ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1). I found this very difficult to answer given the nature of a tertiary referal and major trauma centre, patients presenting to A&E present with an acute abdomen or are refered by their GP with a clinical suspicion of a surgical problem compared to those requiring surgical assesment having been brought in by LAS/Hems are very disimilar and have very disimilar demands on the hospital. Though they may both require similar treatments the way that resorces are triaged change what would be meant by surgical intervention. Further to this there are patients from other hospitals being referred for assessment and treatment. In terms of the number if cases seen through A&E, this varied week by week as to what presented most often, with suspected appendicitis being the most common I saw, only 50% of which actually having an imflamed appendix. In terms of elective proceedures, bowel cancer resection was the more common, though this again varied week by week. Im sure that throughout the year it would be shown that these rates would match a district general hospital and national average rates but how the case is triaged and prioritised will likely be different.

2). Prioritising surgical patients is a matter of triage and availability. Which patients have the greatest risk to life/limb requiring a surgical intervention and where/when is it possible to treat them. Given that the royal london hospital is a tertiary referal centre for trauma, neurosciences, vascular, renal, HBP, colorectal and many other specialties, there is a high demand for beds of any kind. As a result these decisions are being made constantly, is a patient medically fit for discharge, do they have any special health requirements now that will affect them once discharged and what needs to put in place from a social care aspect before discharge. Does someone on HDU need that level of care still or are they able to be stepped down. In clinics, does a patient need ongoing monitoring/treatment/investigation any more or are they able to be discharged.

3). Laparoscopic surgery has changed significantly of the years and has changed surgery again and again, driving innovation in the technical mechanics and operator skills. The implications of laparoscopic training for a patient include benefits in terms of reduced healing time, more rapid mobilisation, reduced pain and need for pain relief but also risks like increased operative time and the potential need to convert to open mid proceedure. Implications for the surgeon are similar to that of the patient, longer operations mean fewer patients fitting onto a theatre list, increased training workload, reduced field of view. All of which have been shown to be minimal changes once fully trained but during the trainging phase there is a marked difference in operative time.

4). During the next two years working as an FY1/FY2 as part of the UK foundation program there will be many different training opportunities to develop my skills with a view to entering a Core Surgical traing post. Having spoken to some of the surgical trainees, I have been recomended to start early developing the knowledge and skills that a surgeon would need. To that end, ALS/ATLS training will be a necessary skillset. Likewise having attended courses for basic surgical skills, basic laparoscopic surgical skills and developed my experience and competence within the surgical profession as much as possible. Completed/Participated in a Audit, clinical teaching, presentations, abstracts and paper publications are all listed as scoring requirements for recruitment into core surgical programs. All of these things must have the overarching indication of my commitment to a surgical specialty.