ELECTIVE (SSC5b) REPORT (1200 words)

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

Objective 1

"What are the prevalent orthopaedic conditions in the population of patients at the RNOH? How does this differ from other centres in the UK?"

The Royal National Orthopaedic Hospital in Stanmore is a tertiary referral hospital that specialises in complex orthopaedic conditions. They are a specialist hospital with theatres, wards, rehabilitation units, outpatient clinics and a prosthetics department on site. While they do treat minor orthopaedic conditions, over 80% of their workload is complex tertiary referral, covering everything from sarcomas, scoliosis and muscular dystrophy in children to revision hip and knee replacements, sports injuries and spinal cord injuries in adults. Their scoliosis unit and sarcoma units are both world famous, boasting the biggest of their kind in europe. The specialist rehabilitation unit for spinal cord injuries, is also well respected globally. Another string to their bow is their research centre. The research centre, run by UCL leads the way in translational orthopaedic and rheumatologic research and has strong links with the royal agricultural college where many surgical techniques and prosthetics are first pioneered on the animals. All of these factors make stanmore unique when compared to other orthopaedic centres. Firstly there are very few true orthopaedic hospitals. Many hospitals such as The Royal London Hospital, only have orthopaedic departments and orthopaedic wards, while some don't even have ring fenced beds. Secondly, the specialist centres that do exists do not undertake cases equivalent in complexity to those seen at the Royal National Orthopaedic Hospital. Thirdly, the centre specialises in non-emergency work only. While the hospital had a helipad for trauma cases many years ago, now surgeons only undertake elective work. With this in mind, there is a singular intensive care ward that typically has no more than three patients at any one time, and takes referrals from the whole hospital. This is markedly different from centres such as The Royal London that specialise in orthopaedic trauma and have designated emergency theatres and large ICUs.

Objective 2

"How are orthopaedic services organised and delivered at the RNOH? How does this differ from other centres around the UK?"

Due to the life-long and complex nature of the paediatric conditions that the Royal National Orthopaedic Hospital treats, it is important that care is delivered seamlessly. Because the Royal National Orthopaedic Hospital has both paediatric and adult wards, continuity of care is ensured and surgeons will often take responsibility for their patients as children, and continue this well into their patients' adult lives. This builds a great relationship between surgeon and patient that you do not often see in other orthopaedic roles. This is different from other hospitals, where patients will be seen in a paediatric unit, before reaching adulthood and having to transfer their care to a senior unit where they have to form new relationships with their treating physician.

© Bart's and The London School of Medicine & Dentistry 2016

Another way that the RNOH differs is that it specialises in all aspects of musculoskeletal care, gathering the best and the brightest in orthopaedics, spinal surgery, rheumatology, sports and exercise medicine and rehabilitation. This is partiularly good for patients, as often referrals from general practice are inappropriate, often confusing rheumatological problems with orthopaedic problems. Once this is identified in clinic, the specialists will often discuss cases across disciplines so that a recommendation can be sent back to the GP as to who would be an appropriate referral. This saves time for the GP and helps guide patient care.

Another way the RNOH differs is that it is an orthopaedic training hospital and trains 15% of all future orthopaedic surgeons from the UK. This means that often patients will see junior orthopeadic surgeons in clinics, on ward rounds and in the anaesthetic room before surgery. From my experience, patients seem all too happy to help train the future orthopaedic surgeons as they are often experts in their conditions, as such it presents a huge learning opportunity for those interested in orthopaedics.

Objective 3

"How does the RNOH differ from general hospitals in the UK in the way it organises patient care?"

Patients are admitted to the RNOH mainly through referrals and transfers from other hospitals, which can be either specialist or general, or they are booked in for an outpatient appointment by their GP. This is vastly different from most other hospitals where orthopaedic referrals mainly come in as referrals from outpatient clinics and sometimes through A+E as a result of trauma eg. RTA or sporting injuries. This means that in the RNOH, every patient has been admitted by an orthopaedic surgeon, usually a consultant, which is not the case in other centres.

Another way the RNOH differs is that they have ring-fenced beds. This means that patients who have undergone orthopaedic surgery are only placed on wards which have orthopaedic patients. This is because of the intrinsic nature of the hospital. In many hospitals around the country this is not the case and data has shown that patients who reside in hospitals without ring-fenced beds do worse in terms of overall morbidity and mortality.

The in house rehabilitation service and prosthetic department also allow the RNOH to stand out when compared with other hospitals. For patients this makes the process of rehabilitation after surgery or injury significantly easier as the RNOH acts as a one stop shop for all their care needs. After hospital discharge, these services continue to provide care for patients until they are no longer necessary.

Objective 4

"Develop the necessary skills for communicating effectively with individuals who are unwell and experiencing a lot of pain"

Over my three weeks at the RNOH I believe I progressed significantly in my communication skills with patients who are unwell or in pain. Although, what I learnt first and foremost was to anticipate the level of pain they would be in post-surgery and to shadow prescribe appropriately to ensure their suffering was eased. This was a huge help when it came to communicating with a patient. The other thing I learnt, particularly relevant in the elderly, was that if you had given them sufficient pain relief

© Bart's and The London School of Medicine & Dentistry 2016

post-operatively, then they were not always as easy to communicate with, often they would be dazed and foggy. This was an important point to consider. In terms of dealing with unwell patients, many of the patients I saw were well, just in need of surgery, but a few had chronic peri-prosthetic infections that were making them feel unwell and a number had sarcomas. The communication needs of these two groups was very different. Those with infections were keen to have the operation and recover, but seemed to have a greater sense of distrust in the medical profession and surgeons in general, while those with sarcoma believed in their surgeons and were keen to have the operations on the whole, while at the same time being understandably scared of their future. This was difficult to balance without being falsely reassuring. Overall, the placement taught me a lot about orthopaedics and a range of musculoskeletal conditions, as well as how to effectively communicate with this cohort of patients.

© Bart's and The London School of Medicine & Dentistry 2016