

colon and rectal injuries, the diversion rate was 37%. This may be higher than in other civilian settings but comparable with military series from Iraq (37%) and Afghanistan (31%).³

In the mid 2000s, perhaps buoyed by civilian experience, a new generation of military surgeons' experience of penetrating colorectal injuries managed without diversion in the field hospital environment resulted in both high anastomotic failure rates (13–30%),^{3,4} and a higher mortality (10.8% versus 3.7% with diversion).³ Lessons from previous wars were, at least in part, relearned as the aphorism predicts. It was then, and still is, uncertain whether it is the high potential energy of the weaponry or the austere circumstances that is the difference in this population.

We are fortunate that in Australia, and hopefully soon in New Zealand, gunshot wounds from military style assault rifles are almost unknown, but the consequence is that experience is likely low. As surgeons, we are encouraged to treat the wound and not the weapon, but I would emphasize that in experienced hands, Elfaedy *et al.*¹ included, 30% of colonic and 50% of rectal injuries from this mechanism are treated with diversion. Diversion may no longer be mandatory, but high-energy weaponry and austerity of surgical service should be considered amongst the usual risk factors for anastomotic dehiscence.

References

1. Elfaedy O, Elgazwi K, Alsharif J, Mansor S. Gunshot wounds to the colon: predictive risk factors for the development of postoperative complications, an experience of 172 cases in 4 years. *ANZ J. Surg.* 2020; **90**: 486–90.
2. Ogilvie M. Abdominal wounds in the Western Desert. *Surg. Gynecol. Obstet.* 1944; **78**: 225–38.
3. Glasgow S, Steele S, Duncan J. Epidemiology of modern battlefield colorectal trauma: a review of 977 coalition casualties. *J. Trauma Acute Care Surg.* 2012; **73** (6 Suppl. 5): S503–8.
4. Steele S, Wolcott K, Mullenix P *et al.* Colon and rectal injuries during operation Iraqi freedom: are there any changing trends in management or outcome? *Dis. Colon Rectum* 2007; **50**: 870–7.

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Dear Editor,

Consultant-delivered care in telehealth and phone consultations during the COVID-19 shutdown period

I congratulate Timm *et al.*¹ for receiving reports of patient satisfaction with Doctor-in-Training-delivered consultations in telehealth published in a recent issue. From our recent experience at the Cairns Hospital Vascular Surgical Outpatient Clinics, telehealth

and phone consultations became the mainstay of reviewing patients during the coronavirus disease 2019 (COVID-19) shutdown period. Being a regional centre, our patients from the indigenous communities were also in complete lockdown. Our catchment involves a wide geographical area.

I am aware that this situation is mirrored elsewhere in Australia, with the full potential of telehealth yet to be completely tapped. My opinion is that any doctor-in-training delivered model, in recent times, should revert to a consultant-delivered model, which is usually our standard of care. Studies have shown that consultant-delivered clinics get improved outcomes for patient care² or are at least more time efficient.³ Back at our clinic during the COVID-19 shutdown period, I would routinely triage the patients into several categories by determining the suitability of registrars and junior doctors in taking on the phone or telehealth review. We worked at our usual outpatient clinics in adjacent rooms, and I was available to participate in any ongoing consult. The workflow was as such:

- (1) Junior doctor appropriate – such as follow-up of stable patients with surveillance scans, with the consultant reviewing the past history and prior scans.
- (2) Registrar appropriate – such as post-operative follow-up with clear plan already laid out prior by the consultant, or less complex new referrals.
- (3) Consultant preferred – follow-up of complex cases and complex patients with multiple issues and complex decision-making

While it is important that doctor-in-training learning is not neglected,⁴ best patient care remains imperative. The categories suggested should be modified according to the experience level of the doctors present, thus affording the needed training.

References

1. Timm B, O'Connor E, Liodakis P, Jayarajan J, Bolton D. We still need the clinic; patient perceptions on doctor-in-training delivered telehealth versus in-person consultation. *ANZ J. Surg.* 2020; **90**: 658–9.
2. Rance C, Richards SK, Jones AE. Front door surgeons: the rise of consultant-delivered acute surgical care. *Br. J. Gen. Pract.* 2016; **66**: 234–5.
3. Lo S, Fergie N, Walker C, Narula AA. What is the impact of consultant supervision on outpatient follow-up rate? *Clin. Otolaryngol. Allied Sci.* 2004; **29**: 119–23.
4. O'Neill PA, Owen AC, McArdle PJ, Duffy KA. Views, behaviours and perceived staff development needs of doctors and surgeons regarding learners in outpatient clinics. *Med. Educ.* 2006; **40**: 348–54.

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