# ANZAPS December Newsletter

2014 RACS ASC Singapore

Inside this issue



## President's Report

I have been honoured to assume the role of President of ANZAPS in May. As I mentioned at our AGM in the Hunter Valley I believe there were at least three major concerns of our association and therefore of my presidency.
These issues in my mind are intertwined with each other and one cannot deal with one without considering the others. Their resolution is vital to determining our professional standing, advocacy for children's medical and surgical services, and Paediatric Surgery into the future.
Simply the issues are:

1. Reversing the trend to diminishing total working hour weeks for trainees
2. Correcting the longstanding Medicare reimbursement imbalances and omissions.
3. Setting the standards for appropriate facility and surgical team for paediatric surgery in children.

The first is progressing with: our College, all surgical specialities and trainee associations giving strong collegiate support for negotiating a 60 -70 hour standard working week for surgical registrars (before overtime can be claimed). Queensland Health is already in negotiation with contractual analysis with the RACS State Committee based on the discussion paper produced by the RACS working party on appropriate working hours for surgical training. This should allow a more sensible approach to registrar rostering and training. Hopefully if all goes well with implementation in QLD the other states will follow. Of course the crisis brought about by the registrar rosters being made to comply with a forty hour week not only made training impossible; it resulted in an onerous load on consultants, who have to work extra hours to support non- training registrars brought in to fill rosters and to prevent poor patient registrar continuity turning into disaster. There is no fatigue leave for the consultants and as seen in Sydney remuneration usually doesn't reflect the extra load that Paediatric surgeons bear.

Medicare is an Australian problem; the New Zealand Health system seems to value the contribution of Paediatric Surgeons more appropriately than in Australia by keeping the consultants on an equal footing within the hospital pay structures as other surgical specialities. This is not only about private practice as the majority of state health systems seem to reimburse departments and salaried consultants using a system that reflects the MBS rate rather than the complexity or specialisation of the procedure.
The Medicare item number review process continues with the main thrust of our explanations and deliberations with Medicare being that current item numbers do not reflect the different pathology, age or size of the child. Our procedures and consultations take longer due to the Paediatric anaesthetic, pathological and technical reasons. Using the same numbers as General Surgeons for procedures does not reflect these increased complexity or safety issues. There are also some new numbers that need to be added to reflect changed practice. So far there does not seem to be many major impediments with going forwards with applications for new numbers, except that Medicare does ask that we don't start becoming obsessed with multiple variations of possible neonatal procedures due to the small numbers, rather try to rewrite some of current descriptions. The draft list is in the newsletter. There also seems to be optimism about loading for neonatal and Paediatric age groups in the areas of common practice. However a loading for Paediatric consultations is currently off the table due to Medicare not wanting applications for similar loadings for all surgical specialities. There is a still a lot work to be done by the committee and we will keep the ANZAPS executive and membership informed on progress.

The last issue is the most complicated and least advanced towards solution. We need to start working with General Surgery, Urology and government to pin down standards and ages. The problem is that we need to provide for the education and support of our colleagues, the rural surgeons, to safely provide elective and emergency surgery for children in remote areas of both countries whilst still trying to deliver access to tertiary Paediatric surgery for every ANZ child. We must continue to be absolutely clear on the role and exclusivity of Paediatric Surgery. Our training and education uniquely makes us the only specialty which determines the benchmarks for standards of surgery in children.

There is cross over with General Surgery, Urology and Cardiothoracic (to a degree every other surgical specialty has a Paediatric sub-specialty area); especially in consideration of who treats adolescents when physiology and pathology can mature faster than psychology.

Our balancing at is: Pragmatism versus idealism; Resource allocation versus distance. The main problem is the metropolitan areas. It is probably simplistic to believe it is simply a question of economic reimbursement that prevents general surgeons in non-Paediatric metropolitan hospitals from taking adolescent or Paediatric cases. The subspecialisation of general surgery, lifestyle concerns, skewed medico-legal perceptions, lack of Paediatric exposure in training, the same issues with registrar rostering (non-Paediatric Surgery consultants often have to "come in" for a "Paediatric" case) as we have; are all factors in the withdrawal of general surgeons and urologists from emergent care of older children.
Possible solutions include which are not necessarily independent:

1. "Hub & spoke" Our current workforce is already stretched with no capacity to start full "hub and spoke" care to all non-paediatric urban hospitals (paediatric surgeons from central paediatric institution having sessions in non-Paeds hospitals to do elective day surgery, outpatients and then attend to all afterhours calls). In order to implement this strategy within a reasonable after-hours roster system and with all the travel involved, there will have to be a substantial increase in overall consultant numbers. However there will be repercussions with dilution of neonatal, complex and oncological cases per individual surgeon or the development of a "two-tier" system of paediatric surgeons – those that do neonates and complex and those that do not. Secondly there will be issues with training if elective day surgery and ambulatory care is outsourced outside the main Paed. Centres.
2. "Paediatric Fellowships" for general surgeons so that these become the surgeons responsible for paediatric simple after-hours care as well as some elective work. This model is difficult to administer regarding accreditation of the Fellowship, determination what these General surgeons are certified to do, the number of these Fellows who can run a paediatric after hours roster and the implication for the value of our own Paediatric Surgery FRACS.
3. Better support of general surgeons doing paediatric after-hour care– teleconference, video-link, education and outreach theatre sessions (doing elective day surgery cases with local general surgeons) in order to create a network that has general acute care surgeons having paediatric surgeon contacts and feeling confident that they are supported in undertaking the responsibility of the surgical care of each case and that appropriate and smooth referral to paediatric institutions then occur.
4. Analysis of common emergent and elective conditions in a "standards of care" position paper. Questions should be asked of each condition (particularly appendicitis, simple lacerations, simple abscesses and possible testicular torsion):

a. Is this a condition which has a time related outcome (urgency) and therefore should it be treated in the institution of presentation?
b. Is this a condition or age or size where paediatric surgical, paediatric anaesthetic or paediatric specialised perioperative care is essential to a safe or optimal outcome?
c. What other factors should be taken into account regarding whether distance or access can safely mitigate the need for tertiary access?
d. What are some of the support mechanisms available to enable a general surgeon or urologist to triage, diagnose and manage the condition?

A position paper would of course endorse that index neonatal paediatric surgical conditions are always managed only by Paediatric Surgeons.

I therefore look for direction from our ANZAPS membership and executive on what solutions we believe will give the best outcome for the children and utilisation of limited tertiary Paediatric resources. This is a focus topic for both countries. Panel debate, working parties, survey and webinars can all be utilised to determine our professional stance.

***"Our training and education uniquely makes us the only Specialty which determines the benchmarks for standards of surgery in children."***

***"Medicare is an Australian problem; the New Zealand Health system seems to value the contribution of Paediatric Surgeons more appropriately than in Australia by keeping the consultants on an equal footing within the hospital pay structures as other surgical specialities."***

*President's Report continued...*

To tackle these issues requires time and resources. We are not a wealthy society by dint of having low numbers and low remuneration for our hours. We cannot afford expensive public relations firms or advocates. Our administrative support consists of half a person. Most of us work excessive hours and do so past the age of usual retirement. It is a paradox – in order to fund a campaign for change in reimbursement and standards of care we need more income and more time, but we will not get more income or time or political clout unless we win these changes. This does not mean we should refrain from continuing to work on achieving our aims. Using my own resources I have visited both the British and American Associations of Paediatric Surgeons this year in order to network on the similar issues that those societies face. In America they grapple with a deregulated medical system (compared to ours) where any hospital can set up Paediatric surgical services as long as they offer a good deal to the insurance company. They are trying to accredit (and limit) hospital services for different levels of complexity of Paediatric surgery care especially for neonatal, severely ill, and oncological conditions based on evidence of outcome based on caseload and facilities.

They also have trouble surprisingly with having enough influence on a federal level and use leverage obtained with aligning themselves as an association with Paediatric who have more numbers, finances and experience at emotional effectiveness. This could be a lesson for us. The British struggle with the same issues of providing after hours and ambulatory care in a system that pursues different political health agendas every decade: the two tier Paediatric surgery system, the health districts system that always tried to keep every patient in house to save its funding, and the loss of control of its own training effectively removing its political authority. Increased consultant numbers in last 15 years resulted in less case load per surgeon (and increasing numbers of papers citing average age patients of greater than 13 years presented in their annual scientific meeting!). The NHS is cutting all consultant wages after not achieving better outcomes with more consultants and because of overall budget deficits. Both associations presented papers and had sessions on these subjects as part of their Annual Scientific Meeting. After attending these meetings I propose that there are some changes we can make now as a society which culturally will help us more forward in prominence and organisation of our stance on topics concerning us professionally.

We are highly specialised and our training is long and the responsibility for what we do extends throughout the child's growth and development into adulthood. We are the advocates for the standards for surgical care for children. We should have pride in our society and belief in our advocacy for children having surgery. A strong and united association is the only way to influence political bodies and continue ownership of our training and continuing medical education. The ANZ tradition of friendship and flat hierarchy should not be abandoned but there is more we can do to increase our profile and relevance to our members.
I don't think I exaggerate by reiterating that if we don't tackle the concerns I outlined at the beginning of this report as a united professional organisation then we will lose the initiative and lose the responsibility for setting the standards.

It is with understanding and regret that ANZAPS accepts the retirement of Mr Hugh Martin from representing us on the Professional Development and Standards Board of the College. Mr Tony Sparnon will take over his duties in the interim. Hugh has worked tirelessly for Paediatric surgery on Council, our Board and on our executive including as President. His contributions to the College, to Burns, to surgical education and the community have been deservedly recognised in his being awarded Member of the Order of Australia (AM) and this year in his appointment to the Court of Honour.
Congratulations and thank you Hugh!

I would like to acknowledge the help I have had in last 6 months in particular from members of our working parties in Medicare Review, Mr Russell Taylor who is invigorating and streamlining our financial situation, Michael Nightingale and his team for Singapore and Mr Anthony Dilley our Board Chair. Ms. Terleetha Kruger in a short time has impressed us immensely with her dynamism, organisation and ability in taking over the reins as our Executive Officer.

***Associate Professor Deborah Bailey***

## 2014 RACS ASC - Singapore

Planning for the 2014 ASC continues to progress at a rapid pace. The provisional program has been published and should have been received by all members. There are a large number of additional tours and partner activities available - the program required extra pages to be inserted due to the number of options!

Unfortunately since this program was finalised it has become apparent there is a clash with the ESPU meeting in Innsbruck, Austria. To accommodate this I have been busy looking at moving the Urology sessions to the Tuesday of the meeting. There are multiple overnight flights available from Singapore and it is possible to leave Tuesday night to arrive in Innsbruck by late morning Wednesday for this meeting. I would encourage anyone planning to travel to ESPU to break their trip with a few days in Singapore to attend the ASC and combine the meetings.

Accommodation at Marina Bay Sands is expected to fill quickly. It is an outstanding venue so I would encourage all those attending wishing to stay at the venue to book their accommodation promptly through Corporate Blue, the conference organiser. Alternative accommodation options are also available.

The Sectional dinner will be a highlight in the Tower Club, close to the conference venue. I have circulated an invitation to SPANZA members inviting them to attend, and if you know of an anaesthetic colleague attending the conjoint ANZCA meeting please extend an invitation for them to come. They are able to book attendance through the ANZCA website.

The final program is being developed. I would certainly invite anyone who would like to present at the ASC to email me at michael.nightingale@rch.org.au and I will do my best to accommodate you. In particular the Registrar paper session will be held as the last session on Wednesday and I hope to present the award at our dinner later that evening, so please motivate your junior staff to attend! I am being ably helped by Prof John Hutson and Prof Yves Heloury to ensure we have an interesting scientific program.
Our colleagues in Singapore have been most welcoming and helpful and I hope this will be an excellent meeting to develop ties between the region and Australasia. I look forward to confirming final plans in the New Year.

***Michael Nightingale***

## Board of Paediatric Surgery

I would like to wish everyone a Happy Christmas and thank them for the support I have received over the past year as Board Chair. We have six new trainees for 2014 and one returnee who has successfully completed General Surgery- welcome back to Gideon Sandler!

The structure and conduct of Paediatric Surgical SET continues to mature – the take up of College courses within our Fellowship is impressive. Most Paediatric surgeons, when canvassed two years ago, have done SATSET. SATSET was taught to all SET trainees at RATS Coogee 2010, and subsequently at Boot Camps 2011, 2012 and 2013, an amalgam of SATSET, Keeping Trainees on Track and Surgeons as Teachers Courses was taught to newly selected trainees. A current survey of surgical supervisors (RACS 2014) shows uptake for these courses is highest for our craft group –I would like our uptake of SATSET in this group to be 100% as a minimum standard. The Process Communication Model course was also taught to 12 of our trainees in Auckland immediately prior to RATS. RATS as a time and place does lend itself to "bolted on" courses, we may be able to make Fellows aware of these in case they would like to participate in both the courses offered and the excellent program that is usually run by Trainees during RATS.

I plan to focus more on our Supervisors during 2014. Improved communication between the Board and Supervisors would mean that Supervisors would have more timely feedback on changes to training and College policy and a better sense of calibration with peers with respect to assessments. Now that our training is competency based rather than time based, the burden on supervisors has increased, as has the expectations that trainees have of their trainers and supervisors.

Flexible training and working hours for trainees have both been topics for review within the College; significant contributions have been made to these discussions by Paediatric Surgery. I anticipate that policy positions/changes will be announced from the College in these areas in the next month or so.

There will be a steady flow of trainees off our training program over the next five years. ANZAPS and the Board will try and facilitate ways in which potential recruiting hospitals and newly minted Fellows can be "matched". This is difficult for hospitals who do not usually host trainees in their senior years, and also dovetails with the issue of some hospitals whose training posts are sometimes (often) unfilled.

I look forward to hearing from all of you regarding these matters in 2014!

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

# PDSB Report

"Professional Development & Standards" – the name of the Board tells a lot. "Standards" inevitably means being involved with CPD. No-one believes that being CPD compliant really means that a surgeon (or any other practitioner, for that matter) will practice to a certain standard, but for now it is accepted as being a practical surrogate. Re-validation? A formal testing process such as an examination is a possibility that is likely to be in the minds of regulators but it would be an expensive exercise. Would it ensure that surgeons practiced to a standard? Of course not. There is so much more to good performance than knowledge (which an examination can test) and reasoning (which an examination may be able to test) that cannot be tested. Communication, humanity, empathy, judgement, professionalism are all necessary to make a surgeon a good practitioner and none of these are easy to test. Qualities such as these must be taught and internalised during one's formative years. This is why our selection Boards look for these attributes in candidates applying for training, knowing that if the basics are there these qualities are likely to be able to be further developed.

So why all the focus on CPD? As I mentioned, it's the best we've got, and AHPRA accepts the College's CPD programme as being satisfactory. To date AHPRA has not requested lists of non-compliant Fellows but legally the College would have to disclose a Fellow's CPD status if an enquiry were made. Those with an ear to AHPRA's thinking feel that within that organisation there is a desire to check the verification of Fellows who are required by the College to verify their return, but at the moment there are not the resources to do so.

One more thing about CPD. Those of you who have read the College's Code of Conduct may recall that being CPD compliant is a requirement of the Code of Conduct. Next year the College may treat any failure to comply as a breach of the Code requiring the individual to sign a Stat. Dec. to the effect that the Code will be complied with in future.

A new policy (yes, another policy!) on telementoring & teleassessment was approved. With the increased use of video recording and transmitting of operations this policy is relevant to those of us who may be in a position of having to assess or mentor a trainee or IMG. If you are put in that position I suggest you look at the policy on the web site.

In New Zealand a "Bariatric Surgery Tool" has been developed. No, it's not a new gadget, but a way of assessing the degree of need of an individual to have surgery for obesity by assigning a score for the various effects of morbid obesity such as hypertension, diabetes and obstructive sleep apnea. The Board was asked to endorse the Tool. There was a lively discussion that brought into focus two different points of view. On one hand, a set of criteria that could be applied to everyone who might be considered for such surgery and thus determine those most in need would give fairness to distribution of resources. (In NZ there is public and political acceptance that health care is rationed.) On the other hand, for the College to become deeply involved in such a process could expose us to a bunch of ethical and legal battles: what criteria make a carpal tunnel release more or less important than a shoulder replacement or a cholecystectomy? If an obese diabetic doesn't get bariatric surgery on the grounds of College endorsed criteria but loses a leg through vascular disease, what protection would the College have? What came out of this useful discussion was that the Board felt the College should express support for the *process* but decline to give endorsement to any particular programme (even though individual Fellows would undoubtedly be involved).

The Academy of Surgical Educators is planning to give awards for excellence in & commitment to teaching. These would be annual and cover a number of categories such as Supervisor of the year, Instructor of the year & Examiner of the year. It is hoped that such a system would help to acknowledge the work done by Fellows in teaching.

The College is raising its profile internationally. It has become a member of the WHO Global Initiative for Emergency & Essential Surgical Care (GIEESC). Joining has no cost although attendance will generate travel costs. David Watters is a member and is chair of one of the 10 working groups. More information is available on **www.who.int/surgery**.

Another international body that the College is now involved with is the Alliance of Surgery & Anaesthesia Presence (ASAP). David Watters was appointed a member and Russell Gruen Treasure of the Executive of ASAP. This body meets during International Surgical Week, which is held every 2 years.

In March next year a tripartite meeting (RACS, RACP & Canadian College of Physicians & Surgeons) will be held in Melbourne ($12^{th}$ to $14^{th}$). The major topics are Faculty development for Supervisors, CPD and Revalidation. It would be useful for our Board to be represented.

This will be my last report on PDSB as I have stepped down from that post. It has been interesting, sometimes challenging, but allowed me to meet a number of highly intelligent and likeable colleagues outside our craft group. Those of you who bother to read this will, no doubt, be glad to stop hearing me bang on about CPD. While overall it has been enjoyable, the task I have not enjoyed is that of reminding those on the list of non-participating and non-compliant Fellows in our discipline that they need to act. I have undertaken this task because I have felt that most of them *are* compliant but have either not got around to putting in the paperwork (or electronic return), or have not fully documented their activities. While most take my nudging with good grace, some seemed to think this was a personal attack. Possibly I was wrong to undertake this task – you are all grown up so should be able to manage this yourselves. I shall, therefore, recommend to my successor that he/she not bother to do this but leave it to the recalcitrant individuals to sign the Stat. Dec. that they will in future abide by the Code of Conduct, or explain to AHPRA why they really should have their registration renewed.

To finish, I would like to thank my colleagues in all disciplines who have educated, supported and befriended me in my College activities, the numerous College staff members with whom I have been in contact, all of whom have been extremely helpful, and particularly our EOs in the last years, Rebecca Letson, Kristy Scalea and now Terleetha Kruger.

***Hugh Martin***

# Council Report

I have brought to the attention of RACS Council the challenges that our specialty of Paediatric Surgery is facing in many parts of Australia and New Zealand with work force issues and the changing work practice. Medical funding and resources are being directed away from the care of the young as our populations are aging. However, children under 18 years still represent 25% of the Australian population compared with 16% for those over 65 years. Whilst between 2000 and 2005 there was a small reduction in the number of children, this has quickly been made up due to the decision of today's parents to have children a little later in life, the baby bonus and a significant increase in immigrants who usually have children. In addition to this we have seen a reluctance of the General Hospitals who have in the past managed some Paediatric surgical emergencies to now be involved in the care of adolescents. The situation is confusing with different approaches in the various jurisdictions. In Adelaide two general hospitals now refuse to admit children under 18 years of age whilst another has chosen 16. A fourth who has a number of visiting Paediatric surgeons and provides an emergency neonatal service still refuses to admit emergency Paediatric surgical patients under 12 years of age.

This has all resulted in a confusing picture with parents and general practitioners unsure who now is looking after adolescent surgical problems. Situations have arisen where the outcome has been far from ideal due to avoidable delays occurring with the transfer of patients from hospitals where care had previously been provided.

To add to this the health authorities have given confusing predictors of the future Paediatric surgical workforce numbers. Health Workforce Australia has concluded that it sees no significant problems with the number of Paediatric Surgeons before 2025. The formula estimating the need for Paediatric Surgeons in the future is based on how many Surgeons are at present looking after the population and then calculating how many will be required for the Paediatric population in 2025. Health Workforce Australia has based their assumptions on a figure of 61 Paediatric Surgeons presently working in Australia.
This compares with:

The Australian Institute of Health and Welfare - 64
The Royal Australasian College of Surgeons – 84 AHPRA – 92

Concerned by the wide disparity in these figures ANZAPS has performed our own assessment of Paediatric surgical numbers. I would like to thank all the regional representatives of ANZAPS who assisted me in completing a census of Paediatric surgeons for the months of February and March of this year and which I presented at the annual general meeting in April.

It identified 88 Paediatric Surgeons working in Australia.
However, 3 have recently retired, 2 no longer practice Paediatric surgery, 2 whilst fully employed as Medical Administrators practice no Paediatric surgery, 1 practices in two states and is often counted twice. In addition there are two Surgeons practicing in full time Paediatric surgical practices who are excluded from other registers as 1 is not a Paediatric Surgeon, but practices as a full time Paediatric Urologist and the other is an IMG who whilst employed as full time consultant by a state department of health was yet to be processed by the AMC/RACS process.
This leaves 80 Paediatric surgeons presently working and practising in Australia rather than the 61 claimed by HWA as the baseline it uses and from which its future predictions have been made.

HWA has made the assumption in workforce issues that all Surgeons wish to work full time. Often FTE's are added to suggest the full time workforce. The assumption that somebody working 0.5 in Queensland and another working 0.5 in West Australia can be added to represent one full time Surgeon is inappropriate. Both Surgeons are on the on-call rosters in their respective states and cannot do both. It takes just as much training, resources and expense to train somebody to become a part time Surgeon as a full time Surgeon.

There are in 13 Paediatric surgeons who are not practising as full-time surgeons and are very content to continue their part-time practice and have no intensions of returning to full-time work. It appears that Paediatric Surgery does attract a significant number of people wishing to be in part time practice and this must be reflected into future workforce commitments.

HWA ignore the change in work practice reported in many Paediatric surgical units with up to a 30% increase in emergency work in the past five years largely due to children over the age of 12 years now being transferred to them. In most jurisdictions emergency Paediatric surgery represents 50% of the overall workload. The recent RACS census has shown that Paediatric surgeons spend far more time doing after hours emergency work than any other specialty.

Finally 19 of the 80 Paediatric surgeons intend to be retired within five years and wish to slowly reduce their work.

This census will need to be updated yearly and include New Zealand. It appears that the correct number of Paediatric Surgeons has been used in the future New Zealand projections, but it is unclear if the present number is adequate and sustainable.

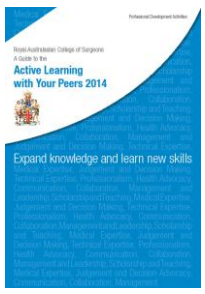
This issue will need to be addressed by all Paediatric surgeons so we can work out our future requirements. At present we are dependent to a large extent on our overseas trained international medical graduates who have filled the breach in many hospitals in both Australia and New Zealand.

Should we take the care of adolescents under our wing so that they do not miss out and receive the often inadequate care they presently do? It may mean the change of our associations name to the Australian and New Zealand Association of Paediatric and Adolescence Surgeons. It is time that we discuss these changes and our future.

***Anthony Sparnon***
***Paediatric Surgery Councillor***

## Professional Development 2014

**The 2014** Active Learning **booklet is available.**




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.

Global sponsorship of the Royal Australasian College of Surgeons' Professional Development Program has been proudly provided by Avant Mutual Group, Bongiorno National Network and Applied Medical.

A brief selection:

**Supervisors and Trainers for SET (SAT SET)**
25 February – Adelaide
Also available as an online module

**Process Communication Model (PCM) – Part 1**
28 Feb to 2 March – Melbourne

**Keeping Trainees on Track (KTOT)**
4 March – Melbourne, 26 March – Gold Coast

**National Simulation Health Educator Training Program (NHET-Sim)**
24 February, Melbourne, 17 March – Sydney

**The Academy Educator Studio Sessions**
11 March – Melbourne, 15 March, Melbourne

**Conjoint Medical Education Seminar – Revalidation**
14 March – Melbourne

**Non-Technical Skills for Surgeons (NOTSS)**
18 March – Adelaide

**Communication Skills for Cancer Clinicians**
29 March – Melbourne

For more information please phone +61 3 9249 1106, email **PDactivities@surgeons.org**
or visit our website **http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/**

## MALT news

As you know, the Board in Paediatric Surgery has mandated the use of MALT for early and mid-SET Trainees.

MALT is seven things:

1. Allows Trainees to electronically record their logbook and produce end of rotation reports for the Board.
2. Allows Supervisors to monitor Trainees more closely – login at any time to view a Trainee's progress where they have cases recorded with you as Supervisor.
3. Encourages Trainees to develop the habit of recording 'audit level data' (outcome indicators like complications). There are many optional fields in MALT for this purpose.
4. A personal log and/or self-audit tool for Fellows. Fellows can login and record their own cases. No-one sees this data but you.
5. An audit tool for departments of surgery or specialties. On request and with the permission of all Fellows concerned, MALT is able to be set up to operate as a peer-reviewed audit.
6. Powerful reporting – MALT already comes with a suite of standard reports. To be launched shortly is a flexible reporting tool whereby each user can design their own reports quickly and easily. The MALT team can also, on request, configure and make reports available to the whole specialty.
7. Configurable to specialty requirements. Not all specialties work the same way. Don't like something about how MALT is set up? Chances are there may be a specialty-specific setting that controls this – just ask the MALT HelpDesk.

## Suggestions for improvements?

Let the MALT HelpDesk know! We keep a list of all requests and review this monthly. Several times a year we release updates to MALT with requested enhancements.

We hope you find the adjustment to MALT a smooth one – contact the HelpDesk at any time if you have concerns or queries! We love to hear from you!

### Want to help?

We are always looking for more testers for the periodic updates to MALT (and for the App). Contact the HelpDesk to volunteer to try out test versions and let us know if we have it right!

### MALT HelpDesk

Phone: +61 8 8219 0900
Email: malt@surgeons.org

## Supervisors - what do you need to know?

1. The Board does not require you use MALT to electronically approve cases.
2. But, if you wish you can login at any time to view the cases where you have been recorded as the Supervisor, to see how your Trainee(s) are progressing. This is the first rotation period using MALT, but as time passes and there is more than one rotation period recorded in MALT, you will also be able to see what experience a Trainee who is new to you has already logged in previous SET years.
3. There is a short video guide for Supervisors available from www.surgeons.org/malt
4. At the end of rotation, the Trainee will print off three end of rotation reports and ask you to sign the paper report so they can submit it to the Board.
5. You can use MALT as your own personal log or self-audit tool. No-one sees this data but you. Tell the MALT HelpDesk if there are procedures you would like added.

## End of rotation - what happens?

The Trainee must:

1. Finalise all cases and make sure they are all marked as **Complete**.
2. Print off **three reports** from MALT: Logbook Summary Report (from the Reports tab in MALT), Majors/Minors and Index Cases (from Qlikview – accessible from a link from the Reports page – to be launched late Nov/early Dec).
3. Ask your supervisor to sign these reports as an accurate reflection of your experience.
4. Provide the signed copies to the Board by date specified on the training calendar
5. Remember the current rotation period deactivates in MALT on **5 February 2014** – after this date you cannot edit your cases for this rotation period.

## Need help?

There are three ways to find out more or get help:

1. The MALT webpage www.surgeons.org/malt has short video guides and PDF user guides. Login to access these.
2. There is a MALT page just for Paediatric Surgery– go to www.surgeons.org/malt and click on the Paediatric Surgery link for information specific to how your speciality uses MALT.
3. The MALT HelpDesk is available Australian CST business hours. There is a small team of dedicated and friendly staff who are very happy to help out. Call on +61 8 8219 0900 or email malt@surgeons.org

## Trainee's Frequently Asked Questions

**Q:** **How do I get the supervisor to sign off on the case?**

**A:** When you are finished, click the green Mark as Complete button. Once you've done this, the case will appear in the Logbook Summary Report that you will print and ask your Supervisor to sign (on paper) at the end of rotation.

**Q:** **Why can't my Supervisor login to approve the cases electronically? I know Trainees from other specialties where this happens.**

**A:** MALT can be configured differently for each specialty. Some specialties do require their Supervisors to electronically review each case and approve it. The Board of Paediatric Surgery has not required this of their Supervisors at this time. However Supervisors can login at any time and view the cases ***where you have recorded them as the Supervisor***.

**Q:** **Why do I have to enter the patient's name and date of birth?**

**A:** These fields have been made mandatory by the Board.

**Q:** **Why do I have to enter the Hospital, SET level and Rotation Period each time I save a case?**

**A:** MALT is being changed so that you can set a default value for each of these so it won't ask you each time. But do remember to check your default settings each rotation to avoid recording incorrect data if these things change! This ability will be available in the next release (late November/early December).

**Q:** **Why can't I find the procedure I'm looking for?**

**A:** MALT searches for the procedure name – but if you call the procedure something else, the search result won't find that different term. However tell the MALT HelpDesk if you can't find something, as we can easily add Alternate Names against a procedure so MALT can also search for these terms as well.

**Q:** **How do I know the full list of procedures the Board wants me to record?**

**A:** There is a full list on the MALT Paediatric Surgery page. Go to www.surgeons.org/malt, click on the Paediatric Surgery link and look for the MALT Paediatric Procedure List link.

**Q:** **I do additional procedures to those in MALT. Can I add these?**

**A:** The Board sets the procedure list. However you can record additional procedures as 'Other' (for instance 'Other major Head and Neck') and note what the actual procedure was in the Comments section. But you can also ask the Board if they would consider adding additional procedures to the list in MALT – contact the Executive Officer Terleetha Kruger on **paediatric.board@surgeons.org**

**Q:** **How do I record if there were different components to an operation?**

**A:** You can record multiple procedures in the one case, each with its own supervision level. There is a video guide on how to do this, available from www.surgeons.org/malt once you login.

**Q:** **The comorbidities are mostly adult conditions – can we add Paediatric terms?**

**A:** This is a system-wide list available to all specialties, but MALT can easily be updated with additional terms. Ask the Board if they would consider adding Paediatric-specific comorbidities to the list in MALT – contact the Executive Officer Terleetha Kruger on **paediatric.board@surgeons.org**

**Q:** **Where is the report the Board wants on Majors/Minors and Index Cases?**

**A:** Reports like these that differ specialty to specialty will be available in the new reporting tool, Qlikview. This reporting tool will be launched shortly before your reports are due to the board (late November/early December) and you'll be sent instructions on how to find the reports you need.

**Q:** **Is MALT backed up regularly?**

**A:** Yes, MALT is backed up by the College daily.

**Q:** **What about the App – I've heard it's coming?**

A: Yes the College is building an iPhone App version of MALT. It is being planned as a simpler interface focused on quick data entry of only the very minimum procedural data. This is now being scheduled for release in 2014.

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