Australian and New Zealand Association of Paediatric Surgeons
Formerly the Australasian Association of Paediatric Surgeons

SEPTEMBER 2008

President's Report

This is the first newsletter of the ANZAPS, that is, the Australian & New Zealand Association of Paediatric Surgeons. Yes, we have officially changed our name as a result of the vote, and the resolution at the last AGM in Hong Kong. It will be a longer process to have the name changed in all our documents and officially registered, but our name change is on the way.

Hong Kong proved a great success. The program was of great value, and we got good value from our visitors. Our thanks to Tom Clarnette and those who supported him. The recently elected President of the College of Surgeons of Hong Kong, C K Yeung, is a Paediatric Surgeon, so our discipline had a high profile. As usual, there was the problem of too many concurrent sessions of interest, but despite this, I believe our meeting schedule, alternate years with the College ASM and other years as a stand alone meeting, gives us the best of both worlds. I think it is important for all surgeons to realise that they are part of a larger group, and that there are matters that concern all surgeons, these being the subjects of plenary sessions, even though the minutiae of their craft are outside the area of knowledge of other surgeons. At the Convocation ceremony it was pleasing to see Albert Shun be presented with his richly deserved ESR Hughes Medal, and Kate Cross and Michael Nightingale receive their Fellowship certificates.

Our thanks to Helen Stokes who very kindly gave a number of pieces of her glasswork as gifts for our visitors. Helen is an internationally recognised glassworker. Heinz Rode is an enthusiastic collector of glasswork. That conjunction seemed to me to be a great opportunity, but I was concerned that I might commit the association to a significant expense. Helen' generosity in donating the pieces was greatly appreciated, and she also consented to speak briefly about her work at our official dinner. It was fascinating to hear how such beautiful pieces are created, and with typical modesty, she did not dwell on the fact that each glass piece, be it one of her signature frogs or whatever, is first made by her out of wax before the glass process starts.

Spencer Beasley and Professor Xia had organised a meeting in Guangzhou on the Saturday after the College/AAPS meeting finished. This went well with all Powerpoint presentations being translated and projected in English and Chinese simultaneously.

Back here, a number of matters deserve mention. The electronic log book for trainees is undergoing field trials and may soon be widely available. It may be suitable for all surgeons to keep a record of their cases for audit purposes.

The Paediatric and Child Health division of the RACP has approached us to form a joint working party on bariatric surgery. We have formed our own group to have input into this working party, and also to have links with the College. So far very little has occurred due to inaction on the part of others.

Those of you involved in making rosters for trainees, or who read material from the English College, will be aware of the challenge that "safe hours" is going to be for our trainees, and our trainers. The trainees' representative who is an observer at Council made some good suggestions about this matter. First, and probably most importantly, is to involve the trainees in the discussions

and decision making. Two practical suggestions:

1. To give accredited trainees exposure to emergency work but limit the number of hours that they are rostered on, for them to do weekends on call, but for non-accredited registrars to do the week nights on call. Obviously, this requires there to be some of both types sharing the roster.
2. To limit the number of unnecessary calls at night, for the surgeons to make a list of the diagnoses that the surgical registrar is to be called about between the hours of 10 (or 11) pm and 7 am.

In my Council report I mentioned the increase in number of graduates and therefore the increase in the number of trainees in surgical specialties. This is an opportunity for everybody to get involved in training. Most of us teach and will be aware of how educational it is for the teacher to teach. It also goes to help accumulate CPD points. Our basic skills of cutting, sowing, and tying are essential tools for all surgeons. How many of us are horrified by how badly our young trainees do these simple things? We can help correct that by getting involved in teaching ASSET courses. At another level, why not get involved in marking CATs, or being part of a DOG?

It has been shown that trainees who choose and use a mentor (or several mentors) are more successful in their training than those who "go it alone". We should all be receptive to trainees who put us in that role, but it carries a big responsibility. Of particular importance is the care with which career advice should be given. It is better to be the active listener, and let the trainee work through the logical consequences of each possible course of action, than to actively give advice. General suggestions, such as reminding them of the need to keep a good balance between career and personal life, and the time constraints of having family, may be appropriate, but resist the temptation of wielding the power that an established consultant has over a trainee. Remember, it is their career, not yours.

The same caution should be taken when speaking with overseas graduates. No one has failed to hear of Dr Patel and Bundaberg. The consequence of that incident is to make the process of assessment, performed by the College under contract to the AMC, extremely strict and exact. If you wonder why it is so slow and meticulous, you have not heard the deceptiveness of some people. Those regulations are on the web site. If you are asked about entry into either country, or recognition of qualifications by the College, do not give advice off the cuff. Refer the person to the web site, or look it up yourself. There have been too many instances where anger and disappointment have arisen because the initial advice was incorrect.

In the near future the College is undertaking another census of surgeons. The response rate for the last one was extremely high so that some meaningful information emerged. This one will be even more important as the information can be compared with the predictions that emerged from the last census, as well as providing up to date information. When it arrives, please fill it in, so making the information from it useful.
Planning for our meeting in Fiji is underway. We are combining with the Paediatric Radiologists, and Vascular Malformations will be a central topic. I suggest that you mark off these dates (12 to 15 July 2009) in next year's diary, and start preparing a topic that you might like to present. See you there.

Hugh Martin AM FRACS
President, Australian and New Zealand Association of Paediatric Surgeons

COLLEGE NEWS

Council Report - June 2008

This meeting was the first that Ian Gough, our new President, chaired, and the newly elected senior office bearers filled their roles. This included Spencer Beasley as Chair of Board of Surgical education & Training (SET).

The President's report contained matters of interest to all surgical disciplines including ours. National Registration is now under way. Nine medical professions are recognised and will remain separate, including nursing, physiotherapy, optometry, chiropractic, and osteopathy as well as medicine and dentistry, with podiatry likely to be recognised in the near future. There is a Ministerial Committee that sits above the various registration Boards, and we are concerned that this body will interfere with the decisions of the Boards. It is possible that this Committee could make rulings on the areas of practice that a given group could cover, opening the way for an administrative decision to allow relatively poorly trained individuals to undertake complex tasks. In case you think this is unlikely, I remind you of Dr Jayant Patel, and how he got to be head of a department. This concern has been expressed to the Federal Minister, Nicola Roxon, who has replied with a letter specifically stating that this committee will not interfere with the day to day functioning of the Boards. While this was very firmly stated, and we have no reason to doubt her word, we must realise that Ms Roxon is a politician, and subject to pressures within her own party.

The President accompanied by Guy Maddern and David Hillis (CEO) met with the Minister the day before Council. The chief purpose of their meeting was to try to secure funding for ASERNIP-S, although other matters were discussed. While some funds are being supplied by the SA government, and some contractual work is available, a body with collected expertise, performing a function that is now being internationally recognised as unique, should not be living from week to week or month to month, but have secure long term financial security. The Commonwealth budgeting cycle has a lead-in time of well over 12 months, so no definite result was achieved, but the Minister gave a very clear indication that she would be supportive. All members of our delegation were impressed by her intelligence, her understanding of the subject and quality of her briefing about the topic, and her attitude of co-operation. We feel that the College may be in an excellent position to work with the present government to solve problems related to surgery, particularly as the AMA has adopted an extremely intransigent attitude, and is likely to be marginalised, thus creating a vacuum in the area of professional advice for the government.

The President and Dr Hillis went on to Sydney where they made a submission to the Commission of enquiry into public hospitals. They were extremely impressed by Commissioner Garling's understanding of the subject, his ability to listen, and his penetrating questions.

Just after Easter, Council held a meeting to review the College's Strategic Plan. For two days we argued in an informal setting (yes, my lack of a tie was universally adopted) about where the College should be going in the next 8 to 10 years. That Strategic Plan is soon to be on the web site having been polished and should be passed at the October Council meeting. In very brief summary, the main thrusts are to do more for individual Fellows, to have a stronger voice in the public arena including being more involved with government in decisions that affect surgery (that is, advocacy), to maintain standards of training but possibly in partnership with other educational bodies, to offer opportunities for Fellows to maintain their skills, and to help disadvantaged groups in Australia, New Zealand, and neighbouring countries. There is much more to it, so I suggest that you take a few minutes to find and read it.

The current mania for collecting statistics means that there are all sorts of interesting figures out there. Of particular relevance to us is the fact that by 2012 there will be double the number of medical graduates. This will put training schemes under great stress, including ours. In order to sustain training, discussions are underway with the Health Workforce Principal Committee to get financial and administrative support for supervisors, and for hospitals to pay for accreditation. At present, accreditation is indirectly funded by the trainees.

Council Report June 2008 continued

The finance report showed that the College is in a stable position, but in no way flush with funds. The recent stock market dive has significantly affected the income from our investments, but since the College no longer relies on this source to help run its day to day activities, it is the money available for scholarships from bequests that is most affected.

The question of Physician Assistants came up. As you probably know, other countries have such people integrated into the workforce, and many surgeons have de facto assistants often from a nursing background. Expansion of the role is likely to appeal to governments to help the shortage of skilled people in the workforce. There are several risks. One major one is to trainees and their exposure to the full breadth of their area of work. Another is that such people may be drawn from a pool that is already undersupplied, such as nurses. Reassuringly, overseas experience is that Physician Assistants mostly come from other medical workers such as ambulance officers or medics from the forces, or from graduates of vaguely related disciplines such as biology or psychology. Finally, there is a risk that government will decree that such people will practice independently: for example that there will be hernia trained "surgeons" who do nothing else, but who are not trained to deal with complications or unusual cases. While these are concerns, it is likely that we may be involved in training some of these people.

The relationship between the profession and industry has been in the public eye recently. Most media coverage has focused on the pharmaceutical industry, but there is the same potential for abuse by the makers of surgical appliances and equipment, particularly expensive prostheses. There are accusations (as yet not investigated and so unsubstantiated) that some surgeons, happily none from our discipline, are taking direct financial reward for using a specific firm's product. None of us would condone so blatant a bribe, I am sure. However, the matter gets less distinct if payment to go to a meeting is involved. It is very important that we not only behave ethically, but that we appear to behave ethically. So beware of any support provided directly from a commercial source.

History shows us that the collective voice of a group is much more likely to be heard than a multitude of small voices. Your College is the collective voice of surgeons and their patients. I invite you to contribute: look at the College web site: vote at elections: get involved in teaching: contact me for specific matters.

Hugh Martin AM FRACS
Council Representative, Australian and New Zealand Association of Paediatric Surgeons

2010 ANNUAL SCIENTIFIC MEETING - PERTH

Thank you to Colin Kikiros for taking on the role of 2010 Scientific Convenor. One of the first tasks is to invite a Paediatric Surgery Scientific Visitor for the meeting. Please e-mail through your suggestions to Rebecca Letson rebecca.letson@surgeons.org by 30 September 2008.

Professional Development and Standards Board Meeting June 2008

Although some of the matters considered at this meeting were of little relevance to Paediatric Surgeons, there were a number that were. Progress is being made on the question of diagnostic quality images being provided to surgeons both for consultations and operations. A meeting that involved the College of Radiology, corporations providing imaging services, government, and the College of Surgeons was held recently. As might be imagined, the corporate bodies were resisting regulation. However, government representatives were very supportive of the profession's attempts to set standards. The views of the two Colleges were closely aligned. The impression was given that once some standards had been agreed upon by the group that government would be happy to see them put into regulations to ensure that they were adhered to by radiology practices.

The document on Surgical Competence and Performance that I have mentioned previously is nearing completion. Once approved by Council it will be distributed. It is the first document of its kind in the world to be produced by a medical college. Its unique attribute is that it covers aspects of a surgeon's life other than technical skill and medical knowledge. It will be useful for all of us to reflect on our own behaviour, to bring aspects of it to the attention of colleagues who are in need of help, and will be very useful for trainees to be able to have a guide as to what standard of behaviour is expected of them. We have all known trainees who perform satisfactorily as far as their clinical work is concerned, but who are not doing well in their relationships with other staff, or parents: this document gives concrete examples of what standard is expected in these areas. Once it is released during September on the College website, I urge you all to read it.

It is now midway through the year and there are still about a dozen active Paediatric Surgeons who have not made a CPD return for 2007. Surprisingly, some of the individuals involved are working in NSW and New Zealand, in both of which CPD compliance is necessary for registration. Since almost all of us work in teaching hospitals, the requirements are probably being met, so it is a matter of documenting them. If anyone needs some advise about this matter, please do not hesitate to contact me. The electronic submission is much easier than the paper based one, even for a computer dinosaur like me. When you are documenting your activities in either form, I suggest that you stop documenting once the target in each section has been met, because if you are audited and have to provide evidence for each activity, having more events documented than you need only means more proof of participation that you have to provide. Selection for audit is random, and 2.5% of Fellows are selected each year. Last year I helped a colleague deal with the request for audit that was made, and I would be happy to help anyone else in that situation.

As many of you know, the College produced a position statement on Emergency Surgery recently. This has been welcomed by governments as it helps them plan, and allocate resources. Having realistic Key Performance Indicators (KPIs) has helped this greatly. Those people who have been in discussion with politicians and bureaucrats about this document have been (yet again) surprised by how uniformed these people, who are making major decisions, are about the role of the College. If ever you have the opportunity to talk with such people, it is helpful to remind them that the College is fundamentally a body that tries to set and maintain standards throughout training and later professional life.

Many of you were there in Hong Kong to enjoy the program. The meeting as a whole was a success but not without a lot of work from this end. If meetings are to be held off shore in future, I think they will be in a different form.

An enormous amount of work is done to maintain a milieu in which we can function most efficiently. Most of the work is invisible to us from day to day. The activities of PDSB and the committees that report to it are in this category. I hope this report gives you a some idea about its activities as they relate to our speciality.

Hugh Martin AM FRACS
PDSB Representative, Australian and New Zealand Association of Paediatric Surgeons

BOARD OF PAEDIATRIC SURGERY

Registrar Annual Training Seminar (RATS)

The Registrar Annual Training Seminar (RATS) held recently in Adelaide was a great success with all active trainees participating in development and educational sessions as well as meetings with the Board regarding the Surgical Education and Training (SET) Program in Paediatric Surgery.

The trainees would like to thanks sponsors Q-Med (Deflux), Johnson & Johnson Medical, Tyco and Karl Storz.

Thank you to Warwick Teague for his organisation of the meeting.
Photography: Neil Price

BOARD OF PAEDIATRIC SURGERY

Congratulations to our new trainees and I welcome them onto our training program as future paediatric surgeons:

- John Atkinson (NZ) – SET1
- Rohan Brent (NT) – SET2
- Kate Ferguson (John Hunter Hospital) – SET3
- Parshotam Gera (Sydney Children's Hospital) – SET3
- Catherine Langusch (The Canberra Hospital) – SET3
- Gideon Sandler (NSW) – SET1
- Emile Tahtouh (NSW) – SET1
- Kenneth Soo (NSW) – SET1

Congratulations also to Naeem Samnakay as he is accepted into Fellowship and commences in Perth.

Currently this year we have 18 active trainees and 3 interrupted or deferred. Following selection we expect next year to have 28 active trainees and 3 interrupted or deferred. We have been endeavouring to fill vacant SET 3- 6 trainee posts, but there is a two year lag before trainees enter what was previously known as advanced paediatric surgery training (now referred to as SET 3 - SET 6). Interruptions and trainees leaving training also results in some accredited posts not being utilised by trainees. Nonetheless we are looking forward to 3 – 4 of our Australian and New Zealand trainees receiving Fellowship every year, commencing in 2009. I therefore urge all Paediatric Surgery units to consider our prospective Fellows when planning workforce replacements and timing of advertisements from now on.

In this newsletter, I hope to clarify the difference between SET 1 -2 posts, and advanced training in paediatric surgery posts in SET 3-6.

As you all know we have a six year scheme with the first two years in surgery in general. When SET was introduced, the Board took on responsibility for trainees from the start of surgical training (rather than selecting after they had completed general surgery). The Board in General Surgery no longer wanted to be considered a "nursery" for the specialities, but paediatric surgery still considered it essential that our trainees were trained in aspects of general surgery. We are responsible for surgical conditions from the premature or even foetal to the adolescent. This covers the range of pathology from the specifically paediatric to those conditions considered "adult", for example: biliary disease, inflammatory bowel disease, adult causes of acute scrotum, bowel carcinomas, direct inguinal hernias and thyroid disease. We also need the skill to approach the thoracic, gastroenterological, urological and vascular systems, and, to deal with rare anomalies.

Paediatric surgical trainees are therefore ideally placed during SET 1 and 2, in rotations in surgery in general in order to: maximise acquisition of clinical competencies in management of conditions that affect adults commonly but occur in children, to understand transition of care, and to learn differences in management during physical maturation of physiological responses,

Some of the competencies and clinical experiences we want our trainees to achieve in these two years in surgery in general are: surgical management of biliary conditions; open and laparoscopic surgical approaches to the adult physique abdomen; principles of stapled bowel anastomosis, and, multiple trauma management.

BOARD OF PAEDIATRIC SURGERY

We therefore have specifically prescribed that SET I and 2 can only be completed in non paediatric settings (ie trainee is not to be doing primarily paediatric surgery). This of course depends or the cooperation of the Board in General Surgery upon whose posts, resources, training and supervision we depend.

We are keen to have input on various issues and encourage discussion with your local Board representative on any SET concern. Suggestions on approaching part-time training, skills acquisition, and the effect of safe hours on training will be most welcome. Thank-you again to all our Board members supported by supervisors and trainers, for the long hours of essential and largely unpaid work to guide our trainees.

Lastly I announce the retirement of Professor Spencer Beasley from the Board of Paediatric Surgery. Spencer's name has been synonymous with training in Australia and New Zealand since the 1980s. He has been involved with all of us as Board member, Chair, Examiner, AAPS President, Councillor and Senior Examiner, and in training two generations of Paediatric Surgeons. Knowing how long are the hours spent on the Board activities of selection, regulation review, policy implementation, review of logbooks and other evaluation and educational tools, and representation of Paediatric Surgery in College meetings, it is difficult to grasp how much of his waking lifetime has been used for Board activities. On behalf of all of us I humbly acknowledge with gratitude his enormous contribution. We look forward to and congratulate him in his continuing role as a leader of the College (Chair of the Board of Surgical Education and Training and New Zealand Censor).

Associate Professor Deborah Bailey, F.R.A.C.S.(Paed.) M.B.B.S.
Chair Board of Paediatric Surgery
Royal Australasian College of Surgeons

MEETINGS AND COURSES

Paediatric Urology Club 2008 Congresss

Theme: Laparoscopic Paediatric Urology

Rafferty's Resort, Newcastle 29-30 November 2008

The Organising Committee have great pleasure in inviting both adult and paediatric urologists and trainees to the 2008 Paediatric Urology Club Congress to be held at Rafferty's Resort close to Newcastle, Australia.
The theme of the meeting is "Laparoscopic Paediatric Urology", and will feature a pre-conference, hands-on live paediatric laparoscopic workshop (at The Children's Hospital at Westmead) and nationally and internationally recognised paediatric urologists.
Weather in the Hunter region is excellent at this time of the year and the venue is an ideal base to visit and explore world famous Hunter Valley vineyards, Nelson Bay, sunning and surf beaches and much more.
Registration includes buffet breakfast and lunches on the conference days and the congress dinner on Saturday night.
Enclosed with this newsletter is the Congress Program, Registration Form and Accommodation Booking Form as well as the Laparoscopic in Children Workshop details and registration form.

The Paediatric Urology Club 2008 Congress values the support of FERRING Pharmaceuticals, Q-Med and Karl Storz Endoscopy. The Laparoscopic Workshop is brought to you by Covidien (Tyco Healthcare).

MEETINGS AND COURSES

Communication

2009 Annual Scientific Meetings of the Australian and New Zealand Association of Paediatric Surgeons and the Australian and New Zealand Society for Paediatric Radiology

Collaboration

Denarau Island, Nadi, FIJI
12 to 15 July 2009

Combining Cultures

Enjoy the opportunity to meet and discuss latest developments within Paediatric Surgery and Paediatric Imaging in magnificent surroundings. The Scientific Program will be supplemented with a Family and Social Program to capitalise on the timing of the meeting for most Australian and New Zealand school holidays.

Please direct all inquiries to:
Mrs Rebecca Letson
Australasian Association of Paediatric Surgeons
E-mail: college.aaps@surgeons.org
Telephone: +61 3 9276 7416

Register your interest for the meeting by 31 October 2008 to be in the running for a Fiji Lonely Planet Guide Book.

OTHER NEWS

CONGRATULATIONS TO SET PROGRAM 3RD YEAR TRAINEE DR WARWICK TEAGUE WHO WAS AWARDED THE R.P. JEPSON MEDAL FOR THE BEST PAPER PRESENTED AT THE 2008 SOUTH AUSTRALIA ANNUAL SCIENTIFIC MEETING.

College Continuing Professional Development (CPD) Program

All active Fellows of the College are required to particpate in the College's CPD Program. Members are reminded that the 2007 CPD Program recertification data forms are now overdue. A further reminder will be issued in August 2008. Please contact Maria Lynch, Department of Professional Standards on +61 3 9249 1282 or via email at maria.lynch@surgeons.org if you require assistance completing your data form or require another copy.

CPD Online

CPD Online allows Fellows to record participation in CPD activities throughout the year using a web based personal online diary. CPD Online can be accessed via the College website at www.surgeons.org. Fellows are able to regularly record participation in activities such as surgical audits, conferences and workshops, hospital meetings, teaching and involvement in research and publications within the categories of the CPD program.

Data is now being collected for the 2008 CPD Program and Fellows have immediate access to updated CPD totals to assist with planning to meet the minimum requirements for the 2007-2009 triennium. Fellows using CPD Online to record your 2008 activities will not be required to complete the hard copy recertification data form.

The Department of Professional Standards is available to provide telephone assistance for CPD Online. Telephone and face to face training is available from 9am-5pm, Monday to Friday. Please contact Maria Lynch, Department of Professional Standards on +61 3 9249 1282.

College Definitive Surgical Trauma Care (DSTC) Course

The DSTC (Definitive Surgical Trauma Care) course is a highly regarded and sought after course available to qualified surgeons and 3rd & 4th year SET Trainees. It is recommended for all surgeons involved in the management of major trauma. Three courses are conducted each year.

For registration details, please contact:

Lyn Journeaux, Executive Officer - Trauma Office
Royal Australasian College of Surgeons
Tel: +613 9276 7448
Fax: +613 9276 7432
E-mail: lyn.journeax@surgeons.org

Contributions to the AAPS Newsletter are encouraged. Please send through news of your seminars, events, personal achievements, surgical positions within your hospital to college.aaps@surgeons.org.

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