# Not a Straight Forward Surgical Career Path

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Specialists Without Borders
Ask A Specialist

My pathway to surgery was not so much circuitous, but an elongated linear path with a few lateral deviations. I always knew from a very young age that I wanted to do medicine. However, rebellion set in when I was a teenager and I was told to leave home aged 16 years. Fortunately in those days in New Zealand despite my young age, I was able to head off to university. Equipped with a lot of anger, I opted to do what I thought was the least demanding of courses, education and teaching. For me, however, there was little satisfaction in teaching others to achieve more than I had at that time.
I found a diploma course in Glasgow which had as its foundation, anatomy, physiology, psychology and kinesiology. That seemed to get me onto a more interesting track and led to a Master's Degree at the University of California; with a double major in sports medicine and sports sociology. My intention was to go back to New Zealand and lecture in sports science/sports medicine. Fate again intervened just as I graduated. A visiting professor from Stellenbosch in South Africa, offered an inaugural scholarship, so that I could do a PhD in sports medicine/sports science.

Arriving in sports mad South Africa at the beginning of 1978, I was confronted for the first time by a racially segregated society. For a New Zealander brought up in a multiracial country, it was a significant culture shock, akin to arriving on another planet, one in which I initially wondered if I would survive on. Stellenbosch University is set in the feet of the beautiful granite Simonsberg Mountains, surrounded by the equally beautiful Paarl vineyards. Stellenbosch at the time was one of the hearts of Afrikanerdom, a university which supported actively the concept of legislated segregation. A system which to me was both an anathema and yet a curiosity. I found as I struggled to adjust that if I was to do my PhD in sports science, I would first need to set up sports science databank, as the research facilities were sadly lacking.

Apartheid while repugnant was starting to fascinate me. As part of my undergraduate studies I had done extra courses in politics and American history. I asked my American supervisor whether I could change my thesis to one on Politics Race and Sport in South Africa. He said good luck with your two South African supervisors. I was very lucky or very persuasive.
The next two years of research for the thesis, provided a fascinating understanding of the concept of apartheid, its cruelty and inhumanity. My flat was raided by the security police and my phone tapped. When it came time to present the thesis, it was initially rejected as it was critical of segregation. There was one supervisor who was vehemently opposed and had refused to sign off on the final chapters. Fate again strangely intervened. A Johannesburg newspaper exposed the secret white South African society called the Broederbond. They were an organisation dedicated to the preservation of white rule. My supervisor was named in one of the cells. He was removed from my committee and the thesis proceeded to its oral defence. I had been meticulous, knowing that the slightest error in research could be the grounds for rejection. Over an hour and a half I defended my research, and to their academic credit they passed it with distinction. The Chancellor on the presentation of my PhD said quietly to me, such determination, we thought you would never make it this far.

You may wonder at this stage where surgery is in the scheme of things. I was about to take my PhD and go back to lecturing in the United States, an associate professorship beckoned along with life in California. Then Mrs Fate walked by again. A chance barbecue, or as they say in South Africa a Braai, in Cape Town weeks before I was due to leave. As it happened the Deputy Vice Chancellor of the University of Cape Town was there, and he wanted to talk about a PhD which by that stage had become quite well known and talked about. Not unnaturally we talked about the very famous Groote Schuur hospital, where Christian Barnard had done the first heart transplant in 1967. As the discussion went on, he said to me smiling, "So when are you going to do medicine." Before adding, "You know no one is going to take you seriously until you have done a medical degree." I looked at him for a second, and with the advantage of a few beers, said, "If you would give me a year off for all the undergraduate anatomy physiology pathology that I have studied, I might apply." He looked at me for a few seconds, smiled again and said, "Why don't you put your application in then and see."

I should say the rest is history but it's not. I was 27 in a foreign country, classified as a foreign student with no money. I phoned everyone I knew, they all said I was crazy, but for the right reason. You were born to do medicine, get on with it. My parents offered to pay the thousand dollars per year, which were the foreign fees to do medicine then in South Africa. That would pay my fees, but not my books or living expenses. I asked around, there were no jobs, either part-time or full-time; these were all taken by the coloured or black population. Just when it seemed like impossibility, I was offered a job harvesting eyes. At that time the Cape Province had one of the highest murder rates in the world. There was therefore no shortage of eyes to be harvested. I would get a call from the police mortuary, and in an area the size of a small Hall there would be bodies packed in tightly next to each other. I would have an order for a number of eyes for the week. I would remove them from the bodies, suture the lids closed so no one ever knew that they had been removed, take them to a little lab, trephine the corneas, and send them off to whoever had ordered them. That paid my way through university.

Doing medicine in South Africa, despite the segregation, was a rare privilege. At that time the University of Cape Town medical school was ranked amongst the top medical schools in the world. Not only was the teaching superb, the exposure to real life

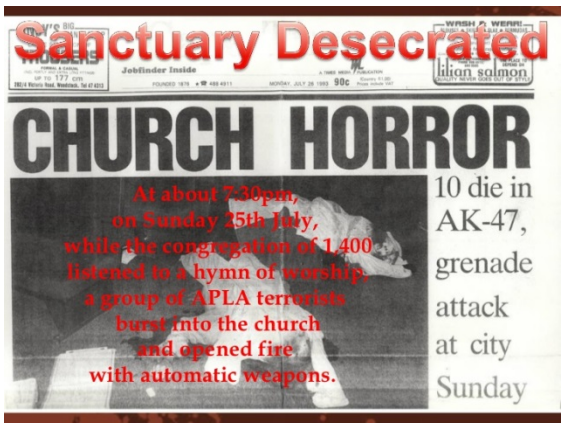
pathology was unparalleled. The trauma training was immense, the medical pathology extreme and raw. In fourth year, I delivered 20 babies under the midwifes supervision. As a fourth year I put in chest drains in the trauma unit. The extremes of medicine were exciting and challenging. Surgery also became more and more attractive, partly through the trauma, but mostly through superb teaching from four professors of surgery. I was slowly hooked, and it also seemed to be a natural fit for someone who loved being able to solve a problem. The seed was sown, however the linear pathway to surgery was not yet at its entry point.

In my final year I met a surgical registrar, who was one of the first female trainees. She tutored me for my final exams, and not surprisingly I did well in surgery, so well in fact did she tutor me, that I married her at the end of the year. At that point, South Africa was starting to undergo transition from white rule. We didn't believe that Nelson Mandela could pull off a peaceful transition. I applied to Waikato hospital in New Zealand to do my internship and my wife was accepted, albeit reluctantly, onto a male dominated surgical training program. She was credited with two years of surgical training, and told that she could write the RACS fellowship. Love now being surgery, I decided through my internship to study for the Edinburgh FRCS. We both passed, and cheekily applied for the New Zealand surgical training committee having only done one intern year. Strangely they agreed to interview me, perhaps it was the recent FRCS. I will never forget my interview. Intrigue and scepticism was evenly mixed. One surgeon on the panel asking why I wanted to do surgery, and was there anything in particular in surgery that I wanted to do. "Liver transplants." I replied. "I don't think we take Walter Mitty applications." he responded. Fortunately by that time I was already in Auckland doing a basic surgical training job at Middlemore hospital. One of two surgeons, who were to become my mentors, was on the committee as well. I was admitted to surgical training the next year.

Surgical training therefore began in New Zealand. My wife was appointed as a consultant to Dunedin and we moved there. As you can imagine the demands for a consultant and a registrar were considerable. The strain on the relationship was enormous. We had decided to separate and she was keen to return to South Africa, when she discovered she was pregnant. That in itself made for some interesting times; it will not surprise most surgeons that she continued operating up to 35 weeks. I distinctly remember receiving a call to come to theatre urgently. When I entered theatre my wife was sitting in the corner, exhausted she said could I please close the laparotomy. Then she announced that she was returning to South Africa and that's where my son would be. Thus began a process which again involved the New Zealand surgical supervision committee. Would they give me permission to complete my final year in South Africa? My mentors in Auckland, Viv Sorrel and Neil Officer, argued my case. I was allowed to go as long as I kept a log book and submitted it to the committee every three months. After the first three months being on call as a vascular registrar every second night in Cape Town I send my log book back to New Zealand. The committee asked for the Vice Chancellor to verify my logbook such were the extraordinary numbers of surgeries I had undertaken. I returned home at the end of the year and wrote the fellowship. Now armed with an RACS I returned to a junior consultant post in Cape Town.

It was now 1992; there was discussion about a transition to black rule in South Africa. The African National Congress party in South Africa, of which Nelson Mandela was the head, was negotiating with the ruling white government. One night after a particularly busy weekend on call, my wife and I had a surgical disagreement. I walked out of the house before realising it was a Sunday night and nothing would be open. One of my

colourful and coloured patients had told me about a multiracial church in which there was amazing singing. Deciding that was a better alternative than going back to face the music I headed to the church in the pouring rain. I sat half way up an elevated auditorium. As I sat down a young girl started to sing, the notes I recall were so pure they made the hairs on my neck stand up. Then through a side door a man in a mask and a camouflage uniform entered. The congregation applauded, obviously I thought, part of a novel introduction to the sermon. Then he shot the young girl on the stage with an AK-47. Four others also in camouflage uniform entered behind him and started firing indiscriminately at the congregation. I dived to the floor curling up underneath the pew. Peering around the end of the pew, I could see the terrorists advancing into the congregation shooting, and throwing grenades laced with nuts and bolts. There were screams as people died and had their limbs blown off. A leg amputated above the knee landed at the end of my pew. The man behind me was shot between the eyes and fell over where I was lying. The woman on my right was shot and fell dead into the aisle. When there was a lull in the shooting I looked around the pew. One of the gun men saw me and threw a grenade. I can still see it wobbling through the air nails and screws stuck to its edge, before it landed in the aisle next to me. I looked at it and it started tumbling down the aisle gathering pace hopping and bouncing like some strange dance, due to the nails and screws stuck on its casing. I curled into a ball put my hands over my head as it exploded. One fragment shattered my left radius and ulna in 14 different places, but my radius stopped it penetrating to my heart. I could feel the blood running down my leg pooling in my shoes as the gunfire continued. A bullet shattered the pew in front of me, I felt the stinging sensation as it penetrated my left flank. Another bullet creased my scalp embedding itself in the concrete step behind me, before suddenly the shooting stopped. An off duty policeman in the congregation had started firing back and the terrorists fled. I looked around there was chaos everywhere. I waved my hand at the end of the pew until someone arrived. It was Justin one of my fourth year medical students. "I'm bleeding." I said as he slowly pulled me out from behind the pew and the body which had fallen on top of me. "Justin we need to find out where I'm bleeding. Rip off my shirt and trousers." There were multiple bleeding points from the grenade fragments, but when he took my shoes off blood spurted from a lacerated dorsalis pedis artery. Despite my other injuries and a ruptured left eardrum, I managed to instruct Justin on how to apply pressure to stop the bleeding. Other friends arrived, ripped out part of the wooden pew and loaded me on carrying me out to one of many ambulances which had now arrived. As this was one of the first terrorist attacks in the world of this kind, there was no trauma plan, no white plan as there was for the Paris tragedy. As a Dr I was put in an ambulance, no drip up but driven at breakneck speed. A trauma consultant, a friend of mine was waiting. Digby wanted to do a laparotomy, my haemoglobin was five but I was certain there had been no abdominal penetration with the bullet. He reluctantly agreed, but then being the friend that he was said he would sit in at the orthopaedic surgery in case I deteriorated. Another great friend and orthopaedic surgeon then took eight hours to put my arm back together so that I could potentially continue my surgical career. He also took a chance, plating my arm rather than using an external fixator. The grenade shattering the radius and ulna had created such gaps in the bone which had little chance of joining. The only


Sanctuary Desecrated

CHURCH HORROR

At about 7.30pm, on Sunday 25th July, while the congregation of 1,400 listened to a hymn of worship, a group of APLA terrorists burst into the church and opened fire with automatic weapons.

10 die in AK-47, grenade attack at city Sunday

thing that really was left intact he said was the neurovascular bundle. Eight weeks later there was callous.

Being a surgeon and a Kiwi, my instinct was that survival meant I should get on with life and in a month or two be back at surgery. Despite the determination, I still had to deal with post-traumatic stress. Diving under beds, when balloons went off at children's parties, I could understand didn't encourage the belief that the effects of the trauma could be mindfully silenced. At that stage there was no real post trauma counselling. I therefore started to write finding a description of the evening cathartic. It unearthed a creative instinct which turned into a medical thriller called, Does It Hurt to Die, which was published by Austin Macauley. There was even interest in turning it into a film for a while from Russell Crowe. Friends however were unconvinced that this was sufficiently cathartic, and ordered me to come and stay with them in Hong Kong for three weeks. Mrs Fate obviously knew about that visit as well. While I was there I went to a surgical conference and met the Professor of Surgery, from Flinders University in Adelaide. Jim Toouli was an international expert in the area of hepatobiliary surgery, in particular Sphincter of Oddi dysfunction. In Cape Town a liver transplant unit was underway, which I had moved to be involved in, Flinders, which was about to start a liver transplant programme seemed a natural fit. The other aspect was that Jim and I seem to gel. He suggested that I applied to Flinders. I submitted my application the next day. I was back in South Africa when I received a phone call. "Am I speaking to Dr Paul Anderson?" I replied in the affirmative and then was told that the broad South Australian accent belonged to a Dr Stephen Birrell. He informed me that he was on the appointments committee for Flinders University. He had been perusing my CV. Quite impressive he said. But was it true that I had been a rugby Junior All Black. I replied that I had been, to which he laughed and then said you have the job, explaining that he needed someone to watch the rugby with. Steve not unnaturally went on to become a great friend and colleague as I took up a senior surgical registrar's position at Flinders in 1993. It was a step down from being a junior consultant, but the nightmares related to the terrorist attack in South Africa started to decrease once I arrived, drinking Steve's very good red wine probably helped a little too.

Flinders was an exciting place to be at the time, especially with the development of the liver transplant programme, guided expertly by Rob Padbury. In theatre there would often be a cast of thousands which always made it interesting, despite the 13 hours of surgery. Despite being a Kiwi, I felt at home, developing an experience with ERCP's and teaching medical students, which I loved, all of which appeared to confirm the future surgical pathway. After a year, Jim decided to go on sabbatical to France. I was duly appointed his locum tenens taking on his lists and his teaching loads. During that time another fork in the surgical road appeared. Professor Jim Watts was the foundation Professor of Surgery at Flinders, hugely respected and a pioneer of bariatric surgery in Australia. Bariatric surgery at the time was very much at the rear end of the surgical spectrum of super specialisation. It was something that most regarded as a super specialty that you did if there was nothing else available. Jim Watts, however, had the foresight to see the burgeoning problem in Australia. He persuaded me to become involved and taught me the essentials of

bariatric surgery/gastric bypass. I have to admit in the beginning I was reluctant learner, partly due to my 'fatist' discriminatory inclinations. After nine months of Jim's tutelage he announced that he was going to retire for health reasons, and asked whether I would take over his private practice, which included 40% bariatric patients. The die was cast, how one could refuse not only the foundation Professor but the doyen of bariatric surgery in Australasia. There was some objection that a Kiwi had been offered the professors practice, versus the local surgeons, however those objections were mostly muted by the sizable cohort of bariatric patients that I was certain to have to deal with. My good friend Stephen Birrell initially thought it was very much a poisoned chalice, adding to my doubts by suggesting that no foreign surgeon had ever made it in the medically incestuous community of Adelaide.

Taking over Jim's considerable private practice meant reducing my public commitment to part-time. I was fortunate that I also inherited Jim's private practice in the beautiful McLaren Vale wine area, an added bonus. Then again as fate would now it, laparoscopic bariatric surgery emerged. I organised to go to Belgium to learn the technique from Dr Bellachew. Returning to Australia I think I was the third surgeon to set up both a clinic and a practice specifically for laparoscopic gastric banding. Paul O'Brien had introduced the technique to Australia approximately six months earlier, and George Fielding had in Brisbane. Both were immensely supportive, Paul in particular with his rare combination of excellent surgical technique and research prowess, contributed immensely to lap banding being accepted as the new wave in bariatric surgery. Very soon the surgical pathway had expanded to include psychologists and dietitians, and a full on Bariatric clinic, with not infrequently 10 to 12 lap band patients being operated on per week. Suddenly bariatric surgery was emerging from the surgical specialty darkness. That it could now be done laparoscopically, demonstrated on a large screen with obvious technical skill required, and generated large amounts of money. It would have been nice to have thought the money didn't matter it was about treating patients who had a great need, but after all we are surgeons.

So bariatric surgery became about 50% of my practice, the rest was now gastrointestinal and hepatobiliary. As one's expertise and reputation grew referral s came from different parts of Australia. The Adelaide practice became one of the most successful bariatric practices with a cohort of approximately 4000 patients in Australia. Clearly now the path ahead to retirement was straightforward. Yet there was to be another surgical intervention; part of me felt guilty about having been trained in South Africa and not contributed in any way medically or surgically. By 2004 when it was a good 10 years since the terrorist attack, I was challenged to lead a medical team to Rwanda. This was part of a worldwide response to mark the 10$^{th}$ anniversary of the genocide. The point was to show that despite the fact that the world, if it had acted, could have prevented the genocide, still cared. My initial reaction to leading a medical/surgical team was no way. I had been shot at in Africa why go back for more. The challenge had come through someone, whose name I now cannot remember, who was head of a charity that coordinated teams to fly into emerging countries to do paediatric corrective cardiac surgery. I had started talking to him at a stand he had at a surgical conference in Sydney. My goodness he was a persistent bugger. He wouldn't take no for an answer. There were text messages and messages on my pager to call him. In the end I thought what would completely put off would be a request that I would consider it if it least 20 people responded to the announcement on their website. Three days later he phoned me and said 30 had volunteered. The team was a combination of nurses, physiotherapists, occupational therapists, hospital administrator, and pharmacist from various parts of the world. I led one team down to the Rwanda/Congo border to a

hospital in Gisenyi. We spent two weeks there, me operating and the rest advising reviewing hospital systems improving where we could. At the end of two weeks most of us were reluctant to go home. There was so much that could be done to improve the lives of the local Rwandans, it couldn't we said just end with a two-week contribution. Trevor Walker, another Kiwi and I, decided we would come back the following year and research as to how an effective contribution could be made. After that visit Specialist without Borders (SWB) was founded as a not-for-profit organisation, to take the highest quality teaching into emerging countries. We decided that was the best way to contribute; analogous to teaching the people to fish so that they can teach others the same.

The next year I put an advertisement in the Surgical News. I had made contact with surgeons in Kigali and at the national University in Rwanda. They were very enthusiastic about a 10 day teaching seminar. My only concern was would there be sufficient like-minded surgeons in Australasia who would want to give up their time, pay their own air fares and accommodation to teach in emerging country. I had estimated we would need seven surgeons to run any kind of effective seminar. 15 applied. I realised then as I continue to realise, that there are many more like-minded doctors willing to give back in some way. I could very quickly see this was going to be a serious proposition, which would be difficult for one surgeon to develop, especially one who had a busy surgical private practice. As a little publicity developed around the concept, offers of all kinds started to come in. The Adelaide brothers' Professor Jegan and Professor Suren Krishnan, not only committed to a national executive, but enthusiastically promoted it and volunteered to come on our first trip. The trip to Rwanda, was successful in convincing all those who came, that there was indeed a great need. Other offers of help emerged, a wonderful executive developed not only with Jegan and Suren from Adelaide, but Katherine Edyvane from Perth, David Birks from Melbourne, Kate Drummond and Anthony Tobin also from Melbourne.

That SWB has now evolved into a significant international teaching organisation, is due in no small part to the national executive, but also a wonderfully gifted programme director, Megan Copeland. Megan took over most of the everyday running and administration but also had great insight into the potential for development. A Specialists Without Borders website was set up as a way to communicate to the public and accept donations, articles were written for newspapers, the occasional article even accepted by Surgical News. As the organisation developed, and its reputation for excellent teaching saw it attract more interest in Africa, an educational curriculum for teaching in developing countries became a requirement. Wanting to ensure that it was the highest level teaching and the most appropriate for the situation, Dr Don Bramwell and educationalists at Flinders University was appointed to the executive. Don's task

was to evaluate our teaching independently and look at ways in which it could be improved in terms of cultural sensitivity and appropriateness. By this stage, we were having offers from nearly all the specialties to come and teach with us. Don and conjunction with the executive, after a trip to Africa with us refined our teaching. We had found, partly due to cultural sensitivities that didactic teaching on our evaluation score sheets was not as effective as we had thought. Innovative teaching techniques were required. With Don's guidance and help we developed special Structured Clinical Instruction Modules for teaching. These and other techniques have become the mainstay of SWB today and in no small part contribute to the hugely positive feedback. One of the long-term aims that I had was that we be able to teach on total patient care. By this stage we had a very gifted intensivist from Melbourne Anthony Tobin, and then another very gifted anaesthetist Brad Hockey on the executive advising. We were now covering medicine and surgery, but for total patient care I thought we needed nurses. That has happened in the last two years and we are now in a situation where at our last teaching venture in Harare Zimbabwe, the nurses seminar was overwhelmed with 83 nurses turning up, to the point where the consultants were co-opted to help teach! The other very pleasing development is the involvement now of an official junior doctors group and medical students. The junior doctors are a group officially under the auspices of the specialists, who come with us to teach medical students. We select our junior doctors from a list of applications each year based on their experience and teaching abilities, and we take four or five medical students to expose them to medicine and surgery in emerging countries. Most years we have 40 or 50 medical students apply to come with us.

You might think this is getting towards the end of the surgical pathway, the organisation now successfully established with independent financial support enabling us to look at purchasing teaching aids such as mannequins. Fully immersed in private practice and a little research, as well as SWB, life seemed fairly well contained. Then I fell off a ladder and fractured a calcaneus. That stopped me operating; the repair didn't go well and had to be redone. What to do, I wasn't ready to retire hurt, and while there was still the considerable involvement with SWB, the surgical desire needed some expression. Talking to my colleagues the one recurring theme seemed to be the surgical personality and how it was detrimental to patient communication. So the next fork on the surgical road became setting up a pilot study, which involved a half hour consultation, free to the patient, with a surgeon (sitting down obviously) trying to sort out medical and surgical misunderstandings/anxieties or misadventures (visit the Ask A Specialist website). The pilot study was successful both from a patient point of view and a surgeon's point of view. I was successfully using all my surgical knowledge across a range of specialties, some of which I had to read up extensively on the night before to be able to advise. The patients were getting a surgeon not stressed by surgery who was able to calmly address their fears and concerns, to the point where the overwhelming response was this pilot study needed to be converted into a permanent clinic. It has and the study has been written up, unfortunately it has not been accepted by the Australasian Journal of Surgery, as a pilot study there were significant limitations.

However its publication might have stimulated further interest from other surgeons about an alternate retirement pathway, one in which they can keep giving to patients. Now with a busy surgical specialist review clinic and a calcaneal fracture finally responding to its latest surgical encounter, the question is does one return to the original pathway, with all its stress and demands. Sorting out a range of patient issues has become quite rewarding, in addition to now lecturing on anatomy and physiology. Given how fate is intervened, I'm not betting against another little deviation, I spot a few beckoning still.