

Bearing Witness, Building Bridges

Reflections from a Craniofacial Surgery Observership & Rural Surgical Workforce Research Project

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PROJECT CONTEXT & PARTNERSHIP

THE PLACEMENT

Six-week clinical immersion embedded with the pediatric Craniofacial & Plastic Surgery team at Lurie Children's Hospital of Chicago, one of the highest-volume pediatric craniofacial units in the United States. I rotated through OR and multidisciplinary clinic sessions across 6 sites in the greater Chicago area, from the main downtown children's hospital campus to community satellite clinics.

Care spans complex reconstructive needs (cleft lip/palate, craniofacial anomalies, microtia) as well as general pediatric plastics, serving a broad socioeconomic and geographic cross-section of families, including those with limited access to specialized surgical subspecialty care closer to home.

My placement combined two roles: a structured clinical observership across the OR and outpatient clinics as well as a supporting position on the team's ongoing rural surgical workforce research project.

COMMUNITY & PARTNER ALIGNMENT

- Host team: attending, and their resident/APP teams, across the Lurie craniofacial & cleft service.
- Patient population: infants, children and adolescents with cleft lip/palate, craniosynostosis, microtia and other congenital or acquired craniofacial conditions. Many of them travelled long distances for specialist reconstructive care unavailable locally.
- My role was strictly non-clinical: observation and research support, working inside the team's existing structures rather than creating a parallel project.

Reflections

Watching different surgeons

Watching four attendings made me think about how I decide what to copy as a student. It is easy to be drawn to someone's confidence or teaching style when I don't yet have the experience to assess their clinical judgement. I became more interested in understanding the reasoning behind an approach before deciding that it was one I wanted to adopt.

The limits of observation

Being in theatre gave me access to complex surgery, but I sometimes found it difficult to judge how much I actually understood. I could follow what was happening without necessarily knowing why that approach had been chosen. That gap became useful: it helped me ask more precise questions and be more honest with myself about what I still needed to learn.

SDG ALIGNMENT

SDG 3 (Good Health & Well-Being): supported the delivery of specialized pediatric surgical care and family health education

SDG 10 (Reduced Inequalities): Participated in a rural surgical workforce research project, that aimed to monitor retention of surgical trainees in the communities, to identify where the training-to-pipeline breaks down and what support is needed to make rural surgical careers sustainable

SMART Goals

Goal 1 · Clinical Immersion

Observership across OR & clinics

S	Observe and document surgical and clinic workflow across the craniofacial service, spanning OR lists and multi-site outpatient clinics.
M	Log ≥30 operative cases and ≥10 clinic sessions across at least 4 attending surgeons and multiple clinical sites.
A	Achievable within an approved observership; requires only shadowing access already arranged with the host institution.
R	Builds direct exposure to paediatric craniofacial care and US health-system structure, relevant to my UK training and future practice.
T	Completed within weeks the 6-week placement (1 June-12 July 2026).

Goal 2 · Research Contribution

Rural Workforce Return Framework

S	Support the team's Rural Surgical Workforce Return Framework through literature synthesis, data structuring, and stakeholder-conversation planning.
M	Complete an assigned workstream and contribute one concrete component (tracker structure or interview guide) to the host-owned framework.
A	Scoped by the host research lead to match my skills and time, without duplicating existing team capacity.
R	Connects clinical observership to the structural question of who trains, and is trained to stay, in under-resourced settings.
T	Delivered across weeks 3-6, aligned with the team's own project timeline.

Goal 3 · Reflective Practice

Weekly ethical-engagement journal

S	Maintain a structured reflective journal on ethical engagement, cultural humility, and my own assumptions as a visiting student.
M	Complete ≥6 written weekly reflections responding to the Laidlaw ethical-engagement prompts.
A	Self-directed; requires only consistent time set aside, no external dependency.
R	Directly fulfils the LiA requirement for critical self-reflection and 3Cs development.
T	Ongoing across all 6 weeks; synthesised into this poster by 30 Sept 2026.

Outcomes

35+

operative cases observed

15

clinic sessions attended

4

attending surgeons

6

clinical sites across Chicagoland

OUTCOME 1 · OBSERVERSHIP

Over two weeks of full clinical immersion I observed 35+ operative cases, including cleft lip/palate repair, cranial vault remodeling and distraction, alveolar bone grafting, otoplasty, microtia reconstruction, and craniofacial trauma/tumour excision, as well as 15 clinic sessions across six sites.

Goal 1 achieved in full: the breadth of cases exceeded my original target, and being present across both OR and clinic let me see the full arc of a single patient's care, not just the operation itself.

OUTCOME 2 · RESEARCH CONTRIBUTION

From week 3 I joined the research team supporting the Rural Surgical Workforce Return Framework: a host-owned tool asking whether rural hospitals that invest time, patients and teaching capacity into training surgeons see that investment returned as sustained local surgical care.

My contribution was intentionally modest: literature synthesis on rural surgical retention and structuring part of a de-identified tracker distinguishing same-region retention, rural-to-rural movement, and exit from rural practice, one small, useful piece of a project that belongs to the host team.

OUTCOME 3 · PERSONAL REFLECTION

Watching residents start rounds at 6:30am, back to back with clinic, then teaching sessions after hours, recalibrated my own idea of stamina. It wasn't about which system works harder: it was a mirror held up to what I actually expect of myself.

Reflections

Seeing surgery within a longer course of care

Moving between theatre and clinic made me think about how differently the team and the family might experience the same operation. I was interested in the procedure and its technical details. For a family, it could be one stage in years of appointments and decisions. I only saw a short part of that process, which made me cautious about assuming I understood the whole experience.

Thinking about access through the research

The rural workforce project made me look more closely at what counts as a successful training outcome. A surgeon moving from one rural area to another might still contribute to rural care overall, while leaving a gap in the community where they trained. Distinguishing those movements in the tracker showed me how a seemingly straightforward measure of retention can conceal quite different local consequences.

Growth, Ethics & Sustainability

3CS REFLECTION

Capacities: sharper clinical observation, structured note-taking under time pressure, and translating messy workforce data into a usable framework.

Change Maker Values: learning to add value without taking space: contributing to research owned by the host team, not building something of my own on top of it.

Character: sitting with discomfort: of being a guest, an observer, and occasionally the least useful person in the room, without needing to resolve it.

ETHICAL ENGAGEMENT CHECK

Did I meet the LiA criteria?

- ✓ Community-led: contributed to a project the host team already owned, rather than proposing my own.
- ✓ Skill-based role: observation and research support only: no unsupervised clinical tasks.
- ✓ Reciprocity: gave research labour in return for access, not just presence in the room.
- ✓ Cultural humility: asked before assuming; treated "why" questions as more useful than "how" questions.
- ✓ Accountability: checked in regularly with the research lead and attendings on whether my contribution was actually useful.

SUSTAINABILITY & NEXT STEPS

- The Rural Surgical Workforce Return Framework remains fully host-owned; findings and the tracker structure stay with the research team beyond my placement.
- I will remain available remotely if the team wants further literature or data support after 24 July.
- Personally, I am carrying the access-to-care question: who trains, and who stays, into the rest of my medical training in the UK.

Closing reflections

What I will remember most about Chicago is how much there was to learn from being allowed into the team's everyday work. Operations that were entirely new to me were part of their working week, yet there were people willing to explain their decisions and make room for my questions. As a visiting student, I was grateful for that generosity.

Six weeks gave me a closer view of a field I'm interested in, and a better sense of how much I still have to learn. As I continue my training, I hope to carry that curiosity with me and, eventually, offer another student the same patience and welcome.

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