Australian & New Zealand Association of Paediatric Surgeons Inc

December 2012 Newsletter

President's Report

Since my last report in August this year there have been a number of important changes within the College in relation to governance and education which also have had implications for ANZAPS. On 25th October, 2012 I attended the Surgical Leaders' Forum at the College in Melbourne and took the opportunity at that time to sign the new partnering agreement with the College on behalf of ANZAPS. Option 1 was the preferred option out of the three available and this allows the College to perform the necessary functions of ANZAPS on our behalf. As we are one of the smallest associations in the College one of the main concerns with this change was that we should not be financially disadvantaged. Recent costings and charges have confirmed that ANZAPS will not be disadvantaged under this new agreement.

On the 20th September, 2012 I attended the Medical Services Advisory Committee (MSAC) information session in Sydney. In 2011 MSAC underwent changes to its terms of reference and governance. The main role of MSAC is to assess changes to the Medicare schedule and determine the real costs for service delivery. Currently, this process takes between 18 and 36 months and with the new system this should be reduced to 12-15months. It is still quite a complex bureaucratic system. In question time I asked on behalf of the ANZAPS, "as a group who would assess our application and the supportive evidence for changes to the Medicare schedule fees?" The answer provided was ASERNIPS. I responded that this committee was chaired by an adult surgeon with little in the way of paediatric surgical experience. I emphasized the need for informed paediatric surgical input into this important assessment and application process both for the benefit of the applicants and also the assessment committee. There was an agreement to look into this. I am sure that Harry Stalewski and his committee will continue to pursue this and hopefully bring it to a satisfactory conclusion.

At the Surgical Leaders' Forum held in Melbourne on 25th October, 2012 the viability of Medicare and surgical services in the health sector over the next 20 years was discussed extensively. It was a very interesting and relevant discussion involving a range of presenters both from the private and public health systems, clinicians and politicians. Overall, it concluded that Medicare is not sustainable in its current form and would consume the entire state budget within the next 20 years. This was largely due to the increased aging population and overuse of the system for minor services combined with an expected reduction in overall tax revenue. The significant difference between private and public health systems was highlighted, particularly in terms of their efficiency and quality of service. Currently, there are 1000 public beds not being used in Victoria. Spencer Beasley summed the situation up well when he said, "Overall, the system is unsustainable and needs dramatic changes involving politicians, CEOs, managers and surgeons".

I am sure we would like to extend our congratulations and best wishes to the recent successful candidates for the Fellowship exam, Sarah Giutronich, Sebastian King and Camille Wu. Congratulations! Also all of our congratulations go to Hugh Martin in recognition of the recent award bestowed on him by the College to Membership of Court of Honour. Well done Hugh and well deserved.

Many of us are finding it difficult to manage the increasing workload within our own practices due to the large numbers of paediatric surgical patients who are being transferred from Metropolitan Hospitals with relatively low acuity surgical problems to the tertiary paediatric surgical centres. We have seen 135% increase in appendicectomies at the Children's Hospital Westmead alone over the last few years. This has put tremendous strain not only on the consultant staff but also the junior staff. The solution to the problem is not easy but suggestions have included, increasing the total number of paediatric surgeons to provide paediatric surgical services both elective and if appropriate emergency to metropolitan and other hospitals. Another option we are currently looking at Children's Hospital Westmead is to train a post fellowship adult surgical trainee for one year within the Children's Hospital and then the person would return to the metropolitan hospital where he/she would manage the low acuity paediatric surgical cases. Also this would involve a commensurate increase in paediatric anaesthesia and nursing. I would be interested to hear how other members are managing this problem.

Plans are now well underway and the website is open for registration to attend the PAPS/ANZAPS combined meeting in April 2013 in the Hunter Valley. Dr Raj Kumar, Prof. Andrew Holland and their respective committees have combined very effectively to put together an exciting academic and social program. I would encourage you all to register for this meeting as soon as possible. The next meeting in 2014 will be in Singapore and Dr Michael Nightingale is in the process of organising this. The 2015 meeting will once again be combined with SPANZA and will be held in New Zealand.

I would like to mention the exciting prospect of having a combined WOFAPS/ANZAPS World Congress meeting in Sydney in 2019. There has been support for this from the WOFAPS. Event organisers in Sydney are currently looking at the proposal to submit to the WOFAPS meeting in Berlin in October next year. I will keep you informed of progress and look forward to the involvement of as many of you as possible should this meeting be confirmed.

As President of ANZAPS I was asked by the WOFAPS Executive to assist in the organisation of the surgical contribution to the 27th International Pediatric Association Meeting (IPA) in Melbourne, 24-29th August 2013. This will be a large meeting with some 3,500 delegates and the surgical component promises to be an excellent program with both national and international contributors. I would encourage you to attend. The web site is; www.ipa-world.org/IPAcongress

As this will be my last President's report I would like to take the opportunity to express my gratitude for all the support I have received from many of you in the ANZAPS. I would particularly like to thank Kristy Scalea our Executive Officer. She works tirelessly to maintain the efficient running of the Association. I owe a great debt of gratitude to all the hard working members of the Executive Committee and the Board. Deborah Bailey has now vacated the position of Chairman of the Board and has been replaced by Anthony Dilley who will maintain the high standard. Deborah Bailey I know will do a great job taking over from me as President in April at the Hunter Valley meeting. I wish her all the very best during her upcoming term as President. I wish all of you a happy, healthy Christmas and New Year and look forward to seeing you in the Hunter Valley.

Professor *Ralph Cohen* **MS. FRACS**
President, ANZAPS

Board Chair of Paediatric Surgery

As incoming Chair of your Board, I would first like to acknowledge the outstanding leadership shown by Deborah Bailey in her time as Chair. Paediatric SET is undoubtedly the gold standard against which other SET programs are measured, and this is largely due to Deborah's dynamism and focus as Board Chair. My colleagues on the Board continue to work hard, and I thank them for their confidence in me.

We have seen the fruits of our new competency based training over the past few years, with accelerated training for some trainees and prudent delays for others. This can only be possible as a result of the training, supervision and meaningful assessments provided by all paediatric surgeons. We all know the workload involved with training has dramatically increased for all Fellows, and I am sure you have the gratitude of all our junior colleagues. I will endeavor to provide regular feedback to Supervisors and Fellows to improve understanding of the process and substance of SET, and will continue to impress upon hospital authorities (during accreditation visits) the importance of the time dedicated to training and the remuneration it should entail to all Fellows.

We have now completed our second Boot Camp. The inaugural event in 2011 involved our four current SET One trainees and I. This year, we had all our successful applicants plus Chris Kirby, Bhavesh Patel, Ashish Jiwane, David Croaker and Neil Price in attendance – I thank these supervisors for the time and expense involved. An open invitation stands for all paediatric surgeons wishing to attend this one day orientation seminar. The SET One year is intended to behave as an extension of selection – the new trainee will get to work in a tertiary paediatric facility to determine whether Paediatric Surgery is a good fit for them. It is also important that the ability of the trainee to undergo training is assessed, hence the comprehensive assessment package that many of you have seen. Unsatisfactory performance (a failure to demonstrate timely acquisition of knowledge and skills as outlined in the assessment package) will likely result in dismissal from training at this early stage.

The rate limiting factor with respect to how many trainees we can have in our system are the two years spent in Surgery in General. The majority of posts we use are rationed out by BiGS, and we have little control over the experience provided in the allocated terms. The Board has identified suitable posts outside the immediate control of BiGS and we request that you let us know of any other potential positions available in your area so that accreditation can be arranged. The SET One program is designed to provide these posts with our trainees who are by then capable of being on call, removing most inflamed appendices, and adept at scrotal exploration. Continued commitment by our SET One hospitals to produce such useful registrars will hopefully ensure that a mutually beneficial relationship is established between our training program and these Surgery in General posts. There will undoubtedly be ongoing discussion concerning the role of these years of general surgery and how they can or should be modified.

At the recent BSET meeting two important issues were flagged. The first relates to safe working hours for our trainees, and Deborah Bailey will continue to spearhead research and discussion of this. The second involves the issue of bullying of trainees reported via a RACSTA questionnaire. Though the sample size is small and difficult to verify, your Board has requested that our trainees read the RACS Bullying and Harassment Guidelines, and we have also asked if a more relevant and accurate assessment of this issue can be made by our trainees with respect to Paediatric SET. Also discussed at BSET were data related to the final Fellowship Examination, as regional pass rates vary significantly (extremely favourable to New Zealand, poor for NSW). Access to public outpatient clinics has been implicated as being one important factor to be considered.

I wish you all a safe and fulfilling holiday season, and a fruitful 2013.

Mr *Anthony Dilley* **FRACS**
Chair, Board of Paediatric Surgery

Council Report – October 2012

At the October Council Meeting it was pleasing to see the progress which has taken place following the work of the strategic planning groups during the past twelve months. All the specialty societies, including the AOA, have indicated the desire to maintain their relationship with the College. Many societies including ANZAPS have already signed new partnership agreements with the others signing up for an extension to mid next year whilst they formalise their specific agreement. This demonstrates an enormous advancement in a short period of time and the strengthened communication and cooperation should allow our College to move forward with trust and respect between all Fellows.

At the Council Meeting it was announced that Mr Hugh Martin is to be awarded Membership of the Court Of Honour. This is an enormous achievement demonstrating Hugh's contribution to our College at all levels over a long period of time. I am sure that all members of ANZAPS would join me in congratulating Hugh on receiving this award.

A number of governance policies are to be reviewed, two in areas that I have raised on behalf of ANZAPS. A safe working hours working party is to be established and chaired by our own Assoc. Prof. Deborah Bailey. In addition working parties have been formed to examine flexible training and mentoring which are both areas in which our board has been active. With the rationing of health finances due to the aging population it is agreed that the adolescence are missing out. A position paper on the uniform treatment of adolescence is to be prepared and I will be representing the paediatric interests.

Of concern was a report from the College Trainee Representative who advised Council that the recent RACSTA end of term survey revealed that the trainees have an increased perception of bullying and harassment. In addition they have concerns that they are receiving an inadequate operating experience due to safe hours and the increasing number of Fellow positions.

It should be noted that Mr Andrew Roberts has retired after 5 years in the role of Clinical Director of IMG Assessment. Andrew has assisted many of us with advice in IMG issues and he should be congratulated on his outstanding contribution. Mr Peter Dohrmann is to succeed Andrew.

Finally I am sure that all members of ANZAPS will be interested in both the recent "RACS Surgical Workforce Census Report 2011" and the "Health Workforce Australia 2025" publications. Health Workforce Australia 2025 suggests that there will be a highly significant shortage of nurses and a shortage of Doctors by 2025. There will also be insufficient postgraduate medical training places for the Graduates seeking them resulting in a system which is highly dependent on the migration of international health professionals. The volume three report examines individual medical specialities under 26 categories with the surgical workforce examined in 5 categories, namely general surgery, orthopaedic surgery, ENT, plastic surgery and other surgery. Paediatric surgery has been grouped along with cardiothoracic surgery, neurosurgery, urology in the "other surgery" group due to the small workforce numbers. They comment "overall the other surgery group was not perceived to have a current shortage although within the group paediatric surgery was found to have some perceived difficulty in filling positions".

The College has pointed out to HWA that its main source of data is the Australian Institute of Health and Welfare medical labour force survey which is a voluntarily survey with a variable response rate. This methodology depends entirely on having comprehensive data sources. It is therefore interesting that the number of Surgeons it presently claims as being active differs significantly from College figures. For example HWA suggests that there are 3963 Surgeons in Australia, whilst the RACS figures suggest 4371. Interestingly AHPRA records that 4963 Surgeons are registered.

The workforce projection is very difficult for our small specialty. However, the data which is presently available is confusing. The Health Workforce Australia data suggests that there are 61 Paediatric Surgeons, the Australian Institute of Health and Welfare claims 64, the RACS records 84 and AHPRA 92. In South Australia for example the number varies from 6 –

10 from these different sources. Health Workforce Australia whose data is used by governments for further planning uses figures supplied by the jurisdictions rather than Colleges, or Associations.

You may question how planning programs can be developed when the basic numbers we are starting with appear so different.

I am recommending to the Executive of ANZAPS that we follow the Neurosurgeons and prepare an Australian and New Zealand Paediatric Surgery Workforce review where we ourselves accurately assess how many active, retired etc Paediatric Surgeons there are in each area, how much and what type of work is being done etc. This is the only way that we can attain truly accurate figures with which future planning can occur. Departments of Health may have endless data but we are all aware that the accuracy is unreliable. Such a census can only be performed with the cooperation that all members answer it honestly and comprehensively.
I wish everyone a Happy Christmas and Good Luck in the New Year.

Mr *Anthony Spanon* **FRACS**
Council Representative

CPD Report – October 2012

One of the purposes of PDSB is to be a forum at which all specialties are represented. Having representation means that the Board needs to know something of the activities of each specialty so each specialty society is asked to submit a report. I have tried to keep this brief: does anybody else really want to know the detailed programme of our Annual Meeting? But others seem to think such detail is important so the reports vary widely in their length and complexity. Obviously bigger societies will have more activity. In an attempt to give some uniformity to what is in the reports it is now suggested that we use a template. The template includes figures: the number of surgeons in the society, the number of that specialty (as registered in the College books) who participate in CPD, the number who fail to comply as well as the number who do not participate, plus percentages. Sadly, the percentage of Paediatric Surgeons who are participating has fallen in 2011 compared with previous years.

I find it most perplexing to see that surgeons do not participate. CPD compliance is mandatory for continued registration in both Australia and New Zealand. If you tick the "yes" box in answer to the question about CPD in your registration application but are, in fact, not compliant, severe penalties are likely. But worse than penalties is the blunt fact that to do such a thing is lying. The College does not supply a list of non-compliant fellows to the registration authority, but it is obliged to answer the question if the registration authority asks if a Fellow is CPD compliant.

The template asks about CPD activities that we have conducted since the previous Council week and what activities we are planning. It also asks about general strategic issues that are affecting professional standards or practice, about research, about rural and remote practice and about humanitarian activities. All this will require individuals to let our EO, Kristy, know about such activities so that the PDSB representative can put this together before each meeting in February, June and October.

Big changes are afoot for CPD starting next year. Because both AHPRA and the Medical Council of NZ have annual requirements for CPD compliance the College is to adopt this time frame instead of a three yearly cycle as it is now. The number of categories is to be reduced to 4, one of which is a new category of performance appraisal, i.e., a "360°". It will not be mandatory. The intention is to encourage reflective practice. It will attract 30 points (so half the annual requirement for categories 3 & 4) and be valid for 3 years.

Another change is that on-line reporting will become mandatory in 2014. The College is looking at ways to have some activities automatically recorded in an individual's log; activities that are College based such as conferences and courses would be able to have this done.

The verification (audit) rate is to be increased to 7% from the current 3.5%. Some statistical work has been done that shows that this sampling rate is enough to give a valid snapshot of the whole Fellowship.

You may recall that there is a College Code of Conduct. You may also recall that in it is an undertaking to be CPD compliant. PDSB has recommended that this be taken seriously from now on, that is, Fellows who are not compliant be required to sign a statutory declaration that they will comply in future. If they fail to comply the next year, consideration will be given to the only penalty available to the College, removal of Fellowship.

I can hear it now – the cries of protest "Why does the College do nothing but make life difficult!" For a start, that ignores the services such as library and courses, the educational activity, the maintenance of your Fellowship as a recognized qualification by the AMC and its advocacy to jurisdictions on matters that profoundly affect the way you practice. But there is another, even more important reason why these requirements are being put in place. It is to do with professionalism. In brief, to claim to be a profession with certain privileges including a degree of self regulation, we must have a number of attributes, one of which is effective self regulation including demonstrable penalties for those who fail to reach a standard that itself must be transparently reasonable. If you wish to read an excellent exposition about professionalism, articles by our first Expert Community Advisor on Council, Geoffrey Davies, are available in the Journal. Of course, if

we want to continue to say to the community "we're an elite, we know best and whatever we say, goes" we will very rapidly find ourselves being even more regulated by government than we are now.

The College is having significant input into the setting up of the national Elective Surgery Urgency Categorization plan. It is important that this is driven by clinicians, not by bureaucrats. For information, go to www.aihw.gov.au

The Australian Council on Healthcare Standards (ACHS) is the non-governmental body that attempts to bring some standards to Healthcare Organisations (HCOs). For surgical patients, Clinical Indicators (CIs) are one aspect of this. The CIs that have been used by them up to now have been criticized. The seven paediatric CIs developed in 1997 were reduced to 6 then in 2000 reduced to 3. ACHS is now requesting that the College and Societies develop better CIs, 6 of which will be generic and 4 specialty specific. ANZAPS will be the body to develop these, but all of us should give the matter some thought. There are some useful questions to be asked when developing CIs accessible at www.apho.org.uk/resource/item.aspx?RID=44584

Neither a poorly chosen indicator with reliable data nor a well chosen indicator with unreliable data are of value.

The new Dean of Education, Prof. Stephen Tobin, gave a presentation on the Academy of Surgical Educators. There has been some confusion in the minds of many people about the Academy's exact role. The Dean made it quite clear that its main role was to support the hundreds of surgeons who teach in the field. Masterclasses on teaching for busy surgeons are planned.

Some good news. The Morbidity Audit & Logbook Tool (MALT) is fully functional and available to all trainees and Fellows. It is greatly improved compared with the first version of the electronic logbook. If you are in a Wifi environment it is available on your mobile, and there are plans to create an app to widen its use on mobiles.

It is clear that the push by some Societies to have more involvement in College decision making has led to the concept that it is the Societies that are represented on PDSB, not the specialty. So if any of your colleagues are not members of ANZAPS, they are not represented in this forum. The more inclusive our Society, the stronger it will be.

Mr *Hugh Martin* **FRACS**
CPD Representative

Professional Development 2013

The 2013 Active Learning booklet is now being distributed. Look out for your copy.
Inside are professional development activities to enable you to acquire new skills and knowledge and reflect on how you can apply them in today's dynamic world.

A brief selection:
SAT SET
26 February, Adelaide; 16 April, Melbourne
The Supervisors and Trainers for Surgical Education and Training (SAT SET) course
assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues.
This workshop is also available as an eLearning activity by logging into the RACS website.

KTOT
5 March, Brisbane; 19 March, Melbourne;
9 April, Sydney
Keeping Trainees on Track (KToT) is the next workshop in the Supervisors and Trainers for SET (SAT SET) series. This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Communication Skills for Cancer Clinicians
9 March, Melbourne
In four hours you will learn evidence-based, step-by-step communication skills that break down the challenge of delivering negative diagnoses to patients and relatives. A trained-actor steps in mid-way through the morning to run a role play exercise where you practise newly-learned communication skills in a safe environment resembling a real-life scenario.

NOTSS
15 March, Adelaide; 19 April, Melbourne
This new workshop focuses on the non- technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve your performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into elements or behavioural markers that can be used to identify a superior or substandard performance. Through a series of interactive exercises you will better understand how these markers can be used to reflect on your own performance and that of the surgeons you work with.

Polishing Presentation Skills
22 March, Melbourne

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings.

Surgical Teachers Course
11-13 April, Melbourne
The two-and-a-half day intensive course enhances educational skills of surgeons who are responsible for the teaching and assessment of Trainees. Participants learn the foundation of improved educational skills, which are further developed during the course through practical application.

Process Communication Model
18-20 April, Melbourne
PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the 6 different personality types; each person represents a combination of these types, but usually one is dominant.

AMA Impairment Guidelines 5th Edition: Difficult Cases
29 May, Brisbane
The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This evening workshop (3 hours) provides surgeons with a forum to review difficult cases, the problems encountered and the steps which can be applied to resolve the issues.

Writing Medicolegal Reports
15 July, Sydney
This workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser.

Finance for Surgeons
19 July, Melbourne
This whole day course establishes a basic understanding of how to assess a company's performance using a range of analytical methods and financial and non-financial indicators. It reviews the three key parts of a financial statement; balance sheet, income (profit and loss) and cash flow. Participants learn how these statements are used to monitor financial performance.

Strategy and Risk for Surgeons
11 October, Melbourne
This whole day workshop is divided into two parts. Part one includes formulating a strategic plan; the strategic planning process; identifying and achieving strategic goals; monitoring performance; and contributing to an analysis of strategic risk.
Part two focuses on the directors' knowledge of risk for the organisation and their monitoring of management's ongoing assessment and treatment of risk.

Building Towards Retirement
16 November, Melbourne
Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. Fellows from a variety of disciplines and their partners join with colleagues and corporate speakers in an interactive discussion format that focuses on three sessions on preparing for retirement, options after retirement and resources to realise options.

To register for these courses, or for more information phone +61 3 9249 1106

New Courses for Fellows and Trainees

The RACS has recently piloted two 3 hour courses, in future to be offered to all trainees and Fellows of the college. Encompassing the surgical competencies identified by the College, these courses not only highlight the key issues that trainees should be aware of embarking on their new surgical careers, but also refresh and develop the core skills that all practicing surgeons should be familiar with.

The first presented course was 'Training standards - interpretation and analysis' . The course objectives were to make the participants aware of and interpret the RACS Required standards for competence and proficient performance across all nine competencies, as well as further develop the ability to apply and assess these standards in their workplace. As a SET 1 trainee, I found this course to be not only informative, but also useful in outlining the expectations the college had, of not only junior, but also senior surgeons. The course outlined an introduction to the college's frameworks to ensure competence amongst all surgeons. What I found most useful were the small group discussions where the standards were applied to specialty specific clinical scenarios which allowed junior and senior surgeons to identify levels of competences .

The aim of the second course offered, ' Surgical decision making - a complex competency' , was to make surgeons aware of the range of cognitive

processes involved in surgical decision making. The course enhanced the decision making process under stress and improved the ability to recognize the factors that influences the quality of decision making. Again I found this course to be extremely useful as it enabled the participant to become involved in small group discussions in order to apply the algorithms created by the college.

Dr *Seema Menon*
SET 1 Trainee

Report from the Executive Officer

2012 has been a very busy year, it was great to see many of you at the ASC in Kuala Lumpur in May and I am very much looking forward to attending the PAPS and ANZAPS Meeting 7 - 11 April 2013 in the Hunter Valley.

I would like to congratulate Dr Camille Wu who has recently passed the Fellowship exam and is now a Fellow of the College. Congratulations also to Dr Sarah Giutronich and Dr Sebastian King who have passed the Fellowship exam and will be completing their final year in Paediatric Surgical training in 2013.

I have enjoyed working for the ANZAPS Executive Committee, thanks to Prof. Ralph Cohen for his committment and professionalism to the position of President. Next year will see new president of ANZAPS Assoc. Prof. Deborah Bailey, I hope that she enjoys the role.

Mr Anthony Dilley has begun his role as the new Chair of the Board of Paediatric Surgery, I hope he finds it as rewarding as Deborah found it.

Welcome to our new 8 Paediatric SET trainees, I wish you all the very best for your training.

Wishing everyone a happy and safe festive season.

Kristy Scalea
Executive Officer ANZAPS

New Members and Trainees

Welcome to the following new members of ANZAPS:

Dr Parshotam Gera
Dr Warwick Teague
Dr Jonathan Karpelowsky
Dr Paromita Das Gupa
Dr Bhavesh Patel

Welcome to the new SET 1 trainees in 2013:

Dr Kiarash Taghavi
Dr Rachel D'Cruz
Dr Philip Urquhart
Dr Brenton Systermans
Dr Giovanni Melino
Dr Catherine Asquith
Dr Giorgio Stefanutti
Dr Eilen Saekang

Upcoming Meetings and Conferences

2013

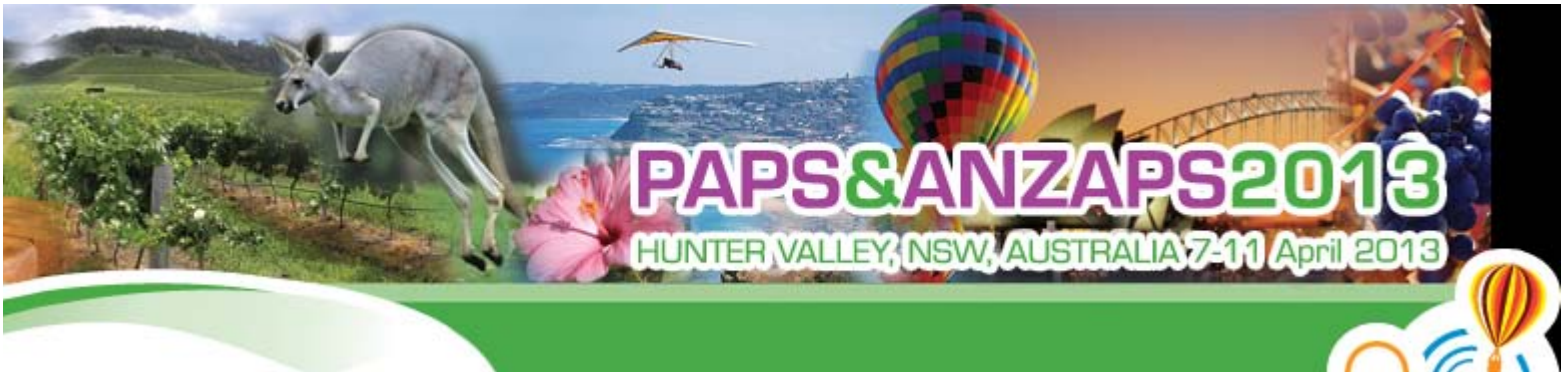
ANZAPS ASM and AGM & PAPS Conference
7th-11th April 2013
Hunter Valley Newcastle, Australia
Combined PAPS / ANZAPS meeting

27th International Pediatric Association Meeting
Melbourne, 24-29th August 2013
www.ipa-world.org/IPAcongress

2014

Annual Scientific Congress, RACS with ANZAPS
Marina Bay Sands, Singapore
6th-9th May 2014

If you have any meeting/conference dates that you would like to appear in the section email: **anzaps.college@surgeons.org**



46th Annual Meeting of PAPS together with ANZAPS ASM

Location: Crowne Plaza Hunter Valley
Date: 6th to 11th April 2013

For more info: www.paps2013.com.au

Preparations continue for our combined meeting with the Pacific Association of Pediatric Suregons next year, now just five months away. The conference web site (please see http://paps2013.com.au/) has been active for some time and contains a wealth of information for members and delegates. Can I make a special plea for those members planning to attend the meeting to register as soon as possible? Whilst discounted early bird registration is still permissible before the 31st January 2013, we do need some money in the kitty to help pay some of the expenses already incurred on your behalf for the conference to run smoothly. Early registration will also ensure that you will be able to secure your preferred accommodation option. Whilst we have negotiated rates at two nearby venues, both will require you to drive to the conference venue.

Abstracts close on the 15th December 2012. I do not anticipate that we will extend this deadline. Junior surgical colleagues presenting at the meeting will be eligible for selection for the PAPS Prize and the ANZAPS Clinical, Research and Poster Prizes. If possible, those presenters eligible for a prize and selected for a full oral presentation will present in a combined session. These awards are prestigious and trainees at all levels should be encouraged to participate.

As can be seen from the programme layout, the meeting is likely to be a full one, but should still provide opportunities for interaction with both local and international visitors together with opportunities for relaxation during the welcome reception, conference tour and banquet. I would ask for local members especially to make welcome our RACS visitor, Professor Agostino Pierro, and all of our international guests, many of whom may be visiting Australia for the first time.

If any member has any concerns about the meeting or suggestions for improvement, please feel free to contact me at any time, after you have registered of course.

With kind regards and best wishes,

Professor *Andrew Holland* **FRACS**
RACS Scientific Convenor

ASC Singapore Report 6-9 May 2014

Planning for the 2014 ASC in Singapore has been steadily progressing over the last few months. There has been strong interest from expressed by many specialty groups for collaborative sessions with Paediatric Surgery and a strong interest from ANZCA, who will be holding a conjoint meeting, about holding mutual sessions. We are in the process of confirming local invited speakers, planning a workshop on the Monday before the meeting commences and bringing together an interesting scientific program.

The venue will be spectacular with amenities including shopping areas, theaters, a casino, the Sands SkyPark, Wonder Full (a light and water spectacular,) a skating rink and the ArtScience museum all within the facility. I am sure this will be an excellent scientific meeting and promote strong ties with our colleagues in the Asian region. I look forward to updating you all as the planning progresses.

Mr *Michael Nightingale* **FRACS**
RACS Scientific Convenor

Obituary – Professor A C Toby Bowring AM

1924-2011

"better get weaving"

Professor Toby Bowring, the founding paediatric surgical professor at Sydney Children's Hospital, Randwick, passed away on 31 October, following a long battle with cancer. "Prof" was a great mentor, friend and clinician to thousands, a thorough gentleman at all times and an inspiration to many. He would, however, wish to be remembered as much for his love of boxing, fishing and shooting, as for his pioneering work as a Paediatric Surgeon.

Professor Bowring was born in Dulwich Hill in Sydney in 1924, the son of a railway conductor. When he was four years old the family moved to Albury, where Toby announced as he commenced at the Infants School that he'd 'come to learn how to be a doctor' (an ambition he identified as being his mother's) and graduated from the local high school with a place in medicine at Sydney University.

Despite living in the town itself, Toby developed a great love for observing nature and outdoor pursuits. As an enterprising young boy in the Depression years, he would ride his bicycle out in to the countryside to shoot rabbits, skin them, and, having calculated the price required to turn a small profit after paying for his ammunition, bring them back to town for sale.

While at university, Toby continued competitive shooting and learned to box, proudly winning a University Blue in the latter. He and his fellow students maintained their fitness by Wednesday afternoon sessions of air raid trench digging. This started with zigzag slit trenches in the grounds of their college, Wesley, before continuing around the campus proper, and eventually finishing in nearby Victoria Park. Toby graduated in 1947 with Professor John Beveridge, with whom he would later found the Prince of Wales Children's Hospital. (now the Sydney Children's Hospital, Randwick) Friendships forged at that time, including with Professor Douglas Tracey, were precious to Toby, and his loyalty and commitment to maintaining them meant he had many truly life-long friends. Indeed, these relationships were rekindled and added to in his retirement.

On graduation Toby took up a place at South Sydney Hospital where he said his real learning began. Working with surgeons he held in high regard, and counting himself fortunate to have the opportunity to do more numerous and more complex procedures than would have been the case had he gone to a larger, teaching hospital, Toby determined that he would be the best junior resident medical officer the hospital had seen. During a short placement at the associated hospital, St Joseph's, Auburn, Toby's promising future took on an even brighter aspect when he captured the heart of the nurse in charge of Casualty. He was impressed with the way she ran her department. Toby and Patricia Stoney were married in 1950.

With the first of their six children in tow, and with Toby working as the ship's doctor, the family travelled to the United Kingdom so he could continue his surgical training. In 1954 their second child was born in London, and in 1955 Pat returned to Australia with the two children and a third on the way, leaving Toby to concentrate on acquiring the Edinburgh and London Surgical Fellowships. Twelve months later Toby worked his passage home to rejoin his family. He took up private rooms in Macquarie Street, and joined the staff of the Royal Alexandra Hospital for Children in Camperdown. The specialty of paediatric surgery, in its infancy at that time, owes a great deal to the pioneering spirit of Professor Bowring and his colleagues.

In particular, Toby was part of the pioneering days of Paediatric Cardiac surgery. Together with his long time friend and fishing partner, Viv Ebsary, Dr Douglas Cohen, who became head of Surgery at Camperdown, and Anaesthetist Victor Hercus, the first cardiac bypass machines were developed. This enabled the correction of previously inoperable cardiac abnormalities, operations we now take for granted. Toby brought these skills with him when he left Camperdown in the early 1960's when the UNSW medical school was established, to start the new paediatric service at Prince of Wales and Prince Henry Hospitals with the foundation Paediatric Professor, John Beveridge. At Prince Henry and Prince of Wales, the specialty of General Paediatric Surgery flourished, encompassing cardiac, trauma, emergency surgery and the very earliest neonatal surgery. The first surviving TOF at Prince of Wales Children's Hospital was performed by him in 1964. Right from those early days, Toby ensured Paediatric Surgery had equal footing with all the other surgical specialties, giving it the status it needed to become a specialty in its own right. More importantly, he recognised the close symbiotic relationship necessary with Paediatric Medicine, stating "(he knew) of no other children's hospital … which came close to it in the integration of medical and surgical services" This has remained a defining feature of the Sydney Children's Hospital, Randwick.

Professor Bowring saw the value in the international camaraderie and family of a small specialty like Paediatric Surgery, and went to great lengths to maintain international friendships and contacts within the specialty. Alberto Pena's innovation in the area of Ano Rectal Malformation management was a turning point in the care of these patients. Toby recognised the importance, so much so that he took it upon himself to personally arrange and largely finance a visit from Pena for him to demonstrate his revolutionary techniques to the surgeons of Sydney. This is a testament to his "whatever it takes" approach and to his standing in the international paediatric surgical

community at the time. His friendship with Terry and Hiro Kishikawa from Nagoya in Japan saw exchange visits and registrar training between their respective institutions flourish. The respect of the paediatric surgical community was demonstrated in his appointment as Chair of the Australasian Association of Paediatric Surgeons and then as president of the Pacific Association of Paediatric Surgeons in the late 1980's. He was also a founding member in 1974 of the Child Accident Prevention Foundation of Australia (now known as Kidsafe). In 1984, Professor Bowring was made a Member of the Order of Australia (AM) for services to medicine, particularly in the field of Paediatric Surgery.

Professor Bowring championed the Art of Paediatric Surgery. At work he was a strong teacher, a quiet innovator and demonstrated a hands-on attention to detail in the care of his patients that remains one of the hallmarks of excellence in the care of sick children. He promoted the needs of children as being unique, along with the need for a separate institution and specialists to care for them. Many of the very standard ways we care for surgical conditions today were established at Prince of Wales Children's Hospital by Professor Bowring- barium enema for intussusception, Tween 80 for non operative management of meconium ileus, tracheal surgery, as well as a painstakingly exacting surgical technique in all the common paediatric surgical conditions.

Toby is remembered by all who worked with him as a gentleman, a great mentor and gifted teacher - a man who always had time for his colleagues, registrars, students and staff at all levels of the institution. He was never in a rush, and required those around him to slow down, take time, listen and learn. (often over a cup of coffee lasting a hour or more). It is a tribute to him that the surgeons trained through Prince of Wales under his leadership continue to draw on what he taught them in their careers – never forgetting the art of their craft and the time and dedication required for success.

His dedication to Paediatric Surgery meant Toby was a somewhat absent father and that Pat was, in his words 'a mother and a little bit of father too'. However, his family remember special times on holidays and weekends where they had more of his time . Holidays to Batemans Bay were a family institution, with Professor Bowring driving the family there , collecting them when he had no holidays to spare, and staying to share all the outdoor pursuits he loved when he was able. In either case, he led the family sing-alongs, instructive commentary on points of interest, and games of 'Spotto'which lightened the then long drive.

Professor Bowring retired on his 65th birthday in 1989, and it was then that a whole new phase of life began. Five years later his wife Pat was diagnosed with breast cancer, and Toby spent much of the 12 months preceding her death in 1997 in caring for her at home. Then on his own, and with a calendar of significant family events to guide him, Toby applied himself assiduously to the new role of family 'hub' and patriarch. He reconnected with old school friends – even travelling to Albury to kindergarten reunions which included their teacher! – and with friends from his university, boxing, fishing and shooting circles. He found new and firm friends at the golf club, and took to his daughter Louise's golf tutelage with enthusiasm and diligence. He became the same font of all knowledge for his grandchildren that he had been for his own children, and instructed them in the ways of fishing, bird calls, astute observation and evidence-based conclusions. He maintained his interest in things medical, was a regular visitor at hospital events, and kept up his subscription to the Australia and New Zealand Journal of Paediatric Surgery, the most recent copy being by his bedside in his last months of palliative care. Even when unwell himself, he was a great source of insight and comfort to friends who were patients or carers of those with less time-rich medicos, spending long hours listening to his friends' diagnoses, doubts and fears, and helping them to understand their conditions and treatment options.

It has been the honour of the current surgeons at Sydney Children's Hospital to have had continued contact with Professor Bowring since his retirement. In 2009, as a tribute to his career and role in establishing the Sydney Children's Hospital, Randwick, the Department of Paediatric Surgery was named in his honour. Fishing remains the official recreational activity of the department.

Before he died, Toby was emphatic in his desire to be remembered as much for his athleticism as a Boxer, Angler and Shooter, as for his unique life as a Paediatric Surgeon. Eddie Shi, the first surgeon trained at Prince of Wales under Professor Bowring's mentorship, observed that the skills Toby demonstrated in these pursuits were what made him a great surgeon – the ambidextrous precision of a boxer, the unlimited patience of an angler and the targeted concentration of a shooter.

The Child Health services of Australia have been a better place thanks to his enormous contribution, may he now rest in peace.

Dr *Susan Adams* **FRACS**

SURGICAL EDUCATION & TRAINING (SET) IN PAEDIATRIC SURGERY

2013 Training Calendar

All trainees to note that deadlines for all assessments should be strictly adhered to. It is the trainees responsibility to ensure that assessments especially mid and end term assessments (log books, evaluations progress overview etc) are submitted to the Executive Officer by the due date. In accordance with the Board of Paediatric Surgery Regulations if these are not received by the due date may result in the rotation not being accredited.

Dates relevant to New Zealand – Black
Dates relevant to Australia - Green

December 2012	
Thur 13	**NZ Trainees –** Deadline for assessment forms to be submitted to the Executive Officer
January 2013	
Mon 14	**AUS Trainees** are to submit completed & signed assessment forms for Rotation 2 2012 to the Executive Officer by no later than 1 February SET 1 – 2 Logbook, Evaluation form, Trainee Progress Overview, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Logbook, Evaluation form, Trainee Progress Overview & 3 MOUSE
Thu 31	Fellowship Examination closing date
February 2013	
Fri 1	**AUS Trainees** – Deadline for assessment forms to be submitted to the Executive Officer
Fri 8	CAT # 1 sent to SET 3-6 Trainees (due 10 May)
Sat 9 – Sun 10	Board Meeting in Melbourne
March 2013	
Fri 1	**NZ Trainees** are to submit completed & signed assessment forms for Dec - Mar 2013 to the Executive Officer by no later than 12 March SET 1 – 2 Evaluation form, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Evaluation form & 3 MOUSE
Mon 4	DOGS # 1 Session 1 Opens (open for 1 week)
Mon 11	DOGS # 1 Session 2 Opens (open for 1 week)
Fri 15	**NZ Trainees** - Deadline for assessment forms to be submitted to the Executive Officer
Mon 18	DOGS # 1 Session 3 Opens (open for 1 week)
Mon 18	**AUS Trainees** are to submit completed & signed assessment forms for Jan - Mar 2012 to the Executive Officer by no later than 1 April SET 1 – 2 Evaluation form, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Evaluation form & 3 MOUSE
Sun 25	DOGS # 1 Session 3 Closed
April 2013	
Mon 1	**AUS Trainees** – Deadline for assessment forms to be submitted to the Executive Officer
Sun 6	Board Meeting in Hunter Valley/PAPS/ANZAPS Annual Scientific Meeting
Thur 11	Paediatric Anatomy Examination Closing date
Tue 16	Fellowship Examination Written Papers (Multiple centres)
May 2013	
Fri 10	CAT # 1 submission deadline to be submitted to the CAT Co-ordinator
Fri 24 – Mon 27	Fellowship Examination – Clinicals/Vivas
Friday 24	**NZ Trainees** are to submit completed & signed assessment forms for Rotation 1 2012 to the Executive Officer by no later than 10 June SET 1 – 2 Logbook, Evaluation form, Trainee Progress Overview, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Logbook, Evaluation form, Trainee Progress Overview & 3 MOUSE
June 2013	
Thur 6	Fellowship Examination closing date
Fri 7	Paediatric Anatomy Examination Written paper

Mon 10	**NZ Trainees –** Deadline for assessment forms & 2014 post preferences to be submitted to the Executive Officer
Mon 10	Deadline for 2014 post preferences to be submitted to the Executive Officer
Sat 15 - Sun 16	Board Meeting in Sydney / selection / allocation posts for 2014
July 2013	
Thur 5	CAT #2 sent (deadline 4 October)
Mon 22	DOGS # 2 Session 1 Open (open for 1 week)
Thur 25	**AUS Trainees** are to submit completed & signed assessment forms for Rotation 1 2012 to the Executive Officer by no later than 8 August SET 1 – 2 Logbook, Evaluation form, Trainee Progress Overview, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Logbook, Evaluation form, Trainee Progress Overview & 3 MOUSE
Mon 29	DOGS # 2 Session 2 Opens (open for 1 week)
August 2013	
Mon 5	DOGS # 2 Session 3 Opens (open for 1 week)
Thur 8	**AUS Trainees** – Deadline for assessment forms to be submitted to the Executive Officer
Sat 10 TBC	Board teleconference
Sun 11	DOGS # 2 Session Closed
Tue 20	Fellowship Examination Written papers (Multiple centres)
Thurs 22	**All NZ Trainees** are to submit completed & signed assessment forms for Jun - Aug 2012 to the Executive Officer by no later than 6 September SET 1 – 2 Evaluation form, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Evaluation form & 3 MOUSE
Fri 30	Paediatric Patho-Physiology Examination Closing date
Sat 31	Paediatric Anatomy Examination Vivas (Melbourne)
September 2013	
Thurs 6	**NZ Trainees -** Deadline for assessment forms to be submitted to the Executive Officer
Fri 20- Mon 23	Fellowship Examination – Clinicals/Vivas (Sydney)
October 2013	
Fri 4	CAT # 2 submission deadline to be submitted to the CAT Co-ordinator
Fri 11	**All AUS Trainees** are to submit completed & signed assessment forms for Jun - Sep 2012 to the Executive Officer by no later than 31 October SET 1 – 2 Evaluation form, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Evaluation form & 3 MOUSE
Thur 17	Paediatric Patho-physiology Examination (Multiple Centres)
Thur 31	**AUS Trainees -** Deadline for assessment forms to be submitted to the Executive Officer
November 2013	
7 - 10	Registrar Annual Training Seminar (RATS)
Fri 8 - 9	Board of Paediatric Surgery meeting
Sat 9	Trainee / Board interviews
Thur 28	**All NZ Trainees** are to submit completed & signed assessment forms for Rotation 2 2013 to the Executive Officer by no later than 13 December SET 1 – 2 Logbook, Evaluation form, Trainee Progress Overview, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Logbook, Evaluation form, Trainee Progress Overview & 3 MOUSE
December 2013	
Thur 12	**NZ Trainees -** Deadline for assessment forms to be submitted to the Executive Officer
January 2014	
Thur 16	**All AUS Trainees** are to submit completed & signed assessment forms for Rotation 2 2012 to the Executive Officer by no later than January SET 1 – 2 Logbook, Evaluation form, Trainee Progress Overview, Mini-CEX, DOPS & 360 self assessment & contact details. SET 3 – 6 Logbook, Evaluation form, Trainee Progress Overview & 3 MOUSE
Thur 30	**AUS Trainees** – Deadline for assessment forms to be submitted to the Executive Officer