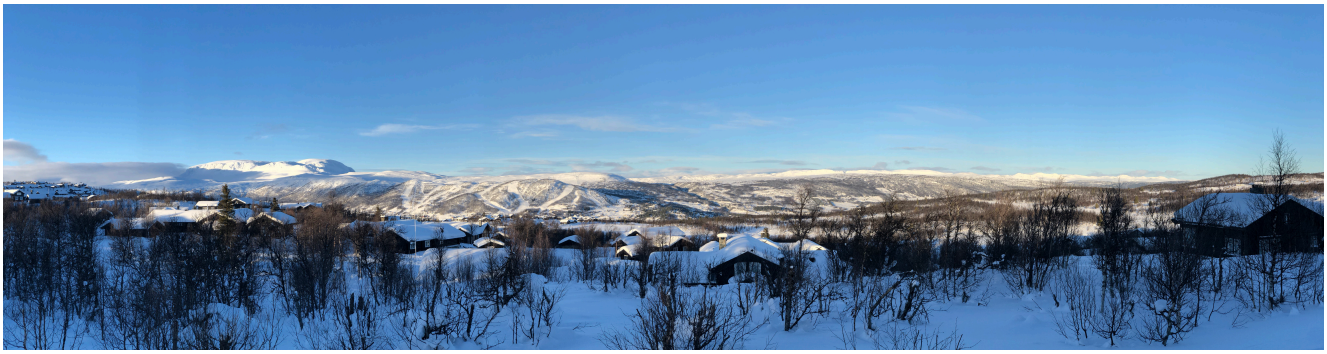
BSSH TRAVEL GRANT REPORT



Patrick Garfjeld Roberts

Norway

I am a post-CCT orthopaedic hand fellow from the Thames Valley Deanery, and I have been kindly supported with a travelling grant from the BSSH to visit Norway for what was originally planned as an unpaid fellowship at Rikshospitalet, Oslo University Hospital.

Why Norway? It was to visit Rikshospitalet, the major Norwegian hand surgery centre in Oslo, to gain exposure in small-joint arthroplasty. I had emailed the local lead there to discuss the chances of a fellowship, but the concept of fellows is less well-established than in the UK/Aus/NZ. They could offer me an unpaid post.

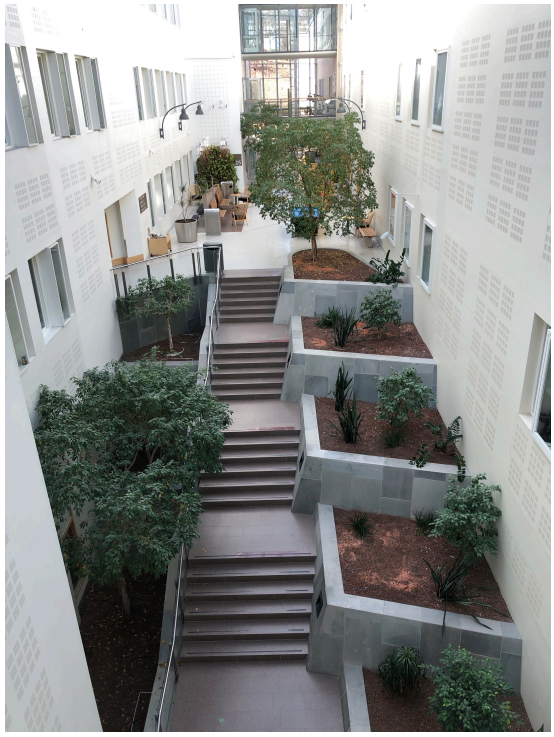
In retrospect, it must have been unusual to them for an unknown quantity to be in contact from the UK about coming to work for them, and I suspect they weren't quite sure what they could do with the odd Englishman cropping up out of the blue who wanted to work for free. But on the back end of the pandemic, the long years of registrar training, and fortuitous timing for the family, it seemed like an adventure worth pursuing and we had savings that could cushion us. And in retrospect again, the fact I accepted those terms was probably a sign to them that I was quite mad. But part of the draw wasn't just the chance to work at a major national centre. It was also a hospital I saw being built as a child.

Being half-Norwegian on my mother's side, every year we would catch the evening flight on the last day of summer term to Oslo and spend the whole of the holiday in my aunt's 'hytte', or cabin, flying back the day before autumn term started up again. On the edge of Nordmarka, the mountainous forest that constrains the northward limits of the city, I would learn the parochial, out-moded brand of Norwegian spoken by my aunt and mother, while enjoying long days of 20+ hours of daylight embodying a hybrid of Pippi Longstocking and Swallows & Amazons.

With patriotic wanderlust, a unique fellowship opportunity, my wife being thoroughly deserving of a break from imploding post-pandemic primary care, and my daughters not entitled to a vote in the matter, we shipped off to Oslo in August 2022 for what we assumed would be a year. The girls would get immersive language exposure by being dropped into local schools, my wife would get a 'gap year', and with the likelihood of working well into my 70s ahead I was in no rush to apply for consultant posts.

We could absorb the financial hit with help from the BSSH, family, and savings. Our one extravagance was annual passes to the local theme park (children are easily distracted from life-changing upheaval by rollercoasters and candy floss). Other than that, we planned a frugal year of unpaid fellowship in one of the worlds most expensive cities. As it turns out, Fate had other plans.

Working at Rikshospitalet



The central corridor of Rikshospitalet

The section for hand and microsurgery is staffed by 10 senior doctors (*overlege*, or consultant) and 4 junior doctors (*LIS/Lege i spesialisering*, or registrar equivalent). The section covers all upper extremity surgery, and is the largest and leading unit for hand and microvascular surgery in the country. It has a national function in replantation surgery (orthopaedic, aurological, and urological, as required) and plexus surgery as well as a regional function in hand surgery for the Health South-East health region, which makes up over half of Norway's population. About 1,800 operations are performed annually, of which 1/3 in the day surgery unit. Each year, approximately 600 serious hand injuries are treated as emergency cases. The section has significant collaboration with other departments on reconstructions with microvascular tissue transfers on the upper and lower extremity, while interestingly the section is entirely staffed by orthopaedically trained hand surgeons. In particular, this applies to extremity sarcomas treated at Radiumhospitalet and head & neck cancer treated at the ENT department. Other special functions include treatment of congenital malformations of the upper extremity and neuro-orthopaedics of the upper extremity. The section has extensive outpatient activity. Research is carried out, particularly within hand prosthetic surgery, microvascular surgery, peripheral nerve/plexus surgery, and dysmelia. Several of the doctors have PhD projects underway.

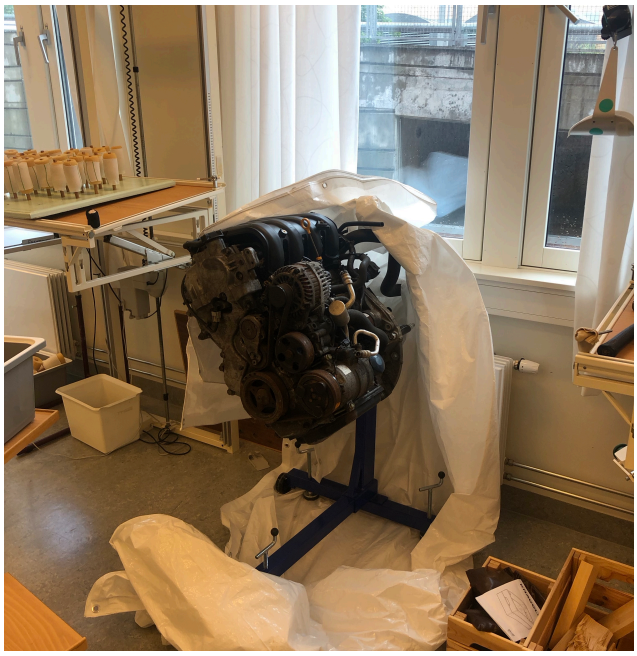
From the moment I started, it was a welcoming, supportive place to be. I had never worked in the Norwegian health system before, and there were plenty of deviations from my usual practice, language being the most obvious.

The first revelation was that chatting with your mother is no match for the language skills developed by schooling, university, and clinical practice. Norway is a large country with tricky terrain, which breeds strong regional identities with accents and dialects (Norway has in fact two competing languages) who were referred in to this national centre from all over the country. Furthermore, plenty of Swedes and Danes (Norway's former colonial overlords when it was a poor seafaring nation have come scurrying back after independence and the discovery of oil) live here and just speak their own languages like they still own the place. The Scandinavian languages are distinct but to a greater or lesser extent mutually intelligible: whether that extent is sufficient for the practice of clinical medicine is still unclear to me.

The second revelation is that, in one of the worlds most digitally advanced healthcare systems, they use their own keyboard. They need to account for their three extra vowels (Æ, Ø, Å), I accept that, but they moved all the other keys around too! Learning to type was tricky enough the first time round: unlearning has proved too much and I have become a 'hunt-and-pecker' again.

The steep early learning curve settled, and it wasn't long before I had my own clinics and theatre lists. The system is very different in Norway to that in the UK. Instead of trainees working as 'apprentices' under a senior surgeon and rotating around, they are more like junior members of the team practicing in their own right. Most hospitals have the breadth of subspecialties on site. Trainee are employed directly by the hospital, not placed by a training programme, with the aim that by the end of training you are promoted in-house to consultant. It's like rising up the ranks of a business, and gives far more incentive for the hospital to train you. So when a junior sees patients in their clinic, they add them to their own lists: if a patient needs an operation they can't do, they identify a suitable list that a senior can help and they do the case together.

The nature of the service at Rikshospitalet means that in addition to the typical hand surgery fare, our cases include replantations, congenital hand, brachial plexus and peripheral nerve injuries, as well as small joint arthroplasty. Beyond the clinical experience, it was eye-opening to have your assumptions challenged and see there are other ways of practicing medicine. Allow me to select a few highlights.



The occupational therapists mean business here

Consent

My very first list was embarrassingly delayed when I couldn't find the consent forms. But the embarrassment was not due to my failure at a simple task: it was due to looking for a document that didn't exist. It takes a while to get your head around as the litigiously defensive mindset of the

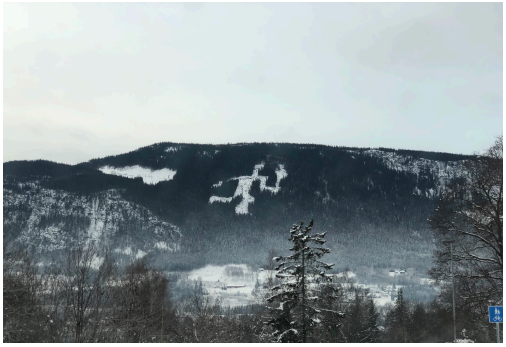
UK still had a hold on me. The consenting process is not a piece of paper, but the sum total of the referral, clinic review, treatment discussion, and pre-op final checks. There is no form to sign. Consent is a process, not an event. I always found the transactional nature of the consenting process almost an intrusion to a good doctor-patient relationship in the UK: the consent form changes the nature of the relationship, but is wholly inadequate to replace the communication that has gone into that relationship where the actual informed decision-making with the patient has occurred. That consent to treatment is essential is not in doubt, the Norwegian experience simply shows there are other ways to handle it. The reasons for this difference are probably complex and long-standing. Contributing factors seem to be cultural perceptions of the role of the health service and it's current effectiveness, the size of the legal sector and the inclination to seek a legal solution to problems, the time permitted with patients before making these decisions (30 minute outpatient appointments are the norm), but also the compensation system in Norway is based on the injuries suffered not the ability to lay blame. I think too many factors conspire against me to bring this back to the UK.

Medical student jobs

It is surprisingly common, so much so that there are more applicants than there are places available, for medical students to support themselves by working in parallel to their studies as care support workers, phlebotomist, and even 'medical students with a licence to practice' from their 4th year. Here they part take in the normal junior doctor role, supported of course, but much like a foundation doctor. In the summer, to balance the generous leave entitlements, there are 6 medical students supporting the department. Overnight, they even hold the replant bleep! It seems they thrive from the responsibility, get a far more realist understanding of the functioning of the hospital than I ever did, excellent practice at their practical skills and prescribing, and importantly, very reasonable remuneration. Annualised it comes to just over 500,000NOK p.a., comparing very favourably with a mid-level reg (about 70% of the equivalent wage) or consultant (just over half). Final year students used to be able to work house officer jobs in the UK. Seeing the system working so well here, I genuinely feel students and the health service would benefit in the NHS with this sort of system.

Ilsetra

The Norsk Handkiurgiforening (their NSSH if you will), host two meetings each year. Once in the autumn, as part of the Norwegian Orthopaedic Association's annual congress which takes place at a central Oslo hotel and conference centre that could be anywhere in the world. A typical business-like meeting, it's attended by almost every orthopaedic surgeon, trainee, physio, and nurse specialist in the country, with the afternoons dedicated to the subspecialty sessions. Hospitals cancel all elective activity and leave behind a skeleton staff (orthopaedic pun intended) for emergency work. With the



The conference held where the Winter Olympics were in 1994

congress lasting three days, there is a good chance (on-calls permitting) that everyone will get to attend for at least a portion of the meeting.

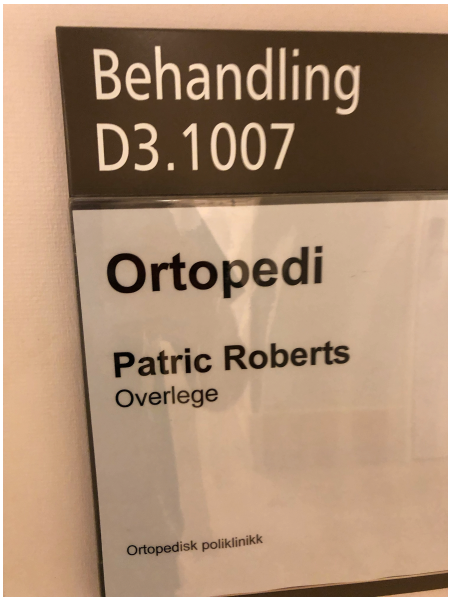
But the real pleasure is the winter meeting. A dedicated hand surgery affair, the small band of 50 or so gather at Ilsetra. The little hotel in the Hafjell cross-country (proper) and alpine (faux) ski area fills for a three-day meeting with hand surgeons. And their families. It's exceptionally welcoming. Partners and kids get the full benefit of the facilities, while the delegates have to wait for the (hearty) break in the middle of the day to ski and socialise.

Our international invited speaker was Tom Quick, from Stanmore's peripheral nerve injury unit, which meant I had an excuse to give my presentations in English (for the benefit of our guest, of course). We were also joined by an eminent neurophysiologist to sharpen up our nerve conduction study knowledge, and presenters from the Norwegian equivalent of the NHS Litigation Authority. Similarly to New Zealand, patients receive payouts based on the degree of harm following problems in medical and surgical treatment, not based on proving legal liability. Personally, my experience is this leads to a more open, less defensive doctor-patient relationship, and matches support to clinical need not the ability to apportion blame. It's also cheaper. A most revealing culture shock occurred when Prof Quick described indemnity costs in the UK: the flat-rate in Norway is 400NOK (just shy of £30).

In a community far more intimate than in the UK, surgeons come together for more than just the presentations, orthopaedic and plastic rivalries give way to games in the heated outdoor pool, fireside stories, and dark evenings with ropey Norwegian beers. A serious academic meeting, but one where the social side didn't invariably slide into shop talk. It was a totally unique experience, and one I fully intend on revisiting annually as my rotas allow.

From unpaid fellowship to locum consultant

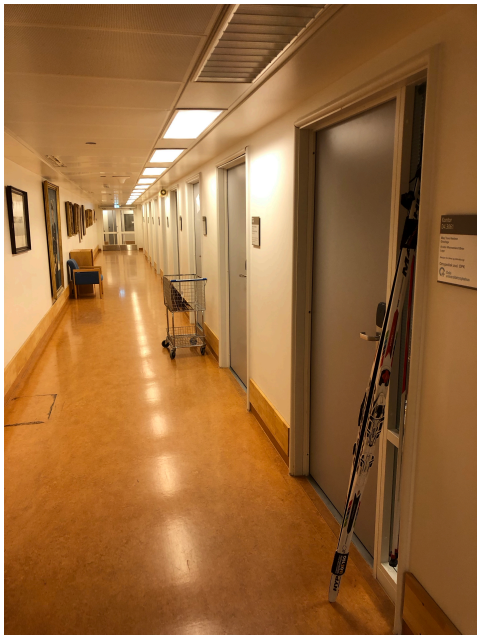
Autumn chilled to winter, which thawed into spring. I was finally in full control of the language, and very happy with the sheer variety of work I was getting on the background of my orthopaedic training. The fact I was unpaid was not sustainable for life, but was suiting us very well this year. The Norwegians have a good work-life balance as it is (my father being surprised one visit when he looked out of his window after years in the City to see rush-hour in Oslo at 3pm), and my unpaid status meant I had a certain amount of latitude in the work I took on, and the chance 'to hygge'. But as chance would have it, two factors conspired to disrupt this balance.



'Name at the end of the bed'

Another junior, and now very much a close friend, slipped on the ice and ruptured his UCL (I was not involved). Soon after, a senior colleague announced she was pregnant (I was not

involved). There was suddenly a shortage of surgeons at our unit, and my status was called into question. The extended Brexit transition period was about to close, but if we acted quickly, I could get my CCT recognised in Norway, allowing me to step up. The paperwork got through under the wire, and after a 5 day microsurgery course in Northwick Park (based at the Griffin Institute, which I would highly recommend), I was appointable.

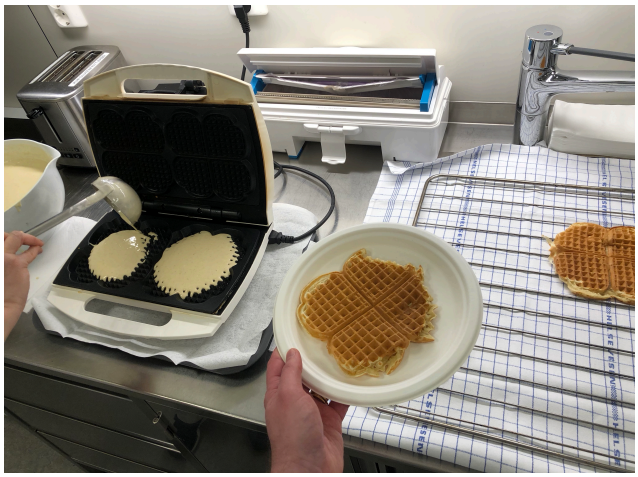


Skiing to work

All of a sudden I was a locum consultant, with replant responsibilities for 55 million digits (and other appendages). There is, I feel, something deeply unnatural about an orthopaedic surgeon doing microsurgery: I tired to explain to my colleagues it's like putting the milk in before the tea, but they didn't get it. The on-calls have been gruelling, but phenomenal learning experiences. I thought the testament to a long procedure was being offered a sip of drink via a straw, but some of my colleagues go as far as to 'snus' (chewing tobacco) behind their masks in the wee small hours. I never anticipated microsurgery would be a significant part of my practice and had no exposure in training, but I am grateful for the support of the BSSH to allow me to be in a position to take the opportunity when it arose.

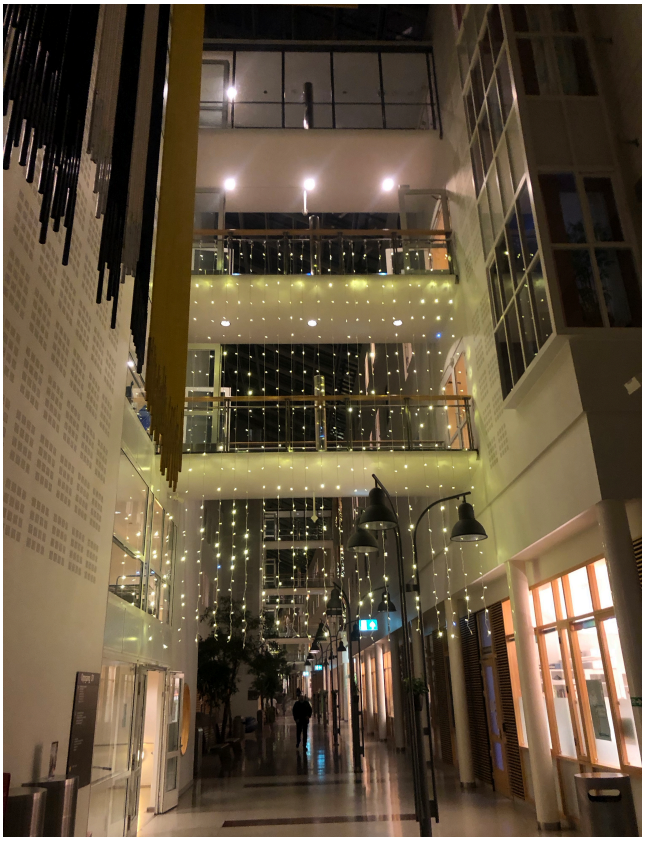
Coming home

After 18 months, I am finally coming back to the UK. My fellowship did not turn out at all like I expected, but I was lucky to be available to make the most of the chances presented to me. I'd like to thank the BSSH for their support for the visit, my colleagues in Oslo for their welcome and guidance, my family for joining me on this adventure. There is plenty I'll take away from this period, and some things I'll try to bring back to the UK, but most of all I've gained so much from being able to experience so richly the 'other side' of hand surgery. We are so lucky to be part of a group that pairs two very unique skill sets from orthopaedics and plastics. Having this chance to delve deeply into the 'other side' has been such a privilege. I don't pretend or hope to be an expert in plastic surgery now, but this year has given me a huge appreciation for the skills they bring to our community at the BSSH. It also confirms my belief that the British model of hand surgery, compared to countries that have a dedicated 'hand surgery' training programme from the outset, is so much richer for the experience that orthopaedic and plastic colleagues bring from their parent



Vaffler in the ward kitchen, every Thursday

specialties. I'm looking forward to getting back into the swing of things in the UK, within the comfort of orthopaedics knowing I have some very clever plastics chums nearby!



Christmas at Rikshopitalet