Australian & New Zealand Association of Paediatric Surgeons Inc

August 2011 Newsletter

President's Report

At last I may have some good news for Australian members regarding developments in the MBS review due to the persistent and diligent action of Harry Stalewski. Whilst there is still a very long way to go its seems there now may be light at the end of the tunnel.

On 24th June Hillary Boucaut, Harry Stalewski and myself met in Brisbane with Dr Richard Bartlett, the first assistant Secretary of the Medical Benefits Division of the Department of Health and Aging and three of his colleagues. They flew specifically from Canberra to be present at this meeting that was held to examine the process of a total MBS review of the Paediatric Surgical Speciality. The Department of Health and Aging provided a large amount of back ground information reviewing the top 50 procedures performed by all Paediatric Surgeons in Australia over three separate periods in the past ten years. In addition information regarding consultations and item numbers that are most commonly used in children was demonstrated.

Harry had prepared a detailed document looking at the many specific areas where discrepancies appear in the paediatric speciality. I believe the meeting was highly successful in demonstrating to the representatives that Surgeons looking after children have specific reimbursement and practical issues not shared commonly by the other specialities. We were able to show that our paediatric surgical training programme is as long as if not longer than most specialities, that our syllabus is larger than all specialities, that our clientele ranges from very premature neonates to adolescents, that the amount of emergency work provided by Paediatric Surgeons is greater than any other speciality and that the length of a paediatric surgical procedure is not necessarily a measure of the complexity of the work performed. We also emphasised that Paediatric Surgeons are more likely to carry out longer consultations than many of the surgical specialities and in the past we have been called "Operating Paediatricians".

There seemed to be a common consensus that paediatric surgery needed a different framework than many of the other surgical specialities. Rather than look at individual item numbers separately and just review some, it was agreed that a total review of the speciality was required to look at the actual time spent in patient care with the benefits in outcome used as the basis of the review.

The Department of Health and Aging are preparing a draft document looking at the future process of the change. This will then highlight areas that we will need to address and provide specific evidence that there has been a change in practice over the last 30-40 years since the paediatric surgery item numbers were formulated. Harry will be asking those who have already expressed an interest to help to look specifically at these areas for evidence which can support our cause. Anyone else who would like to be interested in this process can still contact Harry, as he will need as much assistance as possible.

I would like to congratulate Harry on moving this issue forward and at last we have reached a level and received a commitment from people who can actually assist us in this problem, which we have complained about for decades.

I am sure everybody by now is aware of the possible change in relationship that is being discussed between the Australian Orthopaedic Association and the College. These changes involve not only the Orthopaedic Surgeons but also all members of the Royal Australasian College of Surgeons. The College President Ian Civil is holding a special meeting of the Presidents of all Speciality Associations to discuss a report from the College Relationships Working Party. I will be representing ANZAPS at this meeting

and would like to hear from the membership your views regarding this issue as it indirectly affects us all.

Please send any correspondence to Ms Kristy Scalea (paediatric.board@ surgeons.org).

I have had considerable communication from members regarding CPD issues. Hugh Martin has recently highlighted the fact that 22 paediatric surgeon have failed to provide a CPD assessment with another 9 found to be noncompliant. It is hard to believe that such a large percentage of our workforce may not be accredited. CPD compliance is mandatory in both New Zealand and Australia to remain a registered medical practitioner. I understand that difficulties exist for those in small centres and also if ones hospital is not part of a surgical mortality audit. Hugh is only too happy to help anyone with difficulties with the process. Please bring your concerns regarding CPD to our AGM so we can improve the specific problems that some paediatric surgeons experience.

All Members have received an invitation from College Vice President Keith Mutimer to participate in the "Surgical Workforce Census 2011". I would encourage all Members of ANZAPS to participate. You may recall that the previous census 2009 showed Paediatric Surgery to be in a very poor position in the Surgical Workforce in comparison to all other specialties. I have invited Keith to speak at our AGM and we will have the opportunity to explain problems presently being experienced in most jurisdictions.

We have a very busy last few months of the year with our ANZAPS Conference with SPANZA in Coolum in October, the ANZBA meeting in Brisbane in September and the ANZPUC and APAPU meeting in Melbourne in November.

I look forward to seeing you all in Coolum in October.

Kind regards,

Mr *Anthony Sparnon* **FRACS**
President, ANZAPS

Examination Report from the Senior Examiner

The new format for the Paediatric Surgical Fellowship Exam was sat for the first time in May in Melbourne. Three of the six candidates were successful.

The new format consists of:

Written Paper 1 (50 spot test questions in 2 hours)
Written Paper 2 (8 questions)
Short clinical viva
Medium case viva
Operative viva
Neonatal viva
Clinical imaging and management viva

In addition we welcomed Dr Phil Morreau as a new Examiner joining Peter Borzi, Guy Henry, Andrew Barker, Ralph Cohen and myself.

The next Fellowship Exam will be in Adelaide in September 2011 and in Auckland in May 2012.

The Fellowship Examination process is at present being reviewed under the guidance of the Chairman of the Court of Examiners, Spencer Beasley. All Examiners now need to attend an Examiners training course as part of the preparation to become a new Examiner.

Kind regards,

Mr *Anthony Sparnon* **FRACS**
President, ANZAPS
Senior Examinor, Specialty Court of Paediatric Surgery

Board Chair of Paediatric Surgery

We have recently had another successful RATS (Registrar annual training seminar) in Brisbane. Co-locating with RATS we have a Board meeting to review curriculum and trainee evaluation reports and conduct interviews with all trainees to discuss progress, issues and plans for the future. We also undertake the selection interviews.

This all takes place at the same time to decrease expense and time expenditure. The board members are not paid, but do have their flights and accommodation paid for out of a yearly budget that reflects the number of trainees. Unfortunately in order to have selection at least 2 – 3 weeks before the deadline for results, get trainees together before the end of rotation one (appears to work better than taking the trainees out of their hospitals at the beginning of a new rotation) and dealing with all the different start and finish times for clinical rotations between the different states and New Zealand, we often have demands for mid and end of term evaluations falling at odd intervals. We will continue to fine tune these dates. Look out for the calendar of training events that Ms Scalea publishes every year.

The good news is that processing evaluations and curriculum seems to becoming more streamlined. This is a great incentive for those thinking of becoming involved as Board members of the future. It was wonderful to see how well MOUSE is working for most trainees. Most MOUSES read as ongoing conversations between the trainee and trainer on how to modify and improve technique and operative judgment. This must be stimulating and rewarding for you, the trainers to have these feedback conversations with your registrars. It is proving such a great training tool that the other specialities are starting to pay attention to how we administer our "direct observation of procedure". As the MOUSES are now reflecting better the SET level, we have seen several instances where the evidence from evaluations like the MOUSE has supported the decision that a trainee is performing at a higher level of competency resulting in shortening of duration of training. In early Mid SET we expect a series of the same procedure as the trainee learns the basic paediatric operations (eg neonatal hernia, orchidopexy) with gradual improvement to the level of being judged able to perform procedures independently. In late SET we may not see a series of the same procedure (where are those six TOFs in a row!) but a series of complex cases – like major neonatal index cases. We are looking for acquisition and demonstration of the set of skills ("operative expertise") that paediatric surgeons use to successfully approach and deal with all the myriad variations, challenges and rarities that make up paediatric surgery practice. The Board has seen trainers move rapidly from the "tick box don't give any comment" mentality, still seen in other specialities, to honesty in their feedback. You are generously taking the time to teach and correct the procedure which helps the trainee reach that aim of independent safe practice. The Board and trainees thank you.

Sadly there are trainees who do not progress to higher levels of competency despite extra remediation and lengthening their duration of training. The trainees do move between posts but lack of progression will be seen in each post. There is always confirmation in recording of the same deficiencies in performance noted in different posts for same trainee, which is strong evidence of the strength of the accreditation and evaluation process despite obvious differences in personalities, institutions, geography and caseloads.

As most people know, I am firmly of the opinion that our surgical specialty is the hardest and most demanding of intellect, judgment, technical expertise and nontechnical expertise. Therefore being accepted into our training is a high accomplishment in itself. Failing to progress is not a reflection of the caliber of the person, who is always more dedicated and high achieving than average, but of the fact that satisfactory performance of these difficult skills is not possible for everyone to achieve despite our excellent teachers and remedial support.

2012 sees the first year of our new program where we will be putting new trainees into paediatric surgical posts in paediatric units. There will be a minimum level of competency to be achieved in order to progress to the second year. This level is that of a junior registrar who can take call and perform basic operative techniques. (eg appendicectomy under supervision). Of course some new trainees will already be at this level and will demonstrate higher competencies enabling to them rapidly progress through early SET, whereas some new trainees will be in their first surgical registrar type job and will need to demonstrate aptitude to training by progressing to the minimum level by the end of their first year.

Surgical training is about adult learning. We provide a supportive environment where the resources are available for the adult learner to access. Our trainers will accommodate with tutorials, extra MOUSES, mini-CEX, discussion groups and mentoring. But the trainees must always drive this process. Trainees ask for MOUSE to be done. Trainees organise meetings with their trainers and supervisors. Adult trainees

are prepared to accept negative feedback as a goad to do better and learn. A supportive environment enables learning. Supportive doesn't mean constant positive feedback and doesn't mean that every trainer will be your friend, but trainers do have an obligation to teach if asked and to give honest feedback. Honest negative feedback should be given in a way that assists the trainee to understand what are the issues, how to access opportunities to improve and consequences of failure to progress. Unwarranted or groundless negative feedback is bullying and will not be tolerated by the College. The Board supports trainees to go ahead with forwarding allegations of bullying to the College for investigation.

The curriculum modules have been updated again and are on the website. It is important they are used as a guide for studying whilst understanding the limitations of trying to include every advance or subject in a document that is produced on a yearly basis. The breadth of our curriculum has been proven recently to the government by our Australian and New Zealand Association of Paediatric Surgeons committees using the Board curriculum modules.

Thank you again to all the hardworking supervisors, trainers, examiners, Board members, trainees and Ms Kristy Scalea for our world class training program. Looking forward to seeing you in Coolum.

Assoc. Prof *Deborah Bailey* **FRACS**
Chair, Board of Paediatric Surgery

Professional Development and Council

June 2011

It has been said that the only constant thing in life is change. Couple that with the fact that all change is uncomfortable to some degree and you have the feeling that I have at PDSB.

Why is it that we can no longer have a simple, direct, one to one relationship with our patients? I suppose it is because we now work in an environment where the place that we do our operating is funded and therefore controlled by a large organization, be it private or government, and we rely on many other people with different expertise (medical, nursing, allied health, technical) to get the best result; that is, we work in teams. The money to run all this comes from the community at large via government or fund, with only a tiny fraction of the total cost going directly from the patient to the surgeon if a fee above the various schedules is charged. Inevitably, this means that there is going to be intrusion into our working lives by regulators of one sort or another. The positive aspect is that we are able to do much more for our patients than ever before: reflect on the difference between the present and only a hundred years ago (your grandfather may well have been alive then). We have much more power to influence the course of disease now than ever before.

Every powerful force can inflict harm as well as do good. Hence the legal world impinges on our world.

This is why there is a constantly changing regulatory environment in which we work. If we surgeons can direct some of this change the result will be much more comfortable for us and better for our patients than if some group with no knowledge of the needs of both our patients and us are the ones who make the regulations.

CPD is a fact of life and will never go away. The Australian Health Practitioners' Regulatory Agency (AHPRA) has made it a condition of remaining registered by the Australian Medical Council (AMC). The College's CPD programme is accepted by the AMC as meeting its requirements – indeed, it is highly regarded. As it has been designed by surgeons for surgeons it is much more friendly than it would be if designed by bureaucrats even though you may feel it is somewhat onerous. The new mandatory requirement (in 2010) was to participate in a mortality audit if one was available in your jurisdiction. This has caused some confusion partly because we paediatric surgeons do not have many patients who die while under our primary care so we only rarely would we feel the need to report a death. Participation is not predicated on having a death to report: one can join a mortality audit without having a death to report, and that is all that is required to comply with the CPD requirement.

From our point of view, that is simple. But the organization required is not simple. Mortality audit is only one aspect of audit: outcome audit of one or more aspects of our practice is another matter and more of that later. Mortality audit is extremely expensive. At present it

is funded by government in all jurisdictions. Reasonably, governments feel that if they fund the activity they should own the data and use it as they wish. "There are lies, damned lies and statistics" so the inferences that government may draw from such figures (and make public) may or may not reflect what we would see as truth. There are signs that government may not continue to fund the activity but say to us that it is the responsibility of the profession to fund it.

Even more expensive is verifying compliance with audit. As you may remember, the College asks 3.5% of Fellows to verify their return. Anybody who has done this will know what a pain it is. Verification now no longer demands every aspect of CPD to be covered so this makes the process a little easier. But if one were to view the process from the point of view of the man in the street who wants to be certain that the person who does their operation really is competent, one might reasonably say that a surgeon could go 25 years without being asked to verify their CPD return is not good enough. No change in the current verification rate is contemplated on the grounds of both cost and unpopularity with Fellows but what AHPRA will demand may be different.

Even more difficult is auditing one or more aspects of our results. There are some excellent national examples of this: the breast audit and the joint audit. The breast audit started with government funding but this has subsequently been withdrawn and they are facing a crisis with the possibility of having to cease the audit for lack of funds. Clearly, funding from industry would be seen to be tainted so that is not a potential source. Possibly the most interesting is the Vascular Audit. The Australian and NZ Vascular Society decided to create an audit of their work. An astonishing 92% of members voted to fund this themselves and to make participation a prerequisite of membership of their Society. They have set up a mechanism to deal with outliers. Their report is extremely comprehensive. They own the data so there is little risk of it being misused, and it can be the source of material for research. They see it as the best insurance against accusations of poor performance. I believe ANZAPS should consider how this might be done. If we progress this we know that the software company that the ANZVS used was excellent. Our problem is to find one or more conditions that have a high enough, measurable complication rate that we do enough of to be a discriminator of practical use.

If CPD is a condition of registration it might be that the AMC would request a list of those Fellows who are CPD compliant as a way of checking that a renewal of registration is valid. Again, looking from the outside, it could be reasonably argued that it is the duty of the AMC to ensure that doctors applying for renewal of their registration fulfill the criteria set by the AMC. This would mean that the College would have to supply the AMC with a list of Fellows that are CPD compliant. To date this has not been requested although information about an individual may be. All the learned Colleges are prepared to supply this on the basis of an individual request (indeed, it would be hard to refuse), but this is very different from supplying a list of all Fellows. We in ANZAPS need to think about this in the event of such a request coming from the AMC.

The second edition of the Guide to Surgical Competence & Performance booklet has been produced. Did you ever become aware of the first edition? Or did the copy you were sent end up in the rectangular or circular filing cabinet without cerebral awareness? In case it did, let me remind you that the 9 College competencies were divided into 3 aspects each, and each aspect had 4 good behaviour markers, and 4 markers of poor behaviour listed. It was an extremely useful tool for self reflection as well as drawing attention of trainees to what is expected of them, and I know of one head of department who has used it to point out some negative behaviour of a staff member to that person. The second edition of the guide has had some minor changes in wording but not of sentiment. The big difference is that a rating scale has been added to each of the 27 aspects listed. This rating scale is qualitative so avoiding mathematical averaging or pseudoscience in comparing "scores". It is not intended only to be used for underperforming surgeons or trainees, but as a means of self awareness as well as making oneself aware as to how others view us. Try giving it to your scrub nurse, outpatient staff or departmental secretary. Perhaps it should be used routinely by all of us. It is possible that eventually it may be incorporated into CPD. Having recently completed the performance appraisal issued by the NSW DoH I can certainly say that the College's document is far superior in both relevance and detail. In the near future the relevant pages of this guide will be able to be downloaded from the web site.

Paediatric Surgery is often the leader in terms of developing educational matters. We lead in two new areas. The College is trying to align the stages of progress of trainees with measurable levels of performance. In other words, what is, say, a person at the end of mid-SET supposed to be able to do as far as a TOF is concerned? Know about it? Explain it? Manage it peri-operatively? Do the operation with assistance? Without assistance? Manage the complications? Once

completed, this alignment will allow trainees to know where they should be, allow supervisors to make more relevant, structured comments about progress, and allow the Board to help trainees gain experience in areas that have been deficient previously. The Board has done a lot of work on this matter and is now the only training Board to have done so. Congratulations to Deborah Bailey and the rest of the Board.

Another area in which we lead is in the education of our supervisors. The SAT SET course is designed to help supervisors and trainers to fulfill their roles satisfactorily. To use our man-in-the-street eyes again, it would seem crazy for trainees to be assessed as to their performance when the assessors don't know what they are doing. Overall, only about 45% of Surgical Supervisors have done the SAT SET course, but in Paediatric Surgery – 100%. Congratulations to all our supervisors and to Anthony Dilley for his involvement in this.

A lot of surgeons ask the question "What does the College do for me?" Much of what is done is invisible. As an example of this, the supplementary report to the AMC in response to some specific questions they had asked about the College's compliance to some of their regulations ran to 75 pages. The time and labour on the part of the College staff who did this is enormous. It is another of those activities that allow the rest of us to get on with the job of treating patients with a qualification that is accepted as the premier qualification in Australia and NZ.

College Council is the Board of Directors of the company that is the College. You, the Fellows, are the owners of the company. Since the events of HIH and Onetel in this country, and the company failures overseas that helped precipitate the GFC, the behaviour of directors has been under increasing scrutiny and regulation. Councillors now carry significant legal responsibilities which means they face significant legal penalties if they are found to be failing in this duty. The College is well aware of this so training is now part and parcel of becoming a Councillor. We had a morning of teaching from an eloquent, knowledgeable person from the Australian Institute of Company Directors (AICD). This training is likely to be repeated in future for the benefit of new Councillors.

Which brings me to the matter of new Councillors. My time on Council finishes after the February meeting. For those of you who may be considering nominating, let me briefly describe the position.

Formal Council meetings occur in the last full weeks of February, June and October of each year. The Council meeting itself starts midday Thursday and ends midday Friday. The Thursday morning is taken up by the Surgical Leaders Forum in which topics of interest (such as training in the private sector, relationship between the College and specialty societies, the role of regional committees etc) are discussed. Apart from reading the Council papers, this is not an arduous task, but all Councillors are expected to be on a number of committees. To some extent these lie in the person's areas of interest, be it education, finance, Fellowship affairs, research, outreach or whatever. One may also be voted to fill roles as a Chairman of a committee or into higher office. Specialty elected Councillors are now equal in all respects to generally elected Councillors. It is rewarding to see the mechanics of the profession being made to work, interesting to see the inner workings of the College, and one meets a large number of interesting, competent surgeons that would not otherwise cross your path. As well, your opinion may influence the course of the College and hence the profession as a whole, so you have a chance to contribute significantly.

I hope as many as possible of you will be in Coolum.

Mr *Hugh Martin* **FRACS**
Council Representative

Professional Development Workshops August – Decemeber 2011

Professional development supports life-long learning. College activities are tailored to needs of surgeons and enable you to acquire new skills and knowledge while providing an opportunity for reflection about to apply them in today's dynamic world.

Providing Strategic Direction

9-11 September, Sydney
This 2½ workshop helps you to learn more about organisational and market analysis, sustaining a competitive advantage and strategic measuring systems. You can gain the skills and knowledge to implement an organisational strategy.

Building Towards Retirement
1 October, Brisbane
This program covers key retirement issues including careers after surgery, superannuation, legal issues, maintaining health and well-being and building networks. Learn from surgeons and other experts about planning and making decisions for the next phase of your life.

Practice Made Perfect; successful principles in practice management
3 October, Brisbane
This whole day workshop focuses on the challenges of running a practice. Learn more about the six principles of managing a small business. Practice managers, practice staff and Fellows are encouraged to join these workshops for a valuable learning experience.

Writing Medico Legal Reports *NEW-redesigned evening program*
19 October, Brisbane
This workshop can help improve skills in preparing medico legal reports that comply with court rules. It is an opportunity to gain an understanding of the legalities of expert reports and the lawyer/expert relationship. Learn about report writing from the advocate and surgical perspectives.

STEP (Surgical Teacher Education Program)

* SAT SET Course
7 September, Adelaide | 16 September, Darwin
This 3 hour course explores strategies to improve the management of trainees with a special focus on an effective mid-term meeting. You can learn how to use assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS). It is also an opportunity to gain insight into training policies, legal requirements and the appeals process.

* Keeping Trainees on Track (KToT) *NEW*
5 Sept, Brisbane | 13 Sept, Melbourne | 16 Sept, Darwin | 23 Sept, Hobart
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.

* Surgical Teachers Course
1-3 September, Waitakere Estate Auckland | 20-22 October, Bondi Beach, Sydney
This 2½ day course enhances the teaching skills of surgeons who are responsible for training SET trainees. Learn about adult learning styles, teaching technical skills, feedback and assessment plus change and leadership.

Please contact the Professional Development Department on +61 3 9249 1106, PDactivities@surgeons.org or visit the website at www.surgeons.org

ACT

9 November	Keeping Trainees on Track (KToT), Canberra NEW

NSW

26-28 August	Process Communication Model, Sydney NEW
19 October	Keeping Trainees on Track (KToT), Sydney NEW
20-22 October	Surgical Teachers Course, Sydney

NT

16 September	Keeping Trainees on Track (KToT), Darwin NEW

NZ

1-3 September	Surgical Teachers Course, Auckland

QLD

5 September	Keeping Trainees on Track (KToT), Brisbane NEW
1 October	Building Towards Retirement, Brisbane

3 October	Practice Made Perfect
19 October	Writing Medico Legal Reports NEW
18-20 November	Sustaining Your Business

TAS

23 September	Keeping Trainees on Track (KToT), Hobart NEW

VIC

13 September	Keeping Trainees on Track (KToT), Melbourne NEW
21 October	Keeping Trainees on Track (KToT), Wangaratta NEW
12 November	Communication Skills for Cancer Clinicians

WA

24 August	AMA Impairment Guidelines Level 4/5: Difficult Cases, Perth NEW
21 October	Polishing Presentation Skills, Perth

Board of Surgical Research & ASM 2013

Board of Surgical Reserach

The Board of Surgical Research (BSR) recently completed its interviews for scholarship applicants. Traditionally a candidate's written application has been reviewed and assessed by every member of the BSR. This process occurs over a fairly tight timeframe (typically 2 to 3 weeks) and involves each board member, with a representative from each speciality, reading and scoring each application. As many of these run to 20 or even 30 pages, it is usually a week-end and several evenings work.

Subsequently candidates are interviewed by telephone by the chair and two other 'volunteers' from the BSR. Whilst interesting for the panel members, especially when hearing about novel research from another speciality, it involves considerable time and effort. Depending on the number of applicants and the post-interview discussion, the interviews typically run over two evenings from 18:00 to 22:00. Several board members have queried the value of this process. This year, a comparison of the scores obtained from the interviews with those from the written applications revealed that whilst in the majority of cases there was little impact on the final rank of the candidate, there were both upwards and downward changes for a significant minority. Whilst a full evaluation has still to be performed and discussed at the next BSR meeting in October, at this stage it would seem the interview still has an important role and will continue in 2012.

PAPS/ANZAPS 2013

Planning for the next combined meeting of the Pacific Association of Pediatric Surgeons (PAPS) and ANZAPS continues, ably led by our colleague Raj Kumar, following successful combined meetings in Sydney in 2003 and Queenstown, NZ in 2007.

The meeting will be held at the Crowne Plaza in the Hunter Valley, NSW from Sunday 7th until Thursday 11th April 2013. Please note these dates now. It is worth noting that Easter will be on the week-end before the meeting and that the public school holidays start in NSW on the week-end following the meeting. The Crowne Plaza represents a superb 4.5 star venue for both local and international delegates.

The ANZAPS invited speaker will be Professor Agostino Pierro, from Great Ormond Street Hospital, London, UK. Many of you will know Agostino, who is both an excellent and entertaining speaker and will, I am sure, make a great contribution to the meeting. Please keep an eye on the meeting web page for updates: http://paps2013.com.au

Mr *Andrew J.A. Holland* **FRACS**
BSR Representative and Convenor 2013 for ANZAPS

Paediatric Urology Club Meeting

The program for the combined Asian Paed Urology and the paediatric Urology Club has been finalised for 2011. Our two major international guests are Professor Pierre Mouriquand (ex President ESPU) and Prof Duncan Wilcox (Denver). These two speakers , combined with a large Asian and local faculty, will deliver an exciting academic program designed by Yves Heloury and CK Yeung.

Session topics include hypospadius, VU Reflux, Paediatric Endourology, Neurogenic Bladder and Undescended testis. Abstracts are welcome for presentation (http://apapu2011.com/conference.html) to download the form. Please email these abstracts to Prof Heloury at yves.heloury@gmail.com by August 1, if possible. The social program commences with a sporting day on thurs 25th with golf, sailing and tennis. A dinner in Brighton on the Saturday night is the main club event.

All further details are on the website above and please email us with any queries.

Mr *Chris Kimber* **FRACS**
Convenor

44th Annual Meeting of PAPS

10-14 APRIL 2011

The 44th Annual Meeting of PAPS was held at the JW Marriott Resort in Cancun, Mexico on 10 to 14 April, 2011. The President was Professor Harry Applebaum and the Chairman of the Local Organising Committee was Dr Arturo Aranda. Professor Harry Applebaum handed over the Presidency to me at the annual banquet (see photo).

The scientific and social programmes were very well organised and of the usual high standard. Some 237 abstracts were submitted and 84 oral presentations. There were 275 delegates attending, 96 of these were from Japan. This was a great tribute to our Japanese colleagues who made a tremendous effort to support the PAPS meeting despite their recent earthquake and Tsunami disasters.

The next meeting of PAPS is in Shanghai from 3-7 June, 2012 at the Shanghai Regal International East Asia Hotel, Shanghai, China. This promises to be a spectacular meeting surrounded by the history and culture of Shanghai; an amazing city of almost 23 million people. The local organising Chairman is Professor Shan Zheng, from the Children's Hospital of Fudan University. She, and the Local Organising Committee, have arranged a superb meeting in association with the Scientific Committee Chairperson, James Dunn. The meeting is supported by hosts, China Society of Paediatric Surgeons, Chinese Medical Association and Children's Hospital of Fudan University. For further information regarding registration and abstract submissions, please visit the website www.paps2012.org.

Taking over the PAPS Presidency. From left to right Ralph Cohen, Cynthia Cohen, Linda Applebaum and Harry Applebaum.

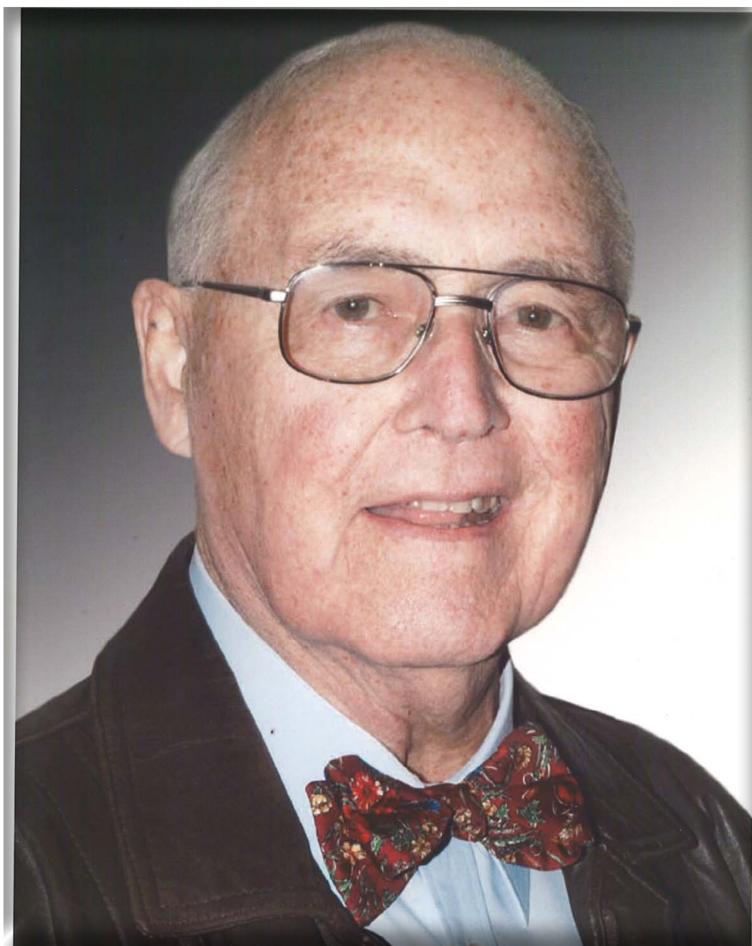
The 45th Annual PAPS Meeting in Shanghai promises to be a scientific and cultural experience not to be missed. Please put this date in your diary and plan to attend. Cynthia and I look forward to welcoming you and your family and friends in Shanghai.

Professor *Ralph Cohen* **FRACS**
President of PAPS

OBITUARY

Associate Professor Robert MacMahon, AM

22.04.1931 - 01.04.2011



Associate Professor Bob MacMahon died recently in Mitcham of cancer. Although publicly most known as a Paediatric Surgeon, he was far more than this - including a teacher, innovator, great counsel, a family man with a delightful sense of humour and founding governor of Make-a-Wish Foundation.

Born in the Sydney suburb of Eastwood, the youngest of six children, he lost his nearest sibling to gastroenteritis in early childhood. He was brought up largely by his father, a railway clerk, after his mother became a chronic invalid. From these beginnings he learned the values of family and cooperation, attributes he cherished lifelong.

A bright, attentive and intelligent student at school and university, he nevertheless had early passions which never left him – surf, rugby, and athletics included – which denied his full application to studies but never prevented him from high achievement. He always maintained that a balanced mind required a healthy body.

He entered Sydney University medical school on a scholarship at sixteen, whence he graduated in 1954. He spent four years of training at the Royal Newcastle Hospital, which included considerable time in the surf and on the rugby field for Newcastle Wanderers. It was here while running 'well baby clinics' that the idea of improving the nutrition of small premature infants occurred to him, remaining one of his lifelong passions.

Later postgraduate training took him to London, Edinburgh and finally Glasgow, where he decided to become a Paediatric Surgeon and where he met

a feisty junior doctor Bessie McDonnell whom he married in 1962. After a year of research in Denver, graduating MSc at the University of Colorado, he returned to Australia to work at the Royal Alexandra Hospital for Sick Children as a research surgeon, the first Fairfax Surgical Fellow at the Children's Medical Research Foundation.

His greatest achievements followed his appointment as the inaugural Head of the Department of Paediatric Surgery at the Queen Victoria Medical Centre (later Monash Medical Centre), Melbourne and at Monash University in 1967. He was appointed Associate Professor of Paediatric Surgery in 1970.

Surrounded by like-minded and courageous colleages at Monash, his interest in the nutrition of small premature infants flourished. In combination with Professor Victor Yu, Neonatologist, and others, he ran a clinical and laboratory research programme in amino acid and mineral metabolism which extended the boundaries of infant care and achieved world-wide recognition. Between 1970 and 1975, the introduction of intravenous feeding in small premature infants increased their survival from 18% to 71%. His hospital and clinic care was multidisciplinary long before the term was coined elsewhere.

He founded the Australian Society for Parenteral and Enteral Nutrition (ASPEN, later AuSPEN in deference to the American equivalent) in 1974 and with typical foresight ensured that all healthcare providers - pharmacists, dieticians, ward staff, doctors, laboratory technicians and others – should be of equal status only dependent on their contribution and not on their title. This organization has consistently encouraged wide-ranging research into nutrition in health and disease, and one of its prizes is named after him.

He was a surgeon of great technical ability, and he shared his knowledge freely with his junior staff to whom he showed great patience and understanding. His care, courtesy and dignity in dealing with sick children and their parents never failed to impress those present.

He was morally a stern man, serving on the Research and Ethics Committee of the Monash group of hospitals for forty years, as President from 1999-2009. He thought long and hard before performing the first human foetal operation in Australia, and subsequently the first in utero repair of diaphragmatic hernia in the country after considerable research. He pioneered in utero laser vesicostomy.

He took the opportunity of a children's unit being within a general hospital to assist in the creation of a multidisciplinary antenatal diagnostic and management facility which has helped to advance perinatal care of babies born with congenital anomalies.

A particular place in his diary was reserved for those less fortunate in life – the chronically ill or those with multiple anomalies such as accompanying spina bifida, for whom he devoted special clinics on Saturday mornings so that families with working parents would be least inconvenienced. He admired the resilience of children with life-threatening illness, which led to his early involvement with the Make-a-Wish Foundation.

As an educator his legacy includes several current Paediatric and General Surgeons, but his influence extends far beyond the confines of this small profession. He taught at all levels in health care up to university and clinical research, and his combined lectures with Dr Leo Cussen, Paediatric Pathologist, entertained decades of medical students at Monash University. He contributed to ten textbooks and authored more than sixty research articles.

His peers elected him Chairman of the Senior Medical Staff of Southern Health. He was foundation President of the Australian Society for Parenteral and Enteral Nutrition. He was President of the Australasian Association of Paediatric Surgeons (the predecessor of ANZAPS) from 1991 to 1993. He was awarded Member of the Order of Australia in the Queen's Birthday Honours of 2010 for service to medicine as a clinician and academic.

In retirement he enjoyed camping in the bush and surfing. He formed an exclusive "Flog" club with retired neighbours, somewhat descriptive of their form of golf (backwards).

He will be affectionately remembered by friends and colleagues for his personal integrity and honesty, for his enthusiasm and achievements, for his intellect and judgment, and his wonderful sense of humour. He was a remarkable Australian.

He is survived by his wife, Bessie, four daughters, eight grand children, his sister Sheilah, and brother Bernard.

Mr *Robert Standen* **FRACS**
Secretary/Treasurer

SPANZA and ANZAPS Conference

20–23 October 2011, Coolum QLD

In a break from tradition, registrations are already starting to come in from surgeons for the combined SPANZA/ANZAPS meeting in Coolum. Workshops are beginning to fill, so those who wish to take advantage of the opportunities offered in the program need to get in soon or they may be disappointed.

The program of invited speakers has been finalised and we look forward to presenting sessions that will stimulate discussion in areas related to surgical safety; both for ourselves and for our patients. George Youngson has particular interests in surgical safety and training, so his presence makes this an important conference for trainees and trainers alike. He has recently been to Melbourne to share his expertise at the invitation of the College of Surgeons, so his thoughts will inform some of the changes to training currently being undertaken by our College.

Abstract submission is now open, and we invite any and all to submit presentations to the scientific committee. Encourage your trainees and would-be trainees to submit, and remind them that there are prizes for the best presentations.

http://www.willorganise.com.au/spanza-anzaps

See you in Coolum.

Mr *Craig McBride* **FRACS and Mr** *Chris Bourke* **FRACS**
Committee organisors

CALL FOR ABSTRACTS

The Organising Committee is pleased to invite submissions of abstracts to be presented at the 2011 SPANZA ANZAPS Conference. Presentations may either be submitted as an oral presentation or a poster.

All abstracts must be submitted online. Please log onto the Conference website www.willorganise.com.au/spanza-anzaps and download the abstract submission form before submitting your abstract/s. This document outlines the format your abstract must be submitted in as well as details on the online submission process.

Accepted oral presentations will occur throughout the meeting. The best anaesthetic paper will be awarded a prize by the SPANZA Committee on behalf of the Society. Poster presentations are ineligible for this prize.

The Nate Myers Clinical Research Prize recognises the life and work of the late Nate Myers. It is awarded by ANZAPS in recognition of original paediatric surgical clinical research excellence. On occasion, ANZAPS may choose to recognise scholarship by awarding other prizes. Fellows of the Royal Australasian College of Surgeons are ineligible for these awards, unless within two years of attaining their fellowship. All other presenters are eligible.

DEADLINE FOR PAPERS: Friday 26th August 2011

RACS and ANZAPS, 6 – 10 May 2012

ANZAPS will be participating in the 81st Annual Scientific Congress of the Royal Australasian College of Surgeons which will be held in the Kuala Lumpur Convention Centre, Malaysia from May 6th – 10th, 2012.

Kuala Lumpur in Malaysia is a melting pot of diverse cultural and culinary delights and this may a good opportunity to combine an interesting holiday (Malaysian Tourism Board website: http://www.tourism.gov.my/) with the AGM and scientific meeting.

The scientific program and meeting is organised in close cooperation with the Malaysian Association of Paediatric Surgeons and two main invited speakers for this meeting are Dato Dr Zakaria Zahari and Dr Anne John. Dr Anne John completed her training in Sydney and single handedly provides surgical care for children in the whole of Sarawak state in east Malaysia while Dato Dr Zakaria Zahari completed his training in Brisbane and is the senior and chief paediatric surgeon at the paediatric institute in Malaysia. The less usual topics in this meeting will be Dr Anne's perspective in the provision of surgical services under challenging circumstances and the discussion on the separation of conjoint twins given by Dato Dr Zakaria and Dato Dr Mahmud.

I hope you will mark this event in your diary and while the provisional scientific program is in its final stages; I look forward to be contacted regarding any suggestions and comments regarding the meeting.

Hope to see you at this meeting.

Mr Wee Yan Chia **FRACS**
Scientific Convenor for Paediatric Surgery

81st Annual Scientific Congress RACS | email: chia_weeyan@yahoo.com

WOFAPS 2011 Annual Meeting

UPDATES IN PEDIATRIC SURGERY: CONTROVERSIES AND ADVANCES
22-25 September 2011 | Tuzla, Bosnia and Herzegovina

Join us in TUZLA for this exciting event and meet with renowned pediatric surgical experts from around the world.

Early Bird Deadline1st August, 2011

Key topics to include:

- **Pediatric Surgery**
- **Minimal Invasive Surgery**
- **Pediatric Urology**
- **Neonatal Surgery**
- **Pediatric and Adolescent Gynecology**
- **Traumatology in Childhood and Adolescence**

www.wofaps-bosniameeting.com

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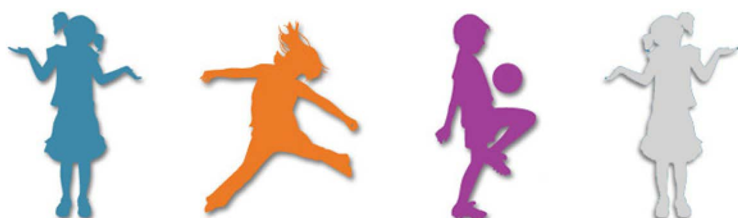

Professor John M Hutson **AO**
WOFAPS Representative

The Academy of Surgical Educators Membership

The College is excited to launch the Academy of Surgical Educators' membership. The Academy aims to increase the number of surgeons with educational expertise and ensure the effectiveness of the College's educational and assessment processes.

Excellence in surgical education is vital to the maintenance of high quality patient care. Many supervisors and trainers have an investment in enhancing the future of surgical education. If you are one of these surgeons, we invite you to apply for Academy membership and share your creative ideas and solutions for advancing surgical education.

There are two levels of membership - members and faculty members. ASE members do not need to be a RACS Fellow or trainee.

Members are people with a strong interest in medical education.

Faculty Members need to have a tertiary qualification or equivalent experience in surgical education. Fellows and others who are essential to the delivery of the educational mission of the College.

To apply for membership, please provide the following:

- **Cover letter explaining your reasons for applying for membership (either member or faculty member)**
- **CV that is no longer than two pages in length**
- **Your RACS ID number**

Please email, fax or post your application through to:

Rachel Lennon
College of Surgeons' Gardens | 250 - 290 Spring Street | East Melbourne | VIC 3002
fax: 61 3 9276 7432 | email: ase@surgeons.org.au

Upcoming Meetings and Conferences

2011

ANZAPS ASM / SPANZA Conference
20 - 23 October 2011
Hyatt Regency Coolum, Queensland
www.willorganise.com.au/spanza-anzaps

SIOP
26-30 October - Auckland
Contact Phil Morreau
email: pmorreau@xtra.co.nz

Australia & New Zealand Paediatric Urology Club and Asia Pacific Association of Paediatric Urologists
25 – 27 November 2011
International Paediatric Urology Meeting
St Kilda Melbourne

2012

PAPS Conference
3 - 7 June 2012
Shanghai, China

ANZAPS ASM
6 – 10th May 2012
Combined RACS
ANZAPS at ASC

2013

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

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