Fellowship Report – United Kingdom (March–April)

Overall, this fellowship was an extremely valuable and enjoyable experience, offering me the opportunity to better understand how two different realities within the UK's National Health Service (NHS) operate. While I gained some interesting surgical insights, the most striking differences were related to organization and workflow. On a personal level, it was also a great opportunity to reconnect with colleagues and meet new professionals.

During the first week (23–27 March), I was based in **Basingstoke** under the supervision of Dr. Hobby. I had the chance to follow him both in his NHS practice and in his private activity. Within the hospital, he is one of three hand surgeons working in an orthopedic unit, meaning that although their focus is mainly on hand surgery, they are also involved in more general orthopedic procedures. From a surgical perspective, I observed the management of fractures that we would likely treat conservatively in Italy, as well as procedures for thumb carpometacarpal osteoarthritis, including trapeziectomy and MAIA prosthesis implantation, similar to our practice. I also witnessed two PIP joint replacements using the Capflex prosthesis, and it was clear that both Dr. Hobby and Dr. Avis work at a highly specialized and advanced level in this field.

One aspect that surprised me, given the common perception of a more efficient system, was that waiting times between surgical procedures were still quite long. Additionally, most operations were performed under general anesthesia, with relatively limited use of locoregional blocks. However, the most notable differences were organizational. Each day began with a structured morning meeting to review the previous day's cases, plan the current surgical list, and discuss new emergency department patients. In the operating theatre, a formal team briefing involving surgeons, anesthetists, and nurses ensured that all preparations were in place. Particular attention was paid to the preoperative time-out procedure, reflecting a strong culture of safety.

Outpatient management was also highly structured. In fracture clinics, imaging was reviewed before patient contact, allowing clinicians to determine which patients required physical examination and which could be managed without it. Telephone follow-ups were widely used, reducing the need for unnecessary in-person visits and improving efficiency. Another interesting feature was the possibility of sending informed consent forms to patients electronically after the initial consultation, enabling them to review the information in advance of surgery. The presence of a surgical practitioner—a specially trained nurse able to independently perform minor surgical procedures—further contributed to workflow optimization. In addition, residents were given significantly more autonomy and responsibility than is typically observed in Italy, both in the operating room and in outpatient settings.

I also attended an "Audit Evening," a periodic event held every few months, where junior doctors present clinical audits. This represents an excellent opportunity to develop presentation skills while also contributing to quality improvement initiatives. Furthermore, a weekly virtual meeting with physiotherapists allowed for multidisciplinary discussion of patients undergoing rehabilitation.

During the second week (30 March – 3 April), I moved to **Salford in Manchest**er, where I was hosted by Dr. Naqui. Due to his involvement in the reorganization and separation of a new hand and orthoplastic unit from the trauma department, I spent more time with his colleagues, including Mr. Koo, Mr. Ruston, and Mr. Racy. This newly established unit includes five hand surgeons—three orthopedic and two plastic surgeons—along with several additional plastic surgeons, creating a highly specialized and collaborative environment.

As in the previous week, the main differences compared to my experience in Italy were organizational rather than surgical, with the exception of a higher volume of procedures for patients with scleroderma, as the center serves as a referral hub for this condition. Daily meetings were again a key feature, with a particularly comprehensive team discussion held every Tuesday to review complex cases. Being a major trauma center, the hospital also hosted a weekly multidisciplinary trauma meeting involving a wide range of specialists, including spine surgeons, neurosurgeons, orthopedic and plastic surgeons, general surgeons, anesthetists, pain specialists, physiotherapists, and nursing staff.

In outpatient clinics, physiotherapists played an even more integrated role. Some of them had advanced responsibilities, including the ability to independently assess and document hand surgery consultations, further streamlining patient care.

In conclusion, these two weeks were intense, stimulating, and highly educational. I return with many practical insights, particularly regarding organizational strategies that could potentially be adapted to improve efficiency in my own setting. I was also very impressed by the warm welcome I received, which contributed greatly to the overall experience. On a lighter note, my stay also allowed me to reassess my expectations of British cuisine in a positive way. I would strongly recommend this type of fellowship to all young hand surgeons seeking both professional and personal growth.

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