Ethicon Foundation Travelling Fellowship Report

Vancouver General Hospital and University of British Columbia. Adult Lower Limb Reconstruction.

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I undertook a twelve-month fellowship in lower limb adult reconstruction at the internationally renowned University of British Columbia Orthopaedic unit. The experience included every aspect of elective adult hip and knee reconstruction in a busy tertiary care centre which sees a large volume of complex problems, especially failed joint replacement with severe bone loss. I was working under the tutelage of professors Duncan, Masri, Garbuz and Greidanus. Each of the staff surgeons in the unit are experts in their field and far reaching reputations. It’s not an exaggeration to call Dr Duncan one the most experienced hip surgeons in the world.

The fellowship exposed me to a wide range of both elective knee and hip pathology. I was involved in outpatient clinics, operating lists and regular educational meetings. There was a strong emphasis on research, and publication and presentation was mandatory. My paper entitled ‘Revision for Trunnion Corrosion after Metal-On-Polyethylene total Hip Replacements’ is currently awaiting publication in the Bone and Joint Journal and my work on the same subject was presented at The Hip Society in October of this year.

The North American’s have a strong work ethic that was reflected in my clinical logbook from the 12 months. The patient was often in the operating room before 07.30am. I performed over 500 procedures, including 203 uncemented hip replacements and 58 revision hip replacements. I also performed 173 total knee replacements and 34 revision knee replacements. The appeal of uncemented hips is very seductive in terms of operating room efficiency, but it would be difficult to justify in the NHS on the grounds of cost and National Joint Registry data. Outpatient clinics were also a time efficient affair. The staff surgeon, with my help, would routinely see in excess of 40 new patients in an all day clinic. Lunch was a luxury seldom afforded.

There was a strong emphasis on decreasing the length of inpatient stay following surgery. The majority of patients were discharge on postoperative day one. All of the total knee replacement patients received an adductor canal block immediately after their surgery and anecdotally this appeared to have a very positive effect on their postoperative pain management, facilitating earlier discharge. This is certainly a technique I will try to use in future practice.

Summary

I do now feel comfortable to start work as consultant in the NHS with a specialist interest in lower limb hip and knee arthroplasty surgery. I believe the fellowship has been excellent preparation for this. It gave me the opportunity to be trained by world experts, learn new techniques and be exposed to challenging cases. Although work
was extremely busy I did still find time for the occasional trip out of town to see the hills (Fig. 1).

The Ethicon Foundation fund was certainly of great financial assistance towards the costs of my fellowship. Vancouver is a very expensive city to live in, but the whole experience has been immensely productive and enjoyable.

Fig. 1
Ethicon Travelling fellowship

Current post – Aesthetic Fellow – The London Clinic.


This report describes my fellowship year at the Fiona Stanley Hospital, in Perth, Western Australia, the travel to which was made possible by the Ethicon Foundation.

Firstly, some description about Western Australia (WA). As a single state of Australia it is estimated to cover a surface area of 2.5 million square kilometres, which is approximately a quarter of the size of Europe. The population is around 2 million (roughly equivalent to Manchester), 70% of whom live in the Perth metropolitan area. Consequently, country areas are sparsely populated, having on average only one person per five square kilometres. Patients often travel huge distances to attend for healthcare, driving over 10 hours for a clinic appointment in some cases. This is alien to a doctor who has only ever worked in the NHS. Western Australians enjoy some of the highest standards of health in the world, partly due to the temperate climate, which allows the famed outdoor lifestyle. However, the downside is a high prevalence of skin cancer. Naïvely perhaps, I had thought that this would be confined to the older generations, who did not have the benefit of sun protection initiatives in their youth. Evidently the message is not fully absorbed by the younger generations. Another huge burden on the healthcare system in WA is the use of methamphetamine, with the highest use in Australia per capita.1 Many of the patients treated for traumatic injuries were ‘meth’ users.

Professor Fiona Stanley is an Australian epidemiologist, known for her public health work and research into child and maternal health, and a former Australian of the year. The hospital, which bears her name, is the largest building project ever undertaken by the government of Western Australia. At an estimated cost of $2 billion, it was completed in December 2013, with the hospital opening its doors in October 2014. Given such investment there will always be supporters and critics of such a project; my first impressions of the hospital were mixed. There were the YouTube videos showing a pristine hospital, seemingly straight from the architect’s drawings, with every conceivable technology and resource that a modern hospital requires. However there were also the negative press releases online describing the hospital as dysfunctional and a crisis ‘waiting to happen’.2 As one of the first fellows to join the department of Plastic Surgery, it was always going to be difficult to gain a true idea of what the job would entail. I took advice from my consultant mentors in the UK, some of whom thought it was safer to undertake a more established fellowship, whereas one colleague in particular told me not to consider it as a gamble, but an opportunity, which I could shape myself. Clearly I took the advice of the latter.

The plastic surgery department is led by Professor Colin Song, who had previously been head of department in hospitals in both Singapore and South Africa. 7 other consultants, some of whom are part time make up the remainder of the senior tier. During my time in the department I was one of two fellows. We were responsible for the daily running of the department and supervision of the 4 service registrars and two interns. Commitments to fulfil on a daily basis were the ward round, the trauma clinic, the elective and emergency operating lists. There were twice weekly outpatient clinics, local anaesthetic lists and weekly MDT meetings covering head and neck cancer and skin cancer. In addition we had additional operating lists at another hospital in Fremantle, a bustling port city outside Perth. The result of all of these commitments was that we were always busy. Due to the nature of plastic surgery being collaborative with so many specialties, I frequently found myself being pulled in multiple directions. A memorable day was when we had two free flaps on table, a full
trauma clinic, a local anaesthetic list and a trauma list – with the bare minimum of staff. Being able to balance all of these demands effectively on regular occasions was initially very challenging, but certainly taught me valuable skills in delegating and stratifying tasks based on clinical importance.

I went in to the fellowship, having recently passed the FRCSed (Plast). I felt my knowledge was up to scratch, but experience was admittedly lacking in certain areas. One of the best opportunities for learning was in the head and neck reconstruction cases. Often done as joint cases with the ENT team, we were reconstructing large facial and aerodigestive tract defects, with a variety of free tissue transfers. On average we were undertaking 1-2 free flaps per week. This gave me good exposure to microsurgery – the consultants with whom I worked were very encouraging in letting me raise the flap and do the micro-anastomoses. By the end of the fellowship, I felt comfortable raising free fibula flaps, with an associated skin paddle based on perforators, preparing the recipient vessels (often the internal jugular vein and branch of the external carotid artery), and undertaking the anastomoses. I learnt how difficult the osteotomies in these types of cases can be, and the benefit of using 3D modelled cutting guides. The head and neck pathologies, especially in some of the patients from remote country communities, who had clearly neglected themselves for too long, were much more advanced than those I had experienced in the UK. Reconstructing the often large defect was immensely satisfying. The fact that we were, on occasion, stretched in terms of manpower, meant I found myself doing significant parts of these operations without a scrubbed supervisor – this was a great learning experience, as it encouraged independent decision making, and the realisation that I could do the constituent parts of the operations myself.

The breast reconstruction service in the department is also busy, with DIEP flaps being undertaken almost every week. Due to the frequency of the cases and the close knit team, it has become a well oiled machine. What impressed me was the culture for learning from anything different that happened in each case. An example was a patient who developed bilateral common peroneal nerve palsies after surgery. The cause was investigated and then special efforts were made to prevent something similar happening in future cases by a focus on safe positioning in each subsequent case.

There was also a busy emergency workload. It sometimes felt like there were a disproportionate amount of dogbites, nailbed injuries and IVDU abscesses (which were normally attributed to “spider bites”), however despite the routine cases there were also some very interesting and unusual cases. Examples included subtotal amputations of the forearm, high upper limb nerve injuries requiring distal nerve transfers, calcaneal loss following a firearm accident and various cases of necrotising fascitis. In addition there was also the opportunity to join some of the consultants in the private sector to gain experience in cosmetic surgery, which was very useful.

My reflections on the fellowship are that it was a genuinely positive, life changing, experience both professionally and personally. There were times during the visa application process that I nearly decided not to go, because the paperwork hurdles seemed never-ending. There were times when we were finishing a free flap at 4am that I was deliriously reconsidering my career choices. However there were also the times that I was ‘commuting’ in to work on my bike along the Swan river with my boss, with a fantastically varied, challenging and interesting operating list coming up that day. Not to mention the times that I enjoyed the outdoor lifestyle with my family, friends and colleagues – such as the stereotypical X-mas on the beach (with factor 50 sun screen on of course...). I was lucky to have had the support of my wife during the fellowship, who looked after our young son throughout the year. The willingness to uproot her family and try to fit in to different groups and cultures was essential for us to have a successful year. Some people say you regret the things you don’t do – based on what I learnt, the genuine people I met, who I now consider as friends, and the perspective it has given me on what life is like in a system outside the NHS, I couldn’t agree more.
My advice to other trainees considering a fellowship abroad, would be that provided the clinical role will give the required experience, the hard work in getting there is worth it. Now we have lived abroad as a family for a year, the prospect of going abroad again feels that much easier, which in turn widens the net for potential jobs in the future.

Ethicon Travel Grant Award

Louisa Ferguson FRCS ORL-HNS
Royal Children’s Hospital Melbourne

Current Training Interface Fellowship in Cleft Lip and Palate Surgery,
Evelina London Children’s Hospital

I undertook a 10 month fellowship in Paediatric Otolaryngology at the Royal Children’s Hospital in Melbourne. I was grateful to receive support from Ethicon, through the Royal College of Surgeons of Edinburgh, to contribute to this fantastic opportunity.

As my ENT training in the West of Scotland was drawing to a close, I knew I wanted to sub-specialize in paediatric otolaryngology, preferably with an interest in paediatric airway and cleft lip and palate. As this combination of specialty interest was yet to be established in the UK, as it is in other parts of the world, then I knew this would be a challenge. I decided to seek out the best paediatric ENT fellowship and combine that with a cleft lip and palate fellowship, to hopefully achieve my dream. In the Royal Children’s Hospital (RCH) I most certainly found that!

The RCH is the major paediatric hospital in Victoria, which services a population of around 6 million. It is a tertiary referral service for all the major sub specialities, including respiratory, ENT, cardiac, trauma and neurosurgery. My interest in complex paediatric airway was certainly satisfied. Under the mentorship and guidance of Professor Berkowitz and Dr Elizabeth Rose, the two senior airway surgeons, I was able to develop my surgical skills in airway management and reconstruction. As the fellow I had the chance to attend all
the airway clinics and theatre lists. There was a huge volume of work, and I performed over 100 airway surgeries as either first operating surgeon or first assistant. The chance to run my own lists, whilst being supported by a Consultant who was running a parallel list was invaluable experience. There was also lots of opportunity to deal with emergency paediatric ENT work. I felt this in particular has stood me in good stead as I transition to Consultant level. There were weekly tracheostomy meetings which were attended by ENT, respiratory and paediatrics. There were also monthly ‘complex airway’ meetings, which as the fellow you were expected to bring and present cases. All of these learning opportunities not only gave me fantastic clinical experience, but also ideas on how departments can set up their MDT’s in different ways. Given my interest in cleft lip and palate, I offered to help out at the cleft clinic in an ENT capacity. As cleft clinics are set up across the world slightly differently, the cleft clinic in Melbourne did not have a routine ENT presence. This allowed me not only to become involved in a sub-speciality area in which I had an interest, but also to help establish a process for which hearing can be managed in children with cleft lip and palate. One of the real benefits of this fellowship is that the RCH has so many sub-speciality areas, it allows flexibility to see and become involved in any areas of particular interest. Sleep medicine, cochlear implants and thoracic surgery are all onsite and would be of interest to anyone training in paediatric ENT.

One of the aspects of the RCH which I found very helpful was the way the clinical office space was laid out. A large open plan area held desks for the junior doctors and admin support staff for each team, with the consultant offices around the edges. Departments that often worked together were
located in close proximity, such that the ENT desks were next to respiratory and plastics, with whom we had overlap of various clinics and MDT’s. This allowed you to easily get to know both the medical and support staff for these specialities, which made dealing with joint and complex cases so much easier. There was also a common lunch space on this level, which gave you a chance to sit down with colleagues every now and then. Again, this just improved communication and camaraderie between the staff, a priority which often seems to be forgotten in the NHS.

As the fellow at the RCH, you are the senior trainee, with 2 registrars and 1 resident also in the team. You are encouraged to support the juniors in both ward and emergency referrals and it was a great opportunity to work with the Australian trainees and gain insight into their training. The fellowship was clinically very busy, with doing a 1:3 on call and independent lists, however there was a real camaraderie within the hospital and after a few months I felt like I knew just about everybody! It also helps that the facilities are great, with free tea, coffee and biscuits (and vegemite for those brave enough), and a lovely balcony in the clinical area where you could sit and have your lunch. At Christmas the CEO and senior management handed out lunch to all the staff in the gardens of the hospital. Christmas music was played and some people even wore Christmas jumpers, despite the 35-degree heat! The RCH certainly knew how to motivate their staff, and I felt that in turn that really showed through the fantastic care the patients received.

Melbourne as a city hardly needs any introduction. It is a fantastic cosmopolitan city, with lots to do whatever your interests are! I was lucky that my husband was able to join me on my fellowship. We took the opportunity to
explore Victoria on bike, which with the beautiful weather and abundant coffee shops was a joy! We also had the chance to attend many sporting events including the Australian Open Tennis final, the Melbourne Cup and the Boxing Day test cricket match between Australia and Pakistan.

The aim of my fellowship was to obtain a solid grounding in paediatric airway management along with paediatric ENT emergency management, in order to allow me to obtain a Consultant position in a tertiary referral paediatric ENT unit. This fellowship certainly met this objective. From both a professional and personal level this fellowship ticked all the boxes. Not only did I leave feeling confident to start the next phase of my career, but also that I had made mentors and friends for life.