I chose to conduct my elective placement at two different hosts countries as they both offer me a different view on cardiothoracic services in Asian health settings. The initial 3 weeks of my elective placement was spent at Narayana Institute of Cardiac Sciences in the booming city of Bangalore in South India. It was in late March when I started my placement and I was greeted by a lot of sunshine and most definitely, the vibrant Indian cuisines. I stayed in one of the hotel accommodations that cropped up in recent years due to the growing demand from patients and their family travelling from afar to visit the hospital. The centre prides in being one of the biggest cardiac centres in the region and they periodically receive trainees from abroad. During my time there, I was working with another elective student from Chicago Medical School and a surgical fellow from Japan subspecialising in adult cardiac surgery. My immediate supervisor, Dr Riyan Shetty was no stranger to the UK. He worked at Great Ormond Street Hospital in the past as an ECMO fellow and we got on really quickly from exchanging experiences living in London. On a busy day, nearly 40 cardiac surgeries were performed at the centre. The centre has a lot of experience with off-pump coronary bypass procedures and indeed, I saw my very first off-pump procedure there. I also scrubbed in for my first cardiac surgery in India, helping as the first assist in a chest closure. During my time when I was not in theatres, I was joining rounds in the intensive treatment unit and assisting procedures by the bedside.

After I have completed my placement in India, I made my way further east to Malaysia. I organised another 3-week placement at Serdang Hospital near the capital of the country. It is the national referral centre for cardiothoracic surgery as well as a teaching hospital for University Putra Malaysia. I was privileged to be supervised directly by Dato’ Dr Hamzah, the national lead for cardiothoracic surgery in Malaysia. He has been heavily involved in setting up the new run-through programme for cardiothoracic training in Malaysia, a result of the bilateral relationship between Minister of Health Malaysia and The Royal College of Surgeons of Edinburgh. I spoke to several trainees under the programme and they felt they have benefited from the structured surgical curriculum laid out by the joint committee. Aside from that, I realised that I lacked exposure to thoracic and aortic procedures and I made an effort to scrub in for those procedures when I had the opportunity. I was able to further hone my surgical skills from closing most of the patients on the elective list, built on my experience gained in India. I also went in to observe an emergency repair of an aortic dissection on a weekend which was worthwhile. Lastly, I am really thankful to be a recipient of the Royal College of Surgeons of Edinburgh and The Binks Trust Students Elective Travel Award which has supported my learning experience in Asia.
During my 8 week elective I spent 4 weeks, from June 2nd to June 30th, at Bwindi Community Hospital (BCH), a southwest Ugandan hospital. This rural hospital, named for the Bwindi Impenetrable Forest National Park adjacent to it, was founded in 2003 by an American Physician and Missionary, Dr. Scott Kellerman, in response to the plight of the displaced and disenfranchised Bwindi Forest indigents, the ethnic Batwa, who were cleared from the forest to protect its better-known inhabitants, the Mountain Gorilla. Seeing that the once hunter-gatherer Batwa were now bereft of their means of subsistence – that is, access to the forest – and additionally without means to finance their growing need for healthcare (due, among other things, to increasing malnutrition, alcoholism and sexual exploitation), Dr. Kellerman aimed to channel some of the park’s immense Gorilla tourism revenue into funding their medical needs. Now, however, thanks to International Aid and other formidable charitable funding streams, along with providing totally free healthcare to the 800 or so local Batwa the hospital also provides massively subsidized healthcare to the thousands of members of its innovative health insurance scheme.

While at the 120 bed BCH I shadowed pediatricians, general surgeons, obstetricians and general medical officers. A typical day would begin at 8am with a simple Church of Uganda service, followed by hospital announcements and, usually, a staff meeting where audit reports were presented. After this, around 10am, each clinician would post to their respective wards and begin their rounds. Lunch would be from 1pm to 2pm and, after this, clinicians would attend to their wards' new admissions - patients channeled in from the hospital’s Outpatient and A&E departments. Under the supervision of each of these clinicians, I led Outpatient consultations, clerked and reviewed medical admissions, assisted on surgical procedures and was tutored on microbiological methods – I’m delighted to now truthfully say I know what “Thick” and “Thin” films actually are!

Though ostensibly the hospital resembled modern, “western” hospitals – with operating theatres, specialist wards, a PICU, and microbiology labs – the nature of the medical cases was still distinctly “Ugandan”. Malaria, TB and HIV hovered at the top of every list of differentials. Nearly every pediatric admission had an extent of malnutrition. Women gave birth without NOS or analgesia, led with midwifery encouragement that was more “stick” than “carrot”. General Medical Officers – the Ugandan equivalent of the UK’s SHOs – were required to fulfill General Surgeon duties – that is, perform C-sections, hernia repairs and amputations. Due to the scarcity and expense of Doctors, the
main prescribers and diagnosticians in the hospital were Nurses and Clinical Officers – a role that the UK’s Physician’s Assistant will now begin to replicate.

What the hospital lacked in terms of resources or equipment couldn’t be – due to the inaccessibility of its location (12 hours by car over woeful “roads” to the capital, Kampala) – assuaged by nearby, better-equipped referral hospitals. I remember distinctly a young boy losing his leg in an RTA because the aseptic standards of the operating weren’t sufficient for orthopedic surgery. In another case, a very young mother with terminal heart failure – due to a mitral valve defect that could have been easily remedied several years earlier, if the procedure were offered - would imminently leave her 2 children orphaned.

BCH is radical and pioneering in some of the services it does offer however. The financial model of the hospital is such that it loses money – thanks to the aforementioned health insurance scheme that subsidizes 90% of each patient’s medical costs – for every consultation, investigation, course of treatment or medical admission. The hospital’s emphasis, therefore, must be on disease prevention, and this is where BCH’s Community Outreach programs function. For instance, to address malnutrition, nurses motorbike out into remote corners of the countryside with knapsacks of vegetables and seeds to host cooking classes and inform villagers on the methods and merits of planting for a vitamin-rich diet. To quell growing HIV exposure rates, surgical teams establish daylong pop-up clinics offering free “Safe Male Circumcision” with sexual health education tagged on. To curb growing poverty rates, precipitated by the cultural norm for having upwards of 8 children (some women will even declare they want 12 children!), free Family Planning – offering free condoms and the full complement of female contraceptives – are hosted, both within the hospital as well as its purlieus. A maternity hostel will house expecting mothers indefinitely if they face domestic abuse at home, and they’ll also provide a platform and counseling for improving the situation of these mothers. Recovering alcoholics are even temporarily given a goat and chickens to care for, to give them structure and purpose throughout their recovery.

In short, then, though beset with distinctly “Ugandan” challenges, BCH has all the trappings of a progressive and forward-thinking health service, and it is thanks to your immensely kind support that I was able to gain an experiential understanding of the obstacles and innovations of this hospital while building my versatility as a clinician. Many many thanks indeed to you!
After an incredible elective, I find myself reflecting on one month as a surgical sub-intern at the Children’s Hospital of New York (CHONY, fondly) a branch of the prestigious Columbia University Medical Centre, during May 2018.

As an aspiring surgeon since early in my medical school career, I could hardly believe that I was about to begin life as a surgical sub-intern in US. I had a number of aims, particularly to see novel technology and advances within the field of paediatric surgery. With this in mind, on May 1st at 6am I changed into my scrubs and white coat and joined rounds led by Dr Steven Stylianos, Surgeon-in-Chief. At this point I knew I had arrived in a centre involved in treating the most rare pathologies in the most unwell children. The first patient was diagnosed with biliary atresia and had undergone a Kasai procedure. Another patient had CLOVES syndrome, a rare genetic syndrome. An acronym, CLOVES is an association of congenital lipomatous overgrowth (CLO), vascular malformation (V), epidermal nevi (E) and spinal deformities (S). In caring for these patients I came to appreciate the huge psychological impact of hospitalisation on young children, and now empathise with the difficulty that children have with maintaining trust in the context of paediatric doctor-patient relationships.

In my time at Columbia I met children and babies with Klippel-Trenaunay Syndrome, VACTERL association, congenital lung emphysema, giant omphalocele, trachea-oesophageal fistula and oesophageal atresia, and duodenal atresia (accompanied by the well-known radiological sign!). However, I also enjoyed seeing how they dealt with more common conditions. I assisted on numerous hernia repairs and “appendectomies”, and learnt new surgical skills. I practiced the sub-cuticular knotless method of closing skin, and observed scar-less “all-in-one appendectomies” where the appendix is removed using one laparoscopic port with a camera and an instrument. The surgeons push boundaries, particularly with regard to minimally invasive techniques. During my last week I observed a thoracoscopic trachea-oesophageal fistula and oesophageal atresia repair on a premature baby at day 3 of life. I was inspired by the surgeons’ skill and the intricacy of the operation, and even more so by the teamwork between the surgeons and the anaesthesiologists to allow for the neonate’s chest to be insufflated whilst maintaining ventilation. Throughout my time in the Operating Room, I observed multi-disciplinary teamwork at its finest.

Overall, it was a privilege to undertake my elective at CHONY and I can only thank those in the Royal College of Surgeons of Edinburgh and the Binks Trust for their support in allowing me this wonderful opportunity to better myself personally and professionally. I developed a sound knowledge of paediatric surgical science and congenital malformations and acquired invaluable surgical skills, essential for success as an aspiring surgical trainee. Columbia Medical are true in their slogan- “Amazing things are happening here.” I am inspired and excited to commence life as an FY1 on the path to a career in surgery.
Padhar Hospital, Madhya Pradesh, India
James Russell

Padhar hospital is a small hospital run by the evangelical Lutheran church, located in a rural part of Madhya Pradesh in India. The generous funds from the Royal College of Surgeons of Edinburgh enabled me to complete an eight-week placement at this hospital, during which I participated in a range of clinical activities such as ward rounds, outpatient clinics and theatre lists.

The surgical team I was attached to was made up of six surgeons, all from different specialties. I therefore got the chance to see a range of surgical specialties such as general surgery, urology, plastics, ENT and orthopaedics. However, I took a particular interest in the maxillofacial surgery as there were many cases of complex oral cancers. Oral cancer is the most common cancer amongst in India due to the widespread practice of betel nut chewing. Patients develop aggressive cancers of the tongue and buccal mucosa at a young age, and will often present late in the course of their disease. These cases were usually complex and were challenging to deal with given the lack of resources. The small size of the hospital meant that I could also easily follow cases through other specialties such as medicine, oncology, radiology and pathology in order to understand the ways in which multidisciplinary treatment operated.

I also participated in several non-clinical activities related to surgery. For example, I gave a presentation to all the medical staff on the diagnosis and management of buccal mucosa cancer at a CME session. I also participated in a clinical audit on drug chart documentation. During my elective, I took a particular interest in the influence of cost on healthcare delivery. I spoke extensively with staff about ways in which the hospital and its partners in Europe helped those who were unable to pay for treatment. Toward the end of the placement there was a cleft lip and palate camp, which was a project organised by a group of surgeons from Hamburg where they would volunteer to complete around 50 operations and cover all the costs of treatment.
Padhar hospital is a very close community and often I was invited to participate in celebrations and excursions with the staff. This region of Madhya Pradesh has many small tribal communities, who often have poor access to healthcare and health education. In addition to my clinical activities, I also took part in two community projects: a newborn malnutrition screening project and an alcohol detoxification camp. These were very enlightening experiences that helped me to understand some of the cultural issues surrounding healthcare delivery in India. During my time at Padhar Hospital, I developed a better understanding for the importance of community in maintaining resilience when dealing with the complex medical needs of a community in a poorly resourced and sometimes isolated centre. I believe that this experience has had a profound effect on my own attitudes toward being a medic and the role of healthcare within a society.
Royal College of Surgeons of Edinburgh Elective Report

Name: Jamie Mawhinney

Position: Medical Student, starting FY1 at Guy’s and St Thomas’ NHS Foundation Trust in August 2018

Grants awarded: Bursary for Affiliate Undergraduate Elective Africa 2018 and The Royal College of Surgeons of Edinburgh & The Binks Trust Students Elective Travel Awards

My elective period was between 08/04/2018 and 03/06/2018. During this period, I attended two elective placements with two host institutions:

- 08/04/18- 06/05/18; Jigme Dorji Wangchuck National Referral Hospital, Thimphu, Bhutan
- 07/05/18-03/06/18; Beit CURE Hospital, Lusaka, Zambia

My group of five outside the Khesar Gyalpo University of Medical Sciences of Bhutan (me, far right)

For both of these placements I was attached to surgery, my main educational objective being to develop my own surgical skills in two countries with different healthcare needs. I am very grateful to the Royal College of Surgeons of Edinburgh and The Binks Trust for supporting my elective.

For the first four weeks of elective I was attached to general surgery in Bhutan alongside a group of four other students working in different departments. I was resident in the capital of Thimphu and working at the largest hospital and tertiary referral centre in the country, the Jigme Dorji Wangchuck National Referral Hospital.

My responsibilities included the daily resident and attending ward rounds, assisting in clinics and theatre, and performing minor procedures. I had the opportunity to practice my own surgical skills in minor as well as major operations, including sebaceous cyst removal and ingrown toenail avulsion. I also gave some teaching myself to students at the school of traditional medicine on the subject of anatomy.

Similar to the UK, all healthcare in Bhutan is free at the point of use. However, many conditions presented at a much later stage than you would expect in the UK due to a less well developed primary healthcare system and poorer infrastructure connecting small rural communities. Also like the UK, Bhutan is a constitutional
monarchy with the king as head of state, and the hospital I was placed at was named after the third king. During our stay in Bhutan, we were very fortunate in meeting Queen Jetsun Pema at an anniversary of the hospital.

Learning about the Ponsetti method of casting for club foot (from left: Mwamba Mulenga, me, Giorgi Lastroni)

Following my elective placement in Bhutan, I travelled to Lusaka for a four-week placement in paediatric orthopaedic, ENT and reconstructive surgery at a small mission hospital. The hospital had an international feel and was run by an American mission organisation with an Italian medical director. The majority of the hospitals work was made up of orthopaedic cases, and therefore this was also where I spent most of my time. The hospital saw a very wide range of pathology although a significant proportion of cases were due to club foot. All healthcare for children was provided free of charge, although the hospital does perform a small amount of private adult surgery in order to support its other activities.

In my time off from the hospital, I was able to explore around the local country, including trips to Victoria Falls on the border with Zimbabwe and to the Lower Zambezi river in the east.
In summary, I had a fantastic time on my elective and this has made a profound impact on my life and my approach to my future career. I would once again like to thoroughly thank the Royal College of Surgeons of Edinburgh and The Binks Trust for their support of this elective.

The orthopaedic team at Beit CURE Hospital of Zambia (from left: Giorgio Lastroni, Malcolm Swann, me, Mwamba)
Elective Bursary Report
Prachi Mann

Dates of placement: 07/05/2018 to 1/06/2018
Current clinical post: Foundation Year 1 trainee
Hospital visited: St. Vincent’s Hospital, Sydney
Award: £250

Awarding body: The Royal College of Surgeons of Edinburgh Bursary

Located on the East coast of Australia, Sydney is the most populous city in Australia with around 5 million inhabitants. I spent my 4 week elective with the cardiothoracic department at St Vincent’s Hospital, Sydney (SVH). SVH is a large tertiary referral and major teaching hospital situated close to Sydney’s central business district. SVH serves an extremely diverse patient population, covering patients from the nearby red-light district at Kings Cross to patients with rare and complex conditions referred from distant hospitals.

Days would ordinarily consist of 7am ward rounds, followed by time spent in pre-admission clinic (PAC) clerking patients, doing ward jobs or observing procedures in theatre. I was fortunate to witness a range of procedures, including Bentall’s procedure, insertion of left ventricular assist devices and minimally invasive mitral valve surgery. It was especially exciting to observe a pulmonary endarterectomy operation for a patient with chronic thromboembolic pulmonary hypertension (CTEPH). Here, a technique called deep hypothermic circulatory arrest was used, which involves induction of severe hypothermia (≤ 20° C) during complete arrest of circulation in order to create a bloodless surgical field and confer cerebral protection.

However, one day in particular stands out. I was surprised to be woken by the buzzing from my phone in the early hours of a pleasant morning in the Australian winter. ‘Hello, this is the transplant co-ordinator at St. Vincent’s Hospital’ the voice on the phone said as I answered it in a slightly dazed state. Two hours after that phone call, I found myself at SVH with the organ retrieval team, preparing to visit a hospital nearby to procure a donor heart for transplantation. I was awestruck by this perfectly optimised process, all conducted to precision by the transplant co-ordinator. We started by checking the specialist equipment to be taken with us, contained primarily in a small suitcase and 3 large blue Esky coolers. After making the 40 minute car journey to the hospital where the donor had died, the retrieval process then began. Watching the surgeons operate, I was able to appreciate the complexities and nuances involved in such a crucial procedure. After the heart was procured, there was a palpable sense of urgency in the atmosphere. We drove back to SVH with a police escort, where the donor heart was transplanted into the recipient. Watching this whole process I felt
an immense sense of privilege. Thinking back to the first human heart transplant performed by Christiaan Barnard in 1967, I realised the personal sacrifice and determination of surgeons, patient and researchers throughout the years which had allowed that patient to receive a transplant.

From my elective, I concluded that the world of cardiothoracic surgery is undoubtedly full of intellectual, ethical, physical and emotional challenges. It is about the battle against disease and the incredible courage of patients and surgeons to gain a deeper understanding of cardiovascular pathology and find novel treatment strategies. SVH truly embodies this spirit and it has been awe---inspiring to observe surgeons work at the frontiers of modern medicine to achieve this and positively impact patient lives.
I was extremely fortunate to be able to spend my elective placement in the Surgical Neurology Branch of the National Institute of Neurological Disorders and Stroke (NINDS) at the NIH Clinical Center in Bethesda, USA and the Department of Neurosurgery at the University Teaching Hospital in Lusaka, Zambia. Both placements offered an eye opener into neurosurgical practice across the globe; serving vastly different populations with significantly differing access to resources.

I spent the first four weeks of my elective with Dr John Heiss and his team at the NIH clinical Center. During my time I was welcomed into the team and encouraged to play a role in the clinical care of patients and I quickly established a routine for my day which would start early in the morning where I would pre-round on the patients and see how they had been doing over the previous day. Later I would join the resident and the clinical nurse specialist for the morning resident round. After which we would go to theatres for the day’s cases. I was grateful for the opportunity to scrub into and assist with nearly all the cases that took place during my rotation. Being able to be so closely involved in the care of the patients I was able to see first hand the dedication and diligence of every member of the team in looking after the patient. More so I was also able to appreciate first hand the impact that the neurological conditions had not
only on the patients lives, but also their families. What was unique to this hospital and department was that all patients who were admitted to the hospital were done so under research protocols. Many of these protocols in neurosurgery looked to study the natural history and pathology of the conditions. So, while the patients were under research protocols the standard of care received was identical to any other hospital in the USA, albeit with closer monitoring than normal during their stay. The ability to select patients from across the globe, meant that I was able to see the management of rarer neurosurgical conditions daily. I observed the care of patients with Von Hippel Lindau, Neurofibromatosis type 2, Cushing’s disease and refractory epilepsy. I was also able to attend weekly departmental meetings and given the opportunity to present interesting cases that I had seen. Seeing patients in clinic allowed me to see the sometimes life changing impacts that the neurosurgical treatments could have on patients’ lives. Especially in the case of patients with refractory epilepsy. Where patients who had suffered from seizures their whole life, now living seizure free and able to get on with their lives. I was also able to see how the surgeons were able to balance their clinical responsibilities with their academic pursuits. The design of the NIH allowed for their research labs to be near both the operating theatres, clinics and wards. Allowing the surgeons to seamlessly move between their academical and clinical roles. This fostered the smooth transition of research from bench to bedside. Another notable difference of the NIH Clinical Center, particularly for those in the USA, was that patients did not have to pay for their treatments and all associated costs including transport and accommodation for patient, some flying in from as far as places like Israel, was covered by the federal government.

Having spent time at an institution that was performing complex neurosurgical procedures and with access to the latest and most advanced equipment, my time at the University Teaching Hospital (UTH) in Lusaka was an eye opener to struggles that many neurosurgical units in low and middle-income countries face. It was also inspiring to see the versatility and ingenuity of the surgeons in overcoming many of the resource limitations they faced. Zambia, a country of over sixteen and a half million people are served by only three fully trained and practicing neurosurgeons, and only two of whom work in the public sector. Compared to Europe where there is around 1 neurosurgeon per 100,000 of the population, Zambia has 1 per over 5 million of the population. Significantly, all three are based in the capital. As a result, patients travel across the country to access neurosurgical care at the UTH.

I was fortunate to join Dr Sichizya and his team at UTH for three weeks. During this time, I joined the team on ward rounds and was lucky to spend time in theatres scrubbing in on cases. I assisted with paediatric VPE shunt insertions in children suffering from hydrocephalus, craniotomies for subdural haemorrhages and tumour resections. It was amazing to see how the surgeons were able to adapt and make do without equipment often take for granted in high income countries. Drilling burr holes using a hand-held DIY drill with a sterilised drill tip, locating drilling sites solely based on surface anatomy. Likewise, access to imaging was often
limited and subject to delays. This was in stark contrast to my experiences in the US and the UK, where one would have access to high speed drills and stealth navigation. Despite the lack of equipment, the surgeons were able to undertake a range of procedures with good outcomes. Attending clinics highlighted the scale of the need for neurosurgical care, with doctors expected to see nearly a hundred patients in a morning. Putting into context what is considered a busy clinic in the UK!

My elective has been one of the most exciting, interesting and perhaps most rewarding part of my medical education so far. Spending time in a world renown academic centre has given me an invaluable insight into balancing research with clinical responsibilities and an appreciation of the challenges and rewards of such a career. My time in Lusaka has also brought home the scale of the inequity in access to healthcare resources particularly in neurosurgical care, but it was heartening and reassuring to see how versatile and resourceful the surgeons were in managing under these circumstances.

I would like to thank Dr Heiss and Dr Sichizya for giving me the opportunity to spend time at their hospitals. I am also extremely grateful to the RCSEd and the Binks Trust for awarding me and undergraduate elective bursary; without whose support this elective would not have been possible.
Report for RCSEd Travel Bursary

Current Post:

Tom Handley, Academic Foundation Programme Year 1, Academic General Surgery NW London, Rotation: General Surgery, West Middlesex Hospital.

Placements:

- Cleveland Clinic (7/5/18 – 1/6/18): Advanced Laparoscopic and Minimally Invasive General Surgery.
- Mayo Clinic (4/6/18 – 29/6/18): Transplantation Surgery (Kidney + Pancreas, and Liver)

I visited the United States in the summer of 2018 to undertake two general surgery placements (acting internships and sub-specialty interests) as part of my elective programme at Imperial College London. The placements required me to have completed at least the first U.S. Medical Licensing Examination (USMLE Step 1) to be eligible to apply. I also needed to acquire a B1 Business/Travel Visa to visit and work at the Cleveland Clinic.

The application windows for each institution differed, as did the prices required by each to complete an elective programme. However, the living costs in each of the midwestern states (Ohio and Minnesota) were reasonable.

At the Cleveland Clinic, I worked largely within the General Surgery team, and rotated with each of the sub-specialities there. This included time with paediatric surgeons, colorectal, endocrine, intestinal transplant and emergency/on-call teams, in addition to working with the minimally invasive group.

I was treated as a first-year graduate, and allocated patients to follow, whom I was expected to present on the rounds each morning. This required me to rise early in the morning (often at 4:30am) to pre-round the patients at 5:00, and have all their observations and blood results ready to present on the round at 6:00am. After this, I was able to spend an extensive amount of time scrubbed in theatres. Additionally, I was given simulation training and exposed to the standards required of general surgery residents (i.e. the tests and examinations they undertake on simulators). Overall, it was an excellent experience, and I learned a huge amount. I spent a great deal of time in endoscopy units with Dr. Jeffrey Ponsky, who was one of the inventors of the PEG-tube, and it was a fantastic opportunity to learn from one of the masters of minimally invasive surgery.

At Mayo Clinic I had the opportunity to follow my passion, which is transplantation surgery. I spent two weeks with each of the teams (Kidney + Pancreas, and Liver). The opportunity to work with the surgeons at Mayo Clinic was inspiring, and the level of care patients received was excellent. The work included much out-of-hours operating, as well as opportunities to travel within the Mayo Clinic hospital group for organ retrieval. Overall I felt that my time there allowed me to improve my technical skills, as well as provided an excellent opportunity to make research contacts and further my experience within the specialty I would like to pursue in the future. I could not have completed the elective without the assistance of the RCSEd Travel Bursary, and am very grateful for their assistance.

Kind Regards,

Tom Handley
Electives are an excellent opportunity to explore future career aspirations, it allows us to learn the challenges that arise within a specialty, the patients that we deal with and what makes that particular field of surgery so exciting. For me, one specialty stood out among all and has been with me throughout my clinical years at the University Hospital of South Manchester, namely plastic surgery. Consequently, I didn’t hesitate to organize an 8-week elective at one of the highest ranked plastic surgery training programs in the US, namely at the University of Texas Southwestern Department of Plastic Surgery (UTSW).

My time at UTSW was divided into several subspecialty rotations across 3 major teaching hospitals, namely Parkland Memorial Hospital, Children’s Medical Center, and William P. Clements Jr. University Hospital. During my time in Dallas, I was very fortunate to get hands-on experience in numerous surgical procedures covering most subspecialties within plastic surgery, ranging from
simple skin lesions excisions and tendon repair, to more complex procedures such as DIEP breast reconstruction, dynamic facial reanimation surgery, cranial vault remodeling, free radial forearm flap phalloplasty, and many more. Compared to the NHS, the sheer amount of patient turnover was incredible, it was extremely efficient and access to resources seemed almost unlimited. We operated at least 4 days a week and managed to operate on more patients in a single week than would normally be achieved in the UK in a month. Consequently, I was able to get a better insight into a wide variety of surgical procedures and improve my operating skills on a daily basis. The expectations from me where high and I was constantly being quizzed to ensure that I did my homework and was well prepared for cases. While keeping up with the caseload was rough, everyone was supportive and keen to teach me. Training in the US focuses on educating junior doctors to become qualified surgeons, whereas within the NHS emphasis seems to be using junior doctors for service provision. There where clear inequalities between patients with insurance and those without, yet it was very valuable to see what healthcare can look like when access to resources isn’t restricted. In those cases, doctors were able to provide the best possible care and rarely had to make compromises. While there is no perfect healthcare system, by all means private hospitals within the US have plenty of flaws, yet this was maybe the first time that I saw how hospital care should be delivered.

Getting to grips with working at a busy hospital system with an incredible high patient turnover proved to be a challenge. I went to hospital every morning at and most days lasted for more than 12 hours. On average, I worked in excess of 70 hours a week, with on-calls that lasted 36 hours long, without more than 3 hours of sleep. After being awake for so many hours, it seems like I was just
functioning on auto-pilot without actually taking anything in. Yet, despite the long hours, I truly loved my time in Dallas and it was absolutely worth it. Junior doctors were happy with their jobs, despite the long hours. There were numerous teaching conferences almost every morning and training sessions on a weekly basis. Junior doctors were guided and supported with care, a lot of time and resources was put into ensuring that they would be the best upon graduation. After experiencing all of this, I do understand why UTSW is currently the best rated training program for plastic surgery.

I’m truly grateful for all the support and teaching I received from everyone at UTSW, everyone was incredibly keen on teaching me and provided me with support throughout my time in Dallas. I’ve learned an incredible amount about surgical problems that I may not see here in the UK and was able to improve my surgical skills. My elective reaffirmed my desire to pursue a career in plastic surgery and I’m looking forward to continue my journey to reach this goal. I would like to thank the Royal College of Surgeons of Edinburgh for their generous support and therefore making it possible for me to spent 2 months in the US.