Mr Jules Dussek

"As it was, Is Now and Never Shall Be"

AS IT WAS:

I entered Guys Hospital medical school at the age of 17 with the intention of being a forensic pathologist but it only took a few minutes in the dissecting room for me to give up that ambition. The first student firm that I was on was partly general surgery and partly working for Mr Brain, a thoracic surgeon and I fell in love with the specialty then. Later I was a student on Lord Brock’s firm. After qualification I did my general surgery in Birmingham. My cardiothoracic training was at the National Heart Hospital, Guy’s Hospital, St. Thomas’ Hospital, and the Brook Hospital. Amongst my trainers were John Parker and Magdi Yacoub (now Professor Sir Magdi,) at Guy’s Robert Brain, Donald Ross and Alan Yates and at the Brook Brian Moore. At St Thomas I worked for Bryn Williams and Mark Braimbridge. Nearly all of these performed both thoracic and cardiac surgery.

This picture shows Mr Brain (left) Mr Ross (right) and Mr Yates all looking quite happy. The location was Lord Brock’s memorial service at Southwark Cathedral. This is a picture of Lord Brock himself after hearing a particularly funny joke.

Brock had a brilliant mind and was a phenomenal pioneer, but he was an absolute tyrant and it took little to upset him. For example, a junior doctor who asked whether a patient would benefit from surgery would receive a tirade telling him that surgery dated back as long as history and included the Incas performing burr holes, the Great War surgeons of the Middle Ages, people like Hunter and Pare, and of course all the modern developments in the specialty which included the pre-operative assessment, operative management, post-operative care, research and development. He would culminate by demanding in a ferocious voice why, if the whole of civilisation had benefited from surgery should this patient be an exception?

Although my experience as a trainee was fantastic the hours were long. Mr Brain’s houseman, a good friend of mine, only left the hospital once in six months and that was to have a haircut. Another houseman shattered Mr Brain with the request for a couple of hours off on a Sunday to see his wife as she had had a baby a few days earlier. He finally acceded to this request on condition that it was two hours no longer. Later, when I was the cardiothoracic SHO a one in two rota was common as was a working week of nearly 120 hours.
They were however great days for training and I was fortunate in being able to perform a large amount of operating unsupervised. I remember the first double valve replacement I ever did was on a Saturday afternoon with no consultant available. The perfusionists were a great help though!

IS NOW:

By ‘Now’ I mean the last decade. I became a consultant in 1980 but the real changes have occurred over the last ten years. They are:

• The advent of Hospital Trusts
• Calman surgical training
• The New Deal on Junior Hospital Doctors hours of work

I don’t think anyone really appreciated the significance of the introduction of trusts for some while. This was one of the biggest changes in the history of the NHS in that it took control of hospitals out of the hands of the doctors and put it into the hands of administrators; in particular the Chief Executive who is directly responsible to the Department of Health and, I suppose, the Secretary of State for Health. Doctors no longer have control of their hospitals. The Calman training programme has received a lot of criticism. (This is a training scheme named after the then Chief Medical Officer. Instead of doing a period as registrar and then applying for and being competitively appointed to a post of Senior Registrar, all for a variable length of time, now trainees are appointed to a fixed six year training programme at the end of which they have to get a Consultant post or become unemployed.) Probably the most significant criticism relates to the fact that once someone is appointed to the training programme it is difficult to get them off the programme if their performance is not satisfactory. This should be soluble and a structured programme for six years must be better than the old ad hoc system. The problem here is that Calman came in at almost the same time as the New Deal. (The New Deal is a term used to describe arrangements brought in to shorten the working hours of junior doctors.) While the hours that I worked as a trainee are clearly unsatisfactory these days, the down side of the new arrangement is that trainees have their training diluted to the point where many trainees now feel that their experience is insufficient for them to take up a consultant post. I do not think that it is the Calman system itself that is at fault, it is the reduced experience that is causing a problem. The answer must be to develop better teaching methods or to extend the length of training. This system has however thrown a considerable strain upon consultants. As one said ‘when I was a trainee I spent most of my time trying to keep my boss happy, now as a consultant I spend most of my time trying to keep my trainees satisfied.’

BUT THEN CAME BRISTOL
By “Bristol” I mean the GMC (General Medical Council) enquiry into paediatric cardiac surgery at Bristol Royal Infirmary. (It had transpired that in the late 1980s and early 90’s that there appeared to be an excessive mortality in paediatric heart surgery at Bristol Royal Infirmary. The GMC held a show trial. The Chief Executive and Medical Director were struck off the medical register and one surgeon was banned from operating on children for 3 years.)

This was to have a massive effect on the medical profession in the United Kingdom. A very expensive public inquiry has been set up and is still yet to report. The government has jumped on the doctor bashing bandwagon and is supported by the press.

These are just a few randomly collected newspaper headlines from the post Bristol days, starting with the sensational cover of the British Medical Journal.

The cardboard shoe box as a coffin was invented on the spur of the moment by the Action Group representing the parents of the deceased children and certainly caught the imagination of the press.

The following pictures conjure up a flavour of the ensuing atmosphere within the British media.

Note the use of the word “Anger” as surgeon is cleared

And just as we had recovered from all this along came Dr Shipman!

The Government was very unhappy to take the blame for all this and wished to devolve their responsibility.

I see that chain of responsibility as being:

• The Government
The GMC responded by writing to the Senate of the four Royal Colleges of Surgeons asking for their response. Tony Giddings on behalf of the Federation of Surgical Specialists Association wrote an excellent response which I recommend you to read. One of the outcomes was that each specialty was asked to monitor standards and this Society has chosen specific marker operations which are monitored each year. They are, as you know, first time CABG’s, lobectomies for primary lung cancer and in paediatrics, uncomplicated VSD's and uncomplicated coarctations. In this we are light years ahead of any other specialty.

AND NEVER SHALL BE:

What it will not be:

• Consultant equality
• Public Trust
• Jobs for Life

Consultant Equality

It used to be accepted that all consultants were equal and it was almost unheard of for one to ask another for assistance. With the new Calman trainees coming through and given that the learning curve is a thing of the past it is inevitable that the new consultants will wish to work with their more senior colleagues. And again, the Senate of Surgery has produced a document entitled Team Working. This does not relate to conventional teams, consultant, registrar, house officer, nurses, physiotherapists and others. but to consultants working alongside each other, scrubbed for the same case. For many perhaps this is nothing new, in fact it is not unusual for me for example on different occasions to operate with an upper G I. Surgeon, a head and neck surgeon, a sarcoma surgeon or a plastic surgeon. What is new perhaps is the implication that there may be junior consultants who will require senior colleagues to assist them. Again this is already happening, especially in paediatric cardiac surgery. I am sure that this is the way things are going to go in the future but it is bad news for the trainees as more and more consultants work together. Furthermore, the implication of this is that it will take up more consultant time. This may even expedite a two tier level of consultants, with junior consultants and senior consultants.
Public Trust

I have already shown how we have been treated by the media and it is going to take a long time to regain public trust. Just as we were getting there, along came Dr Shipman and now the public thinks we are all potential mass murderers. (Dr Shipman was a family practitioner in Manchester who at the time of the lecture was found guilty of murdering a few patients, little were we to know that he has probably murdered several hundred).

I do not think we will ever regain the status that we once enjoyed. Furthermore, we will now have to spend much more time obtaining consent for operations to allay any distrust.

The GMC has responded to this situation by producing a document entitled, "Supporting Doctors, Protecting Patients"

The one thing that this document does not do is support doctors. There would be three steps to the process for handling doctors with problems. When a problem was perceived at local level, an initial review would be taken as to which of four new categories it fell into. Doubts or concerns about clinical performance would lead to referral to an assessment and support centre, a new body that is described below.

Note the words, doubts or concerns. We as a Society have had enormous problems in attempting to define what is poor performance and I am horrified to think that even doubts might lead to a surgeon being referred to one of these centres. Let me quote:

Assessment and support centres (a number around England) run jointly by the NHS and the medical profession would provide both impartial support to the local employer by advising on the action to be taken care and an environment supportive of the doctor undergoing assessment. Each would have a medical director and a board of governors with a lay chairman. There would be strong lay participation in the assessment process. Closer liaison with the GMC would be essential to ensure that cases which should be dealt with by the GMC are referred without delay.

The concept that lay people are going to assess doctors concerning their performance is frankly petrifying, worse is to come.
the details of how the centres will operate will have to be worked out in consultation with interested parties but it is intended that referral would not carry any public stigma. Who are they kidding?

Jobs for life

It has always worried the government that once a consultant is appointed to his position he will remain there until he retires unless he does something awful. I have no doubt that steps will be introduced to monitor consultant performance and to enable substandard consultants to be removed. The GMC intends to introduce a process of a revalidation, and I would anticipate that this would mean consultants being assessed about once every five years. I do not think this is unreasonable, it already happens in other parts of the world but I would like to see a mandatory pay rise linked to each successful revalidation.

I think there could be real problems though for surgeons who have just completed the Calman training programme. It would not surprise me if Trusts were to appoint surgeons at the end of their training to posts for a limited period of time. It’s quite possible they would not be called consultants and in fact the Department of Health does not like that term anyway, the word consultant rarely features in modern documents. They might be appointed as specialists, perhaps only for a limited period of time, perhaps for five years. This could be a pure service contract with a fixed number of procedures to be carried out with no regard to teaching, development of the service etc. It is appealing to the trusts who would obtain highly motivated surgeons keen to prove themselves, but I think a disaster for the profession.

This all looks very gloomy,

BUT

Recently I was clearing some shelves in my office and came across the minute book of our Society. Brock I think was the secretary. The date of the first entry is 1952.
I have abstracted some of the statements from that book.

*before embarking on a higher apprenticeship a post must be held in general surgery so that operative experience may be gained in visceral surgery for a period of not less than 12 months.* nothing new in that.

In fact most Europeans are very keen on the term visceral surgery and wish to make it mandatory for the first two years of training.

Next, it was agreed that the number of senior registrar posts should bear relation to the number of consultant posts likely to fall vacant. This was October 1953. We are still striving for this and I am not sure whether we are doing any better now than 50 years ago.

Now follows one of the most interesting statements.

*Some discussion then followed on the possibility of the establishment of junior consultant posts. No resolution was passed on this matter, but it was agreed it should not be suggested in the report.*

This was October 1953. Dynamite then, dynamite now.

In March 1958 we see *consideration of how to set about preparing a report on the ideal structure of a thoracic surgical unit.* it seems that the minutes of the 1950s could be transcribed straight in to our minutes now.

Look at this quote, *First and foremost we must, as a profession, become more carcinoma-minded* in regard to the lungs. We are carcinoma minded in regard to the breast, and so is the general public. We are less so in the case of the abdominal viscera, but far more so than in the case
of the lungs. Absolutely true, no one would argue with that. But who said it and when? The answer is: R C Brock, British Medical Journal, August 28, 1943

And here he is as president of the Royal College of surgeons with as you see a cast of the bronchial tree he had made himself, a true cardiothoracic surgeon.

And now they are talking of bringing back Matron.

Which leads one to think:

"Plus ca change, plus c'est la meme chose", Alphonse Karr (1808-1890)

Or is it?

Last revised May-01-2001

Revised by Bruce E. Keogh.

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