia facility available to me then and the slides were ingeniously prepared with expired positive KODAK films, which came out no different from others. The presentations were not only well received; they got published shortly after the Conference^{6,7}. It may be of interest to note that data from most of our published works have been partly or substantially presented at scientific meetings. Significantly, presentations made at various International Conferences, based on our research efforts, have all ended up as journal articles in reputable journals. Some of these studies centered on aspects of abnormalities in blood rheology and fibrinolysis, which had not been previously addressed in Nigerian patients with various forms of kidney diseases^{8,9,10,11}. All these attest to the synergy between participation in academic Conferences and scholarship.

There is no doubt that the above highlighted, apparently unusual practices, with tangible beneficial effects, can best be described as Positive Deviance Practices.

REFERENCES:

1. Boyer E L. Scholarship reconsidered: Priorities of the Professoriate. San Fransico: Jossey – Bass; 1990; p1-160.
2. Simpson D, Fincher R M, Hafler J, Irby D, Richard B, Rosenfeld G, Viggiano T. Advancing educators and education: defining the components and evidence of educational scholarship. 2007;

- AAMC https://services.aamc.org/publications/showfile.cfm?file=version86.pdf&prd_id=237&pdf_id=86.
3. Sternin M, Sternin J, Marsh D. Scaling up a poverty alleviation and nutrition programme in Vietnam. In: Marchion T. Scaling up, scaling down: capacity for overcoming malnutrition in developing countries. Amsterdam. Gordon and Breach; 1999.
 4. Oviasu E., Ugbodaga P. Evaluation of percutaneous renal biopsy as a day case procedure: experience from Nigeria. *J. Nephrol.* 1998; 11: 246-248.
 5. Oviasu E., Ojogwu L I. Modified blind approach to renal biopsy: Experience from Nigeria. Proceedings of XVth International Congress of Nephrology, Buenos Aires. 1999; P. 1636.
 6. Oviasu E., Benka-Coker LBO. Renal size in sickle cell haemoglobinopathy. *J. Nephrol.* 1994; 7: 175-177.
 7. Oviasu E., Erhunmwunse R U. How to measure GFR when filtration markers are unaffordable – A study with oral Ranitidine and creatinine clearance. *J. Nephrol.* 1994; 7: 120-122
 8. Oviasu E. Ojeh E A, Famodu A A. Fibrinolytic activity in nephrotic Nigerians. *Clin. Hemorheol.* 1995; 15: 897-901.
 9. Famodu A A, Oviasu E. Fibrinolytic activity in Nigerians with chronic renal failure. *Niger. Medical J.* 1997; 32: 53-55.
 10. Oviasu E, Famodu A A, Ojeh E A. Plasma viscosity in nephrotic Nigerians. *Clin. Haemorheol Microcirc.* 1998; 19: 163-167.
 11. Oviasu E., Famodu AA. Plasma viscosity and fibrinogen in Nigerians with chronic renal failure. *Niger.Postgrad. Med, J.* 1999; 6: 142-144.