The Ronald Raven Travelling Fellowship, 2019

A Report by Paul Sutton

Advanced Colorectal Cancer Fellowship

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Introduction

The Royal Prince Alfred Hospital is home to one of the most well established pelvic exenteration services in the world. As a surgeon with a developing interest in advanced cancer, it was an obvious place to approach for a post CCT fellowship.

Organisation and Logistics

I initially approached the team at The Royal Prince Alfred three years before my intended CCT date to express an interest in coming for a fellowship. It wasn't much of a surprise that there were a number of people who had expressed an interest in the posts for the years running up to that. I kept in regular contact with the department and was invited to apply for the post when it was advertised by Sydney Local Health District, with the interview held in May 2019 prior to an anticipated start date in February 2020. The interview took place by Skype, although there was an option to attend in person.

Being offered the post marked the start of a very long (and expensive) process of preparing for departure. The process included notarization of documents, verification of qualifications, visas, health checks, employment contracts, security checks, working with children checks, occupational health (including seeking some immunisations), medical registration, indemnity, superannuation arrangements, salary packaging, registration for a provider number, bank accounts and obtaining tax file and business numbers. In addition to this was the need to organise accommodation, schooling, flights and transfers. On the UK side of things there were the more obvious tasks of moving house, liaising with schools, my wife negotiating a career break, storage, dealing with banking and services and notifying the GMC, current employer and professional bodies. This process started shortly after my interview and ended with my visa arriving in early December in preparation for a departure in mid-January, therefore I would advise budgeting 6 months (with weekly tasks) and approximately £10k. To that end, I am grateful to BASO – The Association for Cancer Surgery, for their support through the Raven Travelling Fellowship.

The Department

The department consisted of eight consultant surgeons who broadly worked across two exenteration teams, a peritonectomy team and a colorectal team. There were four fellows in the department (two overseas, one CSSANZ and an honorary position) who each rotated through the teams although we would very frequently operate together. Supporting the team was one SET registrar (ST3+ trainee), two SRMOs (CST1-2) and four interns/residents (FY1-2). Most inpatients were housed on a single unit and nearby ICU. The department was fully supported by Upper GI (in Australia this is combined OG and HPB), urology, vascular, plastics and orthopaedics, and a multidisciplinary team including nurse specialists, physios, stoma therapists, a dedicated psychologist, orthotist, researchers and more.

Each week saw four advanced cancer lists which were shared between the exenteration and

peritonectomy teams, plus four colorectal lists. There was a half day endoscopy list each day. There was a weekly radiology meeting on Monday morning, and fortnightly exenteration and peritonectomy MDTs. Patients were referred directly to consultants and seen in their rooms, and then brought by the consultants to the hospital for surgery. As such there was no requirement to attend clinics, but the opportunity to attend to see how patients were prepared for surgery was available.

The hospital was the trauma centre for central Sydney, and also had a busy emergency general surgical take. The colorectal department received the emergency general surgery and trauma take 1 in 3, and colorectal emergencies at all times. A registrar was on call and present in the hospital with fellow's non-resident supporting the call and attending for unwell patients and major emergency procedures as required.

Each consultant also had an alternate weekly list at The Chris O'Brien Lifehouse, an adjacent private comprehensive care centre. Fellows attended these lists also, and supported the consultants in the post-operative management of these patients.

The Job

The daily routine was a 7am ward round and 8am start in theatre. Within a week each fellow would normally undertake three elective operating lists, an endoscopy list and have a day covering the emergency list. Team meetings, for example radiology, M&M and MDTs were held in the mornings from 0730. The on call commitment was 1:4 out of hours and 1:4 weekends, during which all inpatients across both sites would be seen as well as running the emergency service. Unlike the UK, the 'Postgraduate Fellow' is a defined role in Australia. The consultants work at the hospital as 'Visiting Medical Officers', and therefore the fellows are the most senior staff employed directly by the hospital. By definition the fellows have completed their training and are otherwise eligible for consultant practice. The level of responsibility is therefore higher than that experienced in UK training, although consultant support and guidance is always available.

The RPA was the main COVID-19 site in New South Wales during the peak of the pandemic. For approximately 2 months, operative capacity was reduced to around 80% of normal, although the advanced GI cancer programme continued to run.

Training

I was in the fortunate position of having worked the previous year at The Christie Hospital, which is also an exenteration unit. As such I already had some understanding and experience on which to build. The training I received in pelvic exenteration surgery encompassed:

- Fortnightly MDTs
- Attendance at service meetings
- Case reviews with radiology, surgical anatomy and operative planning prior to each case
- Weekly zoom tutorials covering technical and non-technical aspects of exenteration surgery
- Leading the workup of referred inpatients
- (At least) weekly consultant ward rounds to discuss management of post-operative patients and complications
- Operative management of post-operative complications
- Reading and discussing the published literature and experience of the department
- Meeting with each of the members of the multi-disciplinary team to discuss their role within the unit
- Integrating and undertaking research with the Surgical Outcomes Research Centre (SOURCE)
- Being shown the operative toolkit of pelvic exenteration in each of the pelvic compartments, with the opportunity to perform under supervision or with another fellow
- Attending other specialty lists with orthopaedic, urology, vascular, gynaecology and plastic surgeons

In addition to training in pelvic exenteration surgery I had the opportunity to build on my

experience in peritoneal surface malignancy surgery, as well as the full range of colorectal surgery including proctology, pelvic floor and IBD. The nature of the referral base to RPA is that there are fewer primary cancer resections than one might expect for a unit of this size, however I had the opportunity to learn some new tips and tricks for laparoscopic resections and also benefited from some operative training and console time on the Intuitive Da Vinci XI. The endoscopy lists were busy and provided me with the opportunity for independent practice as did the emergency general surgical take.

Sydney and New South Wales

Undoubtedly another draw of the fellowship was the opportunity to live and work in Sydney, and travel around New South Wales. Border restrictions imposed due to COVID-19 meant that opportunities to travel out of New South Wales were limited.

Quite simply, my family and I loved living in Sydney. Despite some reservations in the run up to the trip, our family settled very well into new jobs, schools and social groups. The job was very involved, but time away from the hospital always felt like a holiday with lots of things to do and places to visit. I am so pleased my family have had the opportunity to live in Sydney, with new friends and new hobbies to take home.

Summary

My family and I had a fantastic year in Sydney. The painful logistics of the run-up to our departure are but a distant memory, and we are all the better from having had this adventure. From a work perspective the job is very busy, but the ethos and focus on training and the opportunities available were immense. It's hard to imagine how I could have been better prepared for starting consultant practice with an interest in advanced cancer. I look forward to the next challenge with the support of my new found international colleagues and collaborators, to whom I owe an enormous debt for their support and the time and enthusiasm they have invested in me and my development.