I'm a Finnish third year trainee in obstetrics and gynecology. I visited Aarhus University Hospital in Denmark for 5 days in January. The purpose of my visit was a pure interest to see how treatments differ from one country to the other, and how different treatments can lead to the same outcome. A second interest for the visit is a major change in the Finnish applying system for a trainee position that will change during 2015. I'm involved in a working group that organizes the change and we have taken a lot of example from the Danish corresponding system. I was honored to receive a grant from NFOG for the travel expenses.
Aarhus University hospital (AUH) has about 5000 deliveries annually. It is the second biggest hospital in Denmark, as is the city of Aarhus itself. The hospital is under major constructions and it should be ready in 2018. By then, it will treat approximately 1 million patients per year and be the size of a little village.

Monday 12th January, Delivery Ward

It was my first day in AUH. I had got a preliminary program for my visit and I was organized to go to a different department every day with a local trainee.
The day started in a conference room gathering together all doctors at the obstetrics and gynecology department. After a short look on week-ends most important events, I was paired with a nice second year trainee working at the delivery ward and we went hear a more detailed report on patients on the ward. There are 12 delivery rooms of which occupied were 4 at that moment.
During the day I saw the routines of a trainee that were very similar to ours: fetal scalp blood sampling, an emergency cesarean section due to a cord prolapse and the phone ringing for endless consultations from acute ward and post-delivery ambulatory clinic.
The biggest difference to a Finnish delivery ward was the time that the patients/mothers spend at the ward: in AUH they often went home the same day or even after a few hours after delivery where as in Finland they stay usually 2-3 days. In AUC mothers then come back in 2 days to have a check up of themselves and also for the babies. In Finland mothers giving birth the second or more time may be offered for a short stay, but this procedure hasn't gotten really popular. A sort stay after an uncomplicated delivery would help to diminish the health care expenses and this is a thing Finnish hospitals should consider.
In AUH the rate for episiotomies is very low, 1-2 %, where as in Finland we use it a lot more often, especially with primiparas. I saw one big perineal tear after a normal delivery and a few tears in healing process in the post-delivery clinic.
When it came to the emergency cesarean section, I was impressed how there still was time for check-ups in operation theatre (patient identification, purpose of the surgery) in a smooth manner. The trainee did the section with a senior specialist; in Finland the trainee would have done it independently in this kind of situation. In my opinion it was worth having a senior there, because the senior could evaluate the trainee afterwards by filling up a form after the operation. I was impressed (even jealous!) of the structured educational system and the possibility to get feedback from your senior. My paired trainee told me that they could even ask a senior to come to evaluate their encounterings with patients in an ambulatory setting. For me, feedback is the ground stone for good trainee education.
At the end of the day all the doctors gathered again in the meeting room where we started in the morning. There was a short report and then the trainees hada short journal club, prepared by one of the trainees. The day ended at 15.30 as it would have in Finland, too.

Tuesday 13th January, Day Surgery Department

The day wasn't as usual as always at the day surgery department. This seems always happen when an observer is involved… There were fewer procedures booked for the day and the ones that were booked didn't go by the book. I was just relieved to see that these sort of things happen every where.
The first case was a young patient who had had rectum carcinoma at a very young age and had had radiation therapy. The cervical canal was strictured due to scarring and the aim of the procedure was to try to re-establish cervical canal and place a catheter to keep it open until IVF treatments start. The most valuable thing that I will remember from this procedure is not related to operational techniques but rather to positive and supportive environment that all the specialists and the whole team created. There was cheering when the canal was established and a "Gimme five!" at the end. A positive working environment is an important factor when it comes to work satisfaction and I hope they will value that.
Next there was a laparoscopic hysterectomy where I encountered new, useful operating techniques.
In AUH the trainees (depending of course on their level of experience) can do minor procedures by themselves. For example, a diagnostic laparoscopy was to be done by two trainees with a similar experience. I wondered who decides who is going to be the operator and who is the assistant, and the trainees told me that they make the decision by themselves. I reckon that in Finland there would be competition between the trainees and this kind of a decision-making would be problematic. These days we feel that we don't get enough experience on operating skills, so every time there is a possibility to operate, it must be used…
I also got introduced to a very new way of preoperative decision-making: the hysteroscopic evaluation and staging of endometrial cancer by biopsy. I never had heard of it before, and AUH is the only hospital in Denmark (and MD Margit Dueholm the only specialist) doing them so I felt privileged. The system involves combining ultrasound evaluation at the OR of the myometrial invasion of the cancer and then hysteroscopic sampling of endometrium and cervical canal. By combining this to MRI-scan the accuracy of the staging is more specific and sometimes pelvic lymphadenectomy can be avoided, saving the patient from lymphadenectomy complications. It also helps to decide whether the para-aortic lymph nodes should be removed or not.
There was a trend of having more procedures done in the day surgery department in AUH than what we do in my hospital: we do many of the OR procedures (like conisations and part of the hysteroscopies) in an out-patient setting. This has been proven to be cost-effective for us and the patients are more satisfied when they can have an ambulatory visit rather than day surgery. I think this is something the AUH could learn from us.

Wednesday 14th January, Operation Theatre

Today I learned more about the differences in patient encounters than about clinical medical skills. When it comes to "big operations" in AUH, the patient comes on the ward on the morning. The operator meets the patient, explains once more the procedure and tells about the schedule for the day. This is what we do also in my hospital except that the patients come from home directly to the operation ward (not to the ward where they'll go after the sugery). But then we leave the patient and the nurses take care of the preoperative necessities and we meet the patient next time in the OR (when under anesthesia) and then the next day at the ward. At AUH the doctor actually walks the patient into the operation room, does a quick check-up and introduces also the rest of the personnel to the patient. I also noticed that at AUH every one shakes hands with patients – a good manner that has been forbidden in my

hospital district years ago. I didn't mean to be rude, but I always forgot to offer my hand for a handshake… The operator also promised to call the patient's husband after the surgery to tell how it went. We hardly ever do this. In my opinion the system is more patient-centered in AUH than what it is Finland, at least thus far. The culture is also changing in Finland.
I was also happy I could assist a little during an abdominal hysterectomy. I was also lucky to see the procedure, since in Finland these procedures are scarce. We still have the right to morcellate, so almost all hysterectomies are done vaginally or laparoscopically.

Thursday 15th January, CEPO and emergency outpatient clinic

The day started at emergency clinic. Unfortunately there was only one patient. She came because of a missed abortion. A midwife had seen her the day before, when she had been attending her first routine ultrasound scan. The treatment procedure was pretty much the same, although I had the feeling that in Finland we courage the patients more to choose the medical treatment. The follow up scheme seemed somewhat different: in AUH there was a routine ultrasound scan and hCG control one week after the first visit, where as in my hospital district there is only a hCG control 3-4 weeks after visit. I guess this approach is more cost effective.
The rest of the day I spent at CEPO, a special ambulatory clinic for post-menopausal bleeding. The patients were sent there by private gynecologist or general practitioners and sometimes had already an endometrial sample taken with the diagnosis of cancer. The procedure at CEPO is very structured: the patients are scanned in 3D ultrasound with or without a contrast gel. The idea of using gel is similar to what saline infusion serves in HSSG, only gel is stickier and stays better in the uterine cavity and also works as a local anesthetic (lidocain gel) for subsequent biopsy sampling. The patient is scored by the US findings (endometrial thickness, myometrial invasion, blood vessel typing) and by BMI, age and hormonal use. The trainees do the scanning at first, score the patient, and then their supervisor comes and also scores the patient to see if their evaluation is similar. In the end, a biopsy is taken and in some cases the patient is sent to MRI and often an operative plan is already done at the clinic. The scoring is still being under research, but the ultimate goal would be to evaluate if a scan could be used in stead of MRI and thus save some time.

Friday 16th January, Day Surgery Department and Delivery Ward

For my last day I was set for the delivery ward, but I got informed that there were 3 laparoscopic cerclage operations to be done this same day. Those procedures are rare to be seen, and thus far I'd only seen videos in the internet. I asked doctor Mads Riiskjaer, who was operating, if I could come and watch. Mads told that there is about 15-20 preventive laparoscopic cerclages done annually in AUH and that is also the biggest number of all the Danish hospitals. The procedures are elective and the most common indications are two previous conisations or previous pregnancy loss(es) due to cervix insufficiency.
Dr Riiskjaer was really helpful and let me be the 2rd assistant for the first procedure and the 1st assistant for the second one. The most effective way to learn a procedure is to be "hands-on". I was very grateful for dr Riiskjaer for this opportunity.
For lunch I met a PhD student in obstetrics and gynecology, who just started a huge project on filming all obstetric emergency situations to evaluate team work. She'd been very innovative to put down all the obstacles during the way for the study set-up. It'll be interesting to hear

about the results. She also showed me around the research facilities and we discussed about the Finnish and Danish way to make a PhD-degree. It seemed similar.
The afternoon I spent at the delivery ward. There was a vaginal tear and an urethral laceration that was sutured in the operation theatre. We also examined a few acute patients due to preterm contractions and vaginal bleeding, a patient population often seen in my hospital too.

When the work day ended, it was time to thank every one for a great, helpful, informative and educational visit, take my luggage and head for the airport. I wish to visit the place again, sooner or later!

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