Alcoholic consultant

- An important fact to remember is ~10% of doctors' abuse alcohol at some time in their life time & may co-exist with anxiety/depression

- Be aware that an ill surgeon recognise the problem at a relatively late stage (They are taught to be 'tough' & believe in they will not become ill)

- Be observant as this could be an once off incident

- If frequent this may compromise the patient care. There is a duty of care to the patient by you & the surgeon involved

- Some obligation to help out the professional community as well during their problems

- Human nature is not to become involved but having observant about the unsatisfactory performance itself makes one already involved!!! (a case in UK)

- As a registrar, responsible to both the patient & the involved surgeon

- Not taking any action is unethical to both the patient & the surgeon (Also could end up as unsatisfactory professional conduct as a case in the UK)

- As a junior, it is very unwise to confront or criticise a senior colleague & it should best come from another senior member

- I would approach the head of the unit for assistance & guidance with this difficult problem. If this considered embarrassing a senior colleague in another hospital should be contacted (This largely discharges any professional obligation to inform)

- Help available :-
  - DHAS (Doctors Health Advisory Service)
  - RACS - Health Advisory Bureau

- Medical board notification only if suggested by the head of the unit & the very last option. This is considered as a measure to maintain the trust that the public has placed upon us. May get confidential notification to the surgeon involved

- Professional competence :-
  - usually could remain in practice except in acute & chronic symptoms
  - task of the treating doctor

Amputation of the wrong limb

- A situation to be avoided & can be easily done by meticulous pre-op risk management by marking the side of operation

- Inform consultant urgently

- May need to complete resection of the other limb as this would have been planned for some mandatory reason for eg. sepsis

- Good communication with the patient is mandatory with a lot of time, atleast try to see 2-3 times a day :-
    - this stresses the importance of communication for a surgeon
    - show empathy & concern
    - saying sorry does not necessarily mean accepting legal liability

- Need to inform medical insurance company and be aware of legal issues

- Making necessary precautions to prevent this from happening again

Angry patient in the OPD

- A situation to be avoided by giving appropriate information & communication prior to discharge

- Need to deal with 2 issues :-
    - Hostility / Anger
    - Cause for it (adverse outcome, just waiting too long or other reason)

- Dealing with anger :-
    - Importance of communication skills, conflict resolution skills learned from medical school onwards
    - Privacy
    - Spend ample time especially to listen
    - If very hostile - may need code grey (avoid much as possible)

- Dealing with the associated problem :-
    - Hopefully this would have been addressed prior to discharge
    - Listen & clarify the issues
    - Usual practice is to obtain informed consent highlighting material risks
    - Any reversibility

    - Offer a second opinion

- Inform the consultant involved

- When I was the registrar at GH we had an angry elderly patient pre-operatively when his incisional hernia operation was cancelled for the 2nd time because of not having ICU beds for post-op care

- This was not communicated to us from the previous registrar and we were unaware of this fact

- Communication skill to calm him down:-
    - privacy
    - offered a drink as he was fasting
    - empathic & concerned
    - by this he was calmed down
    - his daughter was an ex-health professional & was encouraging to settle as well

- Address the cause :-
    - explained the area of communication breakdown and the reason
    - subsequently had the surgery afterwards after pre-booking an ICU bed for him

- From this I learnt the importance of communication during change over of registrars

- ?Medical defence for adverse outcomes

Audit :- your experience

- A process involving the review of clinical performance & measurement of performance against agreed standards, the aim of which is quality control

- This is a cyclical process

- This is an essential part of surgical practice :-
        - CME
        - Re-certification (every 3 years)
        - Self-assessment & Peer review

- Important to record it accurately, avoid bias as much as possible & be honest

- Features :-
  - regularly for a defined time period
  - surgeon, assistants
  - operations (minor, major)
  - patient data
  - outcome & complications
  - duration of stay
  - involvement of data base management usually

- Other advantages :-
  - Can be considered as application of evidence to practice (Audit cycle)
  - Identify weaknesses & strengths of the unit
  - Suggestions from colleagues
  - Indicate the work load of a unit
  - Enable comparison

- PMCI audit :-
  - complications from infusaports in that failed access despite proven patency from US
  - due to subclav vein stenosis as most our patients had previous central access
  - we had to change the practice to obtain venograms more liberally rather than US
  - some patients with bilat stenosis had Lumbar ports

- Other forms :-
  - adverse outcome audit
  - case audit

- More complications in one surgeon:- ??
  - may be related to case mix, referral basis, surgery related (surgeon, assistant, theatre staff & equipment)
  - usually presented with the members of the unit
  - should be addressed by the unit head
  - need further details from the medical records to evaluate the situation

Breaking bad news

- As medical practitioners at times we need to deliver bad news to our patients or their relatives in the context of :-
    - Adverse outcomes
    - Life threatening disorder (Cancer)
    - Chronic disease
    - Death of loved one

- This can be distressing to the patient as well as the surgeon

- Excellent communication skills are very important here

- Most successful surgeons are the better communicators

- Communication skills considered to be the best form of indemnity against litigation

- Communication is the interface between health professionals & patients, therefore to the patient, communication is 'everything'

- Patient's fears to be addressed include death, pain, loss of independence, treatments, fear of unknown etc

- Bearer of the bad news should be a person known to the patient & sufficiently senior

- Privacy to express emotions & spend a lot of time

- Provide the news simply and directly and add information as necessary:-
    - patients' have the right to know what's happening
    - some may prefer not to know the details
    - provide positive aspects of treatments etc and create some hope

- Be empathic & concerned (tissues), may touch to console & attentive silence are very important skills

- When I was at PMCI last year, a young lady ~25 years came with a groin lump. She had a thin melanoma removed 10years ago from her lower back

- Resection revealed recurrence of melanoma in multiple lymph nodes with a bad prognosis

- She was just married and was planning to have children. She was with her husband & both were obviously very emotional

- I spent a lot of time delivering the bad news by stages using various techniques of communication skills as I highlighted before

- My self and the consultant involved had to address the issue of prognosis & then create hope by offering further treatments

Challenges as a trainee

- I consider the most important challenge as a trainee is to balance between health, social commitments & devoting considerable time for training & the profession

- Professional activities involve :-
    - running a unit
    - skills & academic
    - teaching & research etc

- Health & social commitments involve :-
    - spending time with family & friends
    - health & fitness

- Without balance it will have an adverse effect on either of them

- Another challenge is to be able to deal with different personalities within a multidisciplinary team in the hospital environment
    - communication skills
    - leadership skills
    - conflict resolution skills

- Catering to the high demands & expectations of the patients with ongoing cost effective measures imposed by health budget

Challenging your capacity for caring

- Capacity for caring is very important attribute of a good surgeon

- As medical professionals we endeavour to care for our patients even at times compromising other factors

- When I was the registrar at PMCI last year the Friday afternoon theatre before the X'mas was quite busy for us as we had to complete a long list before closure for X'mas

- By the time we finished the list was ~2000 & was very tired being on call the night before

- Just before I was about to come home one of our patients with a PEG tube had pulled out her tube and wanted it to be replaced and she was calling from Ringwood

- We do not have an emergency department at PMCI

- Eventhough I had other commitments I decided to stay to replace this rather than sending her to another emergency department, as she was well known to me

Claims for a surgeon having complications

- If a surgeon is having complications more frequently, some thing must be done about that especially if it compromise the patient care :-
    - may be related to case mix, referral basis, surgery related (surgeon, assistant, theatre staff & equipment)

- This is a matter to be dealt by the Head of the unit not by the registrar & to be brought forward to him. This could be apparent in the audit

- The Head of the unit need to consider :-
    - no of claims
    - quality of care
    - medical records
    - personality of surgeon
    - if necessary a way of communicating with the involved surgeon under the circumstances

Clinical study design

- Study design :- PECOT approach
    - P - Population
    - E - Exposure
    - C - Comparison
    - O - Outcomes
    - T - Time

- Cochrane Collaboration :-
    - systematic review of health care interventions

- Prospective clinical trials of surgical techniques are difficult to conduct :-
    - procedural skills of each surgeon vary
    - not ethical to have a 'sham' operation

CME

1) Professional development:-
   - Audit, peer review & hospital credentialing

2) Clinical committees:-
   - MD clinics, CRC/EC etc

3) Clinical knowledge & Skills:-
   - ASC
   - Courses (EMST etc)
   - Clinical workshops
   - Skills laboratories
   - Self assessment programs (SESAP)

4) Teaching:-
   - BST, OSCE, AST etc

5) Research & Publication

6) Professional development:-
   - Leadership courses etc

Communication breakdown - Nigel

- Most successful surgeons are better communicators

- Communication skills considered to be the best form of medical indemnity

- It is also an essential aspect leadership that is necessary to co-ordinate a multidisciplinary team

- Most importantly, communication is the interface between health professionals & patients, therefore to the patient communication is 'everything'

- Communication breakdown can lead to disastrous outcomes

- When I was in GH as Surgical registrar, one of our elderly patients had a right hemicolectomy

- At the end of the operation, I told the resident to organise SC heparin & TED's stockings while I was looking at the next pre-op patient. This was documented in the post-op notes as well

- After a few days he developed sudden shortness of breath & found out to be from a PE. At the time we realised he was not on SC heparin. He was treated appropriately

- I usually take the endeavour to revise the drug chart post-op. However for some reason this was not picked up

- This exemplifies the issue of communication breakdown leading to disasters in this instance compromising patient care

- To avoid this from happening again I always check the drug chart of each patient daily together with the resident

Communication skills

- A good communicator is a good listener

- Attending skills :-
    - Attending to patient (open posture, looking directly, eye contact, facial expression)
    - Self attending skills (Drs attitudes may influence the interview)

- Directing skills :-
    - Open ended questions
    - Focused questions (what do you do for living?)
    - Closed questions (how old are you?)
    - Avoid leading questions, compound questions

- Following skills :-
    - Non-verbal cues (auditory eg. sound, tone, rapidity; visual eg. facial, posture, gesture) > a door-opener (you seem to be upset) will provide more information
    - Clarification
    - Non-verbal (head nodding) & Verbal (uh huh, yes) encouragers
    - Attentive silence

- Reflective skills :-

    - Empathy & Concern
    - Summarising (you seem to be angry)
    - Confrontation

- Barriers to communication :-
    - Language
    - Cultural (sexuality)
    - Age :- Adolescents, Elderly
    - Disabled

- Alternative methods of communication :-
    - writing
    - diagrams
    - professional interpreters

- Non-English speaking patient :-
    - be aware of cultural barriers
    - non-verbal cues
    - interpreters

Conflict resolution - Foxy

- Conflict resolution is an important aspect of leadership qualities that demands excellent communication

- Very important within the multi-disciplinary approach in patient care

- Skills for conflict resolution :-
    - communication skills!
    - recognise the conflict
    - reasons & alternatives
    - acceptable & unacceptable aspects of alternatives
    - combining acceptable portions & formulating a joint decision within a unit meeting

- When I was the surgical registrar at GH last year, there was a middle aged patient who had a laparotomy for a perforated PUD

- The dietitian involved was very keen to commence NGT feeds on the 2nd day post-op & give crushed Losec through that instead of IV Losec

- However as he had gastric surgery I was not very keen for that and I confirmed this with the surgeon involved, as well

- I had to raise the issue in the unit meeting and explained the fact that we have to rest his stomach in order to improve healing

- After appropriate explanation we came to the joint decision to feed him after a few days

- Joint discussion & communication skills are important for conflict resolution

- Can also mention this case as a conflict resolution with a nurse - A nurse under the influence of the dietitian suggested for NGT feeds & crushed Losec instead of IV Losec

Consent for a new procedure

- As a principle one should be experienced & knowledgeable about the procedure before getting informed consent from the patient

- Otherwise one would not give the correct information to the patient thereby not providing the real choices to the patient

- NHMRC guidelines requires to give correct information so that the patient can take the correct decision

- Gaining information about the procedure may be impractical with the circumstances do so by all means if it allows

- Fill in all the paper work & get the consultant involved to do the consent atleast just prior to the list

- At the end treating consultant will be responsible to the patient (Vicarious responsibility)

Consent

- NHMRC Guidelines :-
  - Information & Advice
  - Patients' encourage to make the decisions
  - Patients' should be frank with information

- Patient information should include:-

- natural course of the disease
- investigations, differential diagnosis & treatment
- benefits
- side effects (minor vs. major)
- material risks (including the level of experience of the surgeon! & whether done by a trainee!)
- conventional or experimental
- costs

- Bolam principle :-
  - a doctor is not guilty of negligence if acted in the common way within the profession
  - insufficient now Rogers vs. Whitaker (material risks to be addressed)

- Material risk :-
  - a risk that would be significant to a person in the patient's position

- Factors to consider :-
  - Material risks
  - Common sense dictates the extent of information(CABGS vs. Laceration)
  - Second consultation or second opinion if necessary
  - Desire of information by patient necessitates greater disclosure
  - Provision of full information is impossible
  - Temperament & health of patient may influence extent of information
  - Specialist referrals should be followed-up
  - Difficult to provide information in an Emergency
  - Special circumstances for children, teenagers, disabled and sterilisation
  - Communication is a form of medical indemnity

Coroner

- Function of the coroner is to identify the deceased & find the mechanism & cause of death

- Speaking on behalf of the dead in order to protect the living

- Coroner's cases :-
  - Unexpected death
  - Accident / Injury
  - Death from violent & unnatural cause
  - During or result of anaesthetic

  - Was 'held in care' immediately before death (prison etc)
  - Unable to sign a death certificate
  - Unknown identity

- Coroner is defined by legislation & usually a magistrate

- Traumatic, harrowing experience for family, friends & health professionals

- Finding that a doctor contributed to the death is not equivalent to civil or criminal liability :-
  - may lead to this however
  - devastating especially if publicity

Dealing with criticisms

- It is very important to understand that any training process require feedback from others to enable learning

- The term 'criticism' itself could be associated with a negative connotation, I tend to prefer feedback rather than criticism

- Most of our mentors tend to be sensitive enough to be constructive

- Eventhough they expect it to be constructive, at times we might perceive this as been too critical

- But need to move on without personalities getting involved

- Constructive criticisms :-
  - should be taken appreciatively (eg presentation on MM SB Mets study by Prof Thomas)
  - part of peer assessment
  - occasionally can be hurtful & debriefing with colleagues will be helpful
  - but the key is, it is a way of learning

- If perceived as too critical :-
  - may be related to over expectation, after all you'll be a junior registrar
  - debriefing with the mentor and other colleagues may be helpful

Dealing with errors

- It is a fact that, unfortunately errors happen in surgery as in any other branch of medicine

- Although difficult, it is very important to be open, frank & honest with patients that have an adverse event

- To prevent need an excellent risk management strategy :-
    - informed consent / communication
    - pre-op work up
    - up to date (academic/skills)
    - efficient office, FU etc

- Communication skills become very important here & should be emphasized :-
    - most successful surgeons are the best communicators
    - communication skills considered to be the best form of medical indemnity
    - communication is the interface between health professionals & patients, therefore to the patient communication is 'everything'
    - should involve genuine empathy, concern (no phone calls in between) & spend time
    - privacy
    - opportunity for questions

- Apologising for an adverse outcome should not be confused with accepting legal liability. After all it is common courtesy to say 'sorry' for example

- Need to see & discuss frequently with the patient involved

- Should seek for any reversibility & offer a second opinion as well :-
    - otherwise might perceive as we are trying to hide things

- Need to inform the consultant involved & consider informing the defence organisation as well

Difficult intern

- Key is to prevent from happening

- It is a responsibility of the registrar to train the junior staff
    - clinical
    - skills

- Whenever a new intern takes over:-

    - explain unit's expectations
    - explain my expectations
    - routine
    - give an opportunity to clarify, adjust, take decisions within professional capacity
    - suggestions & guidance to improve as a feed back manoeuvre

- Always explain, educate & rationalise the use of investigations

- If conflict arise discuss & try to resolve or devise an alternative

- Clarify the underlying issues :-
    - lack of skills
    - over worked
    - depressed or
    - simply lazy (too much time in cafeteria, not following up results etc)

- The solution depends accordingly

- Help by :-
    - help to prioritise the work (in order of importance) - allow 10minutes after the ward round for example
    - teach necessary skills
    - evaluate the work load & assist whenever possible & required
    - short circuit the problem if foreseeable (eg if need to go to theatre soon and difficult person to cannulate do it prior)

- Discuss with peers to have an idea
- of the situation & check with previous registrars' of the intern

- If depressed :-
    - make sure under appropriate care is received

- Discuss the difficulties with the unit head especially if this affects the function of the unit

Difficult nurse

- Best is to avoid by having a good relationship with staff :-
    - -explain clinical decisions
    - -prepare to accept their suggestions, alternatives

- Discuss the situation with the person involved, evaluate the problem, try to come to a resolution
- Discuss with peers to have an idea of the situation
- Discuss with the nurse in charge to get an idea
- If necessary joint discussion in a multi-disciplinary atmosphere
- Foxy's PUD case

Difficult relative

- It is a fact that we come across difficult relatives within the profession
- When I was at MH, ~50year old lady had a R hemicolectomy. She had no metastases at the time
- Subsequently had multiple complications with anastomotic leak, then peritonitis, wound break down and enterocutaneous fistula over the next few weeks
- She had expert care by a multi-disciplinary team
- Despite ongoing explanation husband continued to be aggressive & abused all the staff & continued to assume this was secondary to surgical error
- We offered a 2nd opinion, which he accepted. Nothing was added
- At this stage we re-scanned her which revealed multiple small liver mets
- We explained that this is one possible contributing factor for having multiple problems, some how this made him to grasp the situation & he gradually became calmed down
- We learned :-
- (- problems can arise even in R hemicolectomies
    - metastatic disease may cause impaired wound healing)
    - relatives may take time to grasp the fact of their loved one is dying
    - they need a lot of explanation, empathy & time

Discharge at own risk

- Endeavour to explain management issues

- Hostile patient :-
    - Privacy to talk
    - Calm down with communication skills

- Clarify the reason :-
    - Adverse outcome
    - Perceived negligence
    - Social (kids, work etc)
    - Delirium
    - Other

- Surgical background :-
    - Explain the importance of staying

- Still adamant to discharge :-
    - Make sure patient is capable of decision making ie competent
    - ?Discharge at own risk papers
    - Attempt to provide RDNS, HIH etc
    - Warn danger signs, whom to contact
    - Frequent FU eg daily presentation to hospital
    - Dr's letter if going overseas

- Consultant aware

Ensuring correct side operated

- Very important and have legal implications. Need to be meticulous about this & should ALWAYS have routine

- Care should be taken from the first time the patient is seen :-
    - Clear note in the history with appropriate drawings
    - No abbreviations
    - Investigations if necessary to confirm eg X-rays for bony pathology

- Day of surgery :-
    - See the patient pre-op routinely
    - Ask the patient the side without prompting (otherwise may cause ambiguity)

    - Compare with the medical notes and consent
    - Mark with a texture pen (sometimes sarcasm from patients!)

- Operating room :-
    - Inform the side to anaesthetist, nurses etc
    - Consent visible
    - If relevant make sure X-rays visible
    - Position accordingly and give assistance for this

Ethical dilemma

- Withdrawing treatment of the Ethiopian lady

- Need to treat :-
- Young
- Newly married with a one year old daughter

- Withdrawing treatment :-
- No added advantage of active treatment as extensive intra-abdominal disease - futile
- Poor prognosis and refusal for active treatment by the family & patient - autonomy

- Need to learn :-
    - on going futile treatment may compromise palliation
    - need to accept patient's autonomy & respect it
    - aware of limitations of medicine despite being emotional by the fact in a young patient with a 1year old baby

Ethics in animal research

- Surgical techniques were previously learned on humans but now this is often unacceptable and usually practiced on animals :-
    - EMST
    - Skills work shops (microsurgery, endoscopy)

- Animals have been used for :-
    - invention of surgical techniques
    - medical research
    - surgical skills training

- Animal welfare :-
    - testing of cosmetics
    - primate use
    - economise the use (demonstration of animal dissection by qualified staff)

- AEC :-
    - animals have moral rights
    - ensure the distress to animal is minimal and research is justified
    - NHMRC guidelines
    - scientist, a veterinarian, animal welfare worker, independent person

Ethics in clinical research

- Never perform an experiment which might be harmful even though the result may be advantageous to science - Claude Bernard

- Justification to use human subjects:-
    - Information is unique
    - Cannot be obtained in any other way
    - Beneficence

- Is there an obligation to serve as a research subject as part of wider duty to society :-
    - information from research are not always necessary for all members of the society
    - individuals contribute through tax etc
    - should have no compulsion to contribute

- Therapeutic vs Non-therapeutic research:- Beneficence / Maleficence
    - for non-therapeutic research individual harm becomes more important as there are no direct benefits to the subject
    - For therapeutic research risks & benefits are individualised & balanced
    - Unethical to not have any treatment in the placebo group (some form of treatment with the trial drug & placebo so all get some treatment)

- Autonomy, voluntary & informed consent :-
    - Lay terms
    - Justification for the project
    - Free to withdraw

- Justice :-
    - Procedural justice (equal chance of inclusion or exclusion)
    - Aware of vulnerable groups eg prisoners, children etc
    - Distributive justice (benefits of research available to the community not only to the people who can afford for example - unjust/unethical otherwise)
    - Compulsory justice (compensation for any harm)

- New surgical equipment should be considered as research projects until proven & best considered within a research protocol

- Ethics committees :-
    - The primary objective of the EC is to protect (non-maleficence) the interests of the subject & selection justice
    - A secondary objective is to maintain appropriate standard of research
    - Registered & operate on NHMRC guidelines
    - A mixture of lay, medical, religious, legal representatives & a chairman
    - Approve, reject, modification of projects, maintain ethical standards and monitor research in progress
    - The help of CRC for the scientific matters
    - Criticised as been rigid, legalistic, adversarial and slow

- Ethical responsibilities of the researcher :-
    - Sound methodology(selection)
    - Voluntary, informed consent & autonomy
    - Scientific value (literature review & non-repetition)
    - Wider application of knowledge
    - Valid data, Compliance to the protocol
    - PI should be experienced
    - Compliance with CRC/EC & regular reports

Ethics in resource allocation

- 4 main principles :-
    - Beneficence (doing good for the patient)
    - Non-maleficence (avoiding of doing harm)
    - Autonomy (patient as a decision maker)
    - Justice (equal treatment regardless of cultural, ethnic attributes)

- These were devised within the clinical dyad (r'ship with doctor & patient)

- As costs of medicine rise, state for example is involved & controls imposed (Stakeholder model of ethical analysis)

- Because of these consultations essentially occur in a 'crowded office' new concepts have evolved (Virtue ethics, Rights & duties, Discourse ethics, Ethonomics). Eg cardiac surgery may be not justified in the elderly with co-morbidities

- Virtue ethics :-
    - Beneficence & fidelity to duty are the central values
    - If old & frail are excluded from scarce resources (cardiac surg), beneficence & fidelity to duty requires to provide other means to lessen the sufferings

- Rights & duties :-
    - Mutually sustaining r'ship
    - Rights > what an individual deserves within the limits of the society
    - Duty > obligations to an individual within the limits of the society
    - We have no rights unless someone observes a duty to implement them
    - Patients have right for treatment & a duty of disclosure, compliance etc
    - Doctor's duties include ethical service, knowledge, work within law, community welfare
    - Doctor's rights include obtaining confidential info, performing examination, honest disclosure of info, compliance, trust etc

- Community / Discourse ethics :-
    - Finding the community values
    - Conceptual differences (because of differing fields of knowledge) within doctors, policy makers & economists, patients & families (eg outcome)
    - 'Caring for' (legal) vs. 'Caring about' (moral value) ie 2 notions of care

- Ethonomics :-
    - Policy makers, economists, managers & health care workers need to understand one another
    - They need to work together to deliver the best care possible within the inevitable constraints
    - Monetary restrictions should not compromise patient care (eg. type of mesh in hernia repairs)

Evidence based practice

- The use of current best evidence in making decisions about the care of patients (Sackett)

- The practice should be guided by judgement (experience), common sense, just as well as EBS

- Accepted by clinicians as well as administrators & policy makers

- Current perception that practice outside evidence based guidelines may result in litigation

- General principles :-
  - neither individual nor solely external evidence is enough
  - question established practice (change the practice if data from current practice shown to be futile eg. audit)
  - it is not cookbook medicine (not rigorously protocol driven)
  - evaluate & incorporate research into clinical practice

- Some pitfalls :-
  - may follow blindly without critical appraisal (specific study population)
  - the level & significance of the evidence (L I-IV)

- A good example of evidence based practice is the margins for MM surgery :-
- Thin MM (~1mm) -> 1cm margin & no advantage with 3cm - LII (Veronesi, U et al NEJM 1988, Randomized prospective 1cm vs. 3cm)
- No added benefit >2cm margins (Charles Bausch - MD Anderson)
- Should be guided by common sense (margin for eyelid MM in a 85yo with IHD)

- This is a good example that allow us to understand the practice is influenced, not only by evidence but also by other factors & should be catered for each individual

- Degree of evidence :- Guide only
  - \- LI - meta-analysis of RCTs
  - \- LII - atleast 1RCT
  - \- LIII - well designed cohort etc
  - \- LIV - clinical experience, committees etc

- Phase :-
  - 1- small no of patients ~1000
  - 2- larger no
  - 3- full use of the drug when freely available to the public (adverse drug reactions)

Function of the Medical Board

- Registration & renewal
- * Discipline :-   - Ix complaints
- Impairment :-
  - Alcohol, Dementia etc
  - Confidential notification
- Performance assessment :-
  - no legal requirement to enforce
  - increasing public concern
- Usually put public safety ahead of professional interest

Good surgeon

- Excellent communication skills :-
  - best form of medical indemnity
  - patient
  - within the surgical team
  - listening
  - empathy & concern
- Leadership qualities :-
  - Communication skills
  - Conflict resolution
  - Judgement
  - Identification of problems
- Ability to work with patients, families & other health professionals
- Ability to work with a multidisciplinary team :-
  - Communication skills
  - Conflict resolution
  - Identification of problems
  - Open discussion
  - Scheduled meetings (administrative structure)
- Awareness of ethical behaviour

- Capacity for caring

- Skills & Self-assessment :-
    - Ongoing evaluation
    - Self-education
    - Self-audit
    - Change the practice accordingly

- Teaching & Research

Ideal unit

- Most units have their strengths & weaknesses

- Ideal unit is a unit with skilled individuals guided by an enthusiastic leader, working in harmony to achieve best for their patients

- Understanding the contributions from each individual and having flexibility to deal with different personalities within the team

- Expertise available in the aspects of surgery it practices

- Elective surgery :-
    - Wide referral base
    - Opportunity & time for training
    - Waiting list not too long

- Multi-disciplinary approach

- Opportunity to learn :-
    - Unit meetings with various specialists
    - Consultant rounds
    - Support available readily eg Fellows

- OPD :-
    - R/v post-op patients so aware of outcome
    - Learn with interaction with other senior members of the unit
    - Some hospitals have private clinics

- Emergency surgery :-
    - Trauma

  - Should have the capacity to handle & not drain the resources

- On going evaluation :-
  - Unit meetings
  - Audit meetings

- Need to have a good 'morale' within the team(mental attitude, discipline)

Impaired surgeon

- The most important factor is the surgeon involved having insight & seeking appropriate medical expertise

- Need to find out :-
  - acute/chronic
  - temporary/permanent
  - does this leads to a disability?

- Be aware that in general the ill doctors recognise the problem at a relatively late stage (?denial)

- Surgeons have a higher risk of becoming ill :-
  - They are taught to be 'tough' so recognise illness at a later stage
  - Obsessional traits which could lead to anxiety/depression
  - Balance between professional & Family life, can be demanding
  - Inherent stressors eg. intra-op decision making
  - Increasingly difficult work environment (patient expectations & hospital demands etc)

- Other facts to remember :-
  - Impairment/Illness often not identified & hard to treat
  - 8% of doctors abuse alcohol at some time in their life
  - Mood disorders are common (F>M) & may coexist with anxiety
  - Advancing physical disease could lead to psychological disease

- Key points :-
  - never believe that you'll not get an impairment
  - increase of alcohol intake, anxiety & sleep disturbance as a warning signs
  - never prescribe for yourself especially the drugs of dependence

- Recognise colleagues with problems:- ?professional obligation

  - speak directly or via someone
  - offer to arrange treatment
  - make sure FU

- Options available :-
  - DHAS (Doctors Health Advisory Service)
  - RACS (Health Advisory Bureau). Confidential peer support service for fellows, trainees & families. First point of contact for physical or psychological problems

- Professional competence :-
  - usually could remain in practice except in acute & chronic symptoms
  - task of the treating doctor

- May require :-
  - partial/total reduction of practice
  - temporary/permanent

- May need a change of practice :-
  - non-procedural (research, academic) surgery may be still interesting
  - May need controls on especially with regard to substance abuse

Importance of communication

- Most successful surgeons are the best communicators

- Communication skills considered to be the best form of indemnity against litigation

- Communication is the interface between health professionals & patients, therefore to the patient communication is 'everything'

- It is also an essential aspect of good leadership that is essential for co-ordinating a multi-disciplinary team

- Communication should take place in a confidential environment

- Communication breakdown may lead to disastrous outcomes

- Important during adverse outcomes :-
  - apologise

    - adequate explanation
        - discussion
        - opportunity for the patient to ask questions
        - offer a second opinion

- Apologising for an adverse outcome should not be confused with accepting legal liability. After all it is common courtesy

- Communication is important :-
    - informed consent for treatment or surgery
    - withdrawing treatment
    - research
    - conflicts
    - leadership
    - to work with patients, families, multi-disciplinary team
    - most things related to surgery

- Important to remember :-
    - non-verbal cues
    - show interest, attention & be empathic
    - eye contact
    - opportunity repeat, summarise, clarify
    - non-verbal encouragers like smiling, head nodding
    - attentive silence
    - confrontation

Importance of ethics

- The discipline concerned with moral (goodness or badness of human behaviour) obligations related to professional conduct

- It is a set of moral principles

- Gives us the background to respect people & human dignity. Also enable us to understand moral values of medical decision making

- Being ethical provides privileges :-
    - confidential information
    - examination

- Special responsibility to individual as well as the society :-

    - notifiable diseases
    - child abuse
    - may need to breach the confidentiality to protect the society

- 4 main principles that have developed within the clinical doctor & patient relationship (dyad)
    - Beneficence (doing good for the patient)
    - Non-maleficence (avoiding of doing harm)
    - Autonomy (patient as a decision maker)
    - Justice (equal treatment regardless of cultural, ethnic attributes)

- Ethical issues arise in multiple areas of clinical practice :-
    - Withdrawing treatment
    - Organ donation & transplantation
    - Ethics of resource allocation
    - Ethics involved in research

- To understand moral values of those medical decisions ethics is very important

- Withdrawing treatment :-
- When the aim of treatment is not achieved (futile)
- When refused by a competent person (autonomy)

- Organ donation& transplantation:-
    - it prolongs life and quality of recipients but against the principle of doing no harm with respect to the donor
    - act of human kindness & donors respected for their autonomy
    - responsibility to the donor and recipient
    - paid donors in some societies (exploitation)
    - need the respect for cadaver donors
    - organ allocation has ethical standards
    - xenotransplantation (unknown risk to patients & animal welfare)

- Ethics of resource allocation :-
    - Finding the community values eg cardiac surgery
    - Conceptual differences within doctors, policy makers & economists, patients & families (Discourse ethics eg outcome)
    - Policy makers, economists, administrators & doctors need to understand one another (Ethonomics)
    - They need to work together to deliver the best care possible within the inevitable financial constraints

    - Financial constraints should not compromise patient care (eg. type of mesh in hernia repairs)

- To be aware of ethical standards in research :-
    - Animal & Human
    - Avoid bias by drug companies eg side effects

- Involvement of Ethics committees both human & animal

Importance of research

- To realise the importance of research, one should actually be involved in this. For me this was quite evident when I started a MS by research this year & getting involved in a few research projects at PMCI & doing the CLEAR course from the college

- It is a fact that research adds knowledge and is an ultimate good to the society (Abx, Vaccines)

- Current practice is a product of previous research & it is a moral obligation for us to be involved in it and contribute our fare share to improve the knowledge base

- It provides a scientific basis and evidence for our current practice:-
    - margins for MM

- Understanding research enable us to critically appraise them and influence our practice in a better way

- Help us to address a particular clinical problem and enable us to determine the efficacy of each

- Important to have a knowledge of research to be involved in CRC/EC

- To conduct research a sound knowledge, experience is essential :-
    - need to comply with CRC/EC standards

- Should be ethical in research :-
    - Justification to use human subjects
    - Therapeutic vs. Non-therapeutic research
    - Refer to Ethics in research

Injury to testicular artery during IHR

- It is a fact that, unfortunately errors happen in surgery as in any other branch of medicine

- Although difficult, it is very important to be open, frank & HONEST with patients that have an adverse event

- This is a possibility & hopefully raised at obtaining informed consent
    - Major issue if one testis (material risk)

- Inform the supervising consultant

- Possibility of salvage :-
    - ?Microvascular anastomosis
    - Depends on available expertise

- Continue the operation with caution

- Inform the patient when recovered:-
    - Always be honest to the patient
    - Artery was stuck & there was unintentional damage
    - Possible vascular compromise
    - Infertility unlikely provided functional testis in the opposite side

- Spend a lot of time, be sympathetic & provide support

- Testicular US post-op

- Offer a sperm count when recovered

Interview 2002

- Why do you want to do surgery?

- Why general?

- Why you?

- What experience?

- Strengths?

- Weaknesses?

- Your experience with audit? Example of application

- What do you think a good surgical team? Any experience in the way you thought that team work was less than adequate?

- How do you deal with criticisms? Two seniors say that you are globally incompetent what do you do? How to improve your skills?

- Your boss cut the ureter during sigmoidectomy and asks not to tell about that to the relatives and disappear. What do you say to the patient?

- You've discharged a patient with Abdo pain without even doing X-rays. Come back with LBO. They accuse you for not picking it before? What do you say? Do you do mistakes ever?

- Frozen breast biopsy is benign, paraffin is malignant what do you do? Patient thinks pathologist was wrong?

- Evidence based medicine? Levels? Phases of trials?

- Any questions for us?

Leadership experience

- Leadership qualities are an essential component of a good surgeon

- This requires communication skills, conflict resolution skills and a good judgement

- The work atmosphere should be friendly, discussion based and should involve a multi-disciplinary approach

- Need to identify problems and deal accordingly during scheduled meetings

- Conflict resolution with dietitian in a perforated PUD patient

- May be Mrs Chan's story with leadership in the team

Legal issues

- Duty of care is implied when a patient is accepted

- Negligence:-
    - treatment given fell short of the standard required

- Recklessness:-
    - undertaking risk whilst knowing about it

- Simple negligence - Civil liability

- Gross negligence - Criminal liability

- Liability :-
    - need to establish the negligence actually caused the harm
    - for criminal purposes proof beyond reasonable doubt is required

- Simple negligence is inadequate for manslaughter by common law

- Courts now take a balanced & restrained approach to the legal response to accidental injury

- No term as 'medical manslaughter', just manslaughter arising from medical negligence

Medical Boards

- MB's will always put public safety ahead of professional self-interest

- Should retain the trust of the public. For this we must demonstrate that we are able to control the practices of colleagues with unacceptable standards

- First MB in the world established in Hobart

- Function :-
    - Registration
    - Disciplinary action (misconduct etc)
    - Notification of impairment matters (dementia, alcohol etc)
    - Performance assessment (may advice to raise their standards)

New procedure

- Need to balance between increasing experience and potential risks of the procedure

- Research to increase the knowledge in this regard :-
    - Even evaluated elsewhere may not relevant to local conditions
    - Reliability of morbidity & mortality data
    - Level of evidence
    - Consider whether this intended to replace or complement an older procedure
    - Inquire from RACS? ASERNIP-S (Australian Safety & Efficacy Register of New Interventional Procedures - Surgical) whether this is part of a new trial or whether it can be incorporated in to one
    - Internet can be another source of information

- Talk with the surgeon it self and clarify the issues

- Discuss with my colleagues, surgeons anonymously and ascertain whether this happens in other units as well

- Have a responsibility to both the patient and the surgeon

- Should not allow the patient care to be compromised

- New procedures without proven value should be considered as research projects until proven & best considered within a research protocol. I'll discuss about this with the surgeon involved about devising a protocol

- If do not agree, as a junior I would not confront the surgeon and seek the assistance of the head of the unit (Medical practitioner's board last option and guided by the Head of the unit etc)

- Need to evaluate the hospital resources are adequate for this (staff, experience etc)

- A protocol & a consent form formulated and to be approved by Credentials committees, CRC/EC etc together with an application

- Resource utilisation :-
    - present & future costs
    - adequate through put to maintain skills

- Patients need to be advised about this as an experimental procedure :-
    - informed consent

- Monitoring :-
    - audit
    - assess the outcome

    - ?multi-centre

- Role of ASERNIP-S :-
    - evaluation of new procedures
    - notification to Credentials committees
    - register of procedures awaiting assessment

- From the analysis of the data we would be in a position to comment about the new procedure

Nurse refuse to apply saline dressings & instead a new dressing

- The patient's care is eventually the responsibility of consultant involved:-
    - vicarious liability for our actions

- Try to educate the nurse
    - The consultant's opinion comes from years of experience with treating similar patients

- I'll clarify with the surgeon as well because may not have seen the wound & the nurse may well have worked longer with the surgeon & may know the usual preferences

- It should be carried out atleast by myself, if the nurse adamantly refuses

Operation you've never done

- The principles here are :-
- Do not do an operation unless trained to do it
- Do not do an operation that you cannot complete (an example is not do even an appendicectomy alone if unable to perform a right hemicolectomy)

- Depends on whether it is life saving, elective or the nature it self

- Life saving :-
    - contact a colleague familiar with this urgently
    - get advice (??whether it can be done with guidance & proceed if both are comfortable)
    - stabilise and consider transfer? (no AAA repair!)

- Elective :-

  - could be a variation of an operation that you are familiar with eg different type & technique of mesh use in IHR
  - familiarise the procedure with texts, internet, experts, skills work shops
  - if adequate experience with previous operations & is a variation from that can proceed with guidance by experts
  - obliged to tell the patient ethically that this is the first time
  - if possible try to access an expert to give you assistance
  - if a complex, totally new procedure best to be transferred to experts & consider learning this for future

Patient fallen from table

- Things to prevent

- Always help during patient transfer etc, make sure patient safety during anaesthesia & try to avoid the situation

- Inform the anaesthetist, theatre tech etc

- Assess with A/B/C
  - make sure ETT is intact
  - consider Cervical collar

- Perform secondary survey

- Transfer to table when stable

- Consider X-rays

- Inform the consultant

- May need to re-schedule the operation

- Inform the patient :-
  - time
  - empathy & concern

Positives / Why you

- Experience :-
  - year of unaccredited registrar training

    - surgical assisting
    - exp to wider area of surgery including tumours, git, trauma etc

- Passed the exams while working

- Extra courses from RACS :-
    - CLEAR course

- A lot of research experience this year :-
    - MS
    - Principle investigator of a prospective trial at PMCI

- I have had the opportunity to present my work :-
    - RACS
    - Accepted for ASC in May
    - Hopeful to be published in ANZ journal of surgery

- Despite the fact I was not selected in to the program last year I have persevered to improve my surgical skills as well as surgical knowledge by involved in higher studies & research. They are all self-funded

- Apart from the interest I have noticed that I have the other skills important to a surgeon like :-
    - leadership
    - communication skills (quoted as excellent by my previous supervisor)
    - ability to work with patients, relatives & a multi-disciplinary team
    - ethical standards
    - knowledge & self-assessment

- Other skills :-
    - conscientious
    - obsessive
    - punctuality
    - computer/databases (Sean Mackay)
    - clinical photography

- The only opportunity to pursue my interest to another level further is by joining in to the Advanced surgical program

Preventing mishap in A&E

- Handover from A & E staff with Hx, Ex, Ix and working Dx. Need to assess the patient by your self

- Browse the Medical records emphasising on previous admissions, Hx, Ix and correspondence section, consultant summaries etc

- Review the patient, may involve Hx, Ex, +/- Ix

- Devise a problem list, a differential & a mx plan

- Reassess the patient if required

- Discuss with the consultant on call for uncertainties or a senior colleague, a fellow for example

RACS Constitution

- maintain highest principles of surgical practice & ethics
- safeguard the welfare of community
- educate the public
- promote practice of surgery under proper conditions
- arrange adequate post-graduate training
- promote research
- scientific discussion
- other things to achieve above factors

Refusal of treatment

- As medical professionals it is an inevitable fact at times we come across patients refusing treatment

- This should be considered within the context of assessing :-
    - competence of patient
    - overall prognosis of the condition
    - clarifying the reasons
    - exclude cute brain syndrome & any reversibility

- The communication skills are very important here to explain :-
    - the nature of the disease
    - treatments
    - side effects

- outcome of treatment and refusal of treatment

- Should offer alternative treatments and a second opinion if necessary. Use of interpreters for any language barrier

- Providing the patient is competent and a condition with a bad prognosis this may be a valid option respecting their autonomy. If incompetent may need a psychiatric assessment. Offer them to come back if change of mind

- When I was in GH as registrar last year an elderly lady with multiple medical problems presented with a LBO. The investigations were consistent with a constricting tumour

- We offered surgery however as she was exhausted with her other medical problems she refused any further active treatment

- She was competent and was aware of the consequences and was very adamant. We also offered her and the relatives to have a second opinion which they refused

- At the end we had to respect her autonomy & arranged palliative care

Risk management

- Topical & a very important issue of pro-actively determining the risk factors in order to reduce them. Similar to a quality assurance program

- Most things can be preventable. The precautions are for optimum management of patients

- Topics :-
    - Core (skills, communication & prevention :- pre-op, intra-op, post-op & FU)
    - Practice (office atmosphere)

- Skills must be developed to a high standard & maintained through an ongoing program of re-education, peer review & practice audit. Needs to do no harm. Avoid unrealistic expectations

- * Communication is very important :- - the best form of protection against litigation is good communication with patients
    - voluntary, informed consent
    - breakdown leads to disasters
    - non-verbal cues

  - eye contact etc

- Pre-op :-
  - Assessment of comorbidities
  - Previous DVTs, anaesthetic problems
  - Stratification of risks eg low, medium & high risk
  - Medical optimisation
  - Attention to details even for menial tasks like blood results, ECG reports etc (eg. to sign these prior to filing so not missed)
  - Informed consent (material risks), providing time for questions & clarification (offer a second opinion)
  - Always mark the site of surgery pre-op

- Intra-op :-
  - Position, diathermy plates etc
  - Site, Consent & X-rays visible
  - Mentors assistance when required
  - Prosthesis, IV injections should be checked by surgeon itself

- Post-op :-
  - Review the patient atleast once a day
  - DVT prophylaxis
  - Review the drug chart
  - Utilise other disciplines ie MD

- Appropriate FU :-
  - Routine review in clinic
  - Evaluate the complications etc with a routine audit and compare it

- During an adverse outcome :-
  - deal directly with the patient
  - apologise that such an instance has occurred. This is common courtesy & not to be confused with a formal admission of legal liability
  - sympathetic & be concerned
  - full explanation & spend time
  - any reversibility & offer a second opinion if necessary

- Review the risk management strategy especially if something fails

- Efficient & appropriate practice management is an important aspect of risk management program :-

- Overall impression by clean practice, privacy etc
    - Adequate records ie contemporaneous
    - FU of appointments

- MDAV discount for a proper risk management strategy!!!

Safe working hours

- Topical issue in that long working hours not only compromise patient care but also affect health & family life

- Balance b/w work & others

- Otherwise counter productive to the other

- Disadvantages
    - Tired doctor = BAC .05 ?potential effects on judgement
    - The decision making/surgical skills can potentially be affected
    - Could potentially affect family life
    - Lack of time to establish rapport from patients

- Advantages :-
    - Continuity of care
- (get to re-assess patients easily as familiar with them, easier to identify if deteriorates)
    - Rapport - very important in surgery (achieve trust, important for consent & surgical complications)
    - Patients are less likely to be forgotten cf to handover after a shift
    - Self satisfaction to operate on patients that one have admitted

Team work been less than optimal

- Team work is an essential part of hospital environment and it is necessary for better outcomes

- Last year when I was the registrar at PMCI we had a busy Tuesday morning in which I had to be in theatre by 0730AM

- Because of this I wanted the ward round to be commenced at 0700 so I can be in theatre on time

- However the resident had trouble coming at that time as her daughter's child care centre did not open till 0700AM. So we had trouble during the ward round and discharging the patients on time

- After mutual agreement we had a thorough ward round the night before and the Tuesday morning I did a ward round by my self without compromising the patient care. This involved coming to the hospital a bit earlier. Afterwards I handed over the things in order of priority

- In this case the resident's problem was a real issue so rather than compromising the patient care we came with a balanced feasible option

Teamwork experience

- As medicine advances the treatment increases in complexity to the extent that the patient care could get fragmented

- To provide best possible care to the patient teamwork & communication within a multi-disciplinary team is very important

- As the registrar it is essential to have leadership, communication skills, judgement & conflict resolution skills to achieve this

- Major decisions to be taken within the multi-disciplinary atmosphere

- PMCI Mrs Chan's situation - Nasopharyngeal lymphoma and NEC (neutropaenic enterocolitis) following chemotherapy

- Involving ID Reg - Abx combination in a neutropaenic patient

- Interpreter for communication

- Surgeon's to assess the abdomen

- Haem/Onc Reg - regarding G-CSF to increase the WBC

- Radiology registrar for re-assessment via regular abdo imaging

- Dietitian / ICU Reg - TPN as she was sick for a quite a while

- Of course co-ordinating with nursing, other allied health staff for eg. physiotherapy and pharmacist etc as well

- I took Final year Med students as a short case tutorial - so they were also involved, but as an educational exercise for them

Technique / Performance

- Having up to date skills is a professional obligation to the college & a moral obligation to the patients :-
    - CME (225hours/3 years)
    - College re-certification process every 3 years
    - Could compromise patient care otherwise
    - Get behind in comparison to your colleagues

- One of the major cause of adverse events is thought to be from human error due to 'failure in technical performance' so a very important issue to be up to date

- Self education
    - operative surgery text books, journals
    - internet
    - college guidelines
    - college Sat AM sessions
    - surgical conferences, meetings(unit, path, ASC) etc
    - distant education program
    - videos
    - skills laboratories (see one, do one, teach one has become an outdated philosophy)
    - virtual reality simulation

- Self-assessment
    - practice audit (change practice if deemed futile - EBS)
    - regular review of audit and complication rates & compare with other similar units
    - audit/outcome/practice circle (application of evidence for practice)

- Peer education & review
    - Try to get the supervisor as a first assistant while operating
    - Clinical meetings etc
    - Visit specialist centres for skills learning

- Research :-
    - not only learning but also contribute to the system that has helped you

Weaknesses

- Being human we are prone for weaknesses but the important factor is to identify them and try to rectify the problem by devising strategies

- Unrealistic expectation from allied health professionals & juniors :-
    - aware of this
    - always communicate with them and explain what's needed

- I can be a bit obsessive at times - blamed to be too meticulous in closing skin wounds to obtain a perfect result

- Until this year my research experience was minimal, this was one of my weaknesses. However as I have involved in a MS by research, having done the CLEAR course & been the PI of few research projects at PMCI, I am in a better position to apply EBM in to practice

- Operative technique can be improved. That's why I am here to get into the AST!

- At times tend to assume a particular gold standard & tend to forget other possibilities :-
    - Diclox instead of Fluclox
    - use antibiotic guidelines

What if not selected to AST

- I am optimistic to get in to AST however, there is always a possibility of failure

- The first point of action is to have a debriefing session with the college which will enable me to identify the weaknesses so I can devise strategies to overcome them

- *Then I'll continue to complete my research projects and Master of surgery degree next year

- I would re-apply to get in to AST of course guided by the college and my supervisors

What makes a good communicator

- Most successful surgeons are the better communicators

- Communication skills considered to be the best form of medical indemnity

- Communication is the interface between health professionals & patients, therefore to the patient communication is 'everything'

- It is also an essential aspect of good leadership that is part & parcel of co-ordinating a multidisciplinary team within hospital environment

- A person who is aware of the importance of communication as such makes a good communicator

- For this excellent communication skills are required:-
    - Attending skills :-(open posture, looking directly, eye contact, facial expression, privacy)
    - Directing skills :- (Open ended questions, Focused questions, Closed questions & Avoid leading questions)
    - Following skills (Non-verbal cues ie auditory; visual eg. facial, posture, gesture; Non-verbal & Verbal encouragers; Clarification; Attentive silence)
    - Reflective skills (Empathy & Concern, Summarising or even Confrontation)

- A good communicator is also a good listener!!!

- Provide opportunity to ask questions, be friendly & approachable

- Need to be aware of the barriers to communication :-
    - Language
    - Cultural (sexuality)
    - Age :- Adolescents, Elderly
    - Disabled
    - Others?

- Alternative methods of communication :-
    - writing
    - diagrams

- Non-English speaking patient :-
    - be aware of cultural barriers
    - non-verbal cues
    - interpreters

What makes a good surgical team?

- Group of skilled individuals working towards a common goal of providing best possible care to the patients

- Having a good leader with leadership qualities :-
  - communication
  - identification of problems
  - conflict resolution

- Understanding the contributions from each individual and having flexibility to deal with different personalities within the team

- Having regular meetings and open discussion and the ability to express ideas so a joint decision can be formulated

- Need to have a good 'morale' within the team(mental attitude, discipline)

What would you be in 10years?

- Presume to be a Junior consultant after completion of advanced training

- May be returned from overseas after gaining more experience

- Work will involve largely in a public hospital with some private practice

- Spend some time on research, teaching medical students which I always enjoyed :-
  - this will provide the chance for me to help the system that helped me

- At that stage I hope to have a small family may be with 2 kids

- Also some thought to travel to SL or Samoa to provide some of the expertise that I have
  - this would be a reasonable time as work & family commitments would be a bit more flexible then

- Hopefully my photography would be a bit more improved by then

Why surgery

- It is a demanding specialty with a lot of sacrifice although it is very satisfying:-
    - At the end one need to be interested, enthusiastic & enjoy what they do

- Interest :-
    - undergraduate interest of anatomy, dissections, physiology & pathology which are core surgical basic sciences subjects
    - interest in clinical years as a surgical RMO by spending a lot of time but still enjoying it
    - interest as registrar

- Apart from the interest I have noticed that I have the other skills important to a surgeon like :-
    - leadership
    - communication
    - ability to work with patients, relatives & a multi-disciplinary team
    - ethical standards
    - knowledge & self-assessment

- This year by starting a MS by research & involved in other research projects, I have come across another interesting area of surgery. This is a way to contribute to the surgical knowledge as well

- Despite the fact I was not selected in to the program last year I have persevered to improve my surgical skills as well as surgical knowledge by involved in higher studies & research

- The only opportunity to pursue my interest to another level further is by joining the Advanced surgical program

Withdrawing treatment - Principles

- Health :- State of complete physical, mental & social wellbeing (WHO)

- Medicine's aim is to maintenance or restoration of health & relief of suffering

- Decision about one's health ultimately is a matter for the individual

- 2 Circumstances to withdraw treatment on the ground of above facts :- Perfectly legal
    - When futile (ie does not achieve aim of medicine)
    - When refused (autonomy of patient concerned)

- Difficult to withdraw treatment especially when it's prolonging life

- When elderly person's life is drawing to an end, medicine should not be applied merely to postpone death :-
    - reluctant to accept dying
    - may detriment the patient's palliation

- Definition of death :-
    - Irreversible cessation of circulation
    - Irreversible cessation of brain function

Withdrawing treatment

- As medical professionals it is an inevitable fact at times to withdraw treatment. It is a difficult decision and even harder especially when it's prolonging life

- 2 Circumstances to withdraw treatment :- Perfectly legal
- When the aim of treatment which is maintenance or restoration of health is not achieved (ie futile - need experts)
- When refused by a competent person (decision about one's health ultimately is a matter for the individual - autonomy)

- When elderly person's life is drawing to an end, medicine should not be applied merely to postpone death :-
    - reluctant to accept dying
    - may detriment the patient's palliation

- When I was a registrar at PMCI last year we had a young Ethiopian lady presenting with dysphagia & dehydration. She had a gastrectomy 2 years ago in overseas. Did not have any FU gastroscopes since she was pregnant at the time

- Laparotomy revealed extensive intra-abdominal recurrence and she had a bypass procedure with debulking. However she continued to deteriorate without any response

- After long discussions with the patient and the husband with the use of interpreter a joint decision was made to withdraw any active treatment. It was very difficult as she had a 1 year old baby

- We offered community based palliation. Her last wish was to see her parents in overseas which we managed to organise with some difficulty

Wrong breast implant found out just after extubation by nurse

- These are the incidents that could easily be prevented by paying attention to details ie marking the side, checking prostheses, checking IV injections etc
- Always be aware of risk management
- Confirm that this is happened & if you are by yourself inform the consultant involved urgently
- If patient still under anaesthetic and not fully recovered could be argued that they are still under the effect of the previous anaesthetic & should be re-intubated to insert the correct prosthesis
- When recovered it should be mentioned to the patient & explain the whole issue spending extra time. Reassure few times
- Taking necessary precautions to prevent this from happening again
- Need to consider any legal issues
- If found in the ward it is a major problem explanation & a lot of time with the patient is very important
- Need to revise as a second procedure. Offer 2nd opinion
- As a cosmetic procedure imminent legal issues