

ELECTIVE (SSC5b) REPORT (1200 words)

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

I had the privilege of spending the duration of my elective with the Paediatric Orthopaedic team at The Royal London Hospital, Whitechapel; which I sought out due to my longstanding interest in foetal and developmental medicine combined with my more recently discovered enthusiasm for orthopaedic surgery. My placement involved observation and participation in theatre sessions as well as a variety of clinics each week, alongside a wonderful team of consultants, registrars, physiotherapists, nurses, radiologists and administrators.

During my time at The Royal London I met children with a wide variety of orthopaedic complaints ranging from fractures to congenital anomalies, and encountered much higher emphasis on the neuromuscular side of the specialty than I had previously seen in adult patients, along with assessment and management of associated complications. While I have not experienced paediatric orthopaedics in other countries first hand, I have learnt from patients and health care professionals about some of the differences. I was surprised to learn that the incidence of Cerebral Palsy is fairly similar worldwide, although the causes may differ. In countries such as the UK, higher survival rates of premature babies prevent the incidence of CP from declining, while in less developed countries post natal causes such as meningitis may be more common. Other differences in disease pattern relate to care accessibility in other countries, for example while the incidence of malformations such as Talipes equinovarus do not vary massively they may be observed in older children in developing countries due to neglect, while screening, early intervention and follow-up in the UK means that this is uncommon. From my previous orthopaedic experience in Essex I noted differences in disease pattern within the UK as well, such as a higher incidence of paediatric fractures from RTA in London. It is also worth noting that in general, congenital malformations are more common in areas where marrying cousins is the cultural norm, such as in large Pakistani communities of London and Birmingham.

My experience of paediatric orthopaedics has been limited in previous placements due to the specialised nature of care provision. Generally, knowledge and management of paediatric conditions outside of specialist centres such as The Royal London is rather limited. Many DGHs do not have a paediatric subspecialty at all while other larger hospitals, as I witnessed during my time at RLH, make many referrals and phone calls for advice from specialist centres. While this requires patients to travel and increases the demand on such centres, it aims to ensure a high standard of care as surgeons at smaller hospitals are unlikely to have the exposure and therefore the experience to provide high standards of specialised care. Also within the UK, I found that compared to my experiences in adult orthopaedics, children (especially those with neuromuscular conditions) require much more input from a multidisciplinary team such as collaboration with neurologists, GPs hospital and local physiotherapists, occupational therapists and orthotists, as well as input from schools regarding the identification and meeting of a child's needs in an educational environment. The National Health Service in the UK aims to ensure that all children receive the care they need regardless of financial status, preventing the neglect and delayed treatment that is seen in countries where families and or the hospitals themselves cannot afford to seek or provide appropriate and up to date treatments. However while financially beneficial to patients, management in the UK, particularly in terms of rehabilitation, is often suboptimal. I was surprised to learn that in Europe, children with Cerebral Palsy may be kept in hospital for several months post-operatively for physiotherapy training and

rehabilitation while here in the UK physiotherapy follow-up is usually limited to one session per week, with outcomes relying heavily on patients and parents to carry out exercises themselves at home.

During my clinic attendances I felt privileged to gain some insight into the challenges of daily life for children and families coping with disability. While limited physical abilities and peer differences can be understandably frustrating and upsetting for everyone involved I was inspired by the adaptive capabilities, courage and resilience of these young children and teenagers, and while I observed quite a lot of stress, anxiety and frustration during these consultations, I was warmed by the strength and love of parents, dedicated to ensuring minimal suffering and the best possible outcomes for their child. From the wonderful example set by those that I observed, I learnt that there are several ways in which clinicians can help to alleviate the psychosocial impact of paediatric disability through a holistic approach. Firstly by simply being attentive and approachable during consultations ensures that patients and their families feel well supported and cared for; which can be further promoted by having knowledge and experience to make the patient feel understood and less isolated. Equally important is ensuring that physical needs are met, by coordinating MDT services such as the provision of equipment necessary for optimal care such as tailored wheelchairs and hoists, familiarity with local schools and their facilities and providing treatments where appropriate, such as the use of Botox and muscle releases in spasticity. While surgeons can use treatments such as these to reduce suffering and make caring easier, it is important to identify outcome goals with families and ensure that the treatments are helping to achieve them, avoiding unnecessary procedures and further suffering.

I felt very fortunate to spend the duration of my elective among some very inspirational women and am very grateful for the time I have been able to spend with them. Previously my contact with women in the field of orthopaedics has been limited and I therefore hoped to use this opportunity to identify the difficulties that women face in a male-dominated profession and how to overcome them in order to help my professional development. I noted that I witnessed much less discrimination in the paediatric subspecialty than I had experienced previously, with expert knowledge being taken more seriously by male colleagues and no comments made about not being big or strong enough to pursue orthopaedics, though the generally smaller patients would have helped this. I still noted that in trauma meetings the opinions of female surgeons were often not listened to or taken as seriously, however this could in part be due to the females being less experienced than men who have been in the specialty for longer or also surgeons not being used to working with female colleagues due to their relatively small numbers. I hope that these will improve as the number of female surgeons continues to increase. From my observations of those around me I noted the importance of self-confidence, assertiveness and leadership, in not only communicating with professional colleagues but also ensuring the care and safety of patients. These are qualities which I currently lack however I believe that this will come with further experience and gaining confidence in my clinical capabilities.

Overall my time at The Royal London has further affirmed my wish to pursue orthopaedics, particularly paediatrics, and has provided me with great learning opportunities and experiences which will help to advance my personal and professional development.