Travelling Fellowship to The Royal Perth Hospital, Australia
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Venue

My visit to The Royal Perth Hospital (RPH) was supported by the head of department, A/Prof Dieter Gebauer. Alongside him there are four other consultants including Mr Nathan Vujcich, Mr Peter Ricciardo, Mr Leon Smith and Mr Evan Kakulas; I attended theatre and clinics with all of them across my two week placement.

The population of Western Australia is 2.5 million which is about a tenth of the total population of Australia, although the catchment area for this hospital is about 10 times the size of the UK. As a country, Australia is a vast expanse, something which I hadn't appreciated until I undertook this visit, but figure 1 gives you an idea about the distances and geography of the country compared to Europe (and the potential logistics involved in arranging for patients to be seen in Perth from the rest of the state and their immediate catchment area).

Figure 1. Geographical expanse of Australia compared with Europe.

RPH is a level one trauma centre and takes referrals from all across the state of Western Australia. There are three principal catchment areas covering Western Australia and, as well as being the state trauma hospital, RPH is responsible for

routine trauma referrals from the catchment area shown in ORANGE in figure 2. The BLUE area is covered by the Fiona Stanley Hospital, where largely all the head and neck oncology services are based, and the third area, GREEN, is covered by Sir Charles Gairdner Hospital, where the facial trauma and oncology and deformity provision is provided exclusively by plastic surgery, with no input from OMFS.

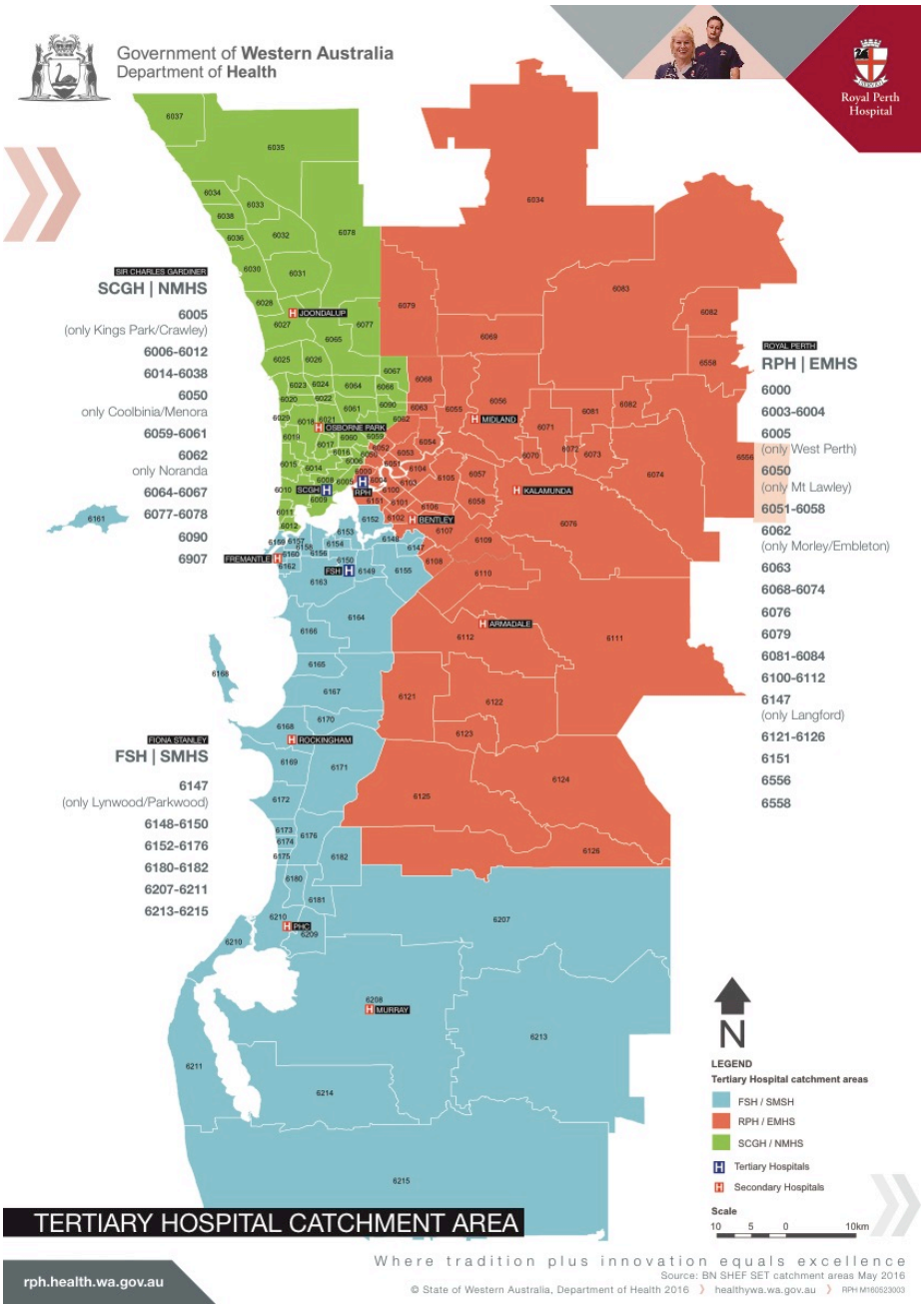

Figure 2. Referral boundaries for Western Australia (excluding major trauma which goes to RPH)

The infrastructure of the health service is such that there is country-wide public sector service which all workers contribute 2% of the annual salary to, known as the Medicare scheme. Associated with this is a private sector insurance system which means patients can choose to undertake their treatment at an external facility (which will require transfer out of the state service into private rooms of

the associated consultant on call – most of these private sector facilities will happily facilitate the transfer of such patients) and this private sector scheme is promoted; otherwise higher earners are heavily taxed accordingly. This does free up capacity in this state teaching hospital, which has a capacity of 450 beds.

The on-call service is not like that in the UK; there are five resident consultants at the RPH who have base operating rights, alongside a number of other largely private practice based surgeons who also help partake in and cover the on-call rota.

The training system is two tiered and there are a number of accredited (allocated a formal training number) vs non-accredited registrars (covers all level of trainee who may or may not be dual-qualified). The working day is largely 7.30am -5pm with on-calls taking place over a 24 hour period. At the RPH there is a medically-qualified intern available during the day, after which there is no SHO/middle grade to filter calls, and calls arrive from across the catchment area for the East of Western Australia as seen in figure 1. If there is a need to operate out of hours, there is a rota of on-call (unpaid) medical/dental students who will come in to assist with the case.

Whilst the catchment area demographics are largely a middle class Caucasian population (and 2.1 million people reside in Perth itself), approximately 30% of the trauma presenting arises in the indigenous population. Reasons from this are multiple and include an epidemic of drug and alcohol abuse (in particular crystal meth). Although I did not experience or see any such drug abuse behaviour out of the hospital whilst in Perth myself, this is probably as a result of the dissipation of the population over a wider geographical area than say the equivalent population in a UK city.
This observation demonstrates the logistical difficulties in arranging care for patients requiring acute assessment and treatment but transportation to the RPH. The western state has an excellent radiology service so that imaging can be shared immediately between all units and this allows appropriate triage of patients who require transportation into base. This is provided by either the State Emergency Medical Services or delayed transfer of patients occurs via scheduled charted flights and travel into RPH clinics.

Clinical Activity
My timetable and placement took over 6 months to arrange; I was originally covered for observational duties only which required me to attain clearance with Occupational Health (serology for chicken pox and tuberculosis which are mandatory for any clinical placement in Australia); however, upon my arrival I was able to observe and assist with all the surgical procedures undertaken during my placement. This was a superb added bonus and certainly made my placement much more enjoyable and useful.

As the RPH is a Level 1 trauma centre, much of this operating was elective trauma and I assisted with a large number of cases including complex panfacial trauma and condylar fractures, in addition to the routine mandibular fracture and cervicofacial infection workload.

I was also very privileged during my visit to have been invited to attend an MDT clinic at the newly opened Perth Children's Hospital and I spent my last morning with children attending with complaints ranging from benign pigmented intra-oral neavus, to resection of ameloblastoma with immediate reconstruction using digital planning, to bilateral condylar fractures not amenable to surgical fixation in an indigenous 15 year old who had attempted suicide. The second part of this MDT planning clinic is attended by both OMFS and plastic surgeons and largely focuses on discussing care of cleft and congenital craniofacial deformity cases. Through this visit I was involved in the primary assessment of a new born baby with an undiagnosed hemifacial microsomia at the Royal Perth Children's Hospital, having attended a call to review said child with the on-call maxillofacial registrar.

Over the first week, my visit coincided with the annual meeting of the Australian and New Zealand Association of Maxillofacial Surgeons, hosted in Perth. As such, clinical activity in the department was reduced on the Thursday and Friday and I was able to attend part of the conference which ran over 3 days into the weekend.

During my visit there was a cadaveric dissection course aimed at OMFS trainees which I was invited to attend, this covered principles of surgical access to the facial skeleton and was superb and well supported by an international faculty including Mr Ben Robertson from Liverpool and almost exclusively former UK based clinical fellows who have returned to Australia to work. The visiting professor was Mr Eric Dierks who gave a superb talk regarding emergency airway access.

What did I see that was different to the UK? The volume of trauma is different to other trauma centres I have worked in and it was interesting and useful to see the discussions that took place regarding trauma referrals and the logistics of arranging for them to be reviewed locally (which may involve instructions to the GP on review pointers). There are established 'Social Care Workers' who help with transportation of indigenous patients to RPH and local accommodation that is sensitive to their needs. Such patients are often accommodated in Perth for anything up to a week afterwards locally so that a formal review prior to transfer back to their usual residence can be arranged. Whilst in the UK we have out-reach clinics to help patients who live more rurally, this takes on a whole new meaning when you consider an area the size of Western Australia.

For me personally, the biggest benefit of this trip was to see how well developed and accepted our speciality is here in the UK, with our defined scope of practice and sub-specialisation. In Australia, recent published work demonstrates that whilst OMFS is the main referral specialty for facial fractures, interestingly facial lacerations are still largely referred to plastics. 67% of referrals for oral cancer are still made to ENT, as patients are directly referred by GDP's, GP's and emergency department clinicians to both a state or private sector facility. For me the clinical governance and ways in which activity is assessed and deemed successful is not regulated to the same same standard of care provision as here in the UK (eg. management of cleft patients requiring bone grafts with CSAG

guidelines or mandatory MDT discussion regarding head and neck oncology patients).

As a trip it was a superb opportunity to see the provision of healthcare in a challenging geographical area. I am now very appreciative of how quickly our patients can be seen and assessed, and largely, through our MDT set up (for cleft/craniofacial/oncology and orthognathic surgery) this means that care is well planned, discussed and subsequently undertaken; with geographic variation in standards and methods of care being less variable. This is certainly not the case in Australia, where as a speciality OMFS is still attempting to gain recognition of its role to play in head and neck cancer, cleft and both congenital and developmental craniofacial deformity.

Cost

The total cost of this trip was about £1600, the vast bulk of which was my airfare and occupational health clearance costs.

Acknowledgements

I am most grateful to the three Royal Perth Hospital trainees, Jamie Olsen, Tom Cooper, and Ragu Krishnamoorthy, who made me feel most welcome and part of their team. I am also grateful to all the RPH consultants who were so hospitable and friendly. The department secretary and administrator at RPH, Miss Heather Witte also deserves a mention as she dealt with my many and multiple queries, and guided me through the administrative process of getting my visit sanctioned and approved with occupational health.

I would recommend the Royal Perth Hospital as a venue for a visit for any other UK senior OMFS trainee, and my only regret was that my visit could not be longer. Having originally only wanted to see trauma in Perth, I think the range of pathology seen in one morning at the Royal Perth Children's Hospital would lend itself alone as a placement. I have a wide range of clinical photographs that I acquired with permission for my own learning, which I am sure I will be useful for future teaching.

I thoroughly enjoyed my visit and am certainly now much more appreciative and mindful of how well we work with allied surgical specialities to collaborate. I am most grateful for the support and generosity of BAOMS with this venture, which was a very memorable and outstanding two weeks.

Miss Nabeela Ahmed
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