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

MAY 2009

President's Report

All of us will be aware of the increasing specialisation of surgery, and the problem of narrowness of expertise that this brings albeit with the advantage of greater knowledge and skill. Even within our own small specialty it is evident. Ours is often cited as the last bastion of General Surgery. Think how much greater is the gulf between a recently qualified Vascular Surgeon (who now does so much endovascular surgery that the old hands worry that the new guys cannot do open surgery), and, say, a neurosurgeon.

The College is well aware of this. Indeed, within its walls the frequently heard mantra is that it is no longer a College of General Surgeons or a College of Specialist Surgeons, but a College of Surgical Specialties. The founding fathers of the College did not foresee this, nor could they be expected to have done so. Some changes in structure are, therefore, inevitable. Having Specialty co-opted, later elected, Councillors was a big change. Another big change has been the inclusion of what has been labelled (for want of a better term) the "Surgical Leaders Forum" as a routine part of Council week. This is a meeting between Councillors and the Presidents of Specialist Societies to which the CEOs of the Societies are welcome. Starting as a once a year meeting during the ASC, it is now a meeting for a full half day on the Thursday morning of Council, with Council starting a half day later than it used to, as well as the meeting at the ASC.

The format has evolved, too. Initially there were a larger number of topics with most of the morning taken up by the invited speakers on each topic, there are now usually 3 or 4 topics, with plenty of time for discussion. So that the CEOs of the Societies have a chance to talk about their own issues, there are meetings of this group prior to the "Surgical Leaders Forum" and they are invited to suggest agenda topics for the latter meeting.

At the Surgical Leaders Forum in February one of the topics was what was labelled "Inter Specialty Co-operation". This boiled down to how much training did a surgeon need in a specialty other than his/her primary one for that person to undertake procedures in the second specialty, and at what level should that involvement be. This is less of an issue for those of us who work in a major tertiary centre, in or near adult tertiary centres, than it is for Rural and Regional surgeons. There is a school of thought that claims that unless a person has done the full 4 or 5 years of training in X specialty, they should not be undertaking any X procedures. This attitude has great difficulty when faced with the problem of emergencies. Spencer Beasley spoke eloquently about the outreach system that he has created in the South Island of NZ. This system has all the elements of success: better access to specialist care by local communities; better communication between local and tertiary centres; improved skills in local communities; better triage of major cases; improved ability of local services to deal with emergencies; and faster transfer when such is needed. This model may not be transferable *in toto* to other places that involve greater distances, or a much larger number of small centres, but the basic outreach concept, that of Paediatric Surgeons visiting centres (at the request of the latter) to do clinics and day stay operating has a lot to commend it. The upskilling of all levels of the local medical community, and the improved communication, will undoubtedly go a long way to solving the problem of providing specialised services to Regional and Rural Australia and New Zealand. I am aware of many examples of this that our specialty has set up, congratulate those involved, and urge anyone who has the opportunity to be part of such a scheme to do so.
Another matter that came up in the Surgical Leaders Forum was the National Health and Hospitals' Reform Commission report. Congratulations to anyone who has read it word by word. It is long. It is

PRESIDENT'S REPORT

full of generalities, profound sentiments, and lofty ideals. However, it contains no concrete solutions, and surprisingly has little mention of hospitals. There are repeated assurances that many of these lofty ideals can be achieved without a large injection of resources. We had the pleasure of having Dr Christine Bennett, chair of the Commission, as a guest. She spoke well, and was clearly well informed about all the topics she was questioned about. However, she did not give any more idea about solutions than had been evident in the Report, and I got the distinct impression that there was such a wide range of opinions within the Commission that decisions were going to be few, as well as being at risk of being "committee decisions", that is, satisfying no one.

At the time of Council you may remember that the WA Minister of Health had expressed doubt about the National Registration and Accreditation Scheme that was being pushed. In particular, it was encouraging to hear that the AMC's independence was considered important. Once a government body is given control of accreditation it opens the way for political manipulation of standards and workforce. Registration and accreditation should be separated. Recently a Senate Committee has been set up to look at the whole process, and the College is making a detailed submission to that enquiry.

While on the subject of the AMC, I suggest that everybody reads the article written by Professors Komesaroff and Kerridge (MJA vol 190, number 4; 204-205, 16th Feb 2009) concerning the draft "Code of Conduct". Their concerns are even stronger than the College's, and are well argued.

A few interesting statistics came out of the Medical Training Review Panel Report. Far from being a "closed shop" and "old boys' club" as it is accused of by the press, the College has increased the number of Fellows completing training from 103 in 2001 to 155 in 2006, a 50% increase, and the number of training positions from 478 in 1997 to 774 in 2007, a 62% increase. But as trainers, we are going to be busy. Domestic medical school graduates increased by only 105 in 12 years 1994 to 2006 (1230 to 1335), while in one year 2006 to 2007 an extra 250 (1335 to 1586) graduates appeared. Specialist training for these people is about to start, but this is only the beginning because by 2012 there will be 2945, to which must be added some 300 to 400 IMGs. We are going to be involved at both the undergraduate and postgraduate levels, so we will be busy.

This will be my last newsletter as President. I want to thank a number of people for their help, the first and foremost being our EO, Rebecca Letson. Rebecca has been incredibly supportive, always there, always has the right policy or letter to hand when needed, and very patient. She has been a superb organiser. The whole Association owes her thanks. Most particularly we wish her well for the forthcoming birth of her first baby (while we are luxuriating in Fiji), and for her 14 months maternity leave. While we shall miss her, her priority is the welfare of her baby and husband, Nathan, and being a full time mother in the critical first year is a decision that we applaud.

Taking over the reins is Jasmine Morris. Jasmine comes to the Association following working for Government agencies in Australia, followed by a period of travel throughout Europe which included a stint editing magazines in Milan (and being the only English-speaking person in the office)!). Jasmine commenced with the Association on 4 May. We welcome her and look forward to working with her.

Thanks also to the Executive. They have made a great contribution. Thanks particularly to those members of the Executive, and those members of the Association, who have responded to my email pleas for input or opinion about various matters. I do not believe that a president can accurately represent the members of the Association without consulting them.

Finally, I want to welcome President-elect Tony Sparnon to the post of President. Having seen Tony in action on a variety of boards and committees, I know that he will add greatly to our Association. Tony, thank you for taking on this task, and good luck.

Mr Hugh Martin AM FRACS
President

Fiji 2009

Annual Scientific Meetings of the Australian and New Zealand Society of Paediatric Radiologists and the Australian and New Zealand Association of Paediatric Surgeons
12th - 15th July 2009, Denarau Island, Fiji
www.fiji2009.com

Communication

Combining Cultures

Collaboration

Bula from the Fiji 2009 ANZAPS organising committee!

The organising committee is in the final stages of putting this meeting together for you. Ji is hard at work, busy preparing a feast as well as settling in to his new job in Suva. We look forward to welcoming you to Fiji to help celebrate his appointment, to raise the profile of children's surgery in the Pacific and share social and academic endeavour.

The venue is excellent and the timing should allow for a relaxing school holiday break. Many delegates are bringing their family, and there is plenty of opportunity to extend your time in and around the many island resorts at Denarau or further afield.

The abstracts closing date is almost upon us, (May 1) and we will be letting you know within 2 weeks of this date if your paper has been selected. I am aware already of many interesting topics and our overseas speakers have got plenty to say as well. I think the educational component will be stimulating and practical. By combining with the paediatric radiologists the opportunity exists to build on our good working relationships. There are many topics where we can learn from one another on the program already and the free papers should be equally of interest. Many surgeons and trainees from the Pacific will also attend and further add to the occasion.

The social program has a relaxed feel to it too and for those of you who just want to do virtually do nothing then there is hardly a better place. On the other hand if you are a sporty type then there will be multiple ways for you to raise your resting heart rate, including our own version of "Survivor Fiji" or the multiple golf courses.

The political situation in Fiji is a potential concern and we are monitoring it closely. If there was any risk or if our governments were to advise against our travel, then we would be forced to defer. I have spoken with the surgeons in Fiji, holiday makers over there for the recent term holidays and business travellers and all assure me that there is absolutely no concern. The 20% devaluation in the Fijian dollar may even make it more attractive!
Please contact me if you have any questions

On behalf of the committee

Phil Morreau
Convener
+6421664983; pmorreau@xtra.co.nz

THE DOUGLAS STEPHENS PAEDIATRIC SURGERY RESEARCH PRIZE

By Durham Smith

A significant new Prize has been established within the RACS Foundation, to honour one of the College's most esteemed Fellows, Frank Douglas Stephens. The Prize was initiated by his family, together with professional colleagues and friends, to mark his 95th birthday. It is intended to award the Prize biennially for an original research contribution by a Paediatric Surgical trainee or a Fellow within 10 years of obtaining the Fellowship in Paediatric Surgery, on the advice of the Australian and New Zealand Association of Paediatric Surgeons. The Prize is to encourage Research and to forward the careers of young Paediatric Surgeons. That it be a Research award is very appropriate, as Douglas Stephens himself had an outstanding career in original research, and by his concern and contributions he has profoundly influenced the lives of many young surgeons.

Douglas gave unstinting service to the College, being on Council 1965-75, Honorary Treasurer 1969-75, and Editor of the ANZ Journal of Surgery for many years. Recognised nationally and internationally for his seminal contributions to the science of surgery in the field of congenital anomalies, resulting in new procedures to the benefit of thousands of children, he is a great unsung hero of Australian society in both war and peace. After secondary schooling at Melbourne Grammar School, he graduated in Medicine from the University of Melbourne in 1936. On completing Residences at the Royal Melbourne and Royal Children's Hospitals, he served Australia with great distinction in a Forward Operating Team in the AIF 6th Division, 2/3rd Field Ambulance, in the Middle East and in the SW Pacific. At El Eisa in 1942 he was awarded a DSO in the field for exceptional bravery attending wounded under heavy enemy fire, an honour he never spoke about. After the war he returned to the Children's Hospital but his enquiring mind was recognized by the award of a Nuffield Research Fellowship for three years at the premier Hospital for Sick Children in London where he began studies of major congenital abnormalities.

On return to Melbourne he was appointed as a Consultant at the Royal Children's Hospital but from the beginning he combined research with clinical practice, and as Director of Surgical Research he became recognized as the master of patho-embryology – the study of the way abnormalities develop in the foetus and newborn. These studies involved literally thousands of microscopic sections of developing organs and tissues, all drawn by him meticulously with great artistic talent, in thousands of man-hours of patient work. By unraveling the underlying processes major advances in the treatment of abnormalities of bowel, urinary and genital organs were initiated.

More than one hundred young surgeons working directly with him, and many more indirectly, have been enormously stimulated into an enquiring and critical approach to surgical problems. Many research papers have emanated from workers in his Department, but in many of these his name does not appear, even though most of the ideas came from him- such was his humility and his earnest encouragement to others.

At the age of sixty-one years his international status was recognized and he was invited to a Chair in Paediatrics and Surgery of Northwestern University in Chicago and at the Children's Hospital there, and over eleven years he made further advances and trained another generation of surgeons. Notwithstanding retirement in 1986, although having published three major books and many articles, he produced a monumental book 10 years later, which is the definitive world authority on developmental anomalies.

He has been honoured by many surgical societies and by the appointment as an Officer in the Order of Australia. But surgery is not the only talent of this extraordinary man. He is very loyal to his friends to whom he is utterly generous, he bears no malice or envy, and humbly brushes aside any reference to his achievements. He is an accomplished water-colour artist, an avid fly-fisherman, no mean golfer still, and until very recently a champion tennis player. This is a remarkable person of originality of thought, prodigious output, an encourager of a host of surgeons of many nationalities, brave in war, gentle in peace, and who has enriched the lives of thousands of children. As Douglas advances into old age, a phrase from Cicero sums him up –"the minds of such stand out of reach of the body's decay". He is of the Ciceronian elect, and it is his ever youngish outlook which enabled him to utilize his rare gifts to such great advantage.

DOUGLAS STEPHENS PRIZE

Far Right: ANZAPS President-Elect Tony Sparnon with Douglas Stephens.

Right: Douglas Stephens with Ed Fenton (right) and Stephens Family Members.

Below: Douglas Stephens with Durham Smith and Jane Stephens.

To make a donation to the Douglas Stephens Paediatric Research Prize, please see the brochure enclosed or contact the Royal Australasian College of Surgeons Foundation for Surgery on +61 (0)3 9249 1200 or Email: college.sec@surgeons.org

BOARD OF PAEDIATRIC SURGERY

It is a credit to those traits which we value in ourselves as paediatric surgeons that we all have concerns that our trainees sometimes encounter personal difficulty when they move between posts.

Although our trainees are fully informed and have agreed to our training regulations when they enter the training scheme, unforeseen circumstances in their families, especially with respect to their partner's careers, lead to distress and request for special consideration.

When you are training in a city of 10 million or more in London, Los Angeles or Toronto you can expect an enormous workload, learned debate, world class research and stimulating trainers. You are probably never going to work in a smaller centre or need to travel much for your training. However we know that a surgeon who has spent their entire training in an area draining a smaller population has a much narrower educational base. In ANZ we have always been aware of the limitations of our distance and smaller populations (but never doubting our knowledge or ingenuity), so we trained in our Australian or New Zealand centre then made the pilgrimage overseas. We can no longer easily access those training posts nor can we expect our trainees to dislocate families and self overseas. So we must provide the widest range of experience and training possible within our shores; in four short years of advanced training. It is all very well to know that there is controversy in management of a condition, but to see those different managements being practiced and discuss the reasons for choosing a course of treatment provides invaluable insight into how to critically analyse and reach clinical decisions.

Therefore we have mandated trainees cannot spend the entire four years of pure paediatric surgery training in the one region/state. I assure you this decision was not made to supply trainees to smaller centers. It is done to expose trainees to different management styles and caseloads. Some centers have great strengths in caseload, proficiency or supervision – and conversely will have a deficiency – moving at least once helps to expose our trainees as much as possible. For example trainees in New Zealand do not see burns patients. I can assure you as an observer, there are marked differences in management of even the simplest conditions between Sydney, Melbourne and Brisbane. The trainees will be able to decide if these differences are important or not to the outcome, and hopefully be stimulated to question, tolerate, accept and adapt throughout their career as a consequence. As a side-effect, perhaps as well they may find that a different region may offer

future employment opportunities. Most Australian and New Zealand surgical speciality programmes now include similar post movements for the same educational reasons.

When there are limited posts, to match training needs with trainee desires is extraordinarily difficult. There are many requests for special consideration which the Board carefully discusses but to avoid subjectivity and accusations of favouritism or otherwise, we always make decisions based on regulations and individual training needs.

Changing subjects slightly - recently the college issued "activity reports". As usual Paediatric Surgery had the highest success rate in the Fellowship examinations. Although the examinations do not test all facets of surgical competency, our high pass rates are a testament to the quality and hard work of our trainees and IMGS, and to the teaching of their consultant surgeons. Congratulations!

We all wish Rebecca and Nathan the best with their new challenges. Rebecca has been the constant guide to Board and ANZAPS members, trainees and IMGs, through the intricacies of College regulation, protocol and obligations. Her cheerful advice and dedication have been invaluable and comforting to many. Rebecca has always gone the extra distance (even to knitting the now famous scarves for new babies for our trainees) and I know she always thought she has indirectly been helping the children of Australia and New Zealand by helping us. Thank you Rebecca and we look forward to seeing you with the new little Letson!

Assoc. Prof. Deborah Bailey F.R.A.C.S.(Paed.) M.B.B.S.
Chair Board of Paediatric Surgery

How to Select the Best for Paediatric Surgery

by Spencer Beasley
Current Chair, College Board of Surgical Education and Training
Former Board of Paediatric Surgery Chair and Senior Examiner

Over the last decade or so the process of selecting the best applicants for paediatric surgical training has been refined almost on a yearly basis. Long gone are the days when your favourite registrar was tapped on the shoulder and was told that he was now on the training program. Gone too are the days when if you were in an accredited training post you were automatically on the program as well. In recent years the selection process has used three main tools:

The curriculum vitae
Referee's reports (or professional performance appraisal)
Structured interview

These tools have been used by all nine specialities, but the way in which they have been used has varied considerably. For example, some specialities have chosen to use the interview as a mock examination, asking specific questions about clinical scenarios in their speciality – a bit like an exam. Similarly, points on the curriculum VTIE were awarded if the applicant had already done time in that speciality, and was already partially trained.

The new SET program means that often applicants are being selected at a much earlier stage (from PGY2) and we have to be certain that we are picking the very best, even though they may not have had much in the way of surgical experience at the time of selection. Indeed, the purpose of the training program is to train them, rather than to select those who have already been partially trained or largely trained elsewhere. This means that we have to use the process to identify those characteristics of the applicants that have some predictive validity in their likelihood of success both in training and also in being able to practice paediatric surgery independently and safely later on.

Recently the RACS held a selection workshop, facilitated by Professor Fiona Patterson from London, looking in detail at the tools that can be used, their validity, and how we might modify our processes to select with greater confidence the type of applicant that we are after. This workshop was attended by three ANZAPS members: Phil Morreau, Jo Crameri and myself. As a result of this workshop it is likely that our selection process will be modified in a number of ways to improve its ability to identify those trainees who are going to make the best paediatric surgeons.

Some of the likely changes are discussed below:

The curriculum vitae will include information that will allow us to make an assessment of the applicant's career progression/career trajectory. This is a concept which allows us to identify who has got the ambition, enthusiasm and drive to succeed even though they may be quite junior and relatively few years out of medical school. This is to ensure that the younger but extremely talented person with considerable potential is not compromised when compared with someone who has been around for 20 years slowly accumulating achievements but with less ability. On the other hand, there are good reasons that some people may decide to enter paediatric surgery relatively late, but still have the prerequisite attributes, and this too will be revealed by their "career trajectory". It was also agreed at the workshop that all specialties would try to develop a generic curriculum vitae, but its component sections could be weighted differently in the speciality according to those factors that the specialty deems most important or appropriate for their type of work that

it entails.
Referee reports perhaps have the least value in their current format. Representatives from each surgical speciality will be attempting to develop a "global rating" and an "open comment" section that may be useful in ranking applicants, and the referee reports will be refined to better reflect attributes rather than competencies alone (given that the younger trainee has not yet attained these competencies). The referee report could also be used to gather "de-selection information".
The importance of the interview is likely to be expanded. The concept of selection station/selection centres was raised. This involves a multi station format which may combine interviews with other assessment activities when used, scenarios will be designed to assess the required aptitudes and would tend to be non-clinical. The Board of Paediatric Surgeons have been giving consideration to this for a year or so, and perhaps are leading the way. Selection stations would be assessing those behavioural domains that we consider important but are not provided for in the CV or referees reports. This is going to mean that the interviewers themselves will need some training. Interviews may be used to assess the following types of attributes:

* judgement under pressure,
* situational awareness,
* problem solving,
* decision making ability,
* organisation and planning skills,
* communication skills,
* leadership and team involvement,
* learning and personal development, and
* integrity.

Clearly, we need to be smarter in the way we select our future trainees. Doing it better, hopefully, will give us a better "end product". We can look forward to young colleagues of the highest calibre.

CRITICAL APPRAISAL TASK

TOPIC: SPLENIC TRAUMA
Answer provided by Dr Warwick Teague

1. What is your approach to the management of splenic trauma in a child during their hospitalisation period?

In addition to the evidence base outlined in Question 2, my approach to in-hospital management of
splenic trauma in a child draws upon the principals of:

i) Advanced Paediatric Life Support (APLS; 2005): management of multi-trauma patient;

ii) APSA Trauma Guidelines (2000): management of isolated splenic trauma (CT grade I-IV);

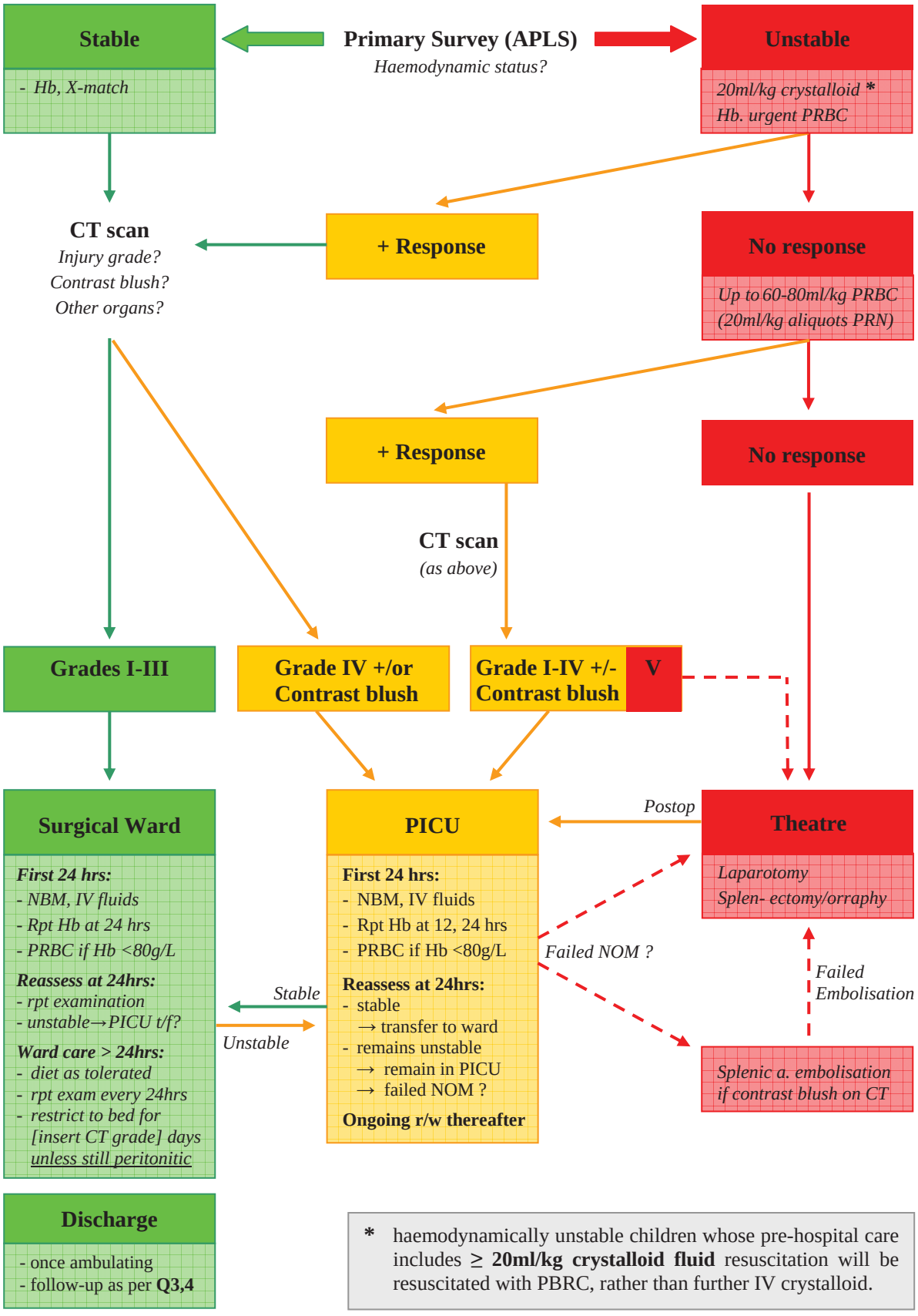
iii) Arkansas Children's Hospital Protocol: protocol guided by the patient's haemodynamic status
(McVay et al., 2008; Mehall et al., 2001).

To focus on management of splenic trauma, my algorithm (see over page) assumes best practice for
management of associated injuries; e.g. to chest, head or bowel. Specifically, secondary and tertiary
surveys must be performed in recognition that NOM of solid organ injury is associated with an
increased risk of missing associated injuries (Miller et al., 2002; Morse and Garcia, 1994).

Further discussion of the algorithm
Assessment of haemodynamic stability is crucial to safe management of splenic trauma in children.
Importantly, CT grade of splenic injury does not always correlate with patient haemodynamic status
(Bond et al., 1996; Lynch et al., 1993; McVay et al., 2008) – a limitation of the APSA guidelines? Indeed, it is important to recognise that APSA Trauma Guidelines (2000) assume haemodynamic stability, and so insufficient to guide management of all-comers. The Arkansas Children's Hospital
Protocol (2001) does address this limitation, but itself highlights a perceived difference in degree to
which North American and Australasian paediatric surgeons will tolerate haemodynamic instability
before abdandoning NOM for splenectomy. According to the Arkansas Children's Hospital Protocol
(2001), children proceeded to splenectomy if still haemodynamically unstable following infusion of
40ml/kg crystalloid and 10-20ml/kg packed red blood cells (PRBC). I have been trained to persist
with NOM unless: a) haemodynamic instability is refractory to transfusion with 60-80ml/kg PRBC,
or b) precipitous deterioration indicates the futility and danger of NOM vs. splenectomy.
Incidence of blood transfusion or splenectomy in grade <IV injury is <10% and <5% respectively
(Stylianos, 2000); I also recommended Hb <80g/L as trigger for transfusion (Pearl et al., 1989).
For these reasons, APSA Trauma Guidelines (2000) recommend ICU care is only required for grade
IV splenic injuries; recall grade V injuries are not addressed APSA guidelines. Further, APSA
guidelines recommend a formulaic approach to determine safe duration of bed rest: (CT grade + 1)
days; i.e. grade II injuries remain in bed for 2 days, grade IV for 5 days. I consider the persistence
of localised peritonism on serial examination to be reason for prolonging bed rest in individual
cases; albeit with the benefit of toilet privileges. Once again, I feel it safest to prioritise individual
patient physiology (e.g. peritonism) over CT appearances and generic guidelines.
A 'contrast blush' (i.e. extravasation) on CT is not a con-

traindication to NOM for splenic trauma,
but may identify patients at risk of failing NOM (Cloutier et al., 2004; Cox et al., 1997; Lutz et al., 2004; Nwomeh et al., 2004; Schurr et al., 1995). Emergent splenic artery embolisation is poorly available in my centre, but is reported to reduce splenectomy rates in patients with 'contrast blush', who present with (or develop) haemodynamic instability (Bessoud et al., 2006; Smith et al., 2006). Complications of embolisation must also be considered (e.g. failure, infarction; Ekeh et al., 2005).

Algorithm for in-hospital management of splenic trauma in children.



* haemodynamically unstable children whose pre-hospital care includes ≥ **20ml/kg crystalloid fluid** resuscitation will be resuscitated with PBRC, rather than further IV crystalloid.

Report on Council February 2009

This report is brief because I was attacked by a vicious Melbourne virus in the first half day of Council.

The two matters of interest that came up while I was there were the College pledge and the advancement of educators and education within the College.

At present, all new Fellows are asked to sign a pledge (as well as pay their money!). After a lot of deliberation and input for which I would like to thank those who responded to me, a final draft got to Council and after minimal changing, was adopted. It is planned to have the group of new Fellows at Convocation repeat this aloud, so it is short, as concise as possible, and (unlike the American College pledge) avoids negatives as much as possible. Not only the exact words were examined minutely, but also the order of ideas and the overall tone carefully crafted. While I am sure not everybody will agree with its detail, it is the final version after much dissection and reconstruction had taken place.

Our College is different from all other surgical Colleges in the world in the degree of involvement in teaching trainees and providing continuing education for its Fellows that it provides. Elsewhere surgical training is the responsibility of universities, departments of surgery, or groups such as deaneries. Colleges may set curricula or examine, but are not heavily involved in teaching. For this reason our College must look to the standard of teaching that its Fellows provide, and so it is a natural corollary that there should be some group within the College whose job it is to improve teaching skills. Already various courses such as SATSET, interview training and Surgeons as Educators exist, but a co-ordinated, long term approach is lacking. Council is just beginning to come to grips with this so has formed a steering committee to progress the matter. A lot of questions remain to be answered such as what the precise function of such a body will be, how that function will be put into action, how it will be funded, and where it will lie in the College structure.

Brevity being the soul of wit, I hope you are now all falling about laughing.

Hugh Martin AM FRACS
Council Representative

Report on PDSB Meeting February 2009

Previously, I have mentioned that the College has been in contact with the Medical Trades Association of Australia (MTAA) concerning the relationship that surgeons have with the industry. The MTAA has almost 90% of firms supplying devices and prostheses in its membership. It is a separate body from the pharmaceutical industry. It is becoming evident that there are examples of quite blatant misuse of industry resources, such as funding families to overseas destinations, as well as some instances of what is now be viewed with suspicion, but which **were** quite common, such as individuals being funded to attend conferences by a commercial company.

The public and the media are questioning such interaction. Evidence from surveys concerning prescribing habits shows that despite individuals denying that they are influenced by gifts or financial support, they really are. It is highly improbable that the human beings prescribing drugs are completely different from those choosing surgical prostheses. So it is, clearly, necessary for us surgeons to have some guidance in determining what is appropriate behaviour, and what is not. For example, for a company to sponsor a meal at a meeting is quite different from a company taking an individual, or group of individuals, to an entertainment that is not part of a professionally organised educational or research occasion.

The Professional Standards Board (PSB) chaired by Prof. Michael Grigg, has compiled a document setting out the standards of behaviour that should be adopted. This is in draft form at the moment, but should be finalised soon. The discussion about this document was lively, but nobody thought it was unnecessary or overly restrictive. How the community perceives us is the reality. When finalised and approved by Council it should be read by all of us, particularly those who have a lot of interaction with the trade.

The very difficult question of what to do if someone transgresses these standards generated even more debate. If the action falls below a legal standard, that is, falls into the jurisdictional definition of corrupt, the appropriate authority should act, but we should be aspiring to a standard of behaviour that is well above the legal minimum. This debate is far from over, but obviously it is pointless to have standards if they cannot be enforced in some way. It may not be pointless to have the standards in place first, as that gives time for everybody to read them, and make any attitude shifts that they need to.

CPD is a permanent agenda item in this meeting. Our group has an excellent record of participation and compliance. Revising the CPD requirements for the triennium 2010-2012 is currently underway, and I thank those of you who made suggestions. What changes will be made I cannot predict at the moment. I have used the new on-line CPD and find it easier than the old version. I suspect that in a few years we may find that we shall be required to use the on-line method exclusively, and the paper based return will be phased out. Some specialties are setting up their own CPD system, and getting it approved by the College, but I do not see that Paediatric Surgery would need to do that, nor do we have the available resources to do it.

Many of you may have noticed that subjects that I raise here subsequently feature in the President's communications, either electronic or in Surgical News.

This is no accident. When specialty representatives were first co-opted to Council their main role was to act as a conduit of information between their specialty and Council, in both directions. Now that Specialty Councillors are elected (not co-opted), and are full members of Council with the right to be elected to any office, as well as carrying full fiduciary responsibility for Council decisions (so have many other roles other than transmitting information), and Fellows get both Surgical news as well as electronic communications, it may be that such reports as this have no place. What do you think?

Hugh Martin AM FRACS
PDSB Representative

Report from the Board of Surgical Research – February 2009

The Board of Surgical Research (BSR) met for the first time this year in February. There were several matters discussed which may be of interest to both fellows and trainees.

The first relates to the acceptance by the college of a period of research towards accredited time in training. In the past a period of 12 months in research was generally accepted as counting towards time in advanced surgical training, always providing that the trainee was making acceptable progress.

With the introduction of the SET program, however (and in some cases even prior to this), several of the speciality boards appear to have take a very different view. There now appears to be extreme variation between the specialties. Neurosurgery, for example, regards 12 months of research as a compulsory, minimum requirement but Urology at the other extreme does not recognising any research as counting towards clinical training whatever the circumstances.

Whilst all the speciality boards have yet to respond, the majority appear to be prepared to at least consider recognition of a period of research towards training, albeit with varying degrees of enthusiasm. The response from the Board of Paediatric Surgery involved submission of the complete SET regulations (a densely packed 15 page document) rather than a potentially more useful practical interpretation and recommendations as provided by other boards. These regulations suggested the possibility of recognition of research time, but only retrospectively and in later clinical years. This would require the trainee to at least take the potential risk of not having this time accredited at all.

My personal view would be that the BSR should be actively encouraging research during and as part of training; that up to 12 months should be able to be recognised as part of the SET program (providing the trainees progress has otherwise been at least satisfactory) and that this should be able to be done prospectively between SET 3-5. In the majority of cases such trainees would often still be participating in some level of clinical activity during their research, and in order to secure competitive funding would have been likely to have had to gone through a fairly rigorous further assessment progress. I will keep you advised of the outcome of these discussions.

Secondly, both the BSR and the council in general are well aware of the many challenges facing academic surgeons in attempting to pursue their career. In order to address some of the financial disadvantages the college plans to announce a new Surgery Research Fellowship. This will be directed towards younger fellows intending to pursue a career in Academic Surgery. At present the criteria are still under discussion, but it is anticipated that preference would be given to those fellows applying within 5 years of obtaining their fellowship.

Finally, there was some debate in relation to the award of college scholarships and the difficulties then encountered when recipients did not present their results to the wider college audience. Fellows will be aware the funding is received from a variety of sources, not just paediatric surgeons and those with an interest in supporting paediatric surgery. Recipients and supervisors need to be responsive to the fact that the award of a college scholarship, in addition to the prestige and financial remuneration, incurs certain obligations and expectations on the part of the college. The BSR feels in general that recipients and their supervisors should be strongly encouraged to present their work to the broader college audience through the ASC rather than a stand-alone sub-specialty meeting. In order to encourage this, the BSR will be investigating allocating a certain proportion of each grant towards conference expenses which would then only be allocated once such a presentation had been made. Present and future recipients should take note!

Should any trainee or fellow have any suggestions, questions or comments in relation to the Board of Surgical Research, please do not hesitate to contact me.

With kind regards,

Yours sincerely

Andrew J.A. Holland

Board of Paediatric Surgery Correspondence to the Board of Surgical Research

Associate Professor Helen O'Connell
Chair, Board of Surgical Research
Royal Australasian College of Surgeons

17 February 2009

Dear Associate Professor O'Connell,

Thank-you for your recent letter dated 23 December requesting that the specialties' training Boards consider crediting time in research as SET clinical training time.

The Board of Paediatric Surgery encourages both formal research and the career path of Academic Surgery, as essential underlying tenets of the professionalism of surgery and the advancement of surgical practice.

However we cannot support the concept of prospectively crediting research time as clinical training time. The introduction of SET has lead to considerable reduction in time in clinical exposure to a level that most Boards consider to be a minimum period. SET however has a competency based rather than a time based focus. Any SET trainee demonstrating early and complete achievement of necessary competencies will have their training time accordingly decreased. Training time is decreased or increased on an individual basis after careful examination of cumulative three-monthly in-training assessments.

Each specialty has determined the emphasis on various competencies that best suit the practice of their own specialty, and therefore some Boards have mandated a year of research as part of their SET program. This requirement is not universal to the specialties, and as such there can not be any broad application of rulings regarding the accreditation of research. The Board of Surgical Research may have to approach the relevant boards regarding the matter of duration of projects for accreditation.

We understand that the encouragement of trainees into research should be supported by the Boards. It may be that the Board of Surgical Research will need to gain College support for an increase in SET training time for all specialties, to allow for compulsory research.

I hope these comments are of assistance to you.

Yours sincerely,

Assoc. Prof. Deborah Bailey F.R.A.C.S.(Paed.) M.B.B.S.
Chair Board of Paediatric Surgery

Making Meetings More Effective, Saturday 27 June 2009, Melbourne

Do you know some of the most efficient ways to conduct meetings? What are the roles and responsibilities for committee chair and members?

The College is pleased to announce that the brand new 'Making Meetings More Effective' workshop will be launched on Saturday 27 June at the College of Surgeons in Melbourne. The workshop takes place between 9.00am and 5.00pm and counts as 7 points towards 2007-2009 totals in the College Continuing Professional Development Program.

This whole day workshop aims to help you understand the principles and characteristics of effective meetings and explores the latest problem solving strategies to make your meeting more productive, letting you spend more time doing what you do best.

If you sit on a committee or a board, you cannot afford not to attend the workshop!

To register or to find out more about the workshop, please contact Ally Chen at Professional Development Department on 03 9249 1212 or email: ally.chen@surgeons.org

COLLEGE PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

In 2009 the College is offering exciting learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will assist you to strengthen your communication, business, leadership and management abilities.

Mastering Intercultural Interactions

29 July 2009, Sydney
Discover how to recognise and use the eight most common communication styles and develop effective strategies for communicating with people from different cultural backgrounds. This workshop aims to enhance your communication skills by exploring a range of cultural value systems. It is essential communication training for surgeons practising in multicultural Australia and New Zealand.

Risk Management: Shared Decision Making

29 May 2009, Perth
This workshop will challenge you to listen, reflect and identify techniques to confirm patient understanding of surgical procedures. In developing the idea of shared decision making between patient and surgeon, this workshop will help you to give clear and easily understood information to all your patients and assist in decreasing your risk of litigation

Surgical Teachers Course

30 July – 1 August 2009, Canberra
17-19 September 2009, Auckland
The Surgical Teachers Course, consisting of two and a half days of challenging and interactive activities, enhances the educational skills of surgeons responsible for the teaching and assessment of surgical trainees. Experienced faculty members employ a range of teaching techniques and presentations to deliver the curriculum.

Further Information
Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: MAY – JULY 2009

NSW: 4 June Mastering Difficult Clinical Interactions, Sydney, 19-21 June Leadership in a Climate of Change, Sydney, 29 July Mastering Intercultural Interactions, Sydney
ACT: 30 July – 1 August, Surgical Teachers Course, Canberra
SA: 16 June Supervisors and Trainers (SAT SET), Adelaide
NT 30 May Management of High Risk Diabetic Foot, Alice Springs; 27 June Supervisors and Trainers (SAT SET), Darwin; 29 July Management of High Risk Diabetic Foot, Alice Springs (PSA)
WA: 29 May Risk Management: Shared Decision Making, Perth
VIC: 26 May Supervisors and Trainers (SAT SET), Melbourne; 27 June Making Meetings More Effective, Melbourne; 4 July Supervisors and Trainers (SAT SET), Ballarat; 4 July; Management of Severe Burns, Bendigo
NZ: 26 May Supervisors and Trainers (SAT SET), Christchurch; 26 June Practice Made Perfect: Successful Principles for Practice Management, Auckland

Surgeons and Trainees Interactions with the Medical Industry

The relationship between doctors, surgeons in particular, and the medical industry has come under increased scrutiny in recent times both in Australia and overseas. It is important that patients have complete confidence that the choice a surgeon makes about which prosthesis is implanted or which technique is used is governed by what is best for the patient.
In response to these challenges, the Royal Australasian College of Surgeons approved a statement on Surgeons and Trainees Interactions with the Medical Industry in February 2009. This is an important initiative that will receive considerable focus and external scrutiny. It has implications for every surgeon.
The statement describes how surgeons should relate to the medical industry and covers a number of practical scenarios. Extensive consultation has taken place to develop the statement, with feedback received from Specialty Societies and Associations, individual Fellows and a number of College committees.
To support the Surgeons Interactions with the Medical Industry statement and the broader Code of Conduct, the College is currently developing a Sanctions Policy.
The statement is available on the College website at: www.surgeons.org/guidelines.
If you have any questions about the statement, please contact Dr John Quinn FRACS, Executive Director of Surgical Affairs, on telephone +61 3 9249 1206 or email john.quinn@surgeons.org.

Professor Michael Grigg
Chair, Professional Standard Committee
Royal Australasian College of Surgeons

Surgical Skills Laboratory dedicated to Paediatric Minimally Invasive Surgery

Minimally invasive surgery in children is a rapidly growing specialty. In order to keep pace with this fast growth, an elaborate surgical skills laboratory has been established at the Children's Hospital at Westmead. This has been proudly supported by Covidien (Tyco Healthcare) and approved by the Board of Paediatric Surgery of the Royal Australasian College of Surgeons.

One of the pivotal activities of this project is to conduct training workshops for Paediatric surgeons and advance trainees using animal models. In keeping with this, on November 28, 2008, an advanced training workshop in Laparoscopic Paediatric Urology and in June 2008 another workshop in Neonatal Thoracoscopy and Paediatric Laparoscopy was successfully organised.

On June 27, 2009, an "Advanced Training Workshop in Paediatric Laparoscopy & Thoracoscopy" is planned. Participants will get hands on experience in Thoracoscopy & lung biopsy, oesophageal anastomosis & diaphragmatic hernia repair or in Laparoscopy fundoplication, colonic biopsies and splenectomy. We hope that the participants find the workshop useful and thank the Paediatric Surgeons of Australia and New Zealand for their support.

Professor Ralph Cohen
Dr Sandeep Bidarkar

Basic & Advanced Training Workshop in Paediatric Thoracoscopy and Laparoscopy

Jointly presented by

The Department of Paediatric Surgery, Children's Hospital at Westmead & COVIDIEN (TYCO Healthcare)

Highlights-

- Hands on experience in thoracoscopy and laparoscopy
- Experienced supervisors
- Introduction to latest equipment in paediatric minimally invasive surgery
- Basic training on lap Simulator and endo-trainer.
- Advance training on animal models
  - Thoracoscopy: lung biopsy, oesophageal anastomosis & diaphragmatic hernia repair
  - Laparoscopy: fundoplication, colonic biopsies, splenectomy & pyeloplasty

Date- Saturday, June 27, 2009.

Contact –

- Professor Ralph Cohen, ralphc@chw.edu.au
- Dr. Sandeep Bidarkar, sandeepb@chw.edu.au

Comment: The Proposed Academy of Surgeons

Over the last 18 months I have written somewhat repetitiously and boringly on the subject of SET and its impact on training via one of its objectives; the shortening clinical training time. The introduction of SET and formative assessment is part of a wider attitudinal change to training. In ANZ we have always prided ourselves on the high quality of our finished product; well trained surgeons versed in all modern techniques and standardised by common Fellowship exit examinations and Board Curricula.

However as training posts have increased in number and distance from traditional tertiary teaching bases, and methods of teaching have changed away from rigid, authoritarian, didactic interactions, the apprenticeship model of training has been increasingly questioned. Clinical skills need to be taught by clinicians. But how do we shorten clinical training time and still end up with every trainee getting standardised exposure to all aspects of training and feedback? How do clinicians keep up with changes in assessment and curriculum? How do the training boards choose the right evaluation and selections tools? How do we keep training out of the hands of bodies more interested in getting technicians willing to be told what procedure to perform based only on cost or institutional expediency? How do we stop surgical education and standards being taken away from clinicians, who are motivated by consideration of the future of the community and not by profit?

The first and most important action is to stay together. Instead of splitting up into multiplicities of interest groups we act together as the College of Surgeons when discussing standards and education with government and other bodies.

Another proposal is to set up an "Academy of Surgeons". Each society cannot afford to employ full time educationalists or run all the courses needed to help train supervisors and surgeons. But the College can employ these people and then we can access their resources. This body of people and resources given these duties is to be called the Academy of Surgeons. The proposal is still being explored, and there are concerns about how this will affect individual surgeons who teach trainees on a day to day basis (the coal face). The idea is that we all as "trainers" would be members of the academy but there would be a "faculty" or "directors" (titles to be decided), who would be drawn from the ranks of academic surgical educators. The Academy would coordinate and develop courses like the SATSET course. Training boards could utilise the expertise of the Academy to develop training courses or tools. Individuals could ask for help with difficulties with training or upgrading skills. Current College portfolios like post graduate development and training could also benefit from the Academy umbrella.

The Academy is the topic of many debates and we all are somewhat sceptical about the processes and motivations. In the end, the trainees and trainers are demanding more robust standardised methods of teaching, selection and evaluation. If the College wants to continue to be acknowledged as the leader of quality surgical education and standards we will have to lead also as in the development of educational authority. I believe after looking at the alternatives that this is the correct direction to be exploring as we future proof our training curricula and methods, and our own continuing medical education. I look forward to further discussion from our membership /fellowship.

Assoc. Prof. Deborah Bailey F.R.A.C.S.(Paed.) M.B.B.S. Chair Board of Paediatric Surgery

From the Executive Officer

As I write my final article for the newsletter for approximately 14 months I am reflecting on how quickly the past five years (four as Executive Officer for the Association) has gone by and how much I have enjoyed my time providing administrative support for both the Association and the Board of Paediatric Surgery.

For those of you not aware, I am 32 weeks pregnant with my first child at the time of writing this and will be heading off on maternity leave on 29 May.

I would like to let you all know that it has been a privilege to work for the Association and the Board and the position has easily been the best job I have had, working for and amongst truly remarkable people that make such a difference to other people's lives.

My estimated date of confinement (quite a funny term, don't you think?) is 13 July which is also the first day of the Scientific Meeting in Fiji. I will be thinking of all those who will be attending and enjoying the hospitality of Jitoko Cama and the Pacific Islands surgeons in what is a stunning location.

Jasmine Morris has commenced as Executive Officer and we have been lucky enough to have handover time (it will be four weeks in total). Jasmine comes to the Association with a Masters in Public History and an interesting working life, most recently with stints in the UK and Italy. Please make Jasmine feel welcome.

In closing, I'd like to pass on my thanks in no particular order to Deborah Bailey, Tony Sparnon, Hugh Martin, Spencer Beasley, Phil Morreau, Andrew Barker, Hilary Boucaut, Joe Crameri, Robert Stunden, Eddie Shi, Tracey Merriman, Michael O'Brien, the ANZAPS Executive Committee, the wonderful Trainees and New Fellows and all the ANZAPS members I have had the pleasure to meet, speak with and correspond with over the years. I wish you all the very best, and hope to see you all in approximately fourteen months!

Rebecca Letson