Australian & New Zealand Association of Paediatric Surgeons Inc

April 2016 Newsletter

President's Report

Welcome to the first newsletter of 2016. It is our hope that these newsletters will remain interesting, relevant and informative. To this end, one of the things I am keen to see is that each newsletter has an update from one of the regions or departments. Personnel change, hospitals get built, needs evolve, retirement and appointments are made. As we can not all get together to talk these things over much of this occurs without others being aware. I will be in touch with a few of you over the next few months and years asking for a brief account of what is going on in your own backyard that might be of interest to us all within paediatric surgery.

Over the course of the last 4 months the ANZAPS executive has been steady if not too frenetic on your behalf. There have been on going discussions around the provision of paediatric surgical services in metropolitan Sydney. It's a complex blend of factors that need consideration and not yet resolved. There has been a Review of the Post Fellowship Education and Training (PFET) Program and it would appear that this process whilst not commonly of relevance to paediatric surgeons is to be simplified.

A great deal of College time and money is being spent on the implementation of the recommendations of the EAG on discrimination, bullying, and sexual harassment. There has been a College Action Plan and of significance to all fellows a revised edition of the RACS Code of Conduct in line with these recommendations, is now in draft format. One of the education goals of the Action Plan was the development of an Educational Framework entitled "Building Respect and Improving Patient Safety"- you will hear a lot more about this in the future.

There is also a strong desire to enhance services for Fellows. Most of us will be using the website regularly and appreciate the easier navigation within. The library remains well utilised and it is becoming easier to keep tabs on CPD activities via automatic activity population and a more mobile friendly platform. But the College still wants to give you more in return for your fees and have asked ANZAPS for feedback on the strategic plan for Fellowship Services by the end of April. Ill be doing this on your behalf along with my Colleagues in the Exec but ask our EO Terleetha Kruger if you would like a copy and I'll happily receive your thoughts and advice by April 30.

Which brings me to my next point; from time to time in conversation one comes across Fellows and trainees full of frustration or criticism of "The College" as though it were some external, mythical and mysterious creature with a life of its own that is unable to be influenced. Who is this College? The College is that same Fellow or Trainee and the College would welcome their time and contribution in so many areas as motivation and good will might allow.

I continue to be astounded by how much paediatric surgeons do for our College and not just in the obvious roles within RACS-Council, Regional Boards, Training Boards, as Examiners, College Committees – but also in the weekend teaching on courses, the afterhours coaching and the development of educational material, the external referees for papers. I'm sure we punch way above our weight. But there is room for more to become involved and as one who has, I can only speak highly of my experiences and satisfaction gained whilst doing so. You are "The College".

I believe that every right implies a responsibility; every opportunity, an obligation; every possession, a duty.
JD Rockefeller American Industrialist 1839-1937

Think about it.

I'd like to make special mention of Danny Cass and the enormous amount of time and effort he has put in over the years to the RACS Trauma Committee. He has been our paediatric representative on this binational group and this included 4 years as Chair. Thanks Danny.

In New Zealand we have recently farewelled into retirement Mr Stu Brown from Waikato and Prof Kevin Pringle from Wellington. Kevin was also awarded an Order of the NZ Order of Merit (ONZM) in the NZ New Year's Honours and I congratulate them both on their retirements, achievements and thank them for their contribution to ANZAPS over the years.

It is now just on a month until we meet in Brisbane. I hope many of us can meet from May 2-6 and use this as a great opportunity to remain up to date and catch up with friends and colleagues. The academic program looks good and there is plenty of time to look at areas perhaps more familiar to other craft groups but none the less an important part of paediatric surgery. Daniel von Allmen is our visitor from Cincinnati. Spencer Beasley will provide the Peter Jones Oration.

Of course the real highlight will be the ANZAPS AGM at Tuesday May 3 at 5.30pm in the Convention Centre. And don't forget to buy your tickets for the ANZAPS dinner on Weds May 4th at 7pm at the Brisbane Club.

Mr Philip Morreau, President

Board of Paediatric Surgery

Dear Colleagues,

2016 has started with the Board in a good position – our trainees are all working hard and our competency based approach to training is making clear headway. During my "sabbatical" this autumn I plan to further develop the SET One Assessment Plan in light of the JDOCS plan, re-visit the trainee self evaluation form (which is a 'down the line ticking exercise' for many trainees currently), and generally go over our curriculum so that it is simpler for trainees, trainers and supervisors to match stage of training with expected competencies across the spectrum of the College nine core competencies. I hope to be able to report progress on these issues in the second half of this year.

We hope to receive further advice from the Examinations Board to our broader community as to how the Fellowship Examination is constructed and pitched at trainees. Our pass rate in this Examination has been disappointing. One aspect of this may be a misunderstanding of trainees, and those preparing them, as to how the Examiners expect the answers to be constructed and delivered. There is now emphasis on the Examination to assess "higher decision making" and some aspects of how the Exam was previously "played" are no longer valid. Hopefully the dialogue this year will make this clearer.

As Chair, I have been co-opted by BSET to Chair a Working Party looking at Diversity on College Boards. This was a pleasing task as our Board ticks many of the "correct" boxes in this respect. As part of the progress I did invite a Community Representative to the last Board meeting and this Rep will likely attend the June Selection meeting also. College Council queried our "emeritus" Board member and will require annual approval of this position from Council. Until the end of last year, our friend and colleague Hugh Martin fulfilled this role – Hugh has been associated with the Board and College for many years and was able to counsel the Board during times when we threatened to re-invent the wheel or re-visit previous minefields. Deborah Bailey, previous Board Chair and subsequent ANZAPS President (and now Examiner) has agreed to stay on and assist in this role. Both Hugh and Deborah have exceeded the nine years of service which usually limits further participation, hence Council's interest.

Selection this year is a little different on face value, but in most respects the same. The successful sitting of the Generic Surgical Sciences Examination is now a pre-requisite for selection (as the old Part One Examination was previously for those of us old enough to remember). The score sheet for the CV has changed mainly to make it fairer and more transparent to score achievements, rather than because the Board has changed significantly what is assessed. We are taking a broader approach to selection of referees – we implore all colleagues to continue to be fair and reasonable in the reports they provide. Over the past decade the referee scores have proved to be the least discriminating component of the selection process – either we consistently get outstanding candidates or our referees support the 'halo effect', we have no evidence as to which is in play. Our interview process is unchanged.

The Logbooks continue to evolve - our trainees are one of the first groups in the College to have the operation descriptions transitioned to "SNOMED". I invite you all to visit the MALT website for information regarding this. In the not too distant future many Fellows of the College may choose to keep an electronic logbook as part of CPD.

I would like to thank Terleetha Kruger and Glenn Petrusch for their ongoing support to the Board, and wish Fiona Bull health and happiness for her impending delivery and maternity leave. I would also like to thank my colleagues on the Board for their continued hard work and support.

Mr Anthony Dilley, Chair, Board of Paediatric Surgery

Council Report for AGM, May 2016

At its last meeting the RACS Council addressed some exciting strategic issues.

The challenge of communicating the outcomes of the RACS response to the expert advisory groups' report on discrimination, bullying and sexual harassment was discussed. The action plan named "Building Respect, Improving Patient Safety" has been carefully refined. Ms Frances O'Connor has commenced duties as Manager of Complaints and Resolution. She will not only centralise the collection of complaints data but will promote engagement with hospitals and jurisdictions in complaints handling procedures. A communication campaign has commenced to help achieve the goal of changing behaviours so that all surgeons understand their own responsibility as role models and champions of acceptable behaviours. The process of engaging with the leadership of the surgical societies has begun to assist in bringing about cultural change. A foundation course for surgical educators has been developed which will enable participants to identify their own personal strengthens and weaknesses and thereby influence the learning environment in which they work. This will establish the basic standards expected of all surgical educators and should result in a better more respectful and productive learning environment.

A thorough and comprehensive review of the College's research strategy was carried out. There was agreement that all research and health technology assessment activities of RACS must be supported by a commercially viable business model. The various and complex research activities that are performed by RACS needs further direction to ensure best possible value is obtained using the existing research funding. A number of possible options were discussed and a new RACS research strategy is being developed to ensure that research remains a dominant and core activity of our College.

The persistent issues involving international medical graduates with their assessments and passage to fellowship was also discussed. Whilst many hold the view that the fellowship exam is the right of passage required by all surgeons, others believe that the exam is only a small part of the assessment of surgical competence. It is recognised that oversight is often poor and very hard to judge in an "out of sight" position. There are challenges to be addressed in developing a fair and transparent IMG assessment program whilst upholding standards. Many specialties including our own are highly dependent on these surgeons. There may need to be more emphasis on documented experience and workplace assessment rather than relying on exam performance. The potential of FRACS in a defined scope of practice and the need for RACS to comply with the Medical Board of Australia's Guidelines for IMG assessment were also discussed.

JDocs has formally commenced and has gone live. JDocs is not a RACS program but rather a framework and guide to aid prevocational trainees who may be interested in a career in surgery. JDocs provides tools so that surgical aspirates can capture their experience and educational activities and develop an ePortfolio. In time some of the specialty education Boards may suggest courses or experiences which may help when applying for their specific programs. JDocs is going to be audited to see if Boards believe it improves the quality of applicants and helps in selection and also if the applicants believe that they are assisted in their preparation for selection. The development of an ePortfolio will allow applicants to develop a professional profile report documenting their evidence of work based assessments and achievements. Their procedural observations and experience can be captured as a record utilising the MALT system, which then can be continued on during their life as a trainee and fellow. Library and eLearning resources will be available and a log of skills obtained will identify gaps in both skills, knowledge and behaviours tracked against the nine core competencies to demonstrate the areas of which can be improved.

Council finished with a moving ceremony to highlight the Maori Health Action Plan, which was presented by the Indigenous Health Committee. This action plan is on the RACS website and I would encourage all to read it.

I am only too happy to hear the views of any ANZAPS members on these or any other issues.

Mr Tony Sparnon, Councillor

Melbourne Colorectal Course 18-20 October 2016

Melbourne Colorectal Course – The Royal Children's Hospital, Melbourne
Invited Visitor – Dr Marc Levitt
Tuesday 18th to Thursday 20th October 2016

Join us in October when Dr Marc Levitt is our visitor at The Royal Children's Hospital for the first time.

Marc is the world's leading expert on colorectal surgical conditions, following his lenghty collaboration wih Dr Alberto Pena.

He is the inaugural Surgical Director of the Center for Colorectal and Pelvic Reconstruction (CCPR) at Nationwide Children's Hospital, and Professor of Surgery and Pediatrics at the Ohio State University. The CCPR aligns specialists within GI, Colorectal, Paediatric Surgery, Urology and Gynaecology to create a comprehensive treatment program assisting children with these complex disorders. He also serves as the program director for the paediatric colorectal surgery fellowship.

Marc received his undergraduate degree from the University of Pennsylvania and his medical degree from the Albert Einstein College of Medicine. He completed his general surgery residency at Mount Sinai Medical Center, a fellowship in Pediatric Colorectal Surgery at Long Island Jewish Medical Center and a Pediatric Surgery fellowship at Children's Hospital of Buffalo. He has been on faculty at the Children's Hospital of Buffalo, Schneider Children's Hospital, and at North Shore-Long Island Jewish Medical Center. He came to Nationwide Children's Hospital in 2014 from Cincinnati Children's Hospital, where he was Director of the Colorectal Center for Children.

Marc has published more than 150 peer-reviewed articles and 60 book chapters, and has delivered over 300 national/international and 100 local/ regional presentations of his work. He has been an invited visiting professor all over the world. He has trained numerous clinical fellows, research fellows, nurses and students and has directed multiple colorectal surgery training courses attended by established surgeons and surgical trainees. He dedicates much of his free time to mission trips to the developing world where he trains surgeons and nurses in complex colorectal techniques.

We will be running a 3-day interactive Colorectal Course, with panel discussions, case presentations and live operating. Invited faculty include Richard Wood (Paediatric Surgeon, Nationwide Children's Hospital), Jeffrey Avansino (Surgeon, Seattle Children's Hospital) and Vinay Prasad (Pathologist, Nationwide Children's Hospital). Marc will discuss his extensive experience in re-do surgery for Hirschsprung disease and anorectal malformations.

We look forward to seeing you in Melbourne in October 2016.

Marc Levitt's visit is kindly supported by the Royal Australasian College of Surgeons.

Mr Sebastian King, FRACS Paediatric Surgeon

Trainee Representative Report

This is always a hectic time of year for the trainees, most having moved cities, state and even country trying to settle in to their 2016 posts. It's the starting of the academic year and many are gearing up for primary, anatomy and fellowship exams. The first sitting of the fellowship exam will be held in Auckland this year, and it will be the first time the first written paper will be offered electronically. This follows the recent transition of the primary, anatomy and pathology exams to this format in 2015. On behalf of all the trainees we're wishing those presenting for the upcoming exam the absolute best of luck.

Another recent development for the trainees has been the transition of the online logbook to the new SNOMED format. We are still in the early phases of this, but a big thank you goes out to Sarah Guitronitch and Dylan Wanaguru for their assistance in the transition and the development of the Paediatric Surgical terms to the program.

In addition to the fellowship exam, April and May will be busy times with the PAPS meeting in Hawaii and the ASC following in Brisbane. We look forward to excellent trainee presentations and posters at both meetings. The Registrars Annual Training Seminar (RATS) dates have officially been locked in for October 15-17 in Melbourne, with a very exciting program involving a full-day of teaching from visiting speaker Marc Levitt.

Many of the senior trainees spent the weekend in Melbourne recently at the SPUNZA Paediatric Urology course. This was once again a fantastic course with a wide range of speakers from across Australia and New Zealand. We're looking forward to the second part of the course again next year, and look out for a possible location change as the course may rotate from the historical Melbourne venue in subsequent years.

As a final note, I just wanted to congratulate our specialty for being leaders in surgical training. This became clear to me as I sat at the Royal Australasian College of Surgeons Trainees Association meeting last week. Our competency based approach is leaps and bounds ahead of many other specialties. Our approach allows the individualisation and flexibility trainees across the specialties are striving towards.

Dr Kimberly Aikins, Paediatric Surgery Trainee Representative

What is the FEX?

The Fellowship exam has developed a lot since many of you sat it. In the past it was used as a tool of assessing the core knowledge of paediatric surgery. However the exam has been evolving and it might be useful for fellows to refresh their knowledge about what the exam has become.

More and more the exam is looking not just at knowledge but how that knowledge is applied when dealing with a clinical problem; how it is used to define an issue, manage it appropriately and anticipate possible future issues, all in a cohesive package. In this regard we a looking for higher order thinking.

We have also taken the curriculum and "blueprinted" it to the exam. This means any area of the curriculum is examinable and indeed all areas will be examined. Beware the examinee who doesn't study a topic because "they never ask about that". Gone are the days when knowing just about Tofs, CDH and Hirschsprungs might get you through.

Each of the vivas has been improved too so the exam is not quite what it was when you sat it many years ago. Anatomy and pathophysiolohgy have been taken out of the final fellowship and are now separate exams that must be sat in the early to mid SET period. However these areas are still examinable; such as the anatomy of a specific area related to an operation or the embryology of a pathological condition so they should not be ignored.
The exam consists of seven vivas, all of equal value.
These are:
Written paper one : spot questions
Written paper two: short answers
Short cases
Medium case
Neonatal Viva
Operative Viva
Clinical imaging and Management Viva.

Each viva is assessed by two examiners who produce an agree mark for the viva. Once that mark is allocated it cannot be changed.

Like all aspects of life the exam has been touched by technology. From this year the "spot" questions can be answered directly onto a computer. The written paper two otherwise known as the short answer paper will also require typing skills in one or two years. Images are being extensively used on lap tops, allowing for not just radiology but also other modalities such as histopathology, isotope scans and urodynamics to be incorporated. It's not just a chest x-ray on a viewing box anymore.

Written paper one : spot questions
This consists of 50 questions, each with an image relating to the question. The image may come with some clinical information. The candidate is asked to provide answers to several sub questions. Each of the 50 questions is of equal value. The exam is now to be answered via computer and the total time for the exam is 2 hours and 10 minutes.

Written paper two: short answers
This consists of 8 questions, all of equal value. Each question may come with subsections to it.
Candidates can answer them in a variety of methods such as bullet points, algorithms, longhand.
Candidates must be aware that poor handwriting or a disorganized answer makes marking harder.
It is anticipated this exam will be answered in the coming years by typing directly to computer.
The paper is of two hours duration.
A repeating problem is that candidates do not answer the question posed, or only in a superficial manner like a medical student and not in depth nor in an organized like a junior consultant. The scatter gun approach scores poorly

Short Cases.
This is done with patients, usually in an outpatient setting.
A pair of examiners will assess history taking and examination with an emphasis on the latter.
Typically 8-10 cases will be seen in a 25 minute period and generally will be standard pediatric outpatient cases such as hernias and undescended testis but also the occasional unusual lesion.

Medium case.
This consists of a single case only with the aim to assess history, examination but then also the management of the case.
These are typically more complex cases with ongoing issues that require management. What the examiners are looking for is the ability to assess the problem, look for the salient issues, prioritize them, sort out appropriate investigations and then manage the overall problem.
The exam is over a 40 minute period, the first 20 minutes is the candidate and examiners with the child and family; the candidate's history and examination is marked. The candidate can use 3 minutes of that time away from the patient if they wish to arrange their thoughts. The candidate and examiners then leave the patient, go to another room where the candidate presents a synopsis of the problem. A full history and examination is not re-presented but rather just the relevant points. The discussion then is about management of the child's condition with the aim of looking into that in some detail. It tests the candidate's depth of knowledge as well as his ability to co-ordinate a management plan.

Neonatal Viva.
This is of 25 minutes and is usually two to three clinical scenarios; including antenatal issues and urology. The candidate is examined on his ability to manage these scenarios with the good candidate able to understand the nuances of managing a difficult neonatal case.

Operative Viva.
This is also a 25 minute viva with 2-3 scenarios. Whilst it does focus on the operative detail it will often revolve around clinical scenarios. Candidates may be asked which operative technique they wish to use and should be able to justify it. They should be aware of the relative issues and shortcomings of the various operations.

Clinical Imaging and Management Viva.
This exam was previously the Urology Viva but now tends to encompass more.
It is a 25 minute viva which looks at the investigations we use in our normal clinical practice. It is expected that the candidate be able to understand and explain what the various investigations they use are , their limitations and benefits.
This exam is not just limited to radiology but may include other modailitie such as manometry, urodynamics and impedence studies as well as histopathology. The candidates are asked question based around a clinical scenario and the candidate takes the examiners through explaining the role of investigations in the case in question. Typically there are 2-3 scenarios discussed in the twenty five minutes.

Observers are becoming more common in the various examinations. Their role is not to exam the candidate but rather may be to assess the quality and process of the exam, examine the examiner or to learn from the process.
It is hoped that local supervisors of training avail themselves of the ability to observe so that they may better understand the examination and be able to guide their trainees appropriately.

Mr Guy Henry, Senior Examiner

New-look RACS website and Portfolio

The RACS website at www.surgeons.org has been updated with an exciting new look. This transformation makes it easier to use the RACS website and navigate on smart phones and tablets. The content of the website and pages remain unchanged but the refresh has received many positive comments.

Read more on the College Website or log in at https://portfolio.surgeons.org.

CLEAR for Consultants 2016

RACS is pleased to announce CLEAR for Consultants in 2016. This Fellows-only course will be held at the College in Melbourne on 11-12 November 2016. The course will concentrate on topics such as: running a journal club, supervision of Trainee research and application of evidence in practice. Participants will be able to brush up on their epidemiology and research skills with Fellow peers and mentors, earn CPD points and are invited to the complimentary course dinner.

For further information and to enrol please see the CLEAR Course for Consultants webpage.

Upcoming Meetings and Conferences

2-6 May 2016
RACS ASC & ANZAPS ASM
Brisbane

3 May 2016
ANZAPS AGM
Brisbane

23 September 2016
5th Annual Percy Pease Symposium
Wellington

15-17 October 2016
Registrar Annual Training Seminar (RATS)
Melbourne

18-20 October 2016
Colorectal Course
Melbourne

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