ELECTIVE (SSC5b) REPORT (1200 words)

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

Paediatric care at Hull Royal Infirmary, part of Hull and East Yorkshire Hospitals NHS Trust, is provided as part of the Family and Women's Health Group. The paediatric unit consists of the Paediatric surgical ward; an entire floor dedicated to the Paediatric Assessment Unit, Paediatric medicine ward and Paediatric High Dependency Unit; the Neonatal Unit and Children's Outpatient clinics. During my 6 weeks elective placement at Hull Royal Infirmary my time was divided between Paediatric surgery, Paediatric medicine, and the Neonatal unit. This gave me the chance to experience some of range of services the hospital and Paediatrics as a speciality itself may offer.

Paediatric surgery was a whole new aspect of care that I had not experienced before. While attached to the surgical team I had the privilege of witnessing and being a part of the journey a patient and their family would take from coming into the hospital to prepare for surgery, to their recovery afterwards. My first surgical experience was a little baby boy, no more than 2 months old, who had come in due to worsening of the classically described "projectile vomiting". He had pyloric stenosis – a condition medical students are often quizzed on at medical school but while here I was told even the surgical trainees infrequently see.

On the morning of the surgery I joined the team in conducting the ward round – seeing the patient before surgery, to do a final check that the baby was still well enough to go to surgery and to update the family and reassure them and any concerns that they may have until we see the baby again in surgery later. Just before the surgery itself, I was in the anaesthetic room when the mother was wheeled in holding her baby in her arms. It struck me when she started crying, almost reluctant to part with her baby for him to go into surgery. This was the first time I had seen so much emotion so close right before a surgery, giving me a glimpse of what emotional strain the parents have to go through when their child is having surgery contrasting to me previous experiences of watching adults go in for surgery for an orthopaedic shoulder operation for example.

The theatre nurses were swift in comforting the mother with phrases said in warm tones such as "he's in good hands"; "we'll take good care of him now" and "Mummy, give him one last kiss before he goes in", making it easier for her to hand over the care of her baby. I could see the importance of showing compassion and empathy to the family of the babies – as this is so important if working in paediatrics to build rapport and trust that the family has in the doctors taking care of their children. I wondered if these skills came naturally or if it was with the years of experience that the doctors and nurses had and how comforting would I have been if I was on the spot in that situation.

While in a paediatric clinic I observed a challenging scenario where the consultant was trying to stress her concern to the grandmother a child of Eastern European background over the fact though she was five years old, her weight was that expected of less than a 3 year old and that this suggested an element of malnutrition. However the grandmother insisted that she was not concerned as the child's mother was also "little" and that they were giving the child nutritional drinks from their home country. This situation highlighted to me one of the challenges of working in paediatrics is the interaction with parents when the ideas and expectations of the parents do not correlate to that of the medical professional. This is especially true if working in a diverse population such as London where parents may be relatively overly worried or unconcerned in different situations based on their

backgrounds and experiences, therefore the communication skills of the doctor is vital in reassuring the parents or raising their attention to the gravity of the situation.

During my time on the elective, I also noticed some of the skills that needed to be developed to take a history and perform a clinical examination in paediatrics. Much less like adults, the practice of taking a history and examination does not always follow a routine structure in the sense that each time these had to be tailored to the age and maturity of the child. I watched as the doctors playfully tickled their tummies during examination to put the children as ease – ensuring their cooperativeness and relaxing their abdomens for examination. I listened as they changed their tone of voice and vocabulary between cooing to comfort babies; asking about favourite foods and making jokes with the young children; to a steady and reassuring voice when explaining medical conditions to the parents. These were the skills that I tried to emulate when I was seeing patients myself.

My experience when examining paediatric patients also varied. It could range from the finesse of fine touch when palpating the abdomen of a baby for a small "olive-shaped mass" or palpating the scrotum of a young child to check for the presence of a testis and locating the spermatic cord. The other end of the spectrum was when I struggled in attempting to perform an ENT examination on a young child where it could be compared to a wrestling match as the child would, understandably, be adverse having a probe inserted into their ear or a wooded tongue depressor inserted into their mouth. The doctor supervising taught me the tricks of performing the examination – recruiting a parent to hold the child in their laps, one hand across their arms and the other hold the child's head still.

Another example would be when I was performing a Newborn Infant Physical Exam on a baby that had been found to have dislocatable hips be a previous examination. Performing the Barlow and Ortolani manoeuvres involved manipulating the hips to see if I could dislocate and reduce the hips. I was apprehensive about this as I was unsure about how much pressure to apply as I didn't want to cause any pain to the baby. But I was reassured when the doctor explained that the manoeuvres themselves doesn't cause the baby to cry and though they may be uncomfortable, not painful. I was thrilled when for the first time I was able to successful feel the "click" on my fingers after performing a positive test.

Having spent these six week in paediatrics at Hull Royal Infirmary, these experiences have allowed me to improve my clinical and communication skills. It has taught me that tough I may see children at times as soft or fragile that need to be treated delicately, there are also times when a more assertive approach may be needed even when they are relatively uncomfortable for the child. Rather than to shy away for fear that the child may be in distress or temporarily losing rapport with the child, these are times when it is in the best interest of the child, such as when it is important to rule out an ear infection or throat infection as the cause of the raised temperature, or to not miss an abnormal hip in a newborn that could be easily treated. I also recognise the importance of involving both the patient and their family during each stage of care. It is important to address concerns and reassure family members that our aim is to make their child better.