

SCTS Annual Meeting

***Including SCTS Ionescu University
& Cardiothoracic Forum***

Double European Award for Pulmonary Hypertension

21st Birmingham General Thoracic Surgery Conference

Teamwork makes dream work

Patient Safety Symposium

Surgical Intervention in N2-NSCLC

RCSE President's Meeting

Smoking Petition

Patrick Magee Medal - call for Abstracts

the bulletin



Society for Cardiothoracic Surgery
in Great Britain and Ireland

December 2013

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Report from The President

James Roxburgh



"Information is not knowledge"

Albert Einstein

My new 27" iMac contains nearly 1 Terabyte of information and although it is truly impressive not even Steve Jobs would have claimed it was knowledgeable.

Knowledge is defined by the Oxford English Dictionary as: *facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject.*

The information on outcomes and performance that Trusts are receiving is increasing in both volume and complexity. Since the Francis Report and the "Everyone Counts Initiative" this data is being looked at in a very challenging environment but with the assumption that Trusts have the knowledge to interpret it. Although HQIP and the Professional Societies are "front men" for the publication of this data they do it at the behest of NHS England and thus responsibility ultimately lies with the Secretary of State for Health. So what is this responsibility? The easy answer is that NHS England must ensure that Trusts have the knowledge to handle this data but this begs the much more difficult question as to how to do it. SCTS has been in discussions with the Professor Norman Williams, President RCS England, and we both agree that this should be done by the the College in conjunction with the Specialist Associations.

The responsibility for this information ultimately lies with the Secretary of State for Health

Pilot

I am very pleased to announce that the College have agreed to fund a pilot scheme with SCTS to provide structured support to Trusts whose results diverge from the normal. At the time of writing the details of the scheme have not been finalised but it is hoped that an outline will have been presented to the Board of Representatives meeting in December. However what is certain that it will not be an off-site case note review, a practice that SCTS and the College has to a large extent abandoned, and is more likely to be a one day visit by 1 or 2 surgeons to help the unit examine the issues themselves. Perhaps more importantly I see this process as one that a surgeon could invoke if they have concerns about the internal analysis or interpretation of their data. It is right and proper that the outcomes of surgery are published and the politicians are understandably pleased with the plaudits they have received. However if this is to develop into a series of mature and truly informative audit publications

then it must be understood that it is wrong to simply publish ever increasing volumes of data. We must ensure that the data is interpreted by those with sufficient knowledge and it is acted upon in a mature and responsible manner.

Everyone Counts

Thoracic surgery is now to be included in the "Everyone Counts program" and although this is earlier than we expected it was always going to happen. I also think that in years to come data on other thoracic procedures apart from lung cancer will be included. This is the direction of travel that is expected by the other surgical specialities and it will focus on outcome measures apart from death. It is therefore vitally important that thoracic surgeons own their data and take control of the programme so that thoracic surgeons are central to their presentation of their outcome data. It was for this reason that the online Dendrite thoracic database has been made freely available to all thoracic surgeons. This was launched last year with a £50,000 grant from the GMC and since it is internet based requires no software installation or support from Trusts. This has been available for 9 months and to date only 4 units have submitted data. Many other surgical specialities are struggling to collect data and lack of a centralised database is one of their major concerns. Richard Page will be writing to each unit to ensure everyone can access the data entry portal and if there are any IT or management issues that are preventing surgeons entering the data. If there are we will do all we can to help you deal with them. This is the the new NHS and simply ignoring it will not make it go away.

In this Bulletin there are the obituaries of three surgeons who have all made significant contributions to cardiac and thoracic surgery and who between them have trained many of the consultants in practice today. Jim Monro, Graham Venn and Frank Collins will be sorely missed.

The fund-raising programme is, at last, bearing fruit and we have already expanded the support for the annual meeting as well developed new relationships with international companies to further develop our educational programme. We have also made applications to several major Charitable Trusts and Foundations but these are a longer term investments of our time and energies but I am sure they will bear fruit in the long term.

Thanks

This is my final Bulletin before I finish my term as President and I would like to thank the two Honorary Secretaries, Graham Cooper and Simon Kendall for all their help and advice over the last few years. It goes without saying that none of this would be possible without Isabelle and Tilly's tireless work throughout the year. Finally congratulations, in advance, to Vipin for another excellent Bulletin.

Honorary Secretary's Report

Simon Kendall



Cardiac and Thoracic Surgery - Can we do both?

Before you start reading this I need to declare a U-turn.

There's something slightly over zealous about the reformed smoker or the born again religious enthusiast.

And having been a strong defender of mixed cardiac and thoracic practice I acknowledge that my change of opinion may cause annoyance, amusement or even both.

However I perceive there's a change in momentum in our specialty and I thought I would use this article to share some news, add some opinion and then try and put in some context.

In the beginning...

As a generalisation thoracic surgery developed alongside the treatment of tuberculosis. Before effective medication sanatoriums were built on the outskirts of the metropolis' where patients could get 'fresh air', rest and a better diet. Papworth, Harefield, Killingbeck, Frenchay, Hairmyres, Broad Green to name a few. These patients often needed surgery for their complications of pulmonary TB and hence surgeons gained experience of thoracic surgery in these centres.

In the cities themselves the general surgeon who had a gastric / oesophageal practice would often make the natural progression to operating on other pathology in the chest having established the team and the techniques to operate in the thorax.

Then there was mass production cardiac surgery...

The development of reliable cardiopulmonary bypass across the pond in the 1960's led to an explosion of this sub specialty. Not only was there the ability to operate on young children with congenital defects but also adults with valve disease and ischaemic heart disease. With cardiac transplantation appearing in the headlines alongside lunar landings this was the exciting place to be, accompanied by the attraction of a significant private practice - and poor Thoracic surgery became the Cinderella specialty.

Mixed Practice Surgery - Cardiothoracic

And hence the reason why the UK has a history of mixed practice surgery - the surgeons, their teams and their theatres were generally in established thoracic surgical centres and it was these centres that adopted cardiac surgery. Initially throughput

was low - a cardiac operation would take all day particularly before safe bypass when patients required cooling in ice baths. The cardiac operation was more challenging and put first on the list - and when possible the more banal thoracic case put at the end of the list. This practice has had a profound effect on thoracic surgeons who have witnessed it done badly - what they saw was the cardiac case being done by the consultant who would then leave a registrar of varied ability to do the thoracic case to a varying standard. Apparently these patients were getting a second class service and is one of many reasons thoracic surgeons are prejudiced against mixed practice.

Having been a strong defender of mixed cardiac and thoracic practice I acknowledge that my change of opinion may cause annoyance, amusement or even both

The Nadir for Thoracic Surgery

The high profile, challenge and potential private practice in cardiac attracted the attention of most surgeons. Very few decided that Thoracic surgery was sufficient alone - perhaps a handful were dedicated to the cause, but others were either the more 'elderly' surgeons who had no appetite for learning all the new techniques required for cardiac or the younger surgeons who weren't able to master the new skills required. This latter group was really quite stigmatising for thoracic surgery in that it became the place to go if you weren't able to do cardiac surgery.

This crisis for thoracic surgery was fully recognised in the 1990s - Peter Goldstraw and colleagues set about saving the specialty. Like any 'minority' group it was not going to be easy - it would take a variety of tactics, some soft and some a little strong!

Changing Practice

There are three relatively recent major changes to Cardiothoracic Surgery that make mixed practice extremely difficult to continue - MDTs, minimally invasive surgery and knowledge base.

MDTs were originally the domain of cancer surgery - in order to iron out the inequalities of access and quality of care a rigid

continued on next page

Honorary Secretary's Report *continued*

framework was established so that every case of cancer is discussed in a multi professional / modality group. These meetings are significantly time consuming - only 15% or so of lung cancers undergo resection - and now the thoracic surgeon is expected to sit through the discussions of the other 85%. The mixed practice surgeon - already super busy with the pressures of cancer breeches and target waiting times for cardiac surgery - found their time being spent in long MDTs and spending a little less time in theatre.

Now the fashion for MDTs has passed on to cardiac surgery - the revasc MDT, the TAVI MDT and the Mitral MDT.

There really aren't enough hours in the working week to do a large mixed practice clinic, do two full days operating and attend the relevant MDTs. There are clearly some gifted colleagues who are achieving this balance and their clinical outcomes are good. But even then there is an undercurrent that isn't articulated - and that is the cardiologists tend to identify with the cardiac surgeon and the chest physicians tend to align themselves to the pure thoracic surgeon - and so the mixed practice surgeon runs around extremely busy but not being particularly appreciated by their physician colleagues, possibly acting in a 'sweeper' role picking up the scraps.

Minimally invasive surgery has also come along - Bill Walker (mixed practice of course) has pioneered minimal invasive lung resection which is now being widely adopted and applied to other procedures such as thymectomy. Minimal access aortic surgery is becoming much more accepted as well as the more challenging minimal access mitral surgery. All of these procedures need extra training and expertise - the portfolio of the specialty has significantly increased and it is evident that individuals cannot deliver it all anymore.

The knowledge base has increased exorbitantly - to maintain CPD in both specialties is a major challenge. It is important to try and appear equal to your 'pure' colleagues who only have half the knowledge to maintain.

Direction of Travel - SCTS, SAC, CRG and Intercollegiate Exam Board.

The **SCTS** is asked by the Royal College of Surgeons to review the job plans of all consultant appointments. This was expertly done by Graham Venn and has now been devolved to the relevant sub committees - and if a mixed practice job is submitted we co-ordinate the response with those sub committees. Their job is to ensure the job plan is deliverable, there is a reasonable balance of theatre time, clinics and MDTs - and of course adequate SPA time. There have been several jobs processed in the last few months - only one proposed to be a mixed practice job but it was clear that the job plan was not sustainable with no lung MDT included.

The **SAC** is trying to train colleagues who are 'fit for purpose'. Currently we are not training enough thoracic surgeons and several recent consultant appointments have had few if any UK trainees applying. The SAC is now accepting bids for 2014 national selection to include thoracic themed training - 4.5 years thoracic and 1.5 years basic cardiac competencies. Part of this is

driven by the realisation that very few trainees are achieving adequate exposure to the full range of cardiac and thoracic surgery in their training.

The new commissioning groups for Thoracic and Cardiac surgery are in the final stages of writing their service specifications - chaired by Richard Page and Danny Keenan respectively. Like the SCTS they are struggling to see how a mixed practice surgeon can deliver the time and expertise to both sub specialties. They are suggesting that there should be no new / replacement mixed practice jobs advertised - and that any existing mixed practice jobs might become a 50:50 split between the two.

And the **exam board** chaired by Jon Anderson (mixed practice) is currently looking to reform the specialist FRCS C/Th exam - and that candidates do a written exam in the generality of the specialty and then they can opt to do either the cardiac or thoracic clinical module - or both if they wish to. The final qualification would still be the same.

For many colleagues this article will not raise their pulse - they will be cardiac surgeons (147), thoracic surgeons (66) or congenital surgeons (32). It will be of interest to the 60 or so mixed practice surgeons, and trainees who thought they might like a mixed practice job. It will also be of interest to the 20 or so units (out of 43) who have mixed practice surgeons, and how it might affect their service as these changes come through.

It is particularly challenging for the 'spoke' units such as Basildon, Stoke, Blackpool, Middlesbrough where the smaller number of surgeons make a split rota more difficult. And there is a balance between local delivery of healthcare and specialisation - how far should a patient with a stage 1 lung cancer travel for their lung resection or their aortic valve replacement?

Is there a need to maintain full rotas at every unit in both cardiac and thoracic surgery? We will need to review the incidence of emergency thoracic surgery - and whether it can be managed by the on call cardiac team?

As I said at the beginning - I apologise for being a convert to the 'pure' model. As a mixed practice surgeon I could recognise I was falling behind the standards of my colleagues in thoracic and cardiac surgery. And in my roles on the SAC, SCTS and exam it is clear how the specialty is changing.

We have many colleagues with a mixed practice working extremely hard delivering good outcomes. They and their trusts will have to decide whether to adopt the 50:50 split recommended by the CRGs and in the meantime it will be worth teams and individuals reflecting whether they are delivering the service in the most optimal way - not only for their patients but also for their own professional fulfilment.

I would welcome any feedback/comments which I will share with the CRGs, SAC, and the examination Board. My email address is: simon.kendall@nhs.net

Double European Award for research into pulmonary hypertension

Mahmoud Loubani
 Consultant Cardiothoracic
 Surgeon/Honorary Clinical
 Senior Lecturer

A Cardiothoracic Research Fellow at Castle Hill Hospital in Cottingham was awarded the Young Investigator Award at the European Association for Cardiothoracic Surgery (EACTS) annual conference in Vienna last month for an unprecedented second year in a row.

Priyad Ariyaratnam, who is undertaking his Medical Doctorate in Hull and York Medical School, is part of a group of healthcare professionals including surgeons led by Mr Mahmoud Loubani, respiratory physicians led by Professor Alyn Morice and perfusionist Rob Bennett looking at the effect of certain stimulants upon the pulmonary circulation.

Acute rises in pulmonary artery pressures following cardiopulmonary bypass remain a thorn in the side of cardiac surgeons and intensivists alike as it is a very difficult entity to manage and carries a significant morbidity and mortality burden. Surprisingly, little is known about the mechanisms by which this phenomenon occurs.

Ischaemia-reperfusion injury has become the trendy area of investigation to explain much of the pathophysiology surrounding cardiac surgery. Despite this, the contribution of ischaemia-reperfusion to pulmonary abnormalities has received considerable less attention. Moreover, as well as a reperfusion element from the re-establishment of the pulmonary circulation after cardiopulmonary bypass, there is the added element of re-oxygenation as ventilation is returned to the hitherto quiescent lung.

Other conditions such as temperature, are also known to affect the tone of systemic arteries in animal models but this not been studied in human models nor its effects discerned in the pulmonary circulation. However, there have been clinical reports that deep hypothermia causes pulmonary hypertension upon re-warming.

Priyad has looked at the contribution of hypoxia-reoxygenation and hyperoxic reperfusion not only in isolated human pulmonary arteries but also isolated perfused human lung models utilising lungs resected from patients with bronchial carcinoma. Further to this, he investigated the role that deep hypothermia and re-warming have on pulmonary artery pressures.

These studies have shown that hyperoxic vasoconstriction of pulmonary arteries appears to be dependent on both extracellular calcium influx and intracellular calcium release from the sarcoplasmic reticulum. Deep hypothermia at 17°C reduced the responsiveness of pulmonary arteries to various stimulants compared to arteries maintained at 37°C. However, from the isolated perfused lung models, neither hypoxia nor hyperoxia in the ventilator or perfusate translated into any significant changes in pulmonary artery pressures. At deep

hypothermia, pulmonary artery pressures were unresponsive with stimulation whereas re-warming caused a reactivation of the stimulatory pathways.

Their results, whilst showing that hypoxia-reoxygenation affects the tone of pulmonary arteries in isolation, demonstrate that there appears to be compensatory mechanisms at the whole lung level to cushion these changes.

Their models may also be of considerable value for those involved in ex-vivo lung perfusion in transplantation as it demonstrates that varying the conditions of human lungs in an ex-vivo environment has varying physiological effects at both the tissue and organ level which may influence donor lung optimisation prior to transplantation.

Mr Mahmoud Loubani



Mr Priyad Ariyaratnam receiving the second Young Investigator Award at the Presidential Dinner in Vienna, October 2013



SCTS Annual Meeting 2014

Ian Wilson

SCTS Ionescu University and SCTS Annual Meeting

The 2014 meeting in Edinburgh marks the 80th Anniversary of the SCTS and we are pleased to announce that the event is packed with world-class international and national guests, which alongside renowned Celtic conviviality will ensure a memorable celebration of this important landmark.

The dates of the SCTS University and Annual Meeting required alteration due to scheduling of the Scotland vs France Six Nations Rugby on the proposed weekend of the event. The Edinburgh International Conference Centre (EICC) accommodated movement of the meeting to allow:

- * The SCTS University to take place on **Monday 10th March 2014**
- * The Annual Meeting to take place on **Tuesday 11th March and Wednesday 12th March 2014**

The Main Meeting will close by 14:00 on the Wednesday allowing participants to return home on the Wednesday afternoon/evening.

Edinburgh has good flight connections, and rail access, ensuring easy travel arrangements. The International Conference Centre is situated in the centre of the city with all grades of hotel facilities within easy reach. Full details are available via links on the SCTS website.

The quality of the educational content of the meeting looks extremely high, and in combination with a wonderful venue for the Annual Dinner, alongside the Scottish ambience, we are sure that the meeting will be a blend of vibrant learning and hospitality.

The SCTS University continues to evolve; maximising the availability of this educational resource in the UK. The SCTS University was launched in 2010 and has developed into a national cardiothoracic surgical educational forum, which is at the heart of the Society's initiative to improve the life-long learning opportunities made available to members. The Society's focus on quality and education is a strategy that has placed cardiothoracic surgery at the forefront of UK health care development and delivery.

Mr Marian Ionescu a pioneering cardiac surgeon in Leeds from 1966-1987, dedicated his life to cardiac surgical innovation and education. His achievements are numerous and include the creation and development of the pericardial heart valve; an innovation that proved to be a major, sustained advance in heart valve surgery. Current day clinical practice continues to be influenced by Mr Ionescu's pioneering work in Leeds, with the



pericardial heart valve used in both heart valve surgery and transcatheter aortic valve implantation around the world. His inspirational life's work led him to create **the Marian and Christina Ionescu Travelling Scholarships** from which many society members have benefited in developing sub-specialty interests in surgical practice over the last decade.

Mr Ionescu's national and international reputation in cardiothoracic surgery, alongside his devotion to advancing clinical cardiothoracic surgery and surgical education in the UK, mirror the ambitions of the society in its current development. In recognition of his enormous contribution to UK cardiothoracic surgery the SCTS has decided to add the Ionescu name to the SCTS University to reflect the motivation of his work. The Edinburgh meeting will host the inaugural SCTS Ionescu University. We are inspired by his contribution to the specialty and the University project is honoured to be associated with his name.

The programme of the SCTS Ionescu University is strong and will include many US and European guest speakers. These world authorities in their field of subspecialty practices include, Professor Jim Cox, Professor Hazim Safi, Professor David Adams, Professor John Elefteriades, Professor Otto Dapunt, Professor Philippe Kohl, Professor Felix Herth, Professor Gilbert Massard, Professor Pierre-Emmanuel Falcoz, Professor Philippe Dartevelle, Professor Dirk Van Raemdonck, Dr Helmut Isringhaus, and Professor Henrik Hansen.

The Educational Streams:

- A Masterclass in Atrial Fibrillation Surgery
- Contemporary Aortic Surgery
- State of the Art Mitral Valve Surgery
- Coronary Artery Surgery: The Evidence behind Decision Making
- Simulation in Thoracic Surgery
- Multispecialty Thoracic Surgery
- Innovations in Thoracic Surgery
- Advances in Management of Sepsis in Thoracic Surgery

SCTS Annual Meeting 2014

Lunch Box Sessions:

- Complex Wound Healing: Prophylaxis and Treatment
- Haemostatic Adjuncts: Understanding the Options
- Advances in Management of Chest Wall trauma
- TAVI Surgery
- Advances in Management of Emphysema
- Minimal Access Mitral Valve Surgery
- Minimal Access Aortic Valve Surgery

All Educational Streams and Lunch Box sessions will be recorded and made available through the SCTS Ionescu Library, to attendees of the SCTS Ionescu University.

In addition to this wealth of opportunity, a session has been established using the **Orpheus Perfusion Simulator**. These 90 minute sessions can be booked on the Registration software, and participants will also be able to attend the remaining components of the Educational Streams and Lunch Box sessions that do not run synchronously with the Orpheus Perfusion workshop to which they are assigned.

On completion of the SCTS Ionescu University the Exhibition Hall will open; canapés and drinks will be available with all stands open to allow interaction with the corporate groups that provide such fantastic support for our event. This will be a great opportunity to reinforce the education of the day, with corporate groups specifically designing stands to facilitate the spread of knowledge, and also to network with colleagues and acquaintances. The corporate support for the SCTS Ionescu University represents a considerable investment in cardiothoracic education in the UK; we are indebted to them for their commitment to our specialty.

Over 350 abstracts were submitted for the 2014 meeting; the scoring of these abstracts was accomplished with timely efficiency and the organisers are appreciative of the time and efforts of all those involved.

The SCTS Annual Meeting starts at 08:00 on Tuesday 11th 2014. Highlights include the Tudor Edwards Lecture by Professor Peter Goldstraw, the Heart Research UK Lecture delivered by Professor David Adams, and a Key Note Address by Jim Cox. James Roxburgh will deliver a Presidential Address on Tuesday immediately before lunch.

The Edinburgh meeting will be the inaugural association of the BTS and BTOG group with the SCTS meeting, and furthers the multidisciplinary collaboration that is fundamental to current day practice.

A Surgical Training session has been designed by Marjan Jahangiri which will be explore fundamental issues within contemporary training; this session takes place on Tuesday afternoon, whilst the Trainees Meeting will occur on Monday evening after the SCTS Ionescu University.

Thoracic Movie and Cardiac Movie sessions on Tuesday evening will allow attendees to interact with the enormously experienced international faculty, who chair the sessions. These sessions will be highly interactive and informative.



Society for Cardiothoracic Surgery
in Great Britain and Ireland
80th Anniversary • 1934-2014

10-12 March
2014

Edinburgh
International Conference Centre

The AORTA Journal is supporting a **“The Great Debate”** in the Aortic Surgery sessions on Wednesday morning: **“Motor evoked potentials in surgery of the descending aorta – need to monitor or not?”** This debate will include Professors John Elefteriades, Hazim Safi, Marc Schepens, Mr Aung Oo, and Dr Michael Desmond. This will be a fabulous educational experience with a truly world-class faculty.

The Royal College of Surgeons Safer Operative Surgery workshop is scheduled for Wednesday morning, designed for surgeons, anaesthetists, nurses and operating theatre personnel of all grades. This interactive multidisciplinary format explores the non-technical skills and other human factors which are related to safe surgical practice.

The Cardiothoracic Forum is once again a very strong programme and offers a chance to interact in this important series of sessions.

Team building is an important component of any group and the 2014 meeting includes the Inaugural 5-a-side Football tournament, which is planned for Sunday afternoon; those wishing to participate should contact Dincer Aktuerk; dinceraktuerk@gmail.com

If this event proves popular other opportunities can be explored. Those members with ideas should put these proposals forward for consideration. We thought that Beach Volley Ball on a March afternoon in Edinburgh would probably not work, but this remains a possibility for future years.

The Annual Dinner will be a Black Tie event with a strong Scottish theme; flame-throwers, bagpipes, sword dancing and an “Address to the Haggis”. It will be an evening of fine dining and entertainment; all topped off with an 80th Anniversary Cake.

The Annual Business Meeting will be on Tuesday evening at 17:15, and the Board of Representatives meeting will be at 13:30 on Wednesday afternoon. Full details of the programme can be accessed via the SCTS website.

Isabelle Ferner, and Tilly Mitchell have performed an enormous amount of work organising this event, alongside considerable contributions from Christina Bannister and Jonathan Hyde. As the organising group we hope that you will join us in Edinburgh to make this special occasion particularly memorable.

Nursing Report

Christina Bannister
SCTS Nursing & Allied
Health Professional
Representative

Cardiothoracic Forum

@ the SCTS Annual Meeting - Edinburgh March 2014

Plans for next years' CT Forum at the Annual Meeting in the International Conference Centre in Edinburgh are going well. The Meeting is planned for Tuesday 11th to Wednesday 12th 2014. I have had a large number of abstracts entered for the CT Forum this year and have accepted 25 for presentation. Congratulations to all who submitted an abstract that was accepted. I look forward to seeing the presentations in March.

The CT Forum has five sessions this year spread over the two days in Edinburgh. Our first session, planned for Tuesday 11th March is based on general cardiac issues, with some presentations looking at the principles of pre-assessment, nurse prescribing and transplant donor choice consent processes.

Following a joint plenary session with the main meeting, I have a CT Forum session with **Andrea Spyropoulos**, the President of the RCN, giving the opening remarks. The main plenary speeches are to be followed by the general thoracic session with six presentations.

I plan to finish off the day with a session updating the Cardiac Advanced Life Support Course (CALS). I have three presentations and an update from Joel Dunning with regards to current practices in cardiac advanced life support and changes in the protocols.

The sessions comprising Wednesday 12th CT Forum are based on **Advanced Nurse Practitioner (ANP), Surgical Care Practitioner (SCP) and Physician Assistant (PA) working practices**. Our first session has an international perspective with plenary talks from David Lizotte, the President of the Association of Physician Assistants in Cardiovascular Surgery (APACVS) in the USA; and Professor Marcus Hoffmann, programme director of the Physician Assistant programme at the DHBW University, Karlsruhe, Germany.

This session is to be followed by a presentation by Maureen Jersby, senior lecturer in adult nursing at the University of Teesside, who will give an update in the future developments in relation to Surgical Care Practitioner education. Discussions around the new updated SCP curriculum will continue with participation from senior members of the SCTS Executive and Sam Nashef, lead surgeon for the SCP Cardiothoracic exam, who have been in consultation with the Royal College of Surgeons. I hope this will be an exciting session with plenty of opportunity for discussion from participants.



Our final session on Wednesday lunchtime looks in-depth at working practices in cardiothoracic theatres with a focus on surgical site infections and cardiothoracic wound management, with presentations examining all aspects of enhanced roles.

I look forward to meeting all participants at the CT Forum from a wide range of backgrounds; from nurses, medical staff, surgical care practitioners, physiotherapists, physician assistants and other allied health professionals across the country. I would like to thank all the plenary speakers, chairs, presenters and participants in advance without whom the CT Forum could not exist. Not only do we all learn from others at the Forum but the networking and shared working practice information that we all get is invaluable. I urge you all to encourage your colleagues in nursing and allied health professional specialities to attend next year's forum in Edinburgh.

Nursing Report *continued*

Other news from Nursing and Allied Health Professionals

The next SCTS Advanced Cardiothoracic Course will take place again at Heartlands Hospital, Birmingham with the continued format of one thoracic day followed by a cardiac day. This is an excellent course and we recommend nurses and allied health professionals to attend. The course is planned to run on the 21st and 22nd February 2014 and places can be booked via Tilly Mitchell at the SCTS on tilly@scts.org

Joint RCS & SCTS Cardiothoracic Advanced Examination

Work continues around this venture with the establishment of a syllabus, examination and Q&A process being created. This is still ongoing but moving forward well. Talks with the Royal College of Surgeons with regards for badging have slowed the process; however we are moving on to the goal of a national advanced examination for all cardiothoracic nurses.

Surgical Care Practitioner Update

Work is still ongoing with regards to developing the SCP role with regards to registration, training & development - including discussions surrounding the continuation of the national cardiothoracic exam which is seen as a clinical workplace standard; and role standardisation. The Royal College of Surgeons has re-examined the National SCP Curriculum and a 2013 document has been published for review. Following consultations with Alistair Marshall, President of ACSA (Association of Cardiothoracic Surgical Assistants) the SCTS has met with the RCS and are working together to progress these issues. The SCTS has now been given the opportunity to review and feedback on the updated syllabus which is due for ratification at the examination board in March 2014. Discussions are still ongoing with regards to the joint RCS and SCTS examination and revolve around a strategic way forward that incorporates the work completed within the university courses but also provides for those who haven't undertaken a university course. Registration of SCP's remains a hurdle and the President of ACSA is lobbying to secure this but it is a major piece of work.

The SCTS fully support the allied health professionals and will continue to engage with the RCS on this matter, and I look forward to working closely with Alistair to push these concepts forward.

EACTS

EACTS this year was held at the Austria Centre in Vienna and the Postgraduate Nurses Day was run on Sunday 6th October with the main themes being patient safety, development of allied professional roles and non surgical skills for surgical teams. The day was well supported from nurses and allied health professionals from across Europe, especially from the UK and Netherlands. There was also participation from Physicians Assistants from the USA and Germany; and these speakers have also accepted invitations to speak at the SCTS CT Forum in Edinburgh next March.

The EACTS Quality Improvement Programme (QUIP) programme still continues - looking in-depth at quality standards across Europe with the concept to bring together common aspects and setting a benchmark for establishing quality improvement. This involves a review of current nursing quality outcomes; the implementation of a quality pathway for patients, and a review of outcome measures, examining established protocols and practice guidelines.

For any nurses and allied health professionals that would be prepared to share good practice with our colleagues around Europe and get involved with the QUIP programme please contact Tara Bartley, Lead Nurse for QUIP at Tara.Bartley@uhb.nhs.uk

Wider nursing issues

The Royal College of Nursing is actively addressing key issues highlighted by recent reports such as Keogh and Francis, especially in relation to the criticism from Francis that the Professional and the Trade union arms of the RCN should be separated, a suggestion that the RCN refutes. There are a number of pieces of work to address this and other fundamental nursing issues.

An RCN Executive Network has been established to create a supportive forum and conduit to take leadership forward and shape the RCN's response to government policy and strategy consultations. The Nursing Practice and Policy Committee are consulting a bank of experts to work on standards of nursing practice, and nursing now feeds into all NICE publications. There is a clear steer on providing standards for safe staffing level. Links have been established with all the Royal Colleges and there is ongoing liaison with Health and Education England and the DoH. The RCN is confident that the voice of nursing is heard across the health agenda.

The RCN Foundation are planning to launch a new project around what the public wants from nursing which directly addresses the points raised about the public perceptions of nursing in recent reports.

Nursing Report *continued*

There has also been a review around the work of the RCN Forums and the roles and work that are undertaken by colleagues around the 4 countries.

Colleagues will be interested to know that the RCN have launched the new library facility which can be accessed in person at their head quarters in Cavendish Square, but they also offer a comprehensive on line and telephone service, where they are able to perform literature searches and advice.


Further Details can be accessed on the RCN web site www.rcn.org.uk

SCTS CT Forum Contacts

The SCTS CT Forum Facebook and Twitter page continue. The CT Forum is for all nurses and allied health professionals to belong to and I encourage you all to sign up to these pages and help us to communicate between all health care professionals working in the field of cardiothoracics, whether it be in outpatient departments, wards, intensive care, theatres or the community. We would like as many nurses and allied health professionals to join, to show that cardiothoracic health professionals have a voice and want to work together to improve the care provided for all patients.

The links for the pages are as follows, please pass these details on to as many nurses and allied health professionals that you all know and encourage everyone to participate.

Follow us at Twitter - @SCTS_CTForum 

Join the Facebook Group - SCTS CT Forum 

If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward their name, address and title to me at Christina.Bannister@uhs.nhs.uk or chrissiebannister71@gmail.com or direct to Tilly Mitchell at tilly@scts.org

Chris Bannister

Nursing & Allied Health Professional Representative

The Patrick Magee Medal

CALL FOR ABSTRACTS

Society for Cardiothoracic Surgery
in Great Britain & Ireland

The Society for Cardiothoracic Surgery in Great Britain & Ireland invites the submission of abstracts of case presentations, original research, literature review or clinical audit to be made at its annual meeting.

Edinburgh International Centre. 10th – 12th March 2014.

- The primary author must be currently registered as a medical student
- All entrants submitting suitable abstracts will be invited to present their work
- All presenter will be granted free registration for the entire meeting
- Certificates will be provided for all those who have presented their work
- Poster presentations will be judged by a panel of surgeons
- A national prize will be awarded for the best poster at the annual dinner

Rules of submission:

The abstract may cover any aspect of cardiothoracic surgery. The abstract must be clearly marked with the name of the student author and supervisors. Abstracts should be 250 words in length and may include a picture or diagram. The submitted work must not have been published elsewhere. Abstracts should be sent to the SCTS administrator by email at:

sctsadmin@scts.org

Closing date for entries is **midnight Sunday 2nd February 2014**

www.scts.org



21st Conference on General Thoracic Surgery

Birmingham 26th to 29th May 2013

*Mr Sridhar Rathinam
FRCSEd(CTh)*

The European Conference on General Thoracic Surgery returned to the United Kingdom to the City of Birmingham on the 20th Anniversary of the organisation. The meeting was held in the International Convention Centre, Birmingham hosted by the Midlands Thoracic Surgeons on behalf of the Society for Cardiothoracic Surgery for United Kingdom and Ireland and the British Thoracic Oncology Group.

The meeting started with the 5th Collaborative Symposium on General Thoracic Surgery in the format of Master's Court hosted and moderated by Mr David Waller, Chair of the Local Organising Committee. World leaders from Europe, North America and Australasia formed teams and debated three alternative modalities of management for the same clinical problems. The interesting presentations led to critical debates and were of a great educational value. The interactive voting system chose Team Europe as the winners of this years Master's court.



This was followed by the Welcome reception with Prof Von Raemdonck welcoming the members and delegates followed by a string quartet recital by the City of Birmingham Symphony Orchestra. The delegates were welcomed by the president Elect of the SCTS Mr Tim Graham who highlighted the Current status of Thoracic surgery in the united Kingdom followed by Mr Pala B Rajesh who showcased Birmingham as a Thoracic Centre.

The main meeting started with the Brompton session with the best abstracts presented in this prestigious session. The various parallel sessions and breakfast meetings covered all aspects of General thoracic surgery. There was a celebration with a cake to celebrate the 20 years of success when the founding fathers of ESTS were honoured. This was followed by the presidential address, **"A piece of cake"** traced the twenty year history of what now has become the largest general thoracic surgical society in the world.



The ESTS Guest lecture was delivered by Prof Peter Goldstraw on the "Evolution of Science in general Thoracic Surgery" over the past 20 years. ESTS has a tradition of having an Extraordinary lecture by a non thoracic surgeon. This year's lecture was delivered by Professor Christopher Imray, Vascular surgeon from Coventry on "The Climb to Everest: Lessons from extreme altitude for critically ill patients."



The conference exhibition showcased the advances from industry partners. The Technocollage on Tuesday highlighted the various innovations. The lunch symposiums complemented the programme to update the delegates on current technology.

The Conference Dinner was held in the Town Hall of Birmingham an imposing neo-classical building which dominates the City centre's Victoria and Chamberlain Squares on the Tuesday evening. The evening started with a recital on the formidable 6,000 pipe organ. Following this the guests were treated to the best of British cuisine. The evening finished with the award presentations.

The last day was a joint Symposium with BTOG addressing various aspects of thoracic oncology. The session also had nursing delegates for the first time in ESTS.

For the first time the conference registered over 1000 delegates from the six continents, who loved the conference venue due to the access from airport, the central location within walking distance from all hotels and recreational sites.



The Local Organising Committee Mr Apo Nakas, Mr Sridhar Rathinam (Secretary), Mr Rajesh Shah (SCTS Rep) & Mr David A Waller (LOC Chair)

The conference programme, sessions, hosts and venue have all led to this being the best and one of the most successful ESTS meetings to date.

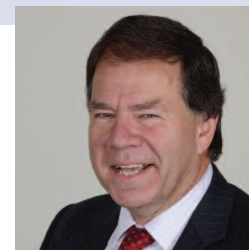
Mr Sridhar Rathinam FRCSEd(CTh), Consultant Thoracic Surgeon

Glenfield Hospital, University Hospitals of Leicester, Secretary of the Local Organising committee, 21st ESTS Conference.

Teamwork makes dream work

Mark Jones

*Consultant Cardiothoracic
Surgeon, Wythenshawe
Hospital, Manchester*



Ours is a high profile specialty and is set against the ever changing landscape of the NHS. Patients have great expectations. Surgeons operate with high levels of technical skill and judgment under increasing levels of scrutiny and accountability.

Barely a week passes without some new media exposé over healthcare delivery. We have perhaps become inured to serious issues which are often sensationalized, with vilification of failing individuals, professional groups, systems or processes of regulation.

Over years all of us will have become aware of instances of units in "difficulties". Sadly, the issues and associated consequences are sometimes not contained, and there follows the unseemly spectacle of public exposure, closely followed by the rumour mill - a lie is half way round the world before the truth has got its boots on!

We are all aware that headline writers are a law unto themselves, and journalism is not always based on fact, but a recent article in the Times titled 'Heart patients "die as surgeons bully staff" ' does not make easy reading.

How, in 2013, after all this specialty has been through, could a unit fail to such a degree that it requires a visit by an external review panel? It cannot be for want of guidance - there are oceans of documents and advice about professionalism, working relationships, clinical leadership and management. Is this the best we can do?

In the past three years, five cardiac surgeons have been dismissed from their posts.

The milestone events of Bristol, Shipman and Mid Staffs brought in to sharp focus the consequences of failing to act promptly. Standards of health care delivery and their associated benchmarking are under the spotlight more than ever before. Yet, there exists an anxiety that some Trusts lack the circumspection and perspicacity over if, when, and how they respond to issues of concern.

The SCTS publication '*Maintaining patients trust - modern medical professionalism 2011 sets the scene*'. "The SCTS believes that every single patient should always receive the best care from every surgeon undertaking cardiothoracic surgery."

This is what we would want for our families, and ourselves so why aren't we behaving in a way that befits a profession that seeks to inspire respect, confidence, and trust?

The two fundamental principles which underscore high quality healthcare delivery are firstly performance. Through our knowledge, clinical expertise and technical skills we are equipped to manage complex medical conditions. Secondly behaviours and values - Good Medical Practice encourages us to work with colleagues in the ways that best serve patients interests, act as positive role models, trying to motivate and inspire colleagues, and leading by example.

Basics

It appears that we need to remind ourselves of these basics tenets of professionalism, and as ever, there's a process.

Successful departments take the appointment of colleagues, very seriously. Colleagues respect each other; they work at cohesion and harmony, and develop a portfolio of skills. They celebrate each others success. They are forward looking, foster good relationships with management and have high feedback cultures. They support colleagues when they are down, self-inflicted or not. Strong clinical leadership optimally utilises strengthened appraisal.

Conflicts within a profession originate for many reasons; insecurity, professional jealousy, change. Envy, remember is the only one of the seven deadly sins not associated with any pleasure! Resentment is described as taking poison and waiting for the other person to die!

All problems start somewhere and are better prevented rather than cured, get them nipped in

the bud. Once established, like many system failures, the roots of dysfunction are often complex, and multi faceted. The experience of RCS invited reviews is generally of three strands to system failure. Firstly there is some errant behavior on behalf of an individual or group, secondly there is an associated lack of insight otherwise known as arrogance, and thirdly, from its inception, there has been poor management of the problem. It

The milestone events of Bristol, Shipman and Mid Staffs brought in to sharp focus the consequences of failing to act promptly. Standards of health care delivery are under the spotlight more than ever before.

Team work makes dream work

seems sometimes that Trusts perhaps fear the consequences of escalating problem resolution with the risk of attracting unwelcome attention.

Factions

In a department where relationships are beginning to deteriorate, dysfunction soon gains traction, factions form; this soon starts to impact on patient care. Difficult colleagues can have very destructive influences. This requires concerted action both by the department and corresponding Trust support.

It is at this stage that common sense and pragmatism must see the light of day. This requires strong leadership, difficult conversations, and an understanding that disruptive actions will have consequences. Those consequences should be early, positive, significant, proportionate, documented and time limited. Tools include the model of situational leadership, 360 degree multi source feedback, psychometric analysis of personality and behavioural type, and performance management to name but a few. These are all available to Trusts, and they should be implemented early on to defuse an explosive situation. There may be similarities between the management of some cardiothoracic surgeons and today's petulant premier league footballers - possibly a job here for Sir Alex Ferguson in his retirement!?

If early attempts at resolution do fail, there exists an armamentarium of tools at a department's disposal. The College invited review mechanism, the National Clinical Assessment Service, and outside consultancy organisations all offer different types of external assessment. In general, however, they do not offer individual solutions to what may be very difficult problems, more of a strategic approach using well-known avenues. By this stage the situation is increasingly difficult, and may be impossible to retrieve.

To return to the beginning, put yourself in the position of the patient. Many of you, through friends, family or personally will have experienced or witnessed a serious illness, the slow unfolding of a diagnosis, the uncertainty, and the vulnerability. Remember, our patients need us. We are very privileged in what we do. Lets behave accordingly. As Sir Ian Kennedy said of the Bristol Inquiry *"Citizens have responsibilities, professionals have duties"*

Surgical Intervention in N2-NSCLC

Damian Smith
Edinburgh



The surgical treatment of N2 Stage IIIA non-small cell lung cancer (NSCLC) seems to have come full circle over the last three decades.

Before the advent of CT it was considered best practice to resect lung primaries in patients with no clinical signs of N2 disease until Pearson et al¹ using mediastinoscopy, reported a dramatic difference in 5-year survival in patients with positive N2 nodes undergoing resection compared to those with negative N2 nodes. Research began to examine the efficacy of multi-modal therapy for N2 disease with trials focusing on induction chemotherapy followed by surgical resection compared to induction therapy followed by definitive chemoradiotherapy. Patients were considered for surgery only if they showed evidence of "mediastinal down-staging" i.e. going from a N2 to N1/0 staging.

Recent RCTs have suggested that there is no statistically significant survival benefit from induction chemotherapy/chemoradiotherapy followed by surgical resection compared to definitive chemoradiotherapy or radiotherapy alone. These two studies had high rates of pneumonectomy, which may have contributed to poor outcomes. One study reported a 7% 30 day operative mortality rate for patients who had pneumonectomy but none of the patients who received a lobectomy died². Given that pneumonectomies comprised 47% of the surgical cohort its conceivable that this will have had a negative impact on overall survival rates. Another study discovered an unexpected high mortality rate amongst pneumonectomy patients and found that when analysed as separate groups there was a statistically significant increase in median survival time for patients who had a lobectomy³. This same study reported less treatment related toxic side-effects and better progression-free survival in the surgical arm and so it seems that although survival rates range from being equivocal to favouring surgical resection as definitive treatment patients do tend to have better quality life after surgery.

Accurate staging is essential to achieving favourable outcomes for surgical treatment of N2 disease. Some centres will stage and re-stage using CT / PET scanning. The role of CT scanning for staging, in particular, has been called into question. Patients with greater than 50% reduction in tumour burden were found, intraoperatively, to have obvious N2 disease whilst other studies reported that patients with no CT evidence of down-staging who proceeded to resection had evidence of downstaging intraoperatively⁴. Mediastinoscopy is the gold standard for downstaging as it can provide adequate tissue for definitive pathological analysis. However, the safety of re-staging is a valid concern as mediastinal fibrosis following induction therapy and a staging mediastinoscopy render the procedure technically much more problematic. Recent studies have shown re-staging to be technically feasible whilst reporting mortality rates of 1% and morbidity of 4%⁵. Increasingly EBUS and EEUS are being used by physicians for initial staging. Oftentimes samples obtained are inadequate for analysis but when they are it has a helpful role in the initial staging of N2 patients.

Choice of induction therapy and assurance of accurate staging are paramount as, despite the conflicting evidence of the efficacy of surgery in N2 disease, what can be said is that incorrect identification or inappropriate selection of patients for surgery will have worse outcomes than definitive chemoradiotherapy. Avoidance of so-called "surprise N2", where evidence of N2 disease is found at resection, is critical, as these patients are more likely to have tumour left behind and have several levels of nodal involvement⁶.

If deciding to proceed with surgical resection pneumonectomy is the main negative predictor. It is associated with higher mortality rates and if chemoradiotherapy, as opposed to chemotherapy alone, is used as induction treatment, is associated with higher incidence of bronchopleural fistula⁷. Positive predictors include single level N2 nodal involvement, evidence of mediastinal down-staging and post-op predicted PFTs.

The role of surgical resection in N2 disease still remains uncertain. There is a moderate to insignificant difference in overall survival rates but patients seem to have a better quality of life when offered surgery. Staging via mediastinoscopy will lead to more accurate staging and re-staging but the safety of re-staging must be taken into account. With the increasing popularity and use of Video Assisted Thorascopic Surgery the immediate complications of surgery will likely be reduced and indeed a report from Sloan-Kettering has quoted an overall 30-day mortality rate of 1.8% with a 4.3% mortality rate amongst patients who had a pneumonectomy performed⁸. The authors admitted themselves that one factor that could have contributed to such favourable results is the fact that the study was undertaken in a very experienced centre with a surgical staff well accustomed to performing these procedures, and, there-in lies the caveat. Unless resections are undertaken at an experienced unit with an interest in accurate staging and re-staging and a surgical team well versed in difficult resections such impressive results are unlikely to be replicated

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Key Topics in Cardiac Surgery

Sunil Ohri, Narain Moorjani, and Augustine Tang

2nd Edition 2013, Hamtun Publishing

Vipin Zamvar

"Key Topics in Cardiac Surgery" is a concise textbook, and as its name suggests covers all the important topics in Adult and Paediatric Cardiac Surgery.

This book covers the basic sciences including the Anatomy, Physiology, and Pharmacology of the heart. There are chapters covering the diagnostic tests which a surgeon should be familiar with, and then there are two sections covering the entire range of Adult and Paediatric Cardiac Surgery.

All chapters follow a similar format, and therefore the book is easy to read, and assimilate information from. The style of writing is very reader-friendly, and would be welcome to the exam-going candidate.

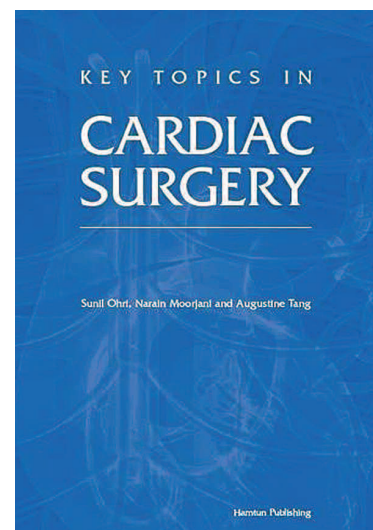
This book would suit two types of cardiac surgical trainees. The first one is the very junior trainee, in his first year in the speciality. This book would be a key source of essential information. As he progresses in his career, he would have to refer to the standard reference textbooks, and our speciality is blessed with many excellent ones. This Key Topics book will be of use also to the senior surgical trainee, when he is revising for the UK Fellowship, or the European Certification or the American Board examinations.

In short, this should be on the bookshelf of every trainee in cardiac surgery. It will also be an important source of information to other trainees coming in contact with cardiac surgical patients like Cardiology and Anaesthesia Residents. Therefore, this book must be in every theatre or ICU library.

Other professionals coming in contact with cardiac surgical patients including liaison nurses, ICU and HDU nurses, perfusionists, and physiotherapists will also find portions of this book useful. Members of the Society should therefore facilitate this book finding its way into their hospital library.

It is available from Amazon, and Wisepress UK, and retails for £65.

Five Stars (*****)





British Heart Valve Society

CORE KNOWLEDGE IN HEART VALVE DISEASE

3rd February 2014
Sherman Education Centre
Guy's Hospital, London

Organised by
Benoy Shah and John Chambers

RCP CPD 6 credits
BHVS 7 points
BSE re-accreditation 2 points

Programme

- 08:30 – 09:00 Registration
- 09:00 – 09:30 **Epidemiology and general care**
Joanne d'Arcy
- 09:30 – 10:30 **Aortic stenosis**
Simon Ray
- 10:30 – 11:00 **Aortic regurgitation**
John Chambers
- 11:00 – 11:20 **Community aspects of valve disease**
Yassir Javaid
- 11:20 – 11:45 Coffee break
- 11:45 – 12:30 **Infective endocarditis**
John Klein
- 12.30 – 13.00 **Mitral stenosis**
Philip MacCarthy
- 13:00 – 14:00 Lunch
- 14:00 – 15:00 **Mitral regurgitation**
Anita McNab
- 15:00 – 15:30 **Right heart valve disease**
Cathy Head
- 15:30 – 16:15 **Prosthetic heart valves**
Chris Blauth
- 16:15 – 16:45 **Multimodality imaging**
Saul Myerson

The registration fee is £50
(£30 for BHVS Members)

You can register online at:

 www.bhvs.org.uk

Trainees Report

*David J. McCormack
& Mick Murphy*

It has been another exciting year in Cardiothoracic Surgery in Great Britain and Ireland.

National selection included the pilot program of ST1 recruitment as well as the traditional ST3 appointment. The standards were high among candidates for both levels of entry. The ST1 recruitment seems likely to continue for the years ahead so it is important that we all inform any medical students, foundation doctors or core trainees that this opportunity exists.

The introductory course for newly appointed ST1/ST3 was a great success once again and looks like becoming an established rite of passage for everyone entering the speciality. There was a strong turn out by faculty and trainees and we are once again indebted to Sorin and Wetlab to making the whole thing possible.

We have been trainee representatives for just over a year. Much has happened in the specialty related to training during this period. Communication of information to trainees has been streamlined through monthly newsletters and a new trainee website (www.tscts.org). Feedback on either of these is always welcomed.

The annual meeting is now just a few short months away and Edinburgh should be a great venue. Sunday will see the first inter-deanery five-a-side football match, and we hope for a lively and informative trainees meeting on the Monday night. The trainee's dinner has become a fixture in the calendar and the meeting and University look very strong this year.

Ethicon continues to generously support the SCTS Scholarship for senior trainees to get intensive and specialist operative experience in renowned centres here and abroad. It is important for potential applicants to plan for these as much as possible.

The future

We look forward to working with you to enhance all aspects of training. Please feel free to contact us if there are any questions or suggestions.

David and Mick

Patient Safety Symposium

*The Royal College of Physicians
and Surgeons of Glasgow*

'How do we keep our patients safe?'

9am - 4.30pm, Monday 10th February 2014



ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

Dear Colleague,

The aim of this Symposium is to focus on the key themes of the Scottish Patient Safety Programme and debate the wider implications of the Mid-Staffordshire Enquiry.

Delegates will have the opportunity to hear from expert speakers in the field of patient safety including Scottish Patient safety programme, human factors, just culture and transparency, governance and patient centred care.

This one day symposium will:

- * Put patient safety in to context, explaining the concept of preventable harm and medical errors and to give some insight into the magnitude of preventable harm within the UK.
- * Identify where most preventable harm occurs, and what improvement work is already underway
- * Provide delegates with the opportunity to share experience from industry and other health services on how we can design systems or methods to help avoid preventable harm - human factors and situational awareness
- * Encourage transparency and learning through cultural change - governance, just culture and patient centred care - which will be highlighted from the Francis report

Who should attend?

- * Doctors (all levels), Nurses (all levels), AHPs and medical students

To download the programme and registration form visit:

<http://www.rcpsg.ac.uk/events/items/patient-safety-symposium.aspx>

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RCSE President's Meeting

The Royal College of Surgeons of Edinburgh is pleased to invite the SCTS membership to attend its annual President's Meeting and Audit Symposium which will take place at the 500-year-old Edinburgh College on Friday 21 March 2014.

The theme for next year's meeting will explore 'Emergency Surgery in the 21st Century' and will bring together world renowned experts from the field of trauma and emergency surgery, as well as include updates from each of the Specialty Associations, including SCTS' Mr Timothy R Graham who will discuss 'The Management of Cardiothoracic Trauma in the 21st Century'.

Other highlights include the Lister Legacy Lecture which will be given by internationally renowned trauma surgeon, Dr Ernest Moore (Denver, USA) who will discuss 'Controversies in Post-injury Haemostasis', as well as the role of the 'Acute Care Surgeon'. Professor Gordon Carlson will deliver the McKeown Lecture on 'Abdominal Catastrophe - the Salvage of Surgical Disaster' and ASGBI's Director of Emergency Surgery, Mr Iain Anderson will discuss the current practice of emergency surgery in the UK.

We are also pleased to be hosting the evening before the Meeting an evening symposium that will explore 'The Role of Human Factors in Healthcare and their Influence on Surgical Performance', which will be delivered by our Patient Safety Chair, Mr Simon Paterson-Brown. This Symposium is free to attend for all those attending the President's Meeting.

For further information or to book online please visit www.rcsed.ac.uk/presidentsmeeting, telephone 0131 0131 668 9209, or email presidentsmeeting@rcsed.ac.uk



FRIDAY 21 MARCH 2014

PRESIDENT'S MEETING AND AUDIT SYMPOSIUM 2014

Emergency Surgery in the 21st Century

With the increasing challenge of delivering an effective and safe emergency surgical service, the focus of the **2014 President's Meeting** will be on models of service provision and will include updates from each of the Specialty Associations.

In addition to the main sessions, the Specialty Association Symposia will run in parallel with the Annual Trainees' Audit Symposium.

INVITATION TO SUBMIT ABSTRACTS

We are now accepting abstracts for the Audit Sessions of the President's Meeting. The closing date for submission is **Monday 6 January 2014**.

The Lister Medal and the Surgeon in Training Medal will be awarded on the day for the best oral presentation.



THE ROYAL COLLEGE
OF SURGEONS OF
EDINBURGH

FROM HERE, HEALTH



www.presmeeting.rcsed.ac.uk
Email: presidentsmeeting@rcsed.ac.uk
Phone: 0131 668 9209

KEYNOTE SPEAKERS

Lister Legacy Lecture

Dr Ernest E Moore, Chief of Trauma at the Denver General Hospital and Editor, *Journal of Trauma and Acute Care Surgery*

McKeown Lecture

Professor Gordon Carlson, Hon Professor of Surgery at University of Manchester, Hon Professor of Biomedical Science at University of Salford, and Consultant Advisor to NICE and DoH

SPEAKERS TO INCLUDE

Mr Iain D Anderson, Consultant Surgeon at Salford Royal Hospital, Manchester, and Senior Surgeon on the UK's Intestinal Failure Unit

Mr Simon Paterson-Brown, Consultant General and Upper Gastrointestinal Surgeon and Honorary Senior Lecturer at the Royal Infirmary of Edinburgh

Professor Sir Keith Porter, Honorary Professor of Clinical Traumatology at the University of Birmingham and Civilian Clinical Lead for the care of injured soldiers returning to the UK from Iraq and Afghanistan

Mr Richard Ward, Consultant Vascular Surgeon at Aintree University Hospital Liverpool and founder of the Aintree Major Trauma Ward

Mr Peter Sedman, Upper GI and Laparoscopic Surgeon in Hull and Education Director of ALS

Dr Ian Zealley, Consultant Radiologist, Ninewells Hospital, Dundee

SPECIALTY SYMPOSIA SPEAKERS

Mr Paul Blair, Vascular Surgeon in Belfast and Vice-President Elect of the VSGBI

Mr Ian Beckingham, President-elect of AUGIS, Consultant Surgeon at Queens Medical Centre and Honorary Senior Lecturer at the University of Nottingham Medical School

Mr Roger Currie, Consultant Oral and Maxillofacial Surgeon, Ayrshire, and RCSEd Council Member (representing BAOMS)

Mr Timothy R Graham, Consultant Cardiothoracic Surgeon and Senior Lecturer in Clinical Surgery at the Queen Elizabeth Hospital Birmingham, University of Birmingham and Royal Centre for Defence Medicine UK, and President-Elect of SCTS

Mr John Hartley, Honorary Consultant in General Surgery, Hull and East Yorkshire NHS Hospitals Trust (representing ACP)

Mr John Keating, Consultant Orthopaedic Surgeon, Royal Infirmary of Edinburgh and Honorary Senior Lecturer, University of Edinburgh (representing BOA)

Mr Umraz Khan, Consultant in Reconstructive Plastic Surgery at Frenchay Hospital, Bristol (representing BAPRAS)

Professor B Nirmal Kumar, Consultant ENT Surgeon and Director of Medical Education at WWL NHS Foundation Trust (representing ENTUK)

Mr R Nelson, Consultant Neurosurgeon, Frenchay Hospital, Bristol, and President of SBNS

Mr Bruce Okeye, Consultant Paediatric, Adolescent and Neonatal Surgeon at St Georges Hospital NHS Trust, London, and Honorary Consultant Paediatric Surgeon at the Royal Marsden Hospital, London (representing BAPS)

Professor John Primrose, Professor of Surgery at the University of Southampton and President of ASGBI

Mr Mark Speakman, Consultant Urologist, Taunton (representing BAUS)

Smoking Petition

PLEASE SIGN THE E-PETITION FOR STANDARDISED PACKAGING FOR TOBACCO PRODUCTS.

Dr Nick Hopkinson is the editor of BTS News, and also the incoming Chair of the BTS COPD Advisory Group. He is working with supporting organisations in the Smoke Free Action Coalition, including BTS, to gather signatures for an open letter from people who work with respiratory patients asking Parliament to support the introduction of standardised packaging for tobacco products.

There is an amendment about this in the Children and Families Bill on which there is expected to be a vote in the week beginning 9th December. It would be excellent if SCTS members were prepared to sign up and pass this link on to other respiratory people so that they can sign up too.

You can find the text of the letter on the Coalition's website as well as in the text below, and you can sign up here. It takes less than a minute and could make a lifetime of difference to many people in the future:-

<https://www.surveymonkey.com/s/standardpacks>

In the UK hundreds of children aged 11-15 start smoking for the first time every day and there is compelling evidence that children's perceptions of cigarettes are influenced by branding. As health professionals working to prevent and treat lung disease caused by smoking, we call on members of both Houses of Parliament to support the amendment to the Children and Families Bill which introduces standardised packaging for tobacco products.

Prohibition of tobacco advertising, promotion and sponsorship mean that cigarette packs are now the key marketing tool employed by the tobacco industry to attract and retain customers. Current tobacco packaging makes cigarettes and smoking appear more appealing and distracts attention from health warnings. Packaging also misleads consumers about the harmfulness of products. Although terms like "light" and "mild" have been banned, smokers still perceive lighter coloured packs to be less hazardous.

Standardised packaging will include requirements that packs are a standard drab colour and have large graphic health warnings front and back. Security features, including number codes and covert anti-counterfeit marks which can be read by scanners, will be retained, so it will be no easier to counterfeit products despite claims to the contrary from the tobacco industry.

Most smokers start before the age of 18 and the younger the age at which they start the greater the health risk. Parliament must take this opportunity and act now to protect children from the tobacco industry.



Congratulations

The Society is delighted to announce the appointment of A E (Fred) Wood as President (Chairman) of the Medical Council of Ireland by the College of Surgeons in Ireland (term June 2013-May 2018). We extend him congratulations and success in his role.

New Appointments

Name	Hospital	Specialty	Starting Date
Mr Aziz Momin	St George's Hospital	Cardiac	May 2013
Mr Manoj Purohit	Blackpool Victoria Hospital	Cardiothoracic	July 2013
Mr Kevlin Lau	Barts Health NHS Trust	Thoracic	June 2013
Ms Donna Eaton	Mater Misericordiae University Hospital	Thoracic	November 2013
Mr Franco Sogliani	Manchester Royal Infirmary	Cardiac	November 2013
Mr Suku Nair	Freeman Hospital	Cardiac & Transplant	November 2013

Obituary

Frank Collins (1943 - 2013) (q 1969)

Having trained in Ireland, Frank spent most of his working life in the department of thoracic surgery in Birmingham. He retired in 2008 at the age of 65 but freely admitted that he was not ready to leave. Thankfully for Frank, his retirement was short-lived and he was soon appointed in Bristol to help revive a flagging service. Having initially been employed on a 6-month contract he went on to spend 5 years there. He was instrumental in helping build the Bristol department into one of the leading thoracic units in the country.

Frank was a master of almost all aspects of thoracic surgery. He even managed to perform a few VATS lobectomies in his final months! However, his greatest contributions were in the development of techniques for tracheal resection (following a fellowship with Hermes Grillo in Harvard), chest wall resection/reconstruction, and surgery for advanced lung cancer. Despite all his achievements, he shunned the limelight. The techniques he developed were seldom published but are practised today by those lucky enough to have worked with him. Frank was gracious, kind and supportive. He was also the master of the understatement. Many an anaesthetist has come undone on taking at face value Frank's typical description of what an upcoming operation may entail - "just a little cut..."

He retired for the second and final time in September 2013. In a rare speech he finally admitted that it was time for him to step down. Both he and his wife Kay were excited by the prospect of being able to travel. They had also bought a plot of land in Cork and had drawn up plans to build a new house there.

Frank fell while out walking and died after suffering complications of the surgery required to treat his injuries. It is tragic indeed that he only lived a little of his retirement. He leaves behind his wife Kay, three children and a young grandson.

For those wishing to express their condolences, cards and messages can be sent to Kay:

Mrs Catherine Collins
9 Rodman Close
Edgbaston
Birmingham
B15 3PE

By Tim Batchelor

Obituary

Jim Monro

James Lawrence Monro died aged 73, on 29 August 2013, after a tenacious battle with prostate cancer.

Jim was undoubtedly one of the leading cardiac surgeons of his generation. He showed that very complex cardiac surgery could be performed safely on infants and neonates and was one of the pioneers of corrective, rather than palliative surgery. He demonstrated that corrective surgery could be performed on infants with Tetralogy of Fallot and Truncus Arteriosus and produced such excellent results that many European surgeons began to follow his lead. He was also a firm advocate of conservative surgery for congenital aortic stenosis favouring this approach over balloon valvuloplasty or more extensive surgery such as the Ross procedure.

His father was Professor of Surgery in Singapore, and Jim was born on 17 November 1939. Jim was evacuated to the United States in 1941, spending the rest of the war in Virginia with his American mother's family. His father was interned in Changi Gaol and did not see his young son for nearly four years.

After the war the family returned to Singapore and Jim went to Sherborne School in Dorset. From there he went to medical school at The London Hospital, where his father had also studied.

After house jobs on the Professorial Units and training in general surgery in Balham, Jim was appointed as registrar at the newly formed cardiac unit at The London. After this he spent two years working at Green Lane Hospital in Auckland, New Zealand with Sir Brian Barratt-Boyes, who was one of the main inspirations behind Jim's future career. He then returned to The Royal London Hospital to complete his training.

In 1973 Jim was appointed as Consultant Cardiac Surgeon in Southampton; he joined Sir Keith Ross and stayed until his retirement in 2004. Over the subsequent thirty years he helped develop the unit into one of the finest in the country. Jim was clearly a very fine surgeon and his attention to detail and his ability to simplify even the most complex of operations inspired many surgeons to become leaders in their field. He also wrote two books on cardiac surgery and published 148 papers.

In 2001, in response to Sir Ian Kennedy's Bristol Inquiry into high operative death rates and issues at other hospitals, he chaired the Paediatric and Congenital Cardiac Services Review Group. Paediatric cardiac services were reviewed across the whole of Britain. His report called for a reduction in the number of units performing children's heart surgery and to his frustration and disappointment, the committee's recommendations have still not been implemented.

Jim was seen as a role model and mentor by many cardiac surgeons across the world. His good name resulted in Southampton becoming an almost obligatory posting for Australian trainees in cardiac surgery and he is remembered with great affection by many surgeons there. In 2001 he was elected president of the Society of Cardiothoracic Surgeons in Great Britain & Ireland, and two years later he became president of the European Association for Cardio-Thoracic Surgery, of which he had been a co-founder.

Jim led an extremely active life right up until his final illness. Despite devoting countless hours to his chosen profession he was an extremely accomplished skier and tennis player. In his youth he had represented Scotland at rifle shooting and after retirement he was able to hone his skills as an extremely capable artist.

He is survived by his wife, Jane, and their three children, Charles, Rosie and Andrew.

Steve Livesey

Obituary

Graham Erskine Venn (1954 - 2013)

Consultant Cardiac Surgeon Guy's & St Thomas' NHS Foundation Trust

For the last decade Graham Venn has been at the heart of British cardiac surgery. He was part of all aspects of the discipline, from being passionate about training junior surgeons, to overseeing cardiac surgical research at St Thomas' Hospital, to being influential in the running and governance of the Society for Cardiothoracic Surgery, to his work linked with the Royal College of Surgeons and finally to his ensuring fair pay and contractual obligations for newly-appointed young consultants. Graham touched the lives of the cardiac surgical world in a way that few have. His wisdom, foresight and passion were remarkable from a young age.

Graham Erskine Venn was born in Kent in March 1954. He was educated at Dulwich college, London and went on to study medicine at The Middlesex Hospital Medical School from 1972-77. Graham knew he wanted to be a heart surgeon as a student and one of his first posts after qualification was as houseman to the illustrious surgeons Jack Belcher, Marvin Sturridge and of course Donald Ross (the surgeon who performed the first UK heart transplant). Graham then went on to train under some of the greatest names in British cardiac surgery - Matt Paneth, Chris Lincoln, Stewart Lennox and Sir Magdi Yacoub. His final part of training was at the Hospital Broussais in Paris working with the father of heart valve repair, Professor Alain Carpentier.

During this period Graham accumulated numerous prizes and distinctions, became a fellow of both the English and Scottish Royal Colleges of Surgeons (RCS) and he went on to become a Hunterian Professor of Surgery of the RCS England in 1989.

Graham was appointed to the staff at St Thomas' Hospital in July 1989 where he quickly adopted a senior management as well as clinical role, overseeing the difficult mergers of The Brook cardiac unit and later the unification of Guy's & St Thomas' cardiac services to form part of the largest UK Trust hospital.

He later became an Apothecary and was made a Freeman of the City of London in 2003.

Within the Society for Cardiothoracic Surgery (SCTS) Graham was influential for 20 years from being an almost permanent member of the executive committee to chairing various society committees such as the professional standards committee and the blood-borne infections panel. Latterly, Graham was a Trustee and Director of SCTS.

In addition Graham worked tirelessly through both the Society and the RCS to raise the standards of the profession; such as leading on job planning (to ensure a fair deal for newly-appointed consultants) and acting as specialty advisor. Graham was also central to the development of the "early

response" initiative, a mechanism whereby the Society and RCS could rapidly respond to adverse surgical outcomes/performance by parachuting a team in and Graham himself formed part of the rapid response team undertaking several exhausting reviews.

Graham was appointed Surgeon to the British Army in 1990, an honorary appointment whereby initially Graham looked after cardiac surgical issues for the entire Army and latterly provided advice on management of chest trauma in overseas battle zones.

Graham was a passionate trainer of young surgeons and already his unassuming face book page is full of praise from his trainees. His final legacy was that the last 3 cardiac surgeons appointed to St Thomas' had been inspired by training under Graham. Two of them went on to train internationally but all 3 wanted to come back to St Thomas' because of Graham's inspiration.

Finally, Graham was an outstanding surgeon who pushed for increasing specialisation in cardiac surgery. His cardiac surgical results in general were outstanding but he was particularly on mitral valve reconstructive surgery - a complex branch of cardiac surgery in which Graham excelled. He was very passionate about surgery and his patients. On one occasion Graham could not operate until another patient had left the ITU to move to another hospital, thereby vacating a post-operative bed. Such was the slowness of the pace it appeared that Graham's patient would be cancelled that day. Graham was having none of it and he went and found himself an old ambulance used for "iron-lung" patients. Graham commandeered it and drove it to the main ITU himself. He was about to escort and drive the discharge-patient himself when the medical hierarchy gained control of the situation and suggested that an uninsured doctor driving a massive ambulance unescorted through the streets of London might not be in the patient's or Graham's best interests.

Sadly, as Graham's health failed he had to give up surgery but he was not one to sit at home! Graham soon became Medical Director of the UK for HCA International, a post he relished as he sought constantly to raise medical standards.

Graham is survived by his wife Liz and her son Joe, his son's James and Jonathan and his baby grandson Ryan.

Christopher Young

Diary of Forthcoming Events

Contact details for courses at
The Royal College of Surgeons of
England, 35-43 Lincolns Inn Fields,
London WC2A 3PE
Tel: +44 (0)20 7869 6300
Fax: +44(0)20 7869 6320

Date: Saturday, January 25, 2014 to Wednesday, January 29, 2014
Meeting: **STS 50th Annual Meeting & STS/AATS Tech-Con 2014**
Venue: Orlando World Center Marriott
Orlando, FL
United States
Website: www.ctsnet.org/events/sts-50th-annual-meeting-stsaats-tech-con-2014

Date: Thursday, February 13, 2014 to Friday, February 14, 2014
Meeting: **1st European Transoesophageal Echocardiography Course on Congenital Heart Disease**
Venue: UCL Institute of Child Health
London
United Kingdom
Website: www.ctsnet.org/events/1st-european-transoesophageal-echocardiography-course-congenital-heart-disease

Date: Monday 10th March 2014
Meeting: **SCTS Ionescu University 2014**
Venue: Edinburgh International Conference Centre, Edinburgh
UK
Website: www.scts.org.uk

Date: Tuesday 11th to Wednesday 12th March 2014
Meeting: **SCTS Annual Meeting & Cardiothoracic Forum**
Venue: Edinburgh International Conference Centre, Edinburgh
UK
Website: www.scts.org.uk

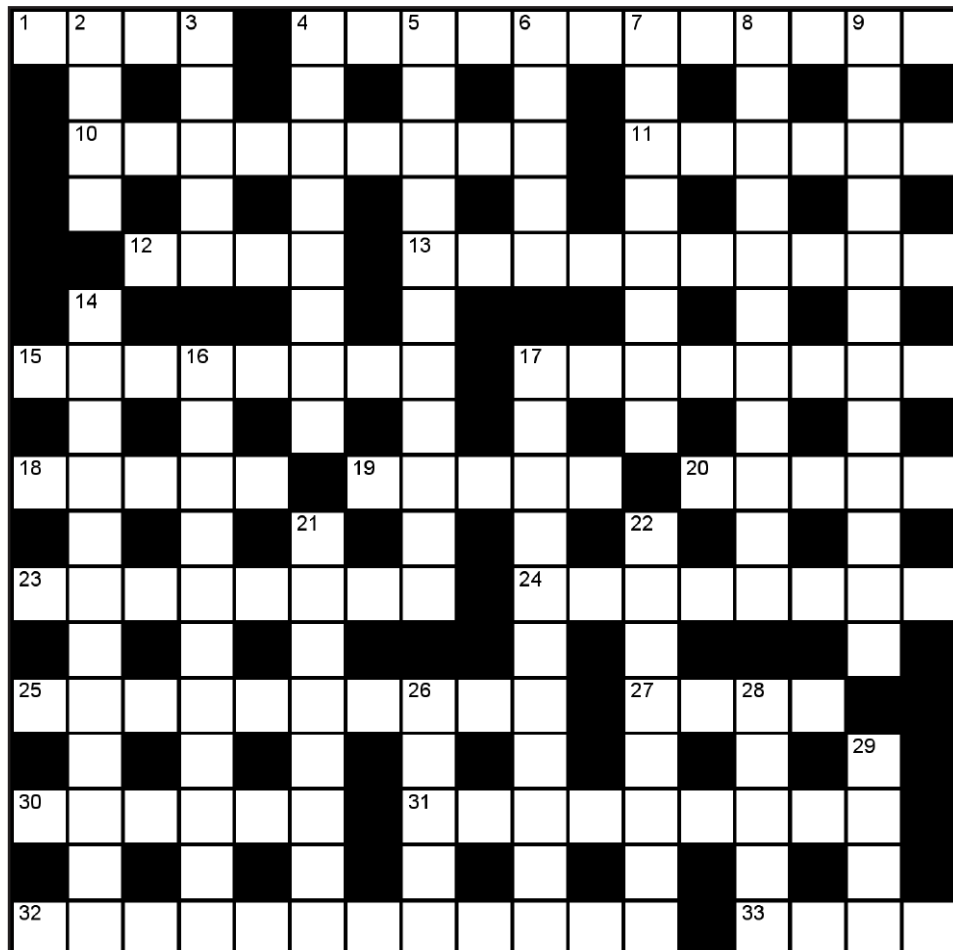
Date: Thursday, April 24, 2014 to Friday, April 25, 2014
Meeting: **AATS Aortic Symposium 2014**
Venue: Hilton New York, Avenue of the Americas NY,
New York
United States
Website: www.ctsnet.org/events/aats-aortic-symposium-2014

Date: Saturday, April 26, 2014 to Wednesday, April 30, 2014
Meeting: **AATS Annual Meeting 2014**
Venue: Toronto Convention Centre
Toronto
Canada
Website: www.ctsnet.org/events/aats-annual-meeting-2014

the crossword



by Sam Nashef

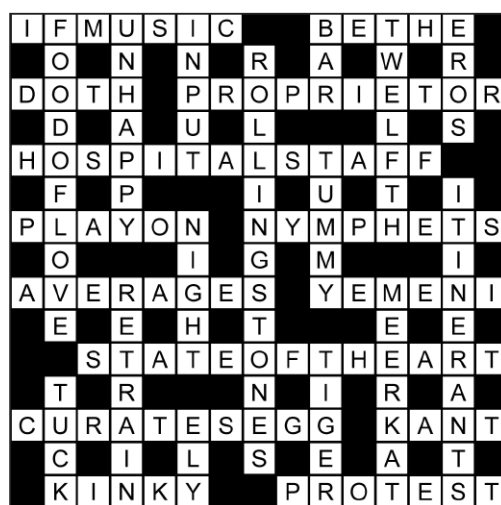


Send your solution by 30 June 2014 to:

Sam Nashef, Papworth Hospital, Cambridge
CB23 3RE or fax to 01480 364744

Solutions from areas over 10 miles from
Cambridge will be given priority.

Last issue's solution



Across

- 1 Shoot sheet (4)
4 13,30 where everyone repeating like Polly Parrot (12)
10 An overdue, desperate attempt (9)
11 Many right out of restraint (6)
12 Hit party (4)
13/17 Wayward son quite a lot richer. Do we really want that? (10,8)
15 Around two pounds invested in grammar: go! (Likely to come back) (8)
17 See 13
18 Lurked in church carpet (5)
19 Craft heading east or west (5)
20 Assign a ring back (5)
23 Sad blow to status of martial arts (4,4)
24 Old country radio she broadcast (8)
25 In a couplet? Perhaps not! (10)
27 Fair boss regularly lies (4)
30 Instrument of French immorality (6)
31 13,30 for Blair's education: Zeus frolics with pixie (9)
32 Telltale signs: poor Meg is suffering (12)
33 Trip to mount (4)

Down

- 2 Free time is the thing (4)
3 Compiler needs help to face up to the press (5)
4 I have a dream that we shall fight - 13,30 for a bit of a nap (Horatio) (8)
5 Two beasts breathe heavily in heraldry feature (4,7)
6 Not all intercessions are brief and to the point (5)
7 The little one said invest again (8)
8 Drive too close, almost reversing over French woman that's a dish (11)
9 Hiss and buzz as 13 30 (12)
14 I face difficult challenge in a short time as an artist (12)
16 Romeo smiled enigmatically, evoking nostalgia (3,8)
17 Queen gutted to be mixed up with guerrilla fighting (11)
21 Sick pet? Let us pay the bills (6,2)
22 Hairdresser firm provided iron to old city (8)
26 Doctrine spells the end of cardiac repeat operation (5)
28 Dog-fighter (5)
29 Old American edition (4)