

the bulletin



Society for Cardiothoracic Surgery
in Great Britain and Ireland

December 2015

Marian Ionescu - Society Address

The History of Cardiac Surgery

Annual Meeting 2016 Birmingham

Minimal Access Surgery - Keeping Safe

Patrick Magee Medal

Encouraging Students

Transparency, Patients & Professionalism

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From the Editor

Welcome to this issue of the Society Bulletin. Feedback from the previous printed version has been encouraging, and so we continue with the paper copy.

This Bulletin contains a variety of articles, and as 2015 draws to a close, members reflect on the events of this year.

Bill Walker's enormous contributions to the speciality of Thoracic Surgery in general, and VATS surgery in particular were recognised by the World Society of Cardiothoracic Surgeons, and at its 25th Anniversary Congress in Edinburgh, he was felicitated with a Lifetime Achievement Award. Congratulations to Bill.

Marion Ionescu (page 5) reflects on the progress made in cardiac surgery over the decades. He describes the early pioneers as those who waded through rivers of blood and hecatombs of young patients. He describes himself as one of the second-generation surgeons, who consolidated earlier progress, and sailed through relatively calm seas. He himself was a pioneer in many ways, and laments now on the high-water mark being one when progress in the UK rolled back. The future may still be bright, but progress now will not be as gory as it once was. Progress will be in small steady steps, rather than the chaotic bursts as in the past.

Ben Bridgewater (Page 34) has contributed immensely to the audit and related activities of our Society over the last decade. In many ways, at times, he has planned and pushed the agenda. He is now moving on to a career in Health Informatics. Best of luck to you, Ben, and we hope to hear from you in the Bulletin again.

Jules Dussek introduced the Bulletin in 1994, and was the first editor. In those days, he had to do the bulk of the typing, and formatting, before it could be sent to be printed and dispatched to all members. How times have changed! Now all contributions are received by email (in an almost ready to go form), and a few flicks of the mouse are all that is required to produce a very presentable Bulletin. Some of the pages of the first issue are replicated in this Bulletin (Page 10). Many of the faces from more than 20 years ago in that Bulletin are still recognisable. A very young Bruce Keogh, was then the President of the Young Cardiac Surgeons Club. Tony DeSouza, Steven Griffin, and Graham Cooper are also seen in their younger avatars. In 1994, Graham Cooper received the Cooper Prize for the best paper.



Vipin Zamvar

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From the editor *continued*

At the Society Office, we do not have copies of the earliest editions of the Bulletin. So if any of you have paper copies of previous editions, can you please send photocopies (or originals) to Isabelle, so we can archive them on the Society website.

We have a number of articles describing the efforts made by many, to attract undergraduates into our speciality, and give them a taste of cardiothoracic surgery, while they are still University students. These are very motivated students anyway, and the kind of experience they get (as described in this Bulletin) must be a very thrilling experience for them.

Andrew Bridgeman (Page 32) describes, the activities of the Society in general, and there are also a few specific examples, further on: Jonathan Ferguson (Middlesbrough, Page 30) has set up a scheme for medical students to spend three weeks in cardiothoracic surgery. One of the medical students describes his experience of the three-week placement. Tony Walker (Blackpool, Page 31) describes a very similar scheme exposing the very young to cardiothoracic surgery. In Edinburgh, students who are very keen on Cardiology and Cardiac Surgery have formed the Edinburgh University Cardiovascular Society, and many of the members regularly come to our theatres and wards (self-arranged placements). In fact some of these students have even written a textbook on Cardiology (Page 53). There is no dearth of initiative amongst these really keen students. At the World Society of Cardiothoracic Surgeons' 25th Anniversary Congress, which was held at the Royal College of Surgeons in Edinburgh in September 2015, we were delighted to welcome 42 medical students from across the globe (including 20 from the UK). They had come to present their research and audit. Surely, the future of our speciality is bright, and a number of medical students are keen on surgery of the heart and lungs. David McCormack (Page 40) gives a brief review of the Pat Magee medal, one of the many ways in which our Society engages with the undergraduate student community. The medal is in its third year now, and three previous winners (Phil McElnay, Charlene Tennyson, and Luke Holland) share their experiences with us.

Education continues to be a theme across Bulletins, and in this one Tara Bartley (Page 14) describes the Society initiatives for the educational opportunities for the Allied Health Professionals. On many occasions, many AHPs find barriers (study leave, finances) to attending meetings and courses. She has also reviewed the 25th Asian CVTS Meeting held in Hong Kong (Page 13), and Andrew Brazier (Page 51) the World Society of Cardiothoracic Surgeons' Meeting held in Edinburgh in September.

The winner of the Crossword competition (July 2015) is a certain surgeon from Glasgow, who is not a member of the SCTS

(shocking!!). When he becomes a member, we will publish his name in the next issue of the Bulletin, and send him his prize (the bottle of Champagne).

Philip Kay is the SCTS historian, and in the coming years, he will be chronicling the contributions of UK cardiothoracic surgeons in the development of Cardiothoracic Surgery worldwide. Jules Dussek describes the Belsey spoon (Page 44). Along with Philip Kay's article (Page 10) it is an interesting reminder of a bygone era. Fashions change, practices change, many operations performed routinely a few decades ago, are obsolete now. Similarly, most of the work we do now, will surely be obsolete a few decades from now. Only change is permanent. Ionescu also reminds us of that through Shelley's "*Naught may endure but mutability*".

However, even though what the pioneers of our specialty did as routine (Belsey, and Brock, portrayed in this Bulletin), may be obsolete now, and even though the path they paved has been covered with overgrowth, their steps have led us where we are now. In that manner, nothing is temporary, everything is permanent.

We would welcome articles of historical (and philosophical) interest for future issues.

Many professional issues continue to grapple our Society. Mark Jones (Page 22) writes about one of them. How do surgeons deal with innovative procedures? How do organisations support these bravehearts? Minimal access AVR is still not routine in many centres, and Vohra (page 19) describes how his centre started off the minimal-access programme. Almost a text-book case!

Another issue that is still in the grey area is one of consent. Simon Kendall (page 24) along with Sarah Murray, set out their views on consent. At times, consent becomes a hot potato when a complication happens, and when the patient or relative then says, "I did not know that". It would be interesting to hear the views from surgeons who have been at the receiving end of a complaint where a patient or relative has challenged the consent taken.

Leslie Hamilton (just retired) discusses his new found hobby of sailing. He is taking part in the Clipper race and will be sailing transatlantic from New York to London. Wish you all the best, Leslie. Enjoy. We would like to hear from you, when it is all done and dusted.

Wishing all of you a very Merry Christmas, and a very Happy New Year.

Vipin Zamvar
Editor

zamvar@hotmail.com

Many professional issues continue to grapple our Society. How do surgeons deal with innovative procedures? How do organisations support these bravehearts?

Marian Ionescu's address to the Society

Mr President, Ladies and Gentlemen

I am very honoured and deeply moved to receive the Lifetime Achievement Award from our Society.

I receive this prestigious distinction with humility because I learned the causes and the value of things; I receive it with great appreciation because I know the valour of my colleagues and I receive it also with great pleasure because I know the song of my heart. It represents for me the culmination of a career which evolved while I was a member of this scientific Society.

In this formal and emotional moment I will take the liberty however to mention very briefly three ideas relevant to this award. They pertain to the space, the time and the human condition. There are very few privileged surgeons who witnessed and participated, from its very beginnings, in this grand and exceptional adventure, this scientific achievement of open heart surgery. To paraphrase Andrei Andreievich Gromyko: I am proud to say: ***I was there, I know, I remember.***

Not long ago, during an interview, Henry Kissinger was asked: what was the influence of the English Industrial Revolution on the development of the western world? He answered ... ***Too early to say!*** And this 'Too early to say' applies to most of our inventions and creations, and even more so to artificial heart valves. As a simple example, when, after a long and difficult struggle, we finally realise our Utopian dream, the successful result is called a great event. This event, in time, becomes a simple fact and sooner or later, with the passage of time, the fact becomes only a distant souvenir in the march of progress. And this happens simply because something better will have been invented. Percy Bysshe Shelley, the great romantic poet, said it beautifully in one of his poems: ***Naught may endure but mutability.***

Finally, I would like to take you to ancient Rome. When a general returned victorious from a military campaign, the Roman Senate would offer him a Triumph. Today, they call it a parade. The general, driving a two-wheeled chariot, was leading his legions of centurions, to the applause of the people massed along the Via dei Fori Imperiali. In fact, few people know that the general was not alone in his chariot.

A slave was behind him, and the slave was whispering in the general's ear repeatedly:



Do not forget, you are mortal too.

And now, I want to express again my great satisfaction and deep appreciation for having bestowed on me this precious award. I shall slowly retire to the quiet corners of my mind and absorb silently the significance of this major event in my life.

About Utopia and the Ephemeral

Several years ago, at one of the Annual Meetings of our Society, I gave a lecture entitled 'About Utopia and the Ephemeral'. That lecture was intended to place, in a new perspective, the idea emanating from the dream of Thomas Moore - The Utopia - published in 1516, and the Ephemerides of Jupiter, described by Galileo Galilei around 1600. At that time, I was mostly looking back at the events which coloured the complex and successful history of the beginnings of open heart surgery in Britain. I tried to describe for the younger surgeons the evolutionary process which, following a period of exuberant

activity of inventions and discoveries, slowed down to a rather stagnant time of consolidation. I started to explain that:

"The ancient Greeks considered that man should accomplish deeds which approach the nobility, the beauty and the permanence of nature and that success would guarantee a form of immortality in the memory of fellow men, outside space and outside time."

In the Judeo-Christian philosophy, to abide by the precepts of the Bible and cultivate virtue and justice was the way to obtain salvation and immortality in the next life, beyond time,

continued on next page

Marian Ionescu *continued*

beyond history. The Renaissance and later the Enlightenment changed all this. Man, with his knowledge and know-how, is capable of taking charge of his own destiny. History became a science, it has a sense, it has direction. Man, society, with reason, logic, imagination and through intelligent action, can reach perfection inside historical time. This modern point of view concerning the role of man in history, placing the aim inside historical time, considers that our accomplishments are within our creative power and probably could be manipulated in such a way as to occur earlier rather than later.

The post-modern era which is almost visible over the horizon appears even more intimidating. Progress and scientific developments occur at such a speed that there is hardly time to understand them, not to mention the chance to critically evaluate the change. As we well know, progress in all fields of activity is not a linear, evolutionary process, but rather a succession of chaotic bursts of activity and creativity related to a multitude of factors.

During the 1950s, the cardiac surgical world was populated by giants. It was a unique period bristling with discoveries, innovations, inventions and fierce competition. During those years, pioneers established the foundations of open-heart surgery, quite often fighting through rivers of blood and hecatombs of young patients. Just a little later, during the time of my generation in the sixties and early seventies, there was in these islands a period of great activity, an atmosphere of great excitement, a continuous effervescence, that sense of exhilaration which springs from self-confidence and achievement and I recall with pride and admiration the names of some of my contemporaries -- Andrew Logan, Donald Ross, Geoffrey Wooller, Denis Melrose, Eion O'Malley, Terence English, Magdy Yacoub, Iarostav Stark and many others who tried to look at the hidden face of the moon and who gave so much to our speciality. One may ask now what happened to that sense of emulation, to that atmosphere of intense activity in these islands? The passion to look, to search, to discover, to create? The enduring possibilities in these lands may still be here but only for those with true grit, those who love to be on the road to the unknown, those with a sense of adventure and of living at the frontier never quite effaced, those who believe in freedom of thought and who get away with living it, those who can strike sparks anywhere, as I said before, those who want to look at the hidden face of the moon. During the sixties and seventies, there was a fantastic, almost universal feeling that whatever we were doing was right, that we were advancing, almost winning, we had that sense of inevitable victory over the old and the unknown; our energy, our ideas would simply have to prevail. I think that we developed the self-confident belief that life should be conducted according to our own rules rather than anyone else's. We had all the momentum, we were riding the crest of a high and beautiful wave.

Years have passed. When you went up a steep hill anywhere in these islands and looked around, with the right kind of eyes, you might have almost seen the high water mark, that place where the wave finally broke and rolled back.

More years have passed. My dreams and wishes have been exorcised. The past gave us the support, the springboard to advance again. Now I look at the present and forward to the future as I realise that those

possibilities are still here, the incentive of awakening the wild indomitable spirit to fight again for the initial primitive dreams to look, to search, to discover, to create. Without apologising, I feel the impulse to scream: What the hell, let's try again, let's give it a roll, let's go for the hidden side of the moon. The ephemeral certainty does exist and you may encounter it often but, in a way, utopia may well exist at the end of a rainbow too or in the secret corners of your dreams and aspirations. As you well know, we really start to act under the fascination of the impossible. And this is the main message to be conveyed - act now, start to challenge the 'impossible', push on that pain in the soul which makes us go beyond ourselves, as Dag Hammarskjold said. Get started and keep going, the road from Nadir to Zenith is long and arduous, the essential is to be continually on the move, whether you reach the summit or not becomes almost secondary. And do not forget that if it works right the first time, you might have done something wrong. Perseverance to the point of stubbornness and hope will help on the way. If you are convinced in your conscience that what you are doing is right, do not let yourselves be discouraged by the uninvited, armchair critics of your heterodoxy and do not seek immediate approval either. Hazlitt says that everything which ceases to be a subject of controversy ceases to be a subject of interest. Great discoveries always have a lag period, they need time to mature. But do not forget either the petty adversities that the world often flung in Paganini's face as a punishment for his "diabolically sublime" genius. It appears to me that the Greek philosophy built on the desire for truth and the sense of tragedy, dealing with existence in terms of the myths of Prometheus, the stealer of fire, and Sisyphus - whose efforts are never rewarded - is not far from the condition of the scientist who is not satisfied with half measures. This may be a better answer to today's problems than a lot of fancy theories.

Man has the capacity to create change, to make progress, and this is all that matters in this imperfect world about which we know so little but often pretend the opposite.

For the future, I want to leave you with a simple exquisite thought written by Emily Dickinson: "*Hope is that thing with feathers that perches in your soul.*"

I wish you all to reach the Promised Land that you hold in your hearts.

Marian Ion Ionescu
Monaco 2015

There are very few privileged surgeons who witnessed and participated, from its very beginnings, in this grand and exceptional adventure, this scientific achievement of open heart surgery.

President's Report

Tim Graham

Dear All

I am very pleased that we are again able to bring you a printed edition of the bulletin due to continuing support from Mr Marion Ionescu. The feedback we have had is that the July bulletin was more widely read than previous electronic editions and generally appreciated by the membership.

National clinical audits

The SCTS/NICOR national adult cardiac surgery audit for the period of 2011 – 2014 was completed during the summer and the information is available on the SCTS website for units and individual surgeons and also now on the consultant outcome programme / NHS website for individual surgeons. During the summer we had a protracted process with NICOR in particular, which required considerable effort from members of the SCTS Executive and especially David Jenkins to maintain the position and interests of the SCTS and its consultant members. We are due to have wash-up meetings with NICOR and subsequently HQIP and NHS England to agree how the process should be taken forward and how and when the 2012 – 2015 adult cardiac surgical audit will be produced. During the summer a sub-group of the clinical audit committee met to agree new definitions for the risk factors to be used in the Euroscore system and they also

produced a guidance document on the interpretation of these new definitions. We are awaiting a response from HQIP following a request to help us deliver the necessary complete audit of adult thoracic surgery. In particular we have asked for support for non-lung cancer thoracic surgery - a substantial part of adult thoracic surgery performed within the UK and Ireland.

Educational issues

The education programme continues to thrive and grow with continuing support from Mr Ionescu, Ethicon/J&J and our other industrial partners. I have recently attended the recent Professional Development Course for SAS/non NTN doctors held in Coventry funded by Covidien. I was impressed with the content of the course, the quality of the faculty and also the enthusiasm of the delegates who now form a large part of the non-consultant workforce in the specialty. We are now arranging for there to be non-NTN/SAS representation on the Executive of the Society.

I have also been able to attend the most recent iteration of the previous Birmingham Professional Development Course for senior NTN's funded by Ethicon and held in their educational facility in Wokingham. Again the faculty were of a very high standard and the senior NTN's and some cardiologists who were also present considered issues including handling complaints and the ombudsman, attending a coroner's inquest, leadership within the NHS, medical error and duty of candour including



referrals to the GMC. The highlight was a presentation from Clare Marx, the President of the Royal College of Surgeons of England, who spoke about "Staying Alive" professionally following appointment to a consultant post. Discussions are now well underway with the organisation of a second annual SCTS universities post-graduate training day. This will be aligned with the Birmingham review course in September 2016, again with the support of Ethicon/J&J, with the potential for approximately 150 delegates to attend. The principle intention of organising this further universities day is to allow members who cannot get to the universities day at the AGM to have access to this SCTS postgraduate educational opportunity. In addition Mr Ionescu has agreed to support the publication of "Perspectives in Cardiothoracic surgery" which will be printed monographs of the proceedings of the Ionescu / SCTS Universities day at the AGM in Manchester last March. Paul Modi is the overall editor for this series and the project is well advanced with publication anticipated early in the new year and repeated for the next Universities day at the AGM in March 2016.

Recently John Butler has put considerable work and expertise into overhauling and updating the educational part of the website making it much more user-friendly and as a consequence the content is greatly enhanced. I would encourage all members to look at this area now.

Mr Ionescu has agreed to support the publication of "Perspectives in Cardiothoracic Surgery" which will be printed monographs of the proceedings of the Ionescu / SCTS University day at the AGM in Manchester last March.

President's Report *continued*

The Executive are in the process of considering options to similarly improve the rest of the website.

We feel it is important to acknowledge that over the past 3 years largely due to the extensive developments in SCTS delivered education across all professional groups we have seen the various membership numbers of the Society rise to above a 1000 (a 15% plus increase) - which is a major testament to the improved benefits which can be obtained through membership of our specialty association.

New committees and appointments

The SCTS Executive earlier in the year agreed that there should be an SCTS Research Committee formed to co-ordinate a society wide approach to clinical research. Professor Gavin Murphy from Leicester has been appointed as the committee chair and he is in the process of forming this committee and jointly outlining its terms of reference. One of the first tasks will be to liaise with the Royal College of Surgeons of England and their on-going research programme. The SCTS Executive also earlier in the year identified the need for and agreed to the formation of an SCTS Professional Standards and Governance Committee to consider issues that have concerned the Executive and its membership recently. Professor Andrew Owens was appointed and he is in the process of forming this committee and outlining the terms of reference together with our lay member Sarah Murray who has a helpful legal background.

External agencies

The Society has recently met with the professional standards group at the Royal College of Surgeons of England to try to improve how job descriptions and person

Please go on to the SCTS website and update your personal portfolio as this is your opportunity to put your own details and practice in perspective – this part of our website is the most frequently visited by the public and our patients

specifications for new consultant posts are dealt with and how SCTS can input to this process and also the subsequent AAC consultant appointment process to optimise the specialist society input. We have identified a relative shortage of assessors for congenital, thoracic and academic consultant posts and we are actively encouraging consultants in these areas of the specialty to undergo assessor training.

Scott Prens partnership

Members of the SCTS Executive recently participated in a further "showcase" event at the Royal College of Surgeons of England prior to the last Executive meeting in October. The focus of the presentations was on partnerships, education and on supporting advanced surgical techniques and clinical audits. Further discussions are on-going with them to try to engage with major trusts and foundations to support our aspirations in these areas.

Joint SCTS/SAC working

I am very pleased (largely due to the endeavours of Simon Kendall and other members of the SAC and members of the SCTS) that there has been the joint production of the Cardiothoracic Surgery UK Workforce Report 2015. This is an excellent example of the benefits of joint working between the SAC and our specialty association. The document has had wide ranging distribution throughout the NHS in England and the rest of the UK as well as the joint surgical colleges, clinical specialty associations and via JCST to educational agencies. The document has been well received and already of considerable use in discussions related to consultant workforce planning throughout the UK. The SAC chairman and myself have recently also been able to meet with the Chair of the GMC and representatives of the JCST to discuss the future direction of training and the curriculum in our specialty and how specialist care can be delivered to our patients in the future .

Current working in the NHS

It is becoming increasingly apparent to myself and the Executive of the SCTS that the environment in which we all work within the NHS is becoming more difficult due to many pressures. We are aware that recently consultants have been dismissed and several others have been in difficulty with their employing trusts with various degrees of restricted practice. The overarching theme for this seems to be that of individual and team behaviour and general professionalism within the work place. With all this in mind we are arranging that the Board of Representatives meeting on Friday 18 December will consider these issues. We are intending to have a session addressing this with external speakers for part of the meeting. There will also

be the usual presentations related to the national clinical audits and updates from education ; the meetings team and the new research and professional standards of governance committees.

At the recent Executive meeting it was agreed that in 2016 the Board of Representatives meeting would be held at the time of the current September/October Executive meeting so that there would be regular 6 month gaps between the Annual General Meeting and the Board of Representatives meeting in the future.

AGM Birmingham March 2016

We are pleased to confirm that Mr Christopher Lincoln has accepted our invitation to receive the Lifetime Achievement Award of the SCTS at the AGM in Birmingham next March. Arrangements for this meeting are proceeding well under the management of the Meetings Team. There has recently been a joint meeting between the SCTS Executive and the Meetings Team with the Educational Committee to align the educational aims and objectives of both the SCTS universities day and the annual general meeting and also to facilitate all

the necessary professional committee meetings which occur around this time. It was confirmed that the leading abstracts will be accepted for publication (according to the wishes of the authors) – we appreciate this is particularly important for trainees wishing to join the specialty through the current system of national selection.

Doctors in training dispute

The current dispute between the UK government, the Secretary of State for Health, the British Medical Association and all doctors in training in England and Wales has caused considerable unrest, particularly within the surgical specialties. The media have become involved causing concern to the general public and our patients. This was discussed at the recent Executive and it was agreed that the trainee representatives on behalf of non-consultant doctors in cardio-thoracic surgery were approaching this situation with a common sense professional attitude. The Executive agreed that any imposed changes were wrong without open and honest negotiation about changes to contracts. There is due to

be a ballot of junior doctors with the potential for industrial action. The Executive feel that any such action would be potentially damaging to both doctors and patients and this position has been echoed in the recent GMC advice for doctors considering industrial action issued at the beginning of November. We feel it is important to emphasise that the Executive continue to recognise that all non-consultant medical staff are vital for us to provide good quality 7 day care for our cardio-thoracic surgical patients and that they are highly valued by and have the support of the whole of the Society.

Finally and again, for consultants, please go on to the SCTS website and update your personal portfolio as this is your opportunity to put your own details and practice in perspective – this part of our website is the most frequently visited by the public and our patients.

And of course - around this time of year myself and the SCTS Executive wish you all a merry Christmas and a happy and peaceful new year - we hope that you all get some time for a well deserved break with your families.

Tim Graham
President



The History of Cardiac Surgery & SCTS

Dear Colleagues

Following my retirement from Clinical practice in Leeds, I have been asked by the SCTS Executive to write a series of historical articles outlining the role of forerunners of the Society in shaping the development of Cardiac and Thoracic Surgery worldwide. These articles will form the beginning of an Archive. I feel quite humble about this appointment as I know several surgeons who are more qualified for the task. To this end I would value your assistance in highlighting momentous achievements in your own Units.

The Beginnings Of Cardiac Surgery

By the end of the Nineteenth Century the pathophysiology of mitral valve disease was well understood. The time was right for the development of Cardiac surgery. However, at a time when great surgical advances were being made in other fields the renowned Austrian surgeon Theodor Billroth made a pronouncement in 1893 that "no man who wishes to retain the respect of his colleagues would dare attempt a suturing of the heart". Though von Rehn (1897) reported a successful repair of a cardiac wound such was the stature of Billroth that the surgical treatment of valvular heart disease was delayed by a further thirty years.

The first surgical approach to the treatment of mitral stenosis was made by Elliot Cutler in Boston (1923). He inserted a valvulotome through the apex of the left ventricle to cut through the stenosed cusps of the mitral valve of a 12 year old girl. The child survived for four years with modest improvement in symptoms. Cutler's next four patients all died within a week of surgery, leading him to abandon the procedure.

On 6 May 1925 Sir Henry Souttar performed a mitral valvotomy on a 19 year old lady who had required multiple admissions for cardiac failure resulting from severe mitral stenosis and regurgitation.

He describes his guiding principles as:-

1. **The operation is carried out on a structure in rapid movement**
2. **There must be no interference whatsoever with the circulation.**

The chest was opened via a curved incision medially along the 4th intercostal space, up along the middle of the sternum and then laterally along the 1st intercostal space. This created a flap that could be rotated laterally and allow division of the 2nd, 3rd and 4th ribs. On opening the chest and again on opening the pericardium the heart developed a tachycardia requiring time to settle. Two stay sutures were inserted into the left atrial appendage which was clamped and opened. A finger was inserted into the left atrium revealing severe mitral regurgitation. When the finger was inserted into the mitral orifice the blood pressure fell to zero. The valve leaflets were relatively pliable so Souttar elected to dilate the valve with that most delicate surgical instrument – the index finger of the surgeon! Following removal of the finger one of the stay



Souttar reflected that this was the first occasion on which the mitral valve had been approached through the left atrial appendage

Philip Kay



sutures tore with subsequent haemorrhage. This was controlled by local compression and the atrial appendage was secured with a ligature. Lily Hine made a good recovery and survived for five more years with improvement in her symptoms before dying of a cerebral embolus.

Souttar reflected that this was the first occasion on which the mitral valve had been approached through the left atrial appendage allowing the interior of the heart to be examined digitally. He believed that this method could not be surpassed for simplicity and directness. However, Sir Henry's groundbreaking work proved to be years ahead of his time. The Physicians of London felt that the operation was unjustifiable and no further patients were referred!!

Once again there was a freeze on mitral valve surgery. Little progress was made until 1948 when Bailey and Harken working separately in the United States and Brock in the United Kingdom (Guy's, Brompton) successfully operated on patients with mitral stenosis. Each had a different technique; Bailey used a commissurotomy knife attached to his index finger, Harken a valvulotome, whilst Brock initially followed Souttar's technique utilizing his index finger. Brock then refined this technique using a mechanical dilator (which he had previously used for pulmonary stenosis). The Brock dilator had a maximal expansion of 3.3cm and was inserted through the apex of the left ventricle. Later Tubbs (St. Bart's, Brompton) developed a dilator whose expansion (up to a maximum of 4.5cm) was accurately controlled by a screw.

So began the era of Closed Mitral Valvotomy, which saved the lives of tens of thousands of young patients with mitral stenosis throughout the world.

PRIZEWINNERS
1994 Annual Meeting of The Society

Mr Anthony C. Ai Suen, British Heart Foundation Research Fellow and Senior Registrar in Cardiothoracic Surgery at the University of Leicester won the Ronald Edwards medal for his paper: "The Effect of Aortic Atherosclerosis on Aortic Graft Patency".

Clivean Cooper, also a Senior Registrar on the South East Thames rotation, won the Cooper prize with his paper entitled "The Relationship of Macrovascularity of Oxygen Supply to Cerebral Tissue Oxygen Tension During Craniopneumy".

Mr S. Gifford is Senior Registrar in Cardiothoracic Surgery on the South East Thames rotation and won the BCTES prize for his paper: "Early Experience with Whole Body 200 DG PET scanning in the Assessment of Patients with Lung Cancer".

David Shorpe of Leeds won the £10,000 St Jude scholarship. This scholarship will contribute to the cost of a project looking at right ventricular dysfunction.

Mr Alan P. Hain, Senior Registrar at Great Ormond Street was awarded the £2,000 scholarship to visit the Boston Children's Hospital and Yale Child Hospital and Mr A. Mason, Senior Registrar at the Freeman Hospital received the £1,000 scholarship to visit St. Paul's Hospital and St. Elizabeth's in St. Louis.

HUNTERIAN LECTURER
On the 16th June Jonathan Ferry gave an elegant and fascinating Hunterian Lecture on "An Investigation of Dependent Discardant Xenograft Rejection" at the Royal College of Surgeons in England.

AMUNDEN SCHOLARSHIPS

YOUNG CARDIAC SURGEONS' CLUB



SCTS Annual Meeting

Birmingham March 2016

Mr C W Barlow, Meeting Secretary

Arrangements for the SCTS 80th annual meeting and Ionescu University to be held at the ICC Birmingham from 13th-15th March 2016 are well underway.

The SCTS Ionescu University will be the 7th iteration of this educational initiative. The aim will be to provide an educational forum to deliver a contemporary review of subspecialist areas of interest within cardiothoracic surgery, to surgeons, surgical trainees and the evolving group of associated paramedical staff; thereby disseminating "state of the art" clinical practice and encouraging progressive development of surgical activity in the UK and Ireland.

SCTS 80th Annual Meeting
13-15 MARCH 2016
BIRMINGHAM



Participants will be exposed to the most contemporary clinical practice in the subspecialist areas, with didactic presentations and group discussions as well as debating sessions facilitated by a national and international faculty. There will be two Cardiac Surgery streams running in parallel. One will be on aortic valve and thoracic aorta surgery in the morning, with a session on contemporary coronary artery revascularisation in the afternoon. The other cardiac stream will have a morning session on mitral valve surgery with an afternoon session on atrial fibrillation surgery. All four sessions will have presentations on both open and minimally invasive surgery as well as the latest technologies. In Thoracic Surgery there will be one stream with sessions running throughout the day on innovations in Thoracic Surgery, debates and controversies as well as contemporaneous developments. The fourth stream will be a Cardiothoracic Forum and wet lab session for the allied medical disciplines. An international faculty of over 25 participants have accepted invitations to speak at the University and participate in the subsequent Annual Meeting. The list of the faculty will be published shortly on the SCTS website. They include pre-eminent Cardiac and Thoracic surgeons from the United States and Europe.

The subsequent Annual Meeting will continue to provide an educational platform in subspecialty areas of clinical practice with a multidisciplinary format offering a significant learning opportunity to develop practice in the United Kingdom in Ireland. The significant national and international faculty has been constructed to explore the most contemporary areas of cardiothoracic surgery and a series of invited lectures will be interspersed with accepted submitted abstracts. More than 300 submitted abstracts have been received and are currently being graded. During the Annual Meeting there will be simultaneous Cardiac and Thoracic Forum sessions covering a wide range

of different fields of interest. There will be a plenary session between 10.30 and 12.30 on Monday 14th March, during which there will be no other activities, and where a lifetime achievement award will be made to Mr Chris Lincoln for his extraordinary contribution to Cardiac Surgery. During this plenary session there will be the award of scholarships, a presidential address and high impact abstracts.

Several satellite meetings will take place and details of these will be found on the SCTS meeting website. These will include patient involvement groups, trainee and student meetings, the congenital sub committee meeting, audit and database meetings, the ACTA committee meeting and the thoracic and cardiac sub committees. There will be the usual format of "giants" interviews as well as scholarship interviews.

The meeting treasurer, Sunil Ohri, has constructed a new series of fees which should provide excellent value for the educational opportunities that are being provided. The full fee schedule is available on the SCTS website. There are significant fee advantages for SCTS members and for early bird registrations. There are separate fee categories for medically qualified consultants, trainees and non-medically qualified registrants. In addition there are separate University and single day fees available for delegates wishing to attend only the University or a single day of the Annual Meeting.

Certain key abstracts will now be published, in a format that is yet to be agreed, but only with the permission of the authors. More details will follow on the website. The full program will appear on the SCTS website with details of the app and how to download the app. A printed programme will be available at the time of registration. As well as the app there will be a newspaper publication – supported by Dendrite as was the case at Manchester in 2015.

Finally, on the social front, there will be the usual football tournament. The annual dinner will be preceded by drinks in the spectacular Birmingham Museum and Art Gallery, and will take place in the magnificent, centrally placed Council Chamber (and will feature a surprise theme).

As in previous years Isabelle Ferner, the lead Conference Organiser, and Tilly Mitchell, the Exhibition Organiser, can be contacted by email or directly at the SCTS offices with any questions or concerns. (Contact details at www.scts.org)

Birmingham 2016 promises to be a stimulating, educationally rewarding and exciting Annual Meeting and Ionescu University. Early bird registration is strongly encouraged.

Mr Clifford W Barlow DPhil (Oxon) FRCS (C/Th)
 Consultant Cardiothoracic Surgeon

The Asian Society for Cardiovascular and Thoracic Surgery 23rd Annual Meeting

Tara Bartley

Members of the SCTS were invited to the Asian meeting to deliver two plenary talks. An interactive session on Training in Cardiothoracic Surgery - Improving Quality and Assessment was delivered by Mr. Tim Graham, Mr. Michael Lewis, Mr. Stephen Rooney, Mr. Alistair Royce (Australia) - and Ms. Tara Bartley was invited to give the opening remarks for the Nursing Meeting – Essentials In Nursing.

The Training in Cardiothoracic Surgery - Improving Quality and Assessment

This session explored the importance of education for current and future surgical teams and the frameworks that have been put in place to underpin excellence.

The session addressed the development of surgical curriculum and use of workplace based assessments; whether distance learning is feasible for Cardiothoracic Trainees; how and why we have created quality assurance of cardiothoracic training programmes; the role of summative assessment in cardiothoracic surgery, if we can define an International standard and if advanced nursing and paramedical roles can support multidisciplinary service working delivery.



We are aware the Cardiothoracic specialty has been at the forefront of workforce planning to ensure that the surgeons and allied health professionals of the future are fit for purpose and can deliver excellent care throughout the patient journey.

The processes involved in selection and training of surgical trainees have undergone rigorous review to ensure the recruitment of trainees with excellent all round ability.

The SCTS has secured a profile at both National level and within the Cardiothoracic specialty to influence the development of the core and specialty surgical curriculum in line with other specialties, and the training and assessment of a quality to meet educational standards. Moreover, the degree to which this is accessible has been expanded to explore different forms of direct and indirect learning.



The desire to augment this training, in addition to the impact upon the workforce resulting from the European Working Time Directive and restrictions of non UK doctors entering the health service has led to the development of allied health professional roles to ensure the specialty continues to provide excellent service delivery.

The unique nature of cardiac surgery throughout the patient journey has resulted in parallel development high quality nursing and paramedical roles.

The session was also able to share the SCTS Education sub committee's strategic vision to encompassing the delivery of education surgical trainees and allied health professionals and celebrate that there is now a comprehensive education programme for all levels of trainees and the allied health professions. The session was well received and provoked an interesting discussion.

The Nurses day – Nursing Essentials

I was privileged to be invited to provide the Opening remarks for the Nurses day during which I was able to celebrate nursing and team working in the UK.

The session was titled Advanced practice in the UK. I was able to give an overview of the development of nursing and AHP roles, the education underpinning practice development and how we measure success. The session drew upon the National work reviewing workforce issues with the Cardiothoracic speciality and achievements over the decade.

The meeting was very well attended and delegates were an extremely enthusiastic audience. Papers were presented on nursing aspects of CALS, ECMO, LVAD, TAVI, negative pressure wound management to name a few. It was a great opportunity to network and reassuring to know that nursing faces the same challenges the world over.

The UK contingent were able to attend the Annual dinner and had the opportunity to experience Asian culture. Mr. Malcolm Underwood was a gracious host and a part of a dedicated team that delivered an extremely successful meeting.

Allied Health Professional Education

Tara Bartley

The SCTS Education subcommittee is seeking to develop an Allied Health Professional (AHP) Education portfolio to underpin knowledge and excellence in practice.

To date the AHP arm runs the following courses annually:

1. Three Surgical Care Practitioner (SCP) master courses aimed at qualified SCPs.
2. The Annual Revision Course for SCP trainees
3. The SCTS Advanced Cardiothoracic two day interactive course which is aimed at nurses, SCP's, physiotherapy, junior doctors and allied health professionals. This runs in the autumn with a one day version at the SCTS annual meeting University day
4. A one day course on How to set up an Allied Health Professional service. This course was run in February at the RCS Edinburgh offices in Birmingham and again in October at St Thomas' Hospital, London.

There is also work in progress on a joint project with BUPA to develop a patient education & information web page on the SCTS web site.

External courses such as CALS are also recognised as excellent educational opportunities.

There is a constant review of content to ensure it reflects evidence based practice and meets current educational standards

While these courses are well established there is a constant review of content to ensure it reflects evidence based practice and meets current educational standards.

A 2015 review of provision has highlighted three further areas where educational provision is required for Allied Health Professionals.

The Joint Royal College of Surgeon, England (RCS) and SCTS Surgical Practitioner examination is no longer endorsed by the RCS and needs to be brought into line with current educational standards. The SCTS feel it is essential that a national benchmark standard is recognised for this cohort of professionals, so Mr Norman Briffa is leading the work that is currently taking place to develop a new diet of the **SCP examination in collaboration with the RCS Edinburgh**. This will be in place in November 2016.

There also needs to be a focus on education and training for Theatre staff so discussions are taking place with Cardio Solutions to provide opportunities for this group of staff.

In addition the Education sub committee have identified a gap in Educational provision for band 5/6 nurses. There is now work in progress to create a course to fill this void, **The Core Principles in Cardiothoracic course**.

The strategic element of delivering such a course is challenging. It is envisaged that the SCTS will develop a core set of lectures/programme/format that will be delivered regionally. Initially this will be with a core faculty (Tara Bartley, Christina Bannister, Bhuvana Bibleraj, David Quinn and Stephen Woolley) with the aim of a 'teach the trainers' approach and a local leader in each region/unit. There is a plan to target seven regions to

bring this course to fruition.

After canvassing opinion at the 2015 SCTS Annual meeting it was highlighted that finance to support attendance and registration are always an issue for Allied Health Professionals. The SCTS are looking to gain support from industry to provide the course to all regions/centers with the ambition to run the first regional course from February 2016.



SCTS Education

The SCTS feels it is a priority to help overcome access barriers to education that underpin the delivery of excellent quality care.

It is recognised that the success of this education vision is not only dependent on the SCTS contribution and support from Industry but that national engagement from all units and professional should be established. The footprint for levels of engagement has been established via networking and attendance at the Cardiothoracic Forum and the established courses. However, it is recognised that provision for band 5/6 nurses is ambitious due to the large numbers and geographical location of units. It is for this reason that the Core Principles course will run regionally with the infrastructure described. Furthermore, the SCTS Education Subcommittee will seek direct support from Directors of nurses, Cardiothoracic Surgeons and lead AHP's in each unit. This in turn will benefit units and patients.

Thoracic Audit Update

Doug West
Thoracic Audit Lead



LCCOP year two

As I write this, the deadline for validation of data in the Lung Cancer Surgery Consultant Outcomes Publication (LCCOP) for English units has just passed. We expect to see the second annual LCCOP report published in early 2016. The outcome measures reported will be identical to last year: 30 and 90 day mortality at unit level, and resection rates. This is the last time that unadjusted data will be published- next year we expect some risk adjustment, within the confines of the comorbidity data held within the NLCA dataset.

We know that the raw National Lung Cancer data contains inaccuracies. Post-collection validation by the surgical teams themselves is vital to ensuring accuracy. The validation process remains highly permissive; tell LCCOP that you have done a case and, provided that you can provide the associated data, it will be added to LCCOP.

data collection for the three projects (LCCOP, database and returns) has become untenable. Submission of data has been falling. These issues have led the Society to close the database at the end of the 2015-16 financial year, and to focus on other audit projects.

The hard work members have put in is not in vain. Lessons learned will feed in to LCCOP and future projects.

Unresolved issues

HQIPs decision to audit lung cancer surgery outcomes is to be welcomed. Lung cancer is a major public health issue, and this work is a large part of the major surgery we perform. LCCOP's major strength is that resection rates are published alongside peri-operative mortality, so surgeons who take on complex cases will have some degree of protection. However, it leaves other areas within thoracic surgery without an audit. The Society has been lobbying HQIP to address this issue, and we have been looking at some novel options outside the current COP to address this problem. The situation remains unresolved, but we hope to report some progress soon.

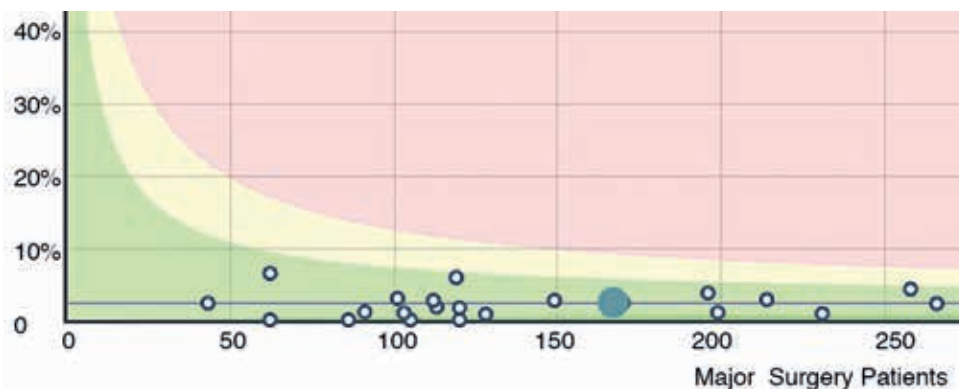
Secondly, as a Society we need to be advancing the cause of thoracic audit in the devolved UK nations and Ireland. We NLCA has long published summarised data from Wales and

Scotland, and we are exploring whether these associations could be extended to LCCOP in some form.

Representation within SCTS

In response to recent changes, the Society has updated its thoracic audit structure. A new thoracic audit group, including representatives from Ireland and the devolved UK nations, has been established. I'm grateful to Mo Asif, Joel Dunning, Juliet King, David Healy, Eric Lim, Kieran McManus, Carol Tan and most recently Ira Goldsmith for joining. They should ensure that the voice of members is heard, and that the considerable expertise within the SCTS can be utilised to support LCCOP and other projects.

We will be holding thoracic audit sessions at the annual meetings, and updating our members via email, on SCTS.org and through presentations at the forum, BTOG and elsewhere. Please let me know your views at these events, or contact me directly at doug.west@bristol.ac.uk.



Please keep LCCOP up to date if your audit lead, data team or contact emails change.

The Society advises the LCCOP project, although it does not commission it. Further discussion is needed on the outcomes published. Are the ones used indicative of good practice, and most relevant to our patients? Are outcomes enough, or should we broaden the focus to some process-of-care metrics (for example, pneumonectomy rates) in the future?

The SCTS Dendrite database

Three years ago, supported by UK GMC funding, the Society established a thoracic database, run by Dendrite. Many units and members have contributed to this project. We are close to securing funding to publish an analysis of the database, and an update on the returns data, in a third "blue book" next year.

However, the database in its current form faces major challenges. It does not have permission to hold patient identifiable data, making linking to NHS datasets impossible. Funding ends in 2016, and with the advent of LCCOP in 2014 the burden of

Cardiothoracic Surgery in the UK

Falling Back or Springing Forward?

As a child born after the first heart transplant was carried out, there was no way of growing up unaware of the giants that seemed to propel cardiothoracic surgery forward.

To some extent, this awe of the speciality partly made me steer clear of a posting in it as a medical student. Strange circumstances led me into this field, and having fallen in love with it since the first day I was allowed to cradle a beating heart in my hands, I still believe that this is probably one of the most rewarding jobs available today. If that is the case, why are we struggling to attract youngsters to our speciality? I am aware that many of the senior surgeons in cardiothoracic surgery are jaded and confused as to what the future turn of events will have in store. Are we a speciality in terminal decline or are we just a group in the wilderness needing redirection to a better future?

PCI

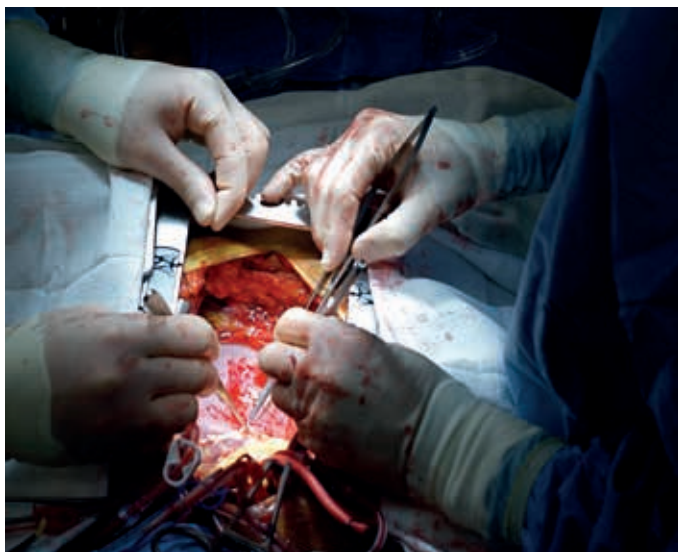
Percutaneous Coronary Intervention (PCI) is considered by many in the field to be the single intervention that started this steady decline in fortunes and stature of Cardiac surgery. I completely disagree. I think this will be in hindsight, looked at as the moment our speciality was forced to move from complacency to innovation. As much as I agree with David Taggart and his evidence collation against the widespread use of PCI, the real drivers of this “disruptional technology” are often patients rather than cardiologists. We have to understand one basic tenant of public psychology. As Steven Levitt describes it, in his bestseller *Freakonomics*;

Perceived Risk = Hazard x Outrage

The hazard (actual risk) of PCI and surgery is often the same in most randomised studies. The stroke, heart attack and death rates are very similar in the short term. Despite this, patients will perceive surgery to be more risky because of the outrage that the idea of surgery creates in the mind. To understand what specific aspect influences the outrage most, I have spoken at length to patients in different countries. The common three issues that come up most often are, sternotomy or “splitting of one’s chest”, the saphenectomy or “the big cut up the leg” and general anaesthesia for its “loss of control”. If we are to win

We need to understand that competing procedures can exist alongside each other rather than having to replace each other.

the battle of risk perception, we, as a group, have to approach each of these systematically and increase the percentage of our patients who can avoid one or all of these violations.



We, in Cardiac surgery, must remember that when it comes to life prolonged or improved, there is no other speciality that matches us for cost effectiveness. Oncological drug companies use persuasive arguments to fund expensive medication to achieve gains in days to weeks. Every time we deal with a congenital heart defect, left main stem disease, severe aortic stenosis or mitral regurgitation we extend life by months to years. Of course, the quality of life improvements are unmatched too. Why then are we not as well reimbursed as some other specialities? There is the constant hope that percutaneous techniques will replace cardiac surgical procedures. It started in the late 1990’s with cardiologists, industry and venture capitalists truly believing that by 2010 there would be no need for coronary artery bypass grafting. We know how wrong that prediction turned out. Today we hear similar predictions on TAVI replacing aortic valve surgery and percutaneous techniques replacing mitral surgery. The real frustration is that more cardiac surgeons believe this than the cardiologists actually involved in these techniques. I have no doubt that TAVI is here to stay. It will find its niche... but will never replace surgical aortic valve replacement. Mitral valve disease will also be treated by a range of options in the future. Our voices need to be more often heard in the corridors of power, making the point that in times of economic downturn, we surgeons are much better value than most medical alternatives.

OPCAB

I am amazed that nearly 20 years after the original papers regarding off pump surgery, we are still debating this issue at

Joe Zacharias

*Consultant Cardiothoracic Surgeon
Blackpool Victoria Hospital*



international meetings. This must mean only one thing. Off pump surgery (OPCAB) is not the disruptive change we had all hoped for. There is no doubt that for a group of patients, OPCAB is excellent. Most of the benefits seem to be related to the lack of aortic manipulation. Some benefits are gained in avoiding cardioplegia. But I do not think that bypass itself is as detrimental as it was initially considered. It is obvious, that patients the next morning after surgery cannot tell you if they had their operation on or off pump. They certainly can, if you don't do a sternotomy. I applaud the few surgeons who are able to do closed chest OPCAB. These are probably surgeons akin to Dr Kolesov and Dr Lillehei. They did procedures that will not be applicable to the wide majority of patients across the world. It was cardiopulmonary bypass that made this speciality what it is today. Trying to avoid it was a great idea but we need to now regroup and pick the lessons learned from this experience and try and apply it to closed chest procedures. We need to use the stabilisers, increase the use of bilateral mammaries to avoid manipulating the aorta, use shunts to protect from regional wall ischaemia and think of many other ways to improve the patient experience. We need to continue to use better and smaller bypass circuits to avoid the dreaded but rare pulmonary complications that sometimes follow, even after the shortest of pump runs. Most importantly we need to partner with industry in making the technology available to do this safely in the hands of many surgeons.

One size doesn't fit all

The next challenge we face as a speciality, is the lack of multicentre registries to answer important questions that would benefit patients. We need to understand that competing procedures can exist alongside each other rather than having to replace each other. One size does not fit all. As a group we need to get better at picking the right approach for the right patient and stop preaching blanket therapies. Cardiothoracic surgery has got too complex for simple answers. Our reputation was made on the back of excellent results and that must be protected even at the expense of a possible reduction of volumes. We must learn from cardiologists how to standardise procedures so that trials can be carried out to answer important questions quickly. If a procedure is too complicated to be reproducible we need to put our best minds to make it simple. We need to collaborate with industry in trying to simplify non sternotomy options to the aortic, mitral and tricuspid valve. If we are to get the next generation interested in our speciality, we will have to embrace technology to make most cardiac surgery safely reproducible in the hands of surgeons interested in a healthy work life balance. The challenge we face as a speciality is not to dumb down training, but to come up with different ways of training to produce competent surgeons

in a shorter period. I was one of the first Calman trainees, with a time limit on our training period. We were expected to be disasters as consultants. Fortunately my trainers pulled out all the stops and I have kept my job into my 11th year despite a period of intense scrutiny! With every passing generation, the surgeons get less talented but technology helps newer surgeons do a better job. It is counter intuitive, but in these economic times it is more technology that will save our speciality and not doing more of the same. I do believe that like minded surgeons need to come together soon to make this a priority.

We, in Cardiac surgery, must remember that when it comes to life prolonged or improved, there is no other speciality that matches us for cost effectiveness.

Finally I would like to say that we presently are starved of visible role models in our speciality. Growing up I was always aware of cardiac surgeons in the popular media. Their struggles for success, against all hardship was covered by the popular media and that led to an interest from young bright kids who wondered if they would grow up into astronauts or cardiac surgeons. With improving technology making single port robotics, destination ventricular assist devices, and minimally invasive valve surgery a reality, we have another opportunity to interest the public in our efforts to improve our already excellent results. It is indeed hard to learn new procedures without a learning curve. But it is being done all around us. As a speciality we need to capture the imagination of our future trainees. We need to continue to attract the most talented to secure the future of this speciality. I was recently asked to speak to a group of medical students about the future of cardiac surgery. I was pleasantly surprised with the knowledge and interest many of them showed towards the speciality. With lung cancer screening around the corner and minimal access solutions to mitral, aortic and tricuspid valves and coronary artery disease becoming more reproducible and miniature destination devices for heart failure in testing, the future of this speciality has never been more exciting. It is for us in the speciality to reinvigorate it, sharing with future generations the huge potential that this amazing speciality has and letting others realise the many gifts it gives each one of us.

Starting Out in Minimally Invasive Aortic Valve Replacement in the UK

Introduction

Clinical effectiveness and patient safety is paramount when introducing a new procedure or technique in the current NHS climate. Here we describe in detail the logical procedure and philosophical approach to establish a minimally access aortic valve replacement programme in the current era. A real example of a National Health Service Trust in the United Kingdom has been described in a step-wise manner. The outcomes of the new procedure established in this fashion are reported and the philosophical lessons learnt from the experiences are highlighted. It is hoped that this paper will act as a template for newly established surgeons to embark on a mini-AVR programme.

Establishing the Need

Minimally Invasive Aortic Valve Replacement (Mini-AVR) is now an established procedure. The first parasternal approach for mini-AVR was reported by Cosgrove and Sabik in 1996 following the minimally invasive revolution in general surgery in the late 1980's. Further evolution has resulted in the upper mini-sternotomy and the right thoracotomy approaches to be currently the most popular ones. Upper mini-sternotomy provides a window through which the aortic root is freely accessible. Without additional risk to the patient, the surgeon applies slight modification to already established familiar techniques. This offers the patients the benefit of prompt recovery in appropriately selected patients and enhances patient choice and patient experience. Although suited for isolated AVR in patients of all ages, mini-AVR is particularly applicable to the elderly, obese, recent smokers and those with impaired respiratory function. As compared to a conventional sternotomy, the hemi-sternotomy leaves the sternum

more stable. We believe that mini-AVR is particularly suitable for patients who may have a higher risk of sternal dehiscence but otherwise suitable for conventional AVR. Hence these are not patients who would be considered for TAVI. Some studies have demonstrated reduction in hospital stay with mini-AVR. With an increasingly elderly population in a

Upper mini-sternotomy provides a window through which the aortic root is freely accessible. Without additional risk to the patient, the surgeon applies slight modification to already established familiar techniques.

tight fiscal climate, reducing the length of hospital stay after AVR, even by 1-2 days, could translate into better overall clinical outcomes and huge savings in the UK and worldwide. Applying this argument would be a key selling point when trying to set up a mini-AVR service in a cardiac surgical unit in Europe. A smaller scar, less pain and blood loss are other potential benefits. In centres where this procedure is well-established, the referral base has significantly increased as mini-AVR is requested both by the patients as well as the cardiologists.

Training

It is also important to establish any training needs, not only for the surgeon, but the whole team including anaesthetists, perfusionists and the scrub team. Before the first cases are performed, local departmental teaching

should be organised (lectures, evidence, videos, etc.) where all disciplines are invited. We used a combination of theoretical information as well as operative footage in order to familiarise the team with the procedure and its potential pitfalls. Visits to 'mini-AVR centres' and attendance at courses targeted at new centres are strongly advised. From the surgical perspective, at least 2 surgeons are required with an interest in minimal access surgery. An experienced aortic valve surgeon teaming up with a newly appointed surgeon would be the ideal combination. Enthusiasm and wisdom are the 2 key elements that are required to set up such a programme. In our unit, JS had performed hundreds of conventional AVRs and had visited a UK centre to observe mini-AVRs. On the other hand, HV had performed >100 conventional AVRs but had spent time in fellowships, first learning minimal access surgery in Belgium and then returning to another fellowship at St. Thomas' Hospital, UK (CPY) focusing on mini-AVR, TAVIs and rapid deployment valves. HV had performed 5 mini-AVRs independently during his fellowship.

Trust Approval

NIPAG Application

In our trust, all new procedures need prior approval from the New Interventions and Procedures Advisory Group (NIPAG). These groups or committees exist in one form or the other in most hospitals. It is crucial that the team endeavours to gain approval from such committees before embarking onto a mini-AVR programme. This ensures patient safety, highlights clinical governance and maintains quality control. The NIPAG application requires description and indications of the proposed procedure, intended benefits, possible complications, summary of evidence base, estimated number of

**Hunaid Vohra**

Department of Cardiac Surgery, University Hospitals Leicester, Glenfield Hospital, Leicester, UK

Jacek Szostek

Department of Cardiac Surgery, University Hospitals Leicester, Glenfield Hospital, Leicester, UK

Christopher Young

Department of Cardiac Surgery, St Thomas' Hospital, London, UK

annual procedures to be performed, names of supporting colleagues, names of performing colleagues and letter of support from lead clinician.

Support from Colleagues

Ideally, the proposed procedure should be discussed with all Consultant surgical colleagues formally and their support sought, even if all of them would not be performing the new procedure. The names of the surgeons performing the operation in the 'setting-up' phase should be specified. Once this phase has passed and the final approval from NIPAG granted, other surgeons may also be able to embark onto the programme with appropriate in-house training.

Proctor

It should be considered compulsory to have a named proctor (CPY in our case) with considerable experience and reputation in the field to provide training and supervision in the first cases performed. The ideal proctor is one with whom at least one of the operating surgeons has worked or trained with before (HV in our case).

Patient Information Leaflet

NIPAG also requires that a patient information leaflet is devised in a language easily understood by patients where it is clearly stated that this is a new procedure to the trust but the surgeons involved are adequately trained and will be initially supervised to perform this. The leaflet informs the patient of the potential benefits and that this operation would not put the patients at higher risk of harm as compared to conventional surgery. Reassurance should also be provided that in case of a serious complication the incision will be made bigger to control the situation. The leaflet is intended to educate the patient

with respect to the 'new technique' and provides them with an option they may wish to consider.

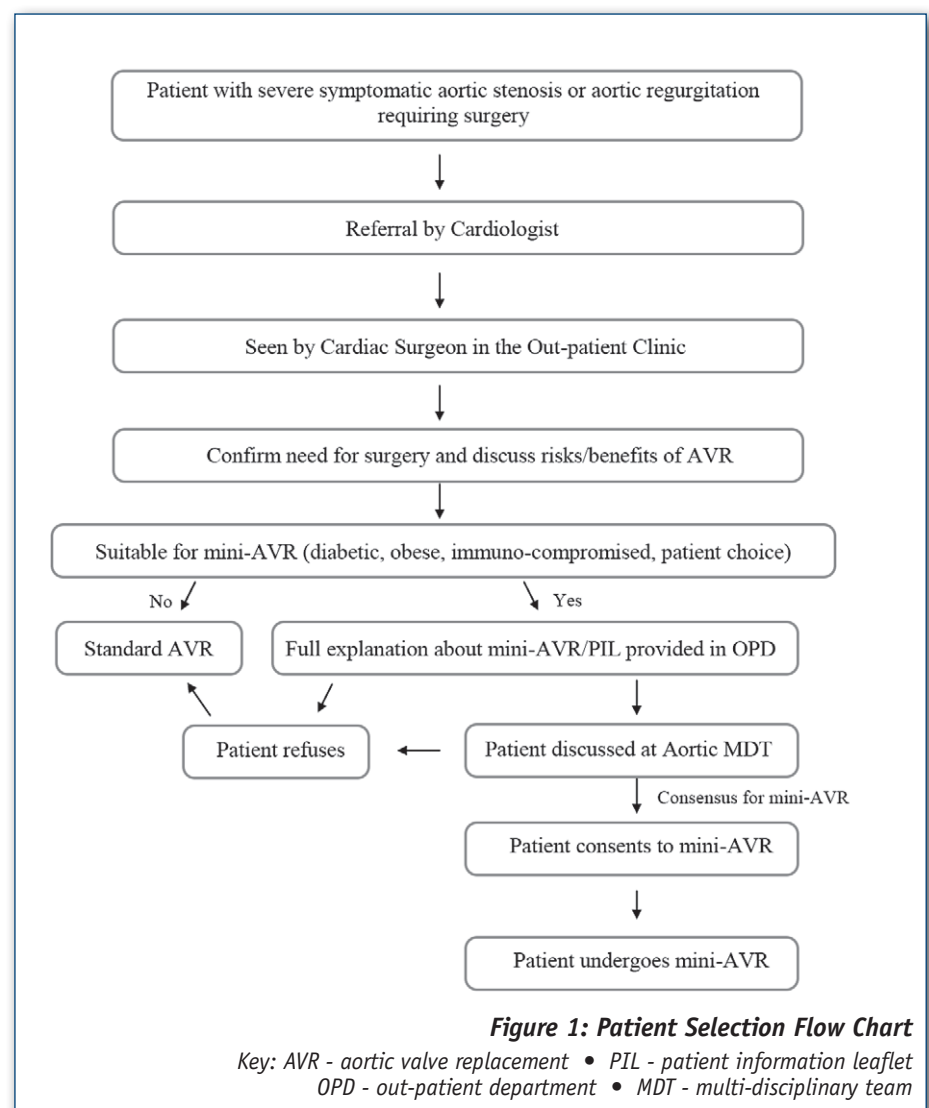
Audit

NIPAG also requires that individual patient audit and a summative audit is provided after the first 20 cases are performed. Any untoward serious event must be reported and copied to NIPAG. This provides the foundation for the final Trust approval. Regardless, once the procedure becomes well-established,

6-12 monthly audit with morbidity and mortality figures would be recommended best practice.

Cost

Although new additional costs can be involved, mini-AVR can generally be performed without the requirement for any special equipment. The Trust Management should be reassured that extra funding would not be required for starting a mini-AVR programme.



Starting Out in Mini-AVR continued

Take-off

Communicate

Before the programme commences, every effort must be made to encourage open discussion in a relaxed environment, to exploit every opportunity to highlight concerns regarding equipment and training and to facilitate team-work and boost morale. This becomes paramount if previous experiences have not been positive. Frequent informal dialogues in corridors and coffee rooms as well as formal discussions at regular Consultant, Monthly Audit and other Clinical Governance meeting should not be under-estimated.

Patient Selection

In the initial period (first 20 cases), patient selection is the key. Avoid very elderly, grossly obese, current smokers and high-risk patients. Once the programme is 'up and running', it is these very patients who might benefit from mini-AVR. At the outset, the skin incision can be made slightly longer as it is the mini-sternotomy and not the skin incision which provides clinical benefit. A flow chart of patient selection for mini-AVR is provided (figure 1, previous page).

Proctor Contract

As the proctor is likely to be working in another trust, he will require a local contract to be able to assist with surgery. To avoid last minute disappointment, ensure that this is organised beforehand. Although sounds tedious, but this can be easily and quickly done by communication between the Human Resources Departments of the 2 NHS Trusts (if applicable).

Team Briefing

Prior to the first case, the whole team must be extensively debriefed (with the proctor present) and ensure that all

equipment required is available. It is important that all members of the team are encouraged to ask questions at this point to provide further opportunity to highlight issues and promote team involvement.

First 20 cases

The first case in our programme was performed by the more experienced surgeon (JS) with the proctor (CPY) as the first assistant and the other surgeon (HV) as the second assistant. The second case was again performed by JS with HV as the first assistant and the proctor observing unscrubbed. During these cases, there were frequent technical points discussed which helped enormously. Thereafter, another 3 cases (unproctored) were performed by the 2 surgeons scrubbed together and then the rest of the first 20 cases were performed by one surgeon individually with the other surgeon on back-up within the hospital, if required. After the first 20 cases, the audit was submitted to NIPAG and final approval granted. Currently, 90% of patients undergoing AVR in our practice are undergoing this via the minimally invasive route. On an average, in our hands, the cross-clamp time is 10 minutes longer and the whole procedure takes 30 minutes longer compared to conventional AVR. Hence, the surgical time of mini-AVR is comparable to conventional AVR.

Examples of technical difficulties

Although not the subject of this paper, nevertheless below are some examples of technical difficulties that we experienced in the initial phase of the program with a brief explanation of how they were solved.

Difficult access:

By increasing the length of the skin incision and/or changing from a J to a T hemi-sternotomy or sternotomy into the

5th intercostal space instead of the 4th space.

Right atrial venous pipe 'in the way':

Use a flat venous cannula and pass it under the retractor before connecting to CPB circuit.

Blocked drain:

Using 2 drains of two sizes smaller instead of one big drain.

Difficulty in placing ventricular pacing wires:

Insert while the heart is arrested before removing the cross-clamp.

Key lessons learnt

- Work together with an experienced surgeon
- Proctor essential
- Always have back up
- Do not be afraid to convert
- It is not as difficult as it sounds

Conclusion

The universal adoption of mini-AVR in contemporary cardiac surgery seems inevitable in the foreseeable future. It is a safe and logical option from the data provided so far from studies and registries. An open-minded and enthusiastic team will undoubtedly be able to facilitate the introduction of this 'new service'. The 'starting-up' period can be daunting for a newly appointed surgeon. However, a sensible approach will provide safe and sustainable outcomes.

Corresponding email:

hunaidvohra@yahoo.co.uk

Personalised External Aortic Root Support (PEARS): update on research and development plans

Tom Treasure & John Pepper
on behalf of
Pears Investigators

The NIHR Research Design Service worked with us on a trial design¹ but it was judged that a randomised trial was virtually certain to fail for two reasons:

1. The rarity of the disease. The number of patients at a point in their lives when they are facing the choice of prophylactic surgery is inescapably small.
2. There are differences in the merits and potential adverse consequences of Bentall and Valve sparing surgery such that people with equipoise in any comparison with PEARS will be rare.

PEARS is a niche innovation developed for aortic root aneurysm due to genetically determined aortic pathology² in which the phenotypic morphology is expressed and aortic root dimensions are increasing.³ It shares the merits of valve sparing root replacement (VSRR) and has some in addition.⁴ Being non-ablative PEARS can be considered earlier in aneurysm progression, reducing the stress of waiting. It presents no obstacle to further surgery ('no bridges are burnt') but to date in no case has further surgery been necessary. With nearly 250 patient years of clinical experience in nearly 60 patients during the past twelve years believe we can make these statements thus far.

- Because of the use of a custom-made open mesh implant manufactured for each patient PEARS must be emphatically distinguished from ad hoc 'wrapping' of the aorta with materials not designed for this purpose.²
- The mesh is fully incorporated with an increase in strength and thickness of the aortic wall.⁵
- After a sudden arrhythmic death of one patient at 4.5 years, the aorta and valve were found to be intact. There was histologically normal collagen in the media of the supported aorta⁷ suggesting healing as a result of the abolition of wall stress.^{9;10}
- The size and shape of the aortic root are unchanged in all patients at a median follow up of six years and as long as twelve years. Wall stress is abolished at the usual site of intimal tear.¹⁰ Taken together these finding make dissection unlikely.
- Aortic valve function has been maintained without exception.¹¹
- The histological incorporation of the mesh means that it cannot migrate.⁶ In two patients in whom a coronary angiogram was performed for other clinical reasons the orifices remained widely patent and of normal appearance after one and seven years.^{7;8}
- Cardiopulmonary bypass can usually be avoided and anticoagulation is not required.¹²
- The only death related to this surgery on an intention to treat basis was due to vascular injury in association with severe pectus deformity, a reminder that 'safe' is a word to use carefully with respect to any aortic surgery.¹¹

PEARS meets the criteria for proof by observational studies.¹³ We propose, on the available evidence, that PEARS can be considered in Marfan syndrome earlier than root replacement. Therefore it will be further evaluated in the time honoured fashion of carefully collected and reported clinical case experience.^{3;11} While it is disappointing to not pursue an RCT, Bentall and VSRR were both established *without* randomised studies. Our policy is to promote the use of PEARS by proctoring surgeons wishing to adopt this technique. We would welcome any enquiries.

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Innovation and minimal access surgery: How do we keep patients safe?

Our specialty continues to innovate, and adult valve surgery, lung resection and pectus procedures are all areas where there has been an impetus towards a minimal access approach, driven by surgeons, patients and industry, with claims of less surgical trauma and quicker return to health. The term “minimal access”, of course, merely refers to the portal employed in approaching the operative area – in all other respects the procedure is similarly invasive to a standard operation. The proportion of such operations continues to rise and it seems likely that, for some procedures, a minimal access approach will become the standard of care.

Introducing these novel methodologies to well-established procedures with consistent and predictable outcomes brings both potential benefit and real risks. Claims of faster recovery and better cosmesis must be weighed against patient safety, which is, or at least should be, our paramount consideration. “First do no harm”, which inspired the title of Henry Marsh’s book¹, is the primary dictum of the Hippocratic Oath, and must always be our guiding principle in patient management. Surgery, of its nature, is pain for gain, and the adoption of new techniques brings inherent challenges.

Risk

For patients undergoing routine cardiac surgery, an operation, when carried out in a conventional way, carries a small and, by widespread opinion, acceptable risk. However, it is indisputable that a few patients have come to grief when those procedures employ a minimally access approach. Some have died, an outcome which would normally be considered extremely unlikely using an orthodox approach. Mortality, as ever, is the tip of the iceberg, and it is likely there will be a corresponding higher level of morbidity. There is, however,

no robust information comparing risks of the two approaches including all cases done. Studies on large series in established centres show that minimal access procedures can be done safely, but concern surrounds the introduction and learning curves of the new techniques. Some units have introduced minimal access programmes which in time have been abandoned on the back of a difficult learning curve and adverse outcomes. One of the fathers of minimal access mitral valve surgery, Hugo Vanermen, has opined that this approach transfers the “pain of the operation from the patient to the surgeon” (and in these instances back to the patient?). Outcomes of death and disability are of course catastrophic, above all for patients and their families, but they can also be catastrophic for health care personnel and systems. They can also erode the confidence that society has in the medical profession if patients and the public believe governance in this setting is not sufficiently robust. Heart disease, as with disease of any vital organ, is perceived by patients and society as a dangerous illness, and any operative surgical approach might be expected to be associated with a high risk of serious complications or death. In cardiac surgery, however, and barring unforeseen catastrophes from left field, first-time patients under 65 years of age should simply NOT die as a result of a straightforward mitral repair, aortic valve replacement or an uncomplicated atrial septal defect closure. In the setting of an innovative procedure we can too easily ascribe an unfavourable outcome to the recognised complications of a heart operation or, in the words of the coroner “a complication of necessary medical or surgical treatment”. Furthermore, one or two such deaths in an annual practice of hundreds of heart operations can be easily ‘lost’ as a small increase in a small numerator of a large denominator.

Errors

We surgeons have all made errors which have harmed patients. In the context of innovative practice, the room for error is further augmented by the need to adopt unfamiliar techniques and the inescapable learning curve. A possible further aggravating factor, when a minimal access operation is proceeding at a snail’s pace, with bypass and cross-clamp times well beyond the norm, may be surgeons’ unwillingness to cut their losses and abandon the approach for whatever reason which, dare it be said, includes stubbornness and, professional vanity.

So, how should we approach the adoption and uptake of new surgical techniques? How do we build in sufficient safeguards to ensure that we ourselves would consider undergoing such a procedure? Importantly, how do we build in triggers which will prevent professional vanity and the enthusiasm and excitement of a new operation to undermine the safety of routine operations?

To err is human, to fail to learn from a mistake is inexcusable, to try and cover up is unforgivable²

The man or woman who makes no mistakes does not usually make anything³

Mark Jones
Steven Hunter
Samer Nashef

There are well-established rules of engagement for new surgical techniques. These can be found in your local hospital practice for new procedures, in specialty-led initiatives, in the Royal College of Surgeons' Good Surgical Practice, and, for example, in recommendations by NICE. Many aspects will need to be considered, including systematic training, wet labs, visiting experienced centres, establishing a multidisciplinary team, and the effective use of proctors and wider professional networks. Some form of guidance as to when to convert a minimal access procedure may be desirable. Hospitals will need to understand that such developments take time and investment.



The openness of consultant outcomes publication has encouraged quality improvement and improved governance. Individual and unit feedback, mortality and morbidity meetings, reflective practice and sharing information within an institution all contribute to this. An audit trail should help all to learn from the cumulative experience of early adopters. The transparency agenda has led to a more managed healthcare environment. This has implications for the introduction of new procedures, and serious consequences for the professionals concerned if there are adverse events. This will not go away.

Learning Curve

There needs to be recognition that minimal access surgery has a learning curve which may differ from surgeon to surgeon, and programmes should be structured and developed accordingly. Informed consent is a professional obligation and a legal responsibility. For a patient undergoing a surgeon's or hospital's first minimal access mitral repair, the consent process is necessarily different from the process for a standard

approach in experienced hands. This must be acknowledged and we disregard it at our peril. The purpose of this article is to encourage reflection and discussion – should the SCTS take a lead in this difficult area? How do we heighten awareness of these issues?

It is imperative that a surgeon is able to embark upon an operation with a degree of confidence, accompanied by a thoughtfully prepared surgical strategy. Insight is essential. That innovation is desirable and important is beyond doubt. Innovation and minimal access surgery, however, bring specific challenges and are not for everyone, and this includes surgeons and patients. Surgeons know this very well. To what extent patients know this is less certain. It is crucial that we professionals take the initiative in ensuring that the full implications are discussed when a patient is asked to consent to such an approach, that we respect the duty of candour as set out in the wake of the Francis report⁴ and, above all, that we, while pursuing innovative practices, do not allow our enthusiasm for the new to undermine the excellent outcomes of tried and tested procedures with an unparalleled safety profile.

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'Consent for Surgery - Are we doing it well?'

In our professional lives we come across different practices in many aspects of care. Helping a patient consent to treatment is one such aspect where there may still be substantial variation.

In cardiac and thoracic surgical MDTs we hear colleagues sometimes expressing paternalistic views that the patient should accept what the MDT decrees, appearing to forget the patient may want to consider the choices. And occasionally in a multi-bedded bay you may overhear a patient being given information and you reflect that's not the same way you would present the same information.

Sometimes you appreciate that the observed style is an improvement on your own methods but sometimes you may witness other styles that you wouldn't consider appropriate such as:

- Posture - standing over the patient looking down on them
- A lack of compassion - launching into a list of serious operative risks and graphic descriptions of the procedures
- Hierarchy of information - starting with rare major adverse complications
- Conveying degree of risk - using percentages in rapid succession
- Language - 'We use the internal mammary artery' 'Your heart becomes a bag of worms'

We have come a long way since the junior doctor asked the patient to sign a piece of paper (a 'consent' form) which basically said consent was given for 'Any operation necessary performed by anybody'.

The first improvement was to focus on telling the patient about the risks of the procedures.

In 2005 David Richens, with the SCTS and the Ombudsman, did a good piece of work considering which risks we should share with the patient: rare ones with major impact and common complications with less impact (see figure1). Thinking on consent has evolved since 2005, but

the overriding principle here is one of respect for human rights. Patients have the right to determine what happens to their own bodies, and a healthcare professional who does not respect this principle and obligation may be liable both to legal action and to action by their professional bodies (including our regulator the GMC).

Duty

Today, we have a duty to share the different choices available to the patient – the pros and cons of medical treatment, stenting, oncology, and surgical strategies such as minimal access, or conduit choice. Our previous lay representative, David Geldard, was a great advocate of 'No decision about me without me,' and this underlies the fundamental change in consent: whereas the patient used to consent to treatment that the doctor told them they must have, the patient now chooses their treatment based on the information they have absorbed from several sources including their doctor. Our role is to provide the information in an understandable manner that allows them to make that choice – and, of course, just because we're surgeons we should avoid conflicts of interest, which can be as basic as a desire to fill an empty theatre slot.

This year there has been a significant legal case involving consent in obstetrics – *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. The emphasis has shifted over time from the long established Bolam principle (the information given to a patient about a procedure was based on what a reasonable body of doctors would deem reasonable), to one where it is the reasonable patient who determines what should be discussed. The court ruling (which included a £5.25 million payout) in the Montgomery case means that it cannot be left to the doctor to determine what is reasonable to disclose. Moreover, the judgement stated that the assessment of whether a risk is material cannot be reduced to percentages. Previously, doctors would state a known

level of risk for a certain complication or negative outcome (usually substantially less than 1%) below which it was not thought reasonable to discuss with a patient, unless they specifically asked about it. Finally, the judgement stated that the Courts have the final say in determining the nature and extent of a person's rights...not the medical profession.

The Royal College of Surgeons and the General Medical Council have published excellent guidance on the standards expected when taking consent:

<https://www.rcseng.ac.uk/surgeons/surgical-standards/professionalism-surgery/gsp/domain-3/3.5.1-consent>

These documents are a very comprehensive resource and are well worth revisiting. Here is just one excerpt from the GMC guidance:

Consent guidance: Partnership

3. For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care.
4. No single approach to discussions about treatment or care will suit every patient, or apply in all circumstances. Individual patients may want more or less information or involvement in making decisions depending on their circumstances or wishes. And some patients may need additional support to understand information and express their views and preferences.

The entire guidance is eminently sensible - But what is our missing ingredient? Might we summarise this by saying we have a lack of empathy?

What's it like for the patient?

Our problem might lie in the fact that we do our job day in and day out – and we become desensitised to the enormity of

*Sarah Murray, Lay Representative
Simon Kendall, Honorary Secretary*

what we do and what it means to the patient. When we take consent we should remind ourselves each and every time what it's like for that patient about to embark on a major intervention – and explain the choices, the risks and the benefits in an understandable and empathic way – adjusting to their individual priorities, such as caring for their disabled relative or their morbid fear of stroke.

Our lay representative Sarah Murray, lawyer and mother of Tom, gives us some invaluable insight:

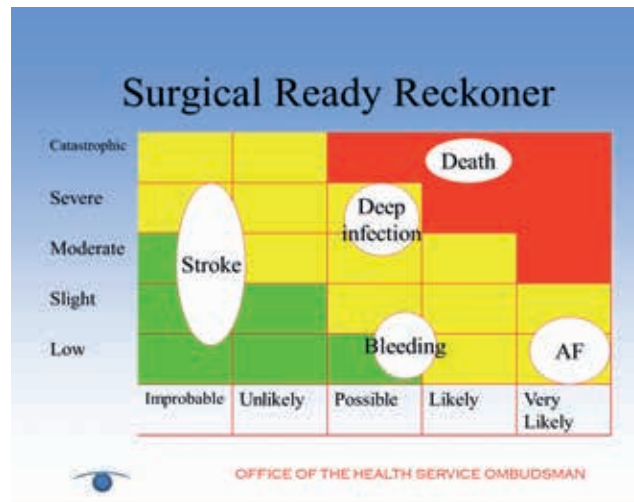
There is a rule in law called the “Egg Shell Skull rule” which in essence states that (God forbid) if you cause harm to a person that you must take that person as you find him/her. In other words everyone is different and one size does not fit all.

So it should be when asking for consent. Regardless of the form and structure you have to adhere to, please think about the following whether asking for consent for children or those who lack capacity:

- **Who are you asking for consent?** Parents, Grandparents, Guardians?
- **Where are you asking for consent?** (in/outpatients? A dowdy uninspiring consulting room, sitting behind a desk, (hopefully not) in a noisy corridor, on a ward with no privacy?)
- **How are you asking?** - What is your tone of voice, manner; are you relaxed, uptight, stressed, business-like, happy, smiling, frowning? Are you inspiring confidence?
- **Parents pick up on everything.** Our senses are heightened and we are looking for every uncomfortable movement, innuendo, nervous twitch. We want to know if you know something we don't.

Remember...

Hospitals addle the brain. The bravest of people I know can be reduced to quivering wrecks just by entering a



hospital. It is alien territory to most of us, and the innate desire to “fight or flight” kicks in. We cover our fear with conventions, sitting in waiting rooms reading newspapers, watching the muted TV, but most of us want out of there FAST. The most articulate person can turn to jelly and sweaty palms just at the thought of an operation.

It can be very stressful; and more so if you know that the outcome of the visit will result in having to give consent to an operation. It is bad enough when it is for yourself, but when it is for your child it is a hundred times worse.

The blood is rushing past the ears and your mind is racing - we can't hear your answers because we are still trying to take in the fact that our child needs an operation.

Think about what you are asking for.

You are asking us to trust you. You are asking for the parent/ guardian of a child to hand them into your care so that you can operate (anaesthetise, cut open and perform a procedure) which will hopefully make the child better. When you are consenting us you already know, and are at home in the operating theatres, know the team of people you work with. You have a relationship with that team. You can visualise what will be done and how the operation should run. You may have done it many times before-successfully. But we don't know or have experience of any of this.

The parents' knowledge about the operation may vary. They might know a lot about the operation and be well informed from Google, have looked at the hospital website but- they don't know your team, don't know how well you work together (are you a nice team? Will you take good care of my child?) They will want to know how many times you have carried out the operation – your success rate and survival rates (or mortality rates depending on

their outlook).

We want to be as pleasant as possible given the authority of the surgeon treating our child as you effectively have the family's wellbeing in the palm of their hands. Some of us are conditioned throughout our lives to look up to, to respect, to be in awe of people who have power or a knowledge that we do not possess. Others are just scared of those people. When we come to the come to the table to discuss consent we are already on the back foot, taking control is not easy. It is hard to throw your four-hapeth into the pile when you have no cards to deal. It is a huge matter of trust in an area we are unsure. In such an emotive situation inevitably there is tension when people try to bring to it an objective decision. It is not easy and no matter how you teach people to deal with the process it really comes down to personality. Some will be better at it than others. In a profession where we demand empathy, the surgeon more often than not needs to switch that button off to deal with the enormity of the responsibility that the decision requires. The trouble with switching off buttons is that it often switches off other emotions at the same time.

Some of us want to be told about the operation in detail, some of us don't but we have to listen to it anyway. Some of us want to know, but do not want it discussed in front of our child so an

continued on next page

'Consent for Surgery - continued

atmosphere is created and may make the meeting stilted. We don't want our child to leave, because they will worry about what we are talking about but at the same time we want the opportunity of asking some questions with which we do not want to burden our child. So consent in such a case may have to take place over a period of time with parents needing to ask further questions and continue a correspondence with you or your team. We all know the NHS is under constant stress and most people do not want to "bother the doctor" but when it comes to your child if you not do the "bothering" no one else will.

When Tom was told he needed a Ross procedure I spent time dancing round questions I wanted to ask -too frightened to ask them in front of him-not wanting to make him anymore anxious. Tom's reaction to the news was he went home and googled Ross procedure and watched the whole operation online. "It was his heart and he wanted to know what was going to be done". His younger sister, who we took to the meeting as well, wanted to know that the surgeon was one of the best at this procedure, that he had done many of them, that he had few deaths and his hands didn't shake. (she was 14 years old).

Nothing is risk free, but what would make consenting perhaps a little easier for parents is the opportunity to consider the consent over time: to ask the questions we need to ask; to find out what questions we should be asking; seek clarification; have access to someone who can help to make sense of the medical jargon; and to be listened to (so that you really hear what we are asking/saying), Kindness.

One of the most powerful exchanges I witnessed was a consultant interviewing colleagues about their lack of post-operative pain relief and care in their hospital. There were a series of complaints from patients and the visiting consultant was part of a team asked to investigate. The surgeons were explaining away these complaints when the consultant quietly said "I have had this operation and I can tell you it is very, very painful."

Not one for exaggerating he stopped the consultants in their tracks. It was a turning on point in the meeting. It took a consultant-to-to consultant exchange to make them stop and think that the patients' complaints may be grounded.

The point is - when asking for consent, put yourself in our shoes - just for a while.

Principles

As already stated; the RCS/GMC guidance is thorough, but here are some thoughts about the general principles that we might also consistently apply:

- Be seated at the same level as the patient
- Show compassion for the predicament that the patient is facing
- Don't appear as if you're reading from a script
- Don't leap to the surgical option but spend time reflecting on the risks and benefits of other treatments – including no treatment at all. What the prognosis might be the effect on symptoms and the risks involved.
- Ensure the patient knows that they remain in control and it is they who will make the decision.
- When discussing the surgery talk about the chances of success before moving on to death and complications.
- With the elderly and frail try and give an indication what quality of life they can expect – and that, even if they survive surgery, this doesn't guarantee they will be as independent or confident when they've recovered from the operation.
- Use numbers to try and explain the percentages in a format they are more able to appreciate the risks – for instance, "if 100 Mr. Smiths like you had this operation 95 of them would expect to survive the operation and get home. Indeed 80 of them would be home within a week of surgery – which means 15 of them might develop a treatable complication that keeps them in hospital longer than they would like. However, out

of 100 Mr. Smiths like you, 5 of them might die or have a major stroke as a result of the operation.

- Copy the correspondence to the patient that also goes to the referring physician and GP using terminology they can understand. This allows them to further reflect on their choices as well as share the risks and benefits with family and friends.
- Be available for further questions and consultations. Sometimes one consultation is not enough for the hesitant patient and being available for their supplementary questions can put their minds at ease.
- By having the risks and benefits stated in the correspondence it allows the other members of the team to present consistent figures as this can cause the patient confusion and anxiety if they are presented with different odds.

We can take this forward and look for consensus between the SAC, the Intercollegiate Exam Board and the SCTS:

- The SAC can help trainers and trainees to agree good practice and have appropriate assessment of the consent process on ISCP. They might also review how many assessments are required for different aspects of consent;
- The Intercollegiate Exam Board will continue to review whether consent is assessed in the exam.
- The SCTS can continue to promote the agenda of professionalism – a part of which is the consent process. We may also consider publishing videos as a tool to improve practice – possibly filming examples of good practice and also examples where it could be improved.

Perhaps in cardiothoracic surgery we are all helping patients consent in an exemplary fashion and there is no reason to change – but at the same time it is worth reflecting on the impact of the Montgomery case and whether we are advising patients on the risks and benefits of their proposed treatments.

Report on the first Professional Development Course for SAS doctors

*Maninder Kalkat,
Consultant Cardiothoracic
Surgeon, Heartlands
Hospital*



The SCTS Education with support from Covidien embarked on delivering educational and training courses for SAS doctors in Cardiothoracic Surgery. In the series of these courses, 1st National Course directed at the Professional development took place on 2nd November, 2015, at University Hospital, Coventry.

The aim of the course was aimed at overall professional development of SAS doctors with particular emphasis on maintaining revalidation portfolio, complaints and response process, informed consent, effective interview and presentation techniques, supporting professional activities in the job roles and CESR application process.

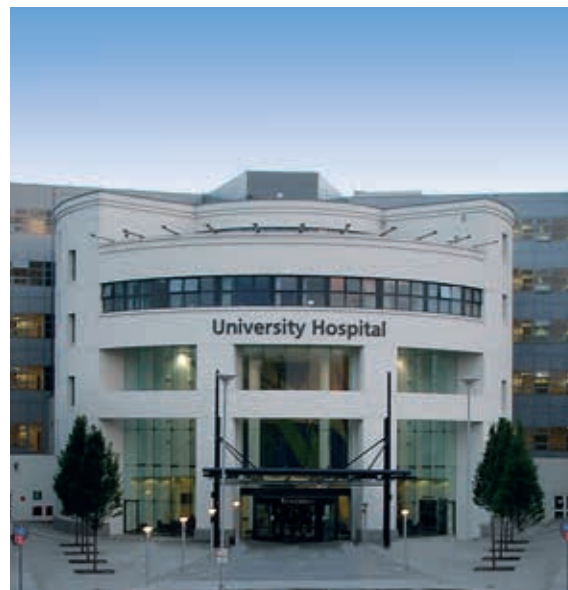
Mr Tim Graham and Richard Steyn, in addition to their allocated topics, conducted an innovative and interactive interview techniques session, scored highly by the delegates in the feedback.

The course was attended by eighteen delegates and eleven faculty members coming from various parts of the country. The day consisted of number of interactive sessions discussing various current issues. Mr Sion Barnard, chairman for SAC and Ms Megan Wilson, CESR Registration Manager at JCST took the audience through CESR process and answered number of queries. Mr Tim Graham and Richard Steyn in addition to their allocated topics, conducted an innovative and interactive interview techniques session, scored highly by the delegates in the feedback. Mr Morgan Mamdouh presented a proposal for continuous development, assessment and career progression for the SAS doctors, which everyone felt needs to be explored further by the Society. The rapidly changing landscape of NHS was discussed by Dr Raghuraman, Associate Medical Director. Other important topics discussed included

revalidation and appraisal, research opportunities and role of SCTS in the career of SAS doctors.

The course also gave opportunity to the delegates to network and interact during lunch and post course dinner. The feedback questionnaire filled by everyone has been analysed. Majority of topic and presenters were rated highly and valuable suggestions noted. All delegates have been e-mailed further questionnaire 4 weeks after the course to assess how the course has changed or helped their practice.

Building on the success of these courses, the educational committee of SCST will continue to organize two courses a year for SAS doctors – Updates in Cardiothoracic Surgery in April and Professional Development Course in October.



University Hospital, Coventry

Tutors' Report

It has been an exciting six months with our portfolio of courses progressing as per our plans. We have had to introduce a refundable deposit system as there were last minute drop outs causing financial impacts. We summarise the various aspects which have happened in the last six months.

Focus on professionalism and human factors

The SCTS education portfolio recognises the importance of the communication, human factors and professionalism in the workplace. The tutors have incorporated the 'Non-Technical Skills for Surgeons (NOTSS) in cardiac surgery' successfully run by Messrs Tim Jones and Mike Lewis into the program with an introduction of thoracic component. The ST5 trainees were invited to the NOTSS Course in the St George's simulation centre. The course had great feedback for the cardiac side with constructive feedback to improve the thoracic component with the Orpheus Simulator. The tutors and course directors have taken the feedback on

board to improve the evolving thoracic component better for next year.

The Birmingham Professional Development Course has been running successfully for the last 10 years which imparts wisdom on professional challenges facing a new consultant. SCTS Education has incorporated this course into the portfolio for the final year trainees for the first time in Ethicon's Pinewood facilities. The course directors were Mr Steve Rooney and Mr Mike Lewis with great support from Professor David Richens and Mr Tim Graham. We had the privilege of hosting Ms Claire Marx, President of the Royal College of Surgeons of England to address the trainees. The programme included aspects of professionalism including complaints, dealing with the coroner, dealing with the ombudsman, medical leadership, communication and interview skills. The feedback as always has been very positive.

Establishing standards

SCTS education portfolio has been successful in delivering the programme with Ethicon partnership for last couple of years. All the courses have been held except the Pre Consultant Course which is due to be held in April 2016. We have also introduced various measures to collect evidence of the impact of the courses so that these could be systematically reviewed to offer objective evidence. The trainees are asked to score themselves anonymously on a self-assessment scale before and after each session in all our courses. We have used the thoracoscopic virtual reality simulator to gain evidence as to the skills of the trainees to give them feedback. We have launched

a programme where index operations or procedures have been identified with the trainees performing the procedure based assessment with the local trainers before and after coming on the SCTS education portfolio courses. This would allow us to see the impact of the skills and the tips offered to the trainees during the various courses.

Independent QA

As the courses have been constructed independent of the Royal colleges by the tutors with the support of the Education committee and the Council of a SCTS and SAC. The Education committee feels it is imperative that these are delivered to a high standard and content. SCTS in partnership with the surgical specialty board of the Royal College of Surgeons of Edinburgh (RCSEd) have approached the Education department of the RCSEd to assess our portfolio independently. They will give us feedback and standardisation to enable us to make our courses better. The course learning objective, feedback and outcomes have been sent to the education department which has looked at this favourably and has given CPD accreditation.

The Tutors have invited Dr Yvonne Hurst, Head of Education RCSEd to visit and quality assure our courses independently. The first visit was to the ST3A the introduction to the specialty training in cardiothoracic surgery in November 2015. We have received very positive feedback and further suggestions to make what is currently an excellent course into an exemplary model for other specialties to replicate.

Faculty training programme

Finally SCTS education acknowledges the need to maintain training standards within the faculty who deliver our courses. We are looking at various

SCTS Education has incorporated the Birmingham Professional Development Course into the portfolio for the final year trainees for the first time in Ethicon's Pinewood facilities.

Narain Moorjani SCTS Cardiac Surgery Tutor
Sridhar Rathinam SCTS Thoracic Surgery Tutor

options of offering a course on faculty training program partnered with educationalists. This will offer the faculty the chance to update current system and techniques of educational delivery as well as assessment. We once again wish to thank SCTS Council, SAC for Cardiothoracic surgery, The Education Secretaries, course directors and the faculty members who were invaluable in this success. We wish to acknowledge the hard work of the trainees' representatives Jonathan Afoke and Amir Sepehrpour who have constantly communicated with the trainees to ensure that they are invited to the correct course. Finally thanks to Ethicon and other partners from industry who have supported us in this journey.

On behalf of Education committee we wish you a Merry Xmas and Prosperous New Year!

SCTS Education Ethicon Course Calendar 2016

Intermediate Viva Course (ST5A) 20-22 January 2016
J&J Campus, Wokingham

Course Directors: **Mr D Whitaker & Mr K Lau**

Cardiothoracic Subspecialty Course (ST6) 8-10 February 2016
ESI Ethicon Centre Hamburg

Course Directors: **Mr S Rathinam, Mr E Akowuah, Mr N Moorjani, and Mr M Shackcloth**

Revision and Viva Course for the FRCS (CTh) (ST7) 7-10 March 2016
J&J Campus, Wokingham

Course Directors: **Mr M Baghai, Mr J Rao, Mr P Modi and Ms C Tan**

Pre Consultant Course (ST8) 11-13 April 2016 ESI Ethicon Centre Hamburg

Course Directors: **Mr N Moorjani, Mr S Rathinam**

Cardiothoracic Intensive Therapy & Surgical Access Course (ST3) 11-13 May 2016 ESI Ethicon Centre Hamburg

Course Directors: **Mr J Dunning, Mr N Roberts, and Dr C Moore**

Core Thoracic Surgery (ST4) 20-22 June 2016 MATTUS Centre Surrey

Course Directors: **Mr T Routledge and Mr N Chaudhuri (TBC)**

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Cardiothoracic Surgery placements for senior undergraduate medical students

Within the ten surgical branches of surgery in the United Kingdom (UK), cardiothoracic surgery is one of the smaller specialties. As such, undergraduate medical students could progress throughout medical school having never experienced a cardiothoracic surgical centre. The department of cardiothoracic surgery at the James Cook Hospital in Middlesbrough, together with the Royal College of Surgeons of Edinburgh (RCSEd), have

set up cardiothoracic surgical placements for medical students within two years of graduation from a UK medical school. This programme has been created, organised, and supervised by Mr Jonathan Ferguson, a Consultant Cardiothoracic Surgeon at this institution. Four students have successfully completed these placements and one of the students, Andrew Bridgeman, outlines the structure of this programme and his experiences.

RCSEd sponsored placement

I first heard about the RCSEd sponsored placement at James Cook University Hospital when Mr Ferguson gave a talk to the 2015 SCTS annual meeting. As a student interested in pursuing a career in cardiothoracic surgery, it sounded like an incredible opportunity. The application process was straightforward but competitive; a brief CV and a short written piece entitled 'Why I want to be a cardiothoracic surgeon' was all that was needed. I was fortunate enough to gain a place and put in contact with Mr Ferguson. After negotiating dates with other successful candidates, I had my 3-week placement confirmed. Both the RCSEd Outreach Team and Undergraduate Team at James Cook were incredibly helpful and made organising the placement easy. The college covered both travel and accommodation costs.

Following a brief induction on my first morning, I was straight to theatre to meet the team, and just in time for the first case. Before I knew it I was scrubbed in and Mr Ferguson was guiding me through my first thoracotomy. This set the stage for the whole placement. I was able to choose which cases to see each day and everyone was happy for me to be involved in some way. Over the three weeks I was taught how to perform saphenous vein harvest, thoracotomy and sternotomy as well as assisting on a number of occasions.

The positive feedback received from Andrew has been echoed by the other students who have experienced this programme. At the recent surgical specialty board meeting for cardiothoracic surgery, we were delighted to learn that the Royal College of Surgeons of Edinburgh will fund these placements for a further year owing to its success. This rotation would not be possible without the support from the entire cardiothoracic surgical team at James Cook Hospital. This allows students who have shown an interest in cardiothoracic surgery to experience the specialty that they may never have had the opportunity to do otherwise and make an informed decision on whether this career choice is for them. This is particularly important given that recent recruitment to our specialty has been offered at the ST1 level and this early experience will allow the student

Andrew Bridgeman,
Final year medical student
University of Bristol



I had the opportunity to be involved in whatever aspects of the department I chose to. I decided to spend most of my time in theatre to further my hands-on surgical experience and understanding of many of the thoracic and cardiac procedures performed. I also gained a greater understanding of everyone's roles within the cardiothoracic surgical team, and learnt a huge amount from each and everyone one of them. This placement also gave me real insight into the life of the cardiothoracic trainee. I think this is an invaluable experience when considering my future career path, allowing me to make a more informed decision.

This placement was the most immersive experience of any surgical specialty I have had during my time at medical school. I felt welcome throughout my time at James Cook and this is credit to the entire cardiothoracic team creating a such a supportive atmosphere. This placement is an incredible opportunity for anyone considering a career in cardiothoracic surgery; it allows you to develop your skills and knowledge of many of the surgical procedures performed, to be incorporated into a cardiothoracic unit and feel like one of the team, to build relationships with potential future colleagues and to gain a real insight into the life of the cardiothoracic surgeon.

to prepare and make themselves competitive. Although this programme is in its infancy, this model offers other small surgical specialties, such as neurosurgery and plastic surgery, a framework in which to develop interest and enthusiasm among medical students for their specialty.

Alan G. Dawson
ST4 ACF in
cardiothoracic
surgery, Glenfield
Hospital,
Leicester and
trainee representative of the
SSB in cardiothoracic surgery



Jonathan Ferguson
Consultant thoracic
surgeon, James Cook
University Hospital,
Middlesbrough



Lancashire Cardiac Centre: Engaging Medical Students

*G Hardman
AH Walker*

Worldwide the number of applicants to cardiothoracic training programmes is declining. As a small specialty with a centralised service, access and exposure to cardiothoracic surgery for medical students and junior doctors is becoming increasingly rare. With this in mind several centres are now developing cardiothoracic surgical careers events and 'taster' opportunities.

At the Lancashire Cardiac Centre we have designed and implemented a week-long residential Cardiothoracic 'studentship' programme. The pilot programme was open to medical students at all levels from the University of Liverpool Medical school. Following application, 4 medical students (year 1 and 2) were selected, with 2 attending for each one-week course in June and July 2015. Accommodation and meals were provided for the duration of the course through collaboration with the undergraduate medical education department and with financial support from Ethicon.

The programme was designed to allow students to shadow a consultant cardiothoracic surgeon and specialist registrar through all daily activities over the course of the week. Students were encouraged to meet, take histories from and examine pre-operative cardiac surgical patients in the outpatient clinic and ward settings. They were supported in reviewing patients in the cardiac intensive care unit and on cardiothoracic surgical wards. They attend all scheduled theatre cases with the named cardiothoracic consultant and registrar, where they observed surgery and the practice of the cardiothoracic anaesthetist and perfusionist.

The concepts of continuing medical education, professional development and human factors were also introduced through completion of case-based discussions and observation and participation on our non-technical skills for cardiothoracic surgery simulation course.



At the start of the course students were given a comprehensive cardiothoracic handbook with literature to support their learning throughout the week. They also received a suture skills box, instrument set, suture material and Arroyo anastomosis simulator for the duration of the programme. Following an informal session for introduction of basic surgical skills and coronary anastomosis they were encouraged to practice these skills outside the timetabled activities. Two further sessions were timetabled for simulation based education, with a formal dry lab for basic cardiothoracic surgical skills and a care of the critically ill cardiothoracic surgical patient session in our simulation and skills centre.

Students completed a self-assessment of learning needs in areas of cardiovascular and respiratory anatomy, physiology and clinical skills, along with an 'attitudes to cardiothoracic surgery' questionnaire. All of the students cited an interest in cardiothoracic surgery as their primary motivation for applying to the course and 'to gain exposure to cardiothoracic surgery' as their primary learning objective. None of the students had any prior experience in the specialty.

Following the course, participants strongly agreed that their understanding of the scope of the specialty, cardiothoracic disease and surgical procedures had improved. All showed an improvement in their knowledge and skills following a self-assessment of learning gains and stated that they felt more confident to pursue opportunities for exposure to specialties outside their medical school curriculum.

For the students, highlights of the programme included the breadth and intensity of exposure during the course, the simulation and skills sessions and the careers guidance they received.

The students remain in contact with the department and have so far completed audit projects and submitted work for presentation at local and national cardiothoracic meetings. We hope to continue to foster these relationships, providing informal mentorship and networks to support career development.

Feedback from the pilot has been used to develop the curriculum and the programme will continue in 2016, with sessions in the Easter and Summer term breaks, along with expansion to applicants from other medical schools in the Northwest region.

Encouraging Students into Cardiothoracic Surgery

Cardiothoracic surgery is given little time in the UK undergraduate curriculum making it difficult for students to gain substantial exposure to the specialty. Career choice has been shown to correlate with early student engagement. With a shift toward early recruitment (increasingly ST1 over ST3) by our own and other specialties, final career decisions need to be made earlier than before. Building on many excellent local initiatives, SCTS Education and the RSM Cardiothoracic Section have been working together on 'national' events.

National Cardiothoracic Careers Day

In late 2014 a pilot one-day engagement event "Cardiothoracic Surgery Careers Day", aimed at medical students and foundation doctors took place in Bristol. The aim was to equip delegates with a greater understanding and insight into what a career in cardiothoracic surgery entails, its subspecialties and what an undergraduate can do to build their experience and CV towards being competitive. At the same time we aimed to introduce some of the basic surgical skills required by the specialty. The event was supported by SCTS Education, The Royal Society of Medicine Cardiothoracic Section and The Association of Surgeons in Training, as well as various industry sponsors. This allowed the event to be run free of charge to delegates.

Cardiothoracic Surgery Careers Day Bristol 2014

The event was organised by a committee of medical students with consultant and trainee oversight. We believe that this peer-led approach maximises the relevance of the event to undergraduates' learning needs. Added to this, it allows a group



of students with an interest in the specialty to participate in the organisation of a national event.

We also wanted to test the appetite for such an event, and were delighted to be quickly oversubscribed. In a small specialty, with students quickly becoming doctors and moving on, sustainability is important. The intention from the outset was to repeat the event each year, at a different medical school, organised by a new local student committee with on-going consultant oversight and support from the previous years' committee. The 2015 event will be in Cambridge with a venue for 2016 to be decided after that meeting.

Student Engagement at SCTS Annual Meeting

SCTS Education also ran a new medical student session at the annual meeting, which also had very positive feedback. This session was well attended with an overflowing room and provided not only an educational experience for students, but also an opportunity for open discussion with trainees and consultants on career advice and how to further engage with students as well as ideas for the year ahead.

Patrick Magee Medal and SCTS Education Elective Awards

SCTS Education also continues to run the Patrick Magee student poster presentation competition. This attracts a large number of high quality abstracts each year, with successful entrants able to attend the annual meeting free of charge. The SCTS Ionescu Medical Student Travelling Fellowship was also created in 2015 for students undertaking an elective experience in cardiothoracic surgery.



Andrew Bridgeman
 Luke Holland
 Oliver Brewster
 Phil McElnay
 David McCormack
 Aman Coonar

RSM Cardiothoracic Section

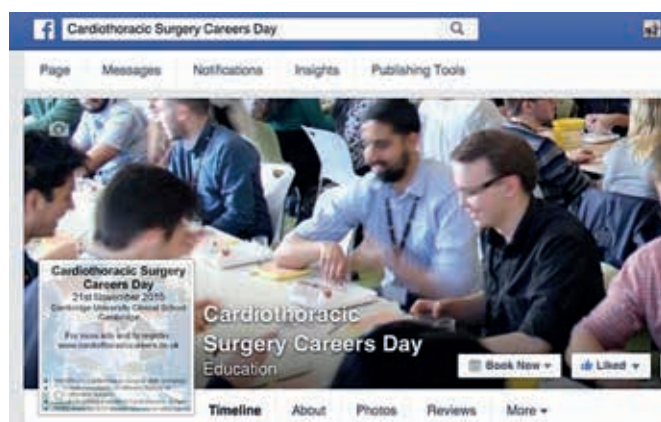
A key goal for the RSM is engagement with the public, students and other specialties. The meetings are student and trainee focussed. Trainee and student presentations are competitively marked with prizes for the best presentations. The November 2015 meeting saw student/trainee led simulation initiatives including low cost skills training systems and trainee-developed apps.

Cardiothoracic Section stand at RSM Specialty Careers Fair 2015

The section runs a stand each year at the annual RSM Specialty Careers Fair. With several hundred students attending, this is as an excellent platform to showcase the specialty. A number of free places are always offered to school students to attend the 2-3 section meetings/year. As a new initiative the section is also offering a number of travel grants to RSM student members to attend the Cardiothoracic Surgery Careers Day in Cambridge. Planning is also under way for an interactive workshop covering anatomy and physiology relevant to cardiothoracic surgery.

Other Initiatives

Of course there are other excellent initiatives. For example The Royal College of Surgeons of Edinburgh recently awarded six bursaries for placements in cardiothoracic surgery at James Cook University Hospital, Middlesbrough, which has received excellent feedback from participants.



The Future

Making an early 'final' career decision became uncommon in the UK, but is now essential to smooth career progression. To ensure cardiothoracic surgery attracts the most talented and able people we need to be even more open and engaging. We recognise that there have been huge changes in the way training happens and our working systems need to adapt.

Final career decisions need to be made earlier than before - so SCTS Education and the RSM Cardiothoracic Section have been working together on national events

Social media, simulation models and digital training allow us to not only fill the gaps but to surpass the reduction in the length and hours of 'old-style' training.

Over the past year the number of events aimed at medical students has grown. We hope this level of engagement will continue to grow over the coming years. Please let us know about any events, local or national, that are open to students so we can assist with advertising as widely as possible. We would also like to develop a database of consultants from as many of the units across the UK and Ireland as possible, who would be happy to be contacted by students to organise placements in cardiothoracic surgery. Please let us know if you would be happy to be contacted.

education@scts.org

<https://www.facebook.com/cardiothoracicsurgerycareersday/>

Transparency, Patients and Professionalism

After 10 years as the lead clinician for the National Adult Cardiac Surgery audit, I have decided to move on to new challenges. It has been a privilege to lead the programme that supports quality improvement and clinical governance on behalf of our professional society. Due to outside developments, the national audit has evolved dramatically in 12 years or so, from being an inward looking process focusing primarily on quality improvement to become a mandated, outward-looking professional obligation supporting growing government commitments to, and public expectations of, transparency and quality assurance. As a group of surgeons we have not been in control of the direction of travel or the pace of change.

The challenges to the NHS in 2015 and the decade to come are clear; enhanced patient empowerment linked to the greater accountability of professionals and organisations, the use of digital and connected information to achieve better health, a move towards more preventative medicine and the need for cost constraint. Publishing named surgeons' outcome data needs to be viewed in this context. The initiative was born in the Bristol Public Inquiry but the theme of the transparent accountability of individual doctors has grown up alongside changing expectations in society, and is reflected in NHS England policy as articulated in the '5 year forward view'.

Over the last 15 years we have moved from publishing whether surgeons achieved a defined, relatively lax benchmark to a complex and appropriate risk-adjusted contemporary standard with sophisticated analysis of acceptable and unacceptable variation from that standard. Mortality rates in UK cardiac surgery are now excellent and better than international yardsticks, and the credit for this goes to the surgeons and their colleagues providing care across the country.

Most hospitals and the vast majority of surgeons have always displayed outcomes which are as expected. Some

have not and matters have required further consideration. It has often been said that, if we as surgeons do not collect and publish data, someone will do it for us, and that is of course true. But I would argue strongly that we should be doing this as it is the right thing to do, and that it should be done with appropriate clinical, methodological and managerial expertise. The SCTS is the obvious repository of leadership expertise and clinical knowledge base. Given ongoing failures in healthcare governance (and it is easy to forget quite how poor the governance systems were in Bristol and Mid Staffs), as a profession and individuals we need to demonstrate our trustworthiness openly and continuously. Transparency is the key to this. Until now there has been no template for us to draw on, so by necessity we have been on a voyage of discovery.

*'Trust me I'm a doctor'
is long gone.
We are now in the
age of shared
decision-making*

We have to accept that, with the explosion of digital and other available information, society is changing. Who amongst us would not use the Internet for assessing best prices and consumer reviews when booking holidays or making major purchases? Who has not used the internet to seek independent information or check the validity of claims made by others? And so it is with healthcare, and the dynamic between the medical profession and the public is changing as a consequence. 'Trust me I'm a doctor' is long gone. We are now in the age of shared decision-making, where doctors and other healthcare professionals support patients and their loved ones to come to the best, bespoke choices for them.

We ignore this development at our peril. We have taken initiatives such as

the Blue books and the SCTS iData App but. As well as providing information on outcomes to support choice of procedure, there is now an expectation to provide the granular level of outcomes of care to support choice of provider, and to provide broader reassurance that overall quality of our surgery is good, actively monitored and remediated where necessary.

Professional Profiles

In this spirit I think the current leadership of the SCTS should be particularly praised for giving patients the chance to see individual professional profiles on the scts.org website. Most of us would wish to seek some level of specific information about a surgeon if our loved ones required major surgery, and because of our position in the profession we can usually obtain this by word of mouth. By contrast, other members of the public are seriously disadvantaged. The majority of hospital websites fall far short on providing what most of us would regard as an acceptable level of detail. Media reports of healthcare governance scandals have raised the level of public concern. For cardiac surgeons, appropriate information can now be displayed alongside activity, outcomes and case-mix data through our professional society website, and some surgeons should be praised for including patient experience measures, training and CPD as well.

It is unfortunate that the take up rate by surgeons remains less than complete. Outcomes and the other softer information should be available for all surgeons. I see the publishing of this data as an individual professional obligation. I have heard a lot of arguments against surgeon level activity and mortality reporting over the years, but it is hard to deny that a growing number of patients expect simple data to be freely available about their surgeon. The feedback we have is that patients find the presence of this information very reassuring when they are going through a stressful life event, even if it does not influence their choices.



So, given the societal expectations and the political position of our elected leaders who set healthcare policy, transparency about the outcomes of individual doctors is here to stay. There is a dynamic in these considerations, with the rights of patients and the public at the one hand, and the doctors at the other. Historically the balance has been stacked heavily against the rights of patients. There is a perception of some in the profession that on some recent occasions the balance may have been shifted too far against the rights of the doctor. It is challenging to get the balance right, and any external perception on the right balance may be disputed by others who are affected by the judgements.

Granular Transparency

Many in the profession remain strongly against granular transparency (in cardiac surgery and more widely) and I think it is worth exploring the real reasons why. Firstly I think people believe that transparency changes practice in the wrong way, by encouraging surgeons and hospitals to turn down the patients who are the highest risk but have the most to gain from surgery. Secondly some people believe that the process will lead to surgeons being randomly and inappropriately stigmatized within their organizations and more widely in the media. Thirdly there is an argument that it not usually the surgeon's fault if there is a bad outcome and the focus on individual reporting takes the emphasis away from organisational and wider team responsibilities. And finally the agenda does make the practice of cardiac surgery even more stressful for the surgeons, with implications for both existing and future surgeons, and the patients.

I accept all of these arguments up to a point, but it is important that they are made appropriately and kept in balance. We know that the predicted risk of patients coming to UK cardiac surgery on objective measures goes up year by year. Surgeons are themselves important factors in the outcomes of patients both due to intra-operative actions and their role in the configuration of the entire care pathway. There are relentless improvements in risk-adjusted outcomes

that are measurable by the audit, but the degree by which transparency drives this process is not clear. Cardiac surgery remains attractive as an option for trainees, but as well all know it is stressful, and it becomes even more so during a cluster of bad outcomes.

By far the most important factor is concern about responses to outcomes that are not where they are expected to be. The British media will do what the British media do when results are published. We can try and inform and influence them, and so we should, but we must be realistic about our ability in this regard. But it is fundamentally important for patients that surgeons should trust the institutional responses to high mortality rates. These actions should be consistent, supportive and robust, keeping patient safety as the most important priority, but the rights and professional/psychological welfare of the surgeon are key. This is, and always has been, the fundamental issue here in my view, ever since we first thought about publishing outcomes. Wider perceptions of the appropriateness of actions that are taken by employers are usually based on anecdote and hearsay with the underlying issues clouded in confidentiality and secrecy, so it is challenging to make informed judgements on the issues.

RCS Learning

There has been some effort to get to the bottom of things by reports such as the RCS Learning from the Invited Review document (and I would encourage all to read this), but we need to go further. We also need to differentiate in our minds between actions taken about individual behaviours or isolated incidents, and consequences from the wider mortality monitoring processes; anecdote suggests it is the former rather than the latter that is more often leading to significant action from employers but there is no doubt that the wider reporting process is changing the dynamic between the rights of patients and the rights of professionals. Institutional capability and capacity for managing these issues is often seriously challenged when they occur, particularly if there is any lack of insight from the individual doctor involved. There are

direct similarities between these themes and those raised by Mark Jones, Steve Hunter and Samer Nashef in their timely thoughts on innovation also published in this bulletin.

The SCTS and other organisations such as NICOR and HQIP can and should continue to do all they can about the methods of data analysis and benchmarking, and these will continually be refined, but in my view the processes are fit for purpose and should not be the target of the profession's primary activities. Diminishing returns will follow from further improvements, which must be transparent but are becoming increasingly complex and less and less understandable to the majority of the profession. Units need to get better at local benchmarking and governance, and there is a challenge here for both the units and the national audit. SCTS, NICOR and hospitals must all support this and surgeons need to engage more.

Much of the recent pushback that has happened about the methods is being seen outside our world as professional protectionism. This perception can impair SCTS's ability to influence the things which are really important for patients and surgeons. This should in my view include an unrelenting focus on individual professionalism fit for 2015 and support and development of expert clinical leadership and management. Medical professionalism in the modern world requires all of us to be both leaders and followers, and the vast majority of us need to become more expert at both. The SCTS should continue to walk the difficult balance between being a professional organization responsible to its membership, but have patient rights, outcomes, experience, safety, empowerment and choice as its primary motivators.

I wish you all the very best in this agenda.

Cardiothoracic Forum

at the Annual Meeting – Birmingham March 2016

The 2016 annual meeting is planned to be held at the International Conference Centre, Birmingham. This will once again give all Cardiothoracic Forum participants the opportunity to network with nurses and allied health practitioners from all aspects of cardiothoracic care, including those working in theatres and on cardiothoracic intensive care and high dependency units. This years' forum will focus on revalidation and assessed practice, we have invited a number of guests from the RCN to speak on different aspects in preparation for the start of revalidation in April 2016. We also have an international faculty participating with professionals from Nursing and Allied Health backgrounds attending from the United States, Europe and the UK. We will once again be offering discounts on registration with one free registration for every three booked.

Next years' meeting will run over the entire three days in March; starting with a Nursing and Allied Health Professional stream at the SCTS Ionescu University. Following the success of last years' 1st Ionescu University stream we again have a full practical day planned. The University day will be split into a half cardiac / half thoracic day, which will enable participants to either take part in the entire day, or join for either the morning or afternoon session and then attend another University stream session with other delegates. Kevin and his team from WetLabs will provide us with an array of hearts and lungs, and we hope it will prove to be an exciting and educational session for all participants. I would like to thank all the company representatives who worked with us last year, and also the surgical faculty that took time to teach the nurses, allied health practitioners and all other participants, and we look forward to working with you in Birmingham. We hope that through increased nursing and allied health participation we will have another successful day in March.

We have worked hard selecting the papers for next years' CT forum presentations during the main meeting. We had 37 abstracts submitted this year, from a wide group of participants ranging from advanced nurse practitioners and SCP's to theatre nurses and critical care practitioners. This will enable us to examine in-depth all aspects of care related to cardiothoracic patients, and will look at service development and improvements across the UK, Europe and the USA.



At next years' meeting in Birmingham we plan to have a number of fascinating plenary sessions. The President of the RCN, Cecilia Anim, has been invited again to give us an up-to-date nursing perspective within her opening remarks and Andrea Spyropoulos, the past RCN President, will also be attending, hopefully both will once again provide some lively discussion points and food for thought. As already mentioned, in April 2016, revalidation for nurses will commence. In relation to this we have invited a number of speakers from the RCN to present their plans for revalidation and also answer questions and concerns the nursing community may have.

Jill Ley, Clinical Nurse Specialist from San Francisco who gave us a very informative presentation entitled 'Wake up from alarm fatigue, using our monitors wisely' at last years' meeting in Manchester, has also confirmed her attendance at the meeting in Birmingham. She is

planning on staying for the entirety of the meeting and will participate in the Ionescu University day; we look forward to discussing global nursing and allied health issues with her, especially from an American perspective.

Each CT Forum we have held has been a big success. We have gained a network of core nurses and allied health professionals across the country that

have in interest in progressing training, development and service provision with cardiothoracic surgery, 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 take this opportunity to thank all the plenary speakers, chairs, presenters and participants 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. However this is only possible with the continued participation from all cardiothoracic nurses and allied health professionals, so we encourage you all to spread the details of the conference, especially the Ionescu University Day and to seek support from your managers and medical colleagues to attend.

Christina Bannister

SCTS Nursing & Allied Health Professional Representative

Ionescu Nursing and Allied Health Practitioner Fellowship

At the end of 2014 SCTS Education advertised the opportunity for two Ionescu Nursing and Allied Health Practitioner Fellowships worth £2,500. Following interviews in Manchester the Ionescu Fellowships were awarded to Emma Hope and Daisy Sandeman.

Emma plans to gain insight into the Aortic Aneurysm pathway and create an Aortic Nurse Specialist role for the service at Southampton General, through her planned visits to Liverpool Heart and Chest Hospital and the Queen Elizabeth II Hospital in Birmingham. Daisy currently is in her 2nd year of her PhD focussing on delirium in cardiac surgery, she plans to visit John Hopkins Institute in Washington, USA where they have specialist teams and units dealing with post-operative delirium. Daisy plans to create a risk assessment model which could be used in all centres in the UK and Ireland based on the knowledge she gains. Both Fellows have been keeping in touch with their progress for their visits, and I look forward to hearing their experiences within a presentation at the annual meeting in Birmingham. They also will be able to share their experiences by writing a paper for the SCTS website and Bulletin.

The 2016 Ionescu Nursing and Allied Health Practitioner Fellowship has been advertised and we look forward to awarding another two Fellowships to nurses and allied health practitioners who wish to develop their role and the service they work within.

I would like to personally thank Mr Ionescu for his support in creating these Fellowships for the nurses and allied health professionals, and will feedback the results of the 2015 visits.

Advanced Cardiothoracic Course

This year's Advanced Cardiothoracic Course was held at Solihull Hospital in Birmingham during October 2015. Once

again this was a highly successful course and over 30 participants took part in the interactive teaching sessions and wetlabs over the two days of the course. Feedback from the course was excellent and we would like to thank Kevin from WetLabs and Covidien, Ethicon, Cryolife and all members of the faculty that participated. We would also like to thank Cardio Solutions for their sponsorship of the event, and look forward to working with them again in the future.



Developing an Advanced Allied Health Professional Practitioner Service Course

Due to the changes in cardiothoracic workforce in the UK related to the EWTD and issues in recruitment of the junior doctor workforce, a course was put together to examine the role of nurses and allied health practitioners in new ways of working. The first course was held last December at the Royal College of Surgeons of Edinburgh in Birmingham, and Advanced Nurse Specialists across the UK presented their experiences of setting up their services. The feedback was very positive, and we ran the same course again in early October 2015, at St Thomas' Hospital in London. We had

a number of delegates from across the UK participating in presentations from centres with established advanced AHP services, and we hope they returned to their units with fresh ideas of new ways of working, and also a new network of colleagues keen to share ideas and service developments. We look forward to continuing this course in 2016 and will post details of the next course on the SCTS Nursing & AHP pages of the website.

Band 5/6 Nursing Competencies and 'Train the Trainers Course'

Following feedback from ward nurses at the annual meeting in Edinburgh, we are currently creating a Cardiothoracic Nursing Clinical Development Course 'Core Principles of Cardiothoracic Surgery and Care of the Patient following Surgery'. This course will be aimed at Band 5/6 nurses and we plan to create a framework of core competencies for ward based nurses that will underpin a 1-4 day programme. The course will compose of lectures and scenario simulation with an aim to identify local trainers that will be able to replace the core SCTS faculty and teach the course at a local level, utilising the resources of written lectures and content provided by the SCTS. The aim is to create a national workforce of nurses with appropriate knowledge to care for the cardiothoracic patient and to act as a benchmarking assessment tool across the UK and Ireland.

Further details from the above courses can be found in Tara Bartley's Nursing and Allied Health Practitioner Education Sub-Committee Bulletin Article.

Surgical Care Practitioner Update

Consultations with the Surgical Care Practitioners remain ongoing, currently there are many streams of work progressing.

Throughout 2015 there have been a number of Master Classes held at the Manchester Surgical Simulation Centre,

continued on next page

Cardiothoracic Forum *continued*

Manchester in collaboration with SCTS Education and Ethicon. In April 2015 there was a SCP Master Class in Thoracic Surgery. The Master Class in Cardiothoracic Surgery was held on 23rd June, and the Master Class in Cardiac Surgery was held on 8th September 2015. All courses were well attended and feedback was excellent. We would like to thank the surgical faculty and all the clinical international trainers from Maquet, Sorin, Terumo, Sonasite and Karl Storz for their participation in these courses, and we also thank Ethicon for sponsoring the courses.

Following consultations with the Royal College of Surgeons of Edinburgh, the SCP exam was held in December at the RCS, Edinburgh in Birmingham. There was a revision course held prior to the exam on the 1st and 2nd September in the CTCCU seminar room, Wythenshawe Hospital, Manchester; details again on both the SCTS and ACSA websites. Work remains ongoing to update the SCP course for the exam, with a rigorous QA process being developed. Thanks go to the RCS, Edinburgh for all their help, support and backing for this process. A 'silver scalpel' award for the best candidate was again donated by Swann Morton, and will be awarded at the annual meeting dinner.

CTSNet Allied Health Portal

Over the past year work has been ongoing to create an Allied Health Portal within CTSNet. Nurses, perfusionists and physicians assistant from the US and UK have been having regular meetings to establish allied health pages with clinical practice protocols, meeting presentations, published papers, educational videos and an online discussion forum for allied health professionals within the CTSNet site. Some allied health content is already on the CTSNet site and we encourage all nurses and allied health practitioners to keep looking for the detail. One excellent video discussion related to 'Human Factors and Cardiothoracic Surgery' is on the CTSNet portal with insights from Joel Dunning, Tara Bartley, Jill Ley and Arie Blitz. For any nurses or allied health practitioners that would like to provide

good clinical protocols, journal articles or options for videos please contact me on chrisiebannister71@gmail.com

EACTS

The postgraduate nurses' day at EACTS was once again run by nurses and allied health professionals from the UK, the Netherlands, and Denmark. This was held at the Amsterdam RAI Conference Centre, Amsterdam on Sunday 4th October 2015, and had a focus on patient frailty and creating safe environments for patients.

The SCTS CT Forum top marking presentations were invited to present at this meeting, and the participants listened to plenary talks from Specialist Nurses and Allied Health Practitioners from across Europe. Delegates from cardiothoracic centres in the UK and Ireland attended the meeting, and shared their knowledge and experiences with other nurses and health care



professionals from across Europe.

For the first time the presentations were peer reviewed by the nursing and AHP audience, and EACTS donated a prize of 1000 Euros for the best presentation. I am especially pleased to inform you all that Jose Luis Pomar presented the award to Brenda Andrews, a Nurse Case Manager in Thoracic Surgery at Southampton General Hospital, for her fascinating talk on the Nurse Case Manager and Advanced Nurse Practitioner role in Thoracic surgery at Southampton General Hospital. Congratulations go to her and our thanks go to EACTS for the award.

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

SSI Network

The Cardiac SSI (Surgical Site Infection) Network aims to share best practices to reduce the incidence of SSI, as well as to share cardiac surveillance methodologies. This is also a forum to review collectively new research and national initiatives as to reduce the incidence of surgical site infections. Throughout 2015 I have attended three of the meetings and have been able to discuss from a national perspective issues around wound surveillance and surgical site infections. This network is a fantastic forum for all units to work together to reduce the incidence of surgical site infections. Presentations about current research have been presented in both the CT Forum at the SCTS annual meeting, at the postgraduate nurses and AHP day in EACTS, as well as within national cardiac conferences held in the UK. Work is ongoing to commence a number of multi-centre studies.

If you are a healthcare professional with an interest in SSI surveillance in cardiac surgery we would be delighted to hear from you. Please either contact myself at chrisiebannister71@gmail.com or connect to the SSI Network to join the group at <https://www.networks.nhs.uk/nhs-networks/ssi-cardiac-network>



Bupa/SCTS Patient Information Website Portal.

Currently there is a nursing project running to create patient information pages for the SCTS and Bupa Websites. The aim is to create a central repository of Quality Assured information which will provide accurate information regarding cardiac surgery for both patients and their relatives; and to provide a resource for nurses and allied health practitioners working with cardiac patients. A group of nurses met during the annual meeting in Manchester with researchers from Bupa for an insight meeting and discussed the patient journey and pathway around Aortic Valve Surgery and a patient survey has been given to a group of patients with regards to the information they receive. The content for these pages has been written and currently is being reviewed, and a selection of nurses, surgeons and patients are filming videos for the website, detailing their experiences. If any nurse or allied health practitioner would like to get involved in the project or has specific patient information they would like to share please contact me on chrisiebannister71@gmail.com

National Nursing & Allied Health Developments.

NHS England's Chief Allied Health Professions Officer, Suzanne Rastrick, called on the AHP workforce to engage in the delivery of a £5m initiative to improve the health and wellbeing of health service staff. In October NHS England Chief Executive Simon Stevens announced a £5m initiative to support wellbeing initiatives for staff saying: "The NHS has got to lead by example in helping our own staff and hopefully other employers will follow suit." "There are a number of challenges to introducing this sort of initiative to an organisation as complicated and vast as the NHS but, as one of the largest employers in the world, we also recognise the benefits". The focus of the initiative includes reasons for sickness absence, while supporting staff to stay well to benefit them and their service users. A new White Paper from an AHP organisation, the British Dietetic

Association 'Supporting healthier working lives through dietitian-led wellness initiatives', recognises that some unhealthy practices can be influenced by the working environment. For example, healthcare workers are more likely to work in environments with irregular shifts, and thus may experience more barriers to achieving regular eating and exercise patterns. While shift workers are also more at risk of developing obesity, metabolic syndrome, type 2 diabetes and cardiovascular disorders. Good nutrition and hydration, alongside other healthy habits and good employment practices, keep the UK workforce healthy and productive. Suzanne stated that Allied Health Professions have among them people with the training and experience to deliver a healthier NHS workforce.

Taking effect from April 2016, revalidation is straightforward and will help nurses and midwives demonstrate that they practise safely and effectively. The new process replaces the current Prep requirements and nurses and midwives will have to revalidate every three years when they renew their place on the register.

The NMC stated that revalidation builds on existing renewal requirements by introducing new elements which encourage nurses and midwives to reflect on the role of the Code in their practice and demonstrate that they are 'living' the standards set out within it. Revalidation will help to encourage a culture of sharing, reflection and improvement amongst nurses and midwives and will be a continuous process that nurses and midwives will have to engage with throughout their career. It will allow nurses and midwives to demonstrate that they practice safely and effectively, strengthening public confidence in the nursing and midwifery professions.

The NMC Chief Executive and Registrar, Jackie Smith said, "We warmly welcome confirmation from the Department of Health that England is ready for the implementation of revalidation for nurses and midwives, as planned from April 2016. "The introduction of revalidation is the most significant

change to regulation in a generation and we firmly believe that it will give the public confidence that the people who care for them are continuously striving to improve their practice."

SCTS CT Forum Contacts.

We have recently made some changes to the SCTS Website – we have amalgamated the Nursing and Allied Health Professionals pages, with a home page, meetings pages and useful links. Please continue to check these pages for up to date courses and information. If you have any courses to be advertised please contact me on the email addresses below.

The SCTS CT Forum Facebook and Twitter pages 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:

[Follow us at Twitter - @SCTS_CTForum](#)
[Join the Facebook Group - SCTS CT Forum](#)
 - please pass these details on to as many nurses and allied health professionals that you all know and encourage everyone to participate.

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 chrisiebannister71@gmail.com or direct to Tilly Mitchell at tilly@scts.org

Chris Bannister

Patrick Magee Medal – Encouraging Student Engagement in Cardiothoracic Surgery

Patrick Magee was a truly inspirational man. He was a council member of the British Heart Foundation, president of the Society for Cardiothoracic Surgery in Great Britain and Ireland, president of the cardiothoracic section of the Royal Society of Medicine and of the section of cardiothoracic surgery in the Union of European Medical Specialists. He was also chairman of the Specialist Advisory Committee for Cardiothoracic Surgery. Pat served as a member of the Intercollegiate Exam Board in Cardiothoracic Surgery and was lead examiner for the tri-collegiate examination in cardiothoracic surgery of the Royal College of Surgeons of Edinburgh, the Academy of Medicine of Singapore and the College of Surgeons of Hong Kong. He will always be remembered for his dedication to mentoring and supporting trainees throughout the nation and through generations.

Encouraging Students – Supporting Development

The SCTS has developed a proactive student engagement programme to attract the brightest undergraduates to the specialty. A highlight of this programme is the annual Patrick Magee Medal.

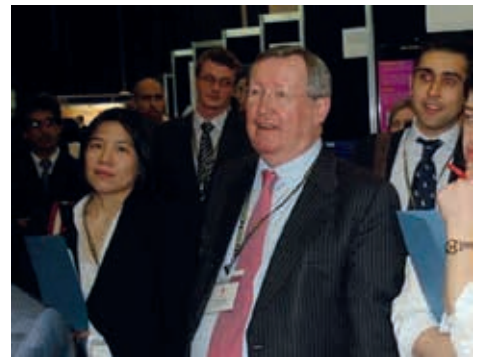
In 2016 it will be in its seventh year. The Patrick Magee Medal has enjoyed great popularity with undergraduates and there have been over 250 posters with an equivalent number of students attending the annual meeting. An extremely diverse range of subjects have been covered with posters on all aspects of cardiac surgery, thoracic surgery, congenital surgery, critical care and basic science.

Projects have been presented from every UK cardiothoracic unit and also internationally from 5 continents.

History of the Medal

The SCTS Student Poster Prize was created with the mission of encouraging student exposure to our specialty. It was structured to promote undergraduate academic or clinical work with a direct cardiothoracic consultant mentor.

With successive iterations, the enthusiasm of trainees to support student involvement has become more evident. We strive to foster a working relationship between students within



Patrick Magee judging the inaugural SCTS Student Poster Prize, 2010

a department, so as to allow them to develop and pursue an interest in cardiothoracic surgery. All participants are granted complimentary access to the SCTS Annual Meeting (including the SCTS University) and gain familiarity with the format of a large scientific conference. Many students have enjoyed the opportunity to discuss the specialty with established surgeons.

From the inaugural year of 2010, Patrick Magee was closely involved in setting up the prize and kindly invested much of his time and enthusiasm into the project. It was felt appropriate that after his premature passing, the prize be named in his honour.

Current Format of the Event

Abstracts are welcomed in any aspect of cardiothoracic surgery (case report, audits, systematic reviews, original research or perspective pieces). For students hoping to present in Birmingham, the deadline is 1st February 2016 (so there is still time!). Students that submit good quality abstracts are invited to display a poster outlining their work. After marking, authors of the top 6 posters are invited to orally present their work and field questions from a friendly panel of surgeons. The oral presentation ceremony is opened with a few words to remind us of Patrick Magee's inspirational dedication to training and his enthusiasm towards the next generation. The winner of the competition is presented with an award each year and a Sorin sponsored place on the Par Excellence Course.

Of the hundreds of students that have enjoyed the opportunity to present their work, many have chosen to pursue a career in cardiothoracic surgery. Charlene, Phil and Luke discuss their experiences overleaf.



David J McCormack FRCSEd (CTh)
Simon Kendall MS FRCS (CTh)
Graham Cooper MD FRCS (CTh)



Phil McElnay – NIHR Academic Clinical Fellow

Cardiothoracic Run-through

I entered the Patrick Magee Medal in 2011 and it was an extremely valuable experience. I got more involved in the SCTS meeting and got a taste of academic cardiothoracic surgery. It helped inspire me to pursue an academic surgical career and 3 years later I was appointed as an NIHR ACF run through trainee in cardiothoracic surgery. I've continued to pursue academic cardiothoracic surgery - I have been fortunate enough to be able to be part of European Guidelines working groups. I've also been keen to ensure training remains of highest quality and that others can benefit from initiatives such as the Patrick Magee Medal. This has seen my appointed to roles such as Association of Surgeons in Training (ASiT) Honorary Secretary and European Society of Thoracic Surgery Trainee Representative. I have been constantly inspired and encouraged by more senior surgeons and I hope that the Patrick Magee Medal will continue to inspire even more students.



Charlene Tennyson

Cardiothoracic Run-through (ST2)

As a finalist at the inaugural SCTS student poster competition (2010), I was privileged to have met Mr Patrick Magee who offered words of encouragement in my early aspirations to train as a Cardiothoracic surgeon. The following year, I was awarded the Society medal for best forum presentation.

In 2014, I was appointed a run through position in the North West. My career to date has been influenced and guided by some of the most inspiring and talented trainees in the profession.

I would encourage all students considering a future in cardiothoracics actively participate in society meetings. The Patrick Magee Prize is an excellent educational experience and perfect introduction into the world of cardiothoracic surgery.



Luke Holland

Academic Foundation Doctor (Cardiothoracic Surgery)

I presented my undergraduate research project on echocardiography in valve patients at the Patrick Magee Medal in 2013. This experience was my first chance to deliver an oral presentation to a national audience and, more importantly, it was in the field of surgery that I am most passionate about. This was an invaluable experience and I am quite sure that this presentation has helped me to secure my academic foundation doctor post in cardiothoracic surgery, contributed to me being able to sit on the Royal Society of Medicine's cardiothoracic section council, and will strengthen my application for cardiothoracic training in due course. Any student interested in cardiac or thoracic surgery should submit their work for consideration of this award; you may just find that a whole host of opportunities become available to you.

The Joint Surgical Colleges Fellowship Examination

E E John Smith

Chair, Cardiothoracic Board,
Joint Surgical Fellowship
Examination

eejsmith@btinternet.com

Some of us have been around long enough to remember the old FRCS. Each Royal College - Edinburgh, England, Glasgow and Ireland - ran its own exam and typically it was taken about four years after graduating. Thus it was essentially an 'entry exam' into training and it could cover virtually any area of surgery. Certainly there was no means of formal assessment at the end of training. Progression to a consultant post depended on nebulous factors such as the amount of support from seniors for whom one had worked, including the number of telephone calls made before interviews by consultants on your behalf - and the calls were not necessarily the helpful variety!

Now of course we have in the UK and Ireland the Intercollegiate FRCS. All the surgical Royal Colleges have come together to run a single exam aided by a secretariat based in Edinburgh. There is a Board overseeing each of the surgical sub specialties, including naturally cardiothoracic surgery. Alongside workplace-based assessments, obtaining the diploma FRCS facilitates the award of a certificate of completion of training and progression to a consultant appointment.

The Intercollegiate FRCS has become, I firmly believe, the gold standard of clinical examinations. There is extensive input from educationalists and psychometricians ensuring that important factors such as reliability and validity are properly addressed, and thus that there is outstanding quality assurance. The Boards are confident that successful candidates have the necessary knowledge base of a day one UK/Ireland consultant.

More recently the colleges have again come together to produce the JSCFE - the Joint Surgical Colleges Fellowship Examination. Several specialties are offered including cardiothoracic surgery. This examination is aimed at the 'international market', and is likely to attract candidates who are not eligible to sit the Intercollegiate FRCS but nevertheless wish to obtain an equally valuable qualification.

How does this differ from the present FRCS? In reality the differences are relatively minor. Section 1 consists of two papers - single best answers (SBAs - assessment at 'knows' level) and extended matching items (EMIs - assessment of 'knows how'). While the standard remains that of the knowledge base of a

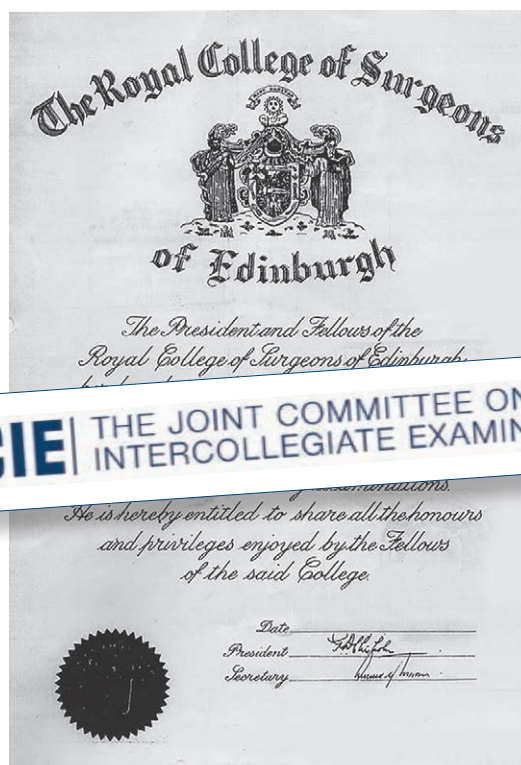
day one UK/Ireland consultant, questions which are peculiar to local administration, government, health service structures, etc. are not included. The papers are offered at numerous PearsonVUE centres located worldwide. Successful candidates can progress to Section 2, the clinical examination, and the likely venue for the first exam is Bangalore, India. While in the early days there will be heavy reliance on experienced UK/Ireland examiners, it is the intention to recruit gradually increasing numbers of appropriately trained international examiners over the coming years.

The requirements for sitting the exam are laid out in detail in the JSCFE website but, in brief, candidates should ideally have passed the MRCS exam, though this is not essential. However, completion of a locally recognised surgical training programme is mandatory, confirmed by three appropriate structured references. Thus the exam is aimed at those in the international community who are about to complete or have recently completed their training.

Why should surgeons choose to sit this demanding examination? I believe many will be seeking a prestigious high-quality international qualification and will value their entitlement to use the

Royal Colleges' post-nominals FRCS. More importantly, patients and the public can be reassured that a surgeon achieving this standard has the knowledge and skills to practise independently. I therefore commend this examination to those surgeons around the world who aspire to the highest levels of surgical achievement.

Full details of the examination are available at www.jscfe.co.uk.



**The Intercollegiate
FRCS has become,
I firmly believe,
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of clinical
examinations**

Are we doing things properly?

Andrew Owens
Sarah Murray

The Society has grown and changed enormously since its inception in 1934. The evolution of its role in data collection following the establishment of the register in 1977 has been well-documented, and debated, elsewhere.

In keeping with other professional societies it has however a broader remit than data collection – the stated aims are:

1. To continuously improve the quality of healthcare that our members deliver to patients in an open and accountable manner;
2. To ensure that we influence the direction of education and development of surgeons-in-training and related health care professionals;
3. Ensure that regulation when required is fit for purpose;
4. To meet the professional demands of our members as regards information and guidance surrounding the practice of cardiothoracic surgery;
5. Support education and professional development through Society scholarships and bursaries;
6. Represent GB & Ireland in cardiothoracic surgery at an international level to foster exchange of concepts and ideas which may enhance our practice.

Throughout the year there are matters arising that require specific attention referring to professional standards and the Executive felt that the SCTS structure was not able to give appropriate time, nor adequate responses, to such matters. Furthermore, given the Society's position as a company limited by guarantee and a registered charity it was also felt important to ensure that the Society, and in particular the Executive, was adhering to the principles of good governance.

To address both these issues, it was proposed that a Professional Standards Committee should be established.

Terms of reference for the committee were subsequently prepared with membership of the committee consisting of the President Elect, the Lay Representative and an Elected Trustee – Prof. Andrew Owens was appointed to the latter position after interview. The membership and terms of reference were subsequently ratified at the October Executive.

Two work streams

After discussion it was agreed that the Committee should have two overarching work streams. As part of a rolling governance programme it will review the governance of the Executive itself, specific areas for review include the composition and balance of the Executive and its sub-committees; the process for nomination and appointment of members to various positions on the Executive and sub-committees; standing orders for the conduct of its business; a code of conduct and register of interests and compliance with relevant legislation.

The second area of work will be to undertake reviews of specific areas in response to requests for advice from the Executive or Members. A number of questions and particular subjects have been proposed – the first issue the committee will address is the production of guidelines for the introduction of new techniques. Other likely to follow will address issues regarding working with industry, changes in the legislation surrounding hospitality and subject experts for clinical enquiries.

We recognize that the membership of the Committee does not have the expertise, or resources, to undertake this work in isolation and will co-opt members as appropriate – these will include members of the Society, chairs of sub-committees and professional advisers.



Members of the Society are welcome to approach anyone in the Committee if they have issues that they feel should be addressed – these will be handled in confidence when requested. Not all queries will be within its remit – the main roles are to ensure good governance of the Executive and provide overarching guidance on issues pertaining to professional standards – the latter aspect cannot replace the role of the Executive in areas such as outcome reporting, nor can it influence issues that fall under the remit of employment legislation.

This is a new initiative for the Society and the Committee's role will undoubtedly evolve with time and experience. We hope its work will reassure members that the Society is undertaking its responsibilities with integrity, providing them with guidance to be confident that they are working to the highest standards in all areas of their practice.

The Executive felt that the SCTS structure was not able to give appropriate time, nor adequate responses, to all matters arising.

A new use for the Belsey spoon

Jules Dussek
retired thoracic surgeon



What is a Belsey spoon? If you are not a thoracic surgeon or a theatre nurse of a certain age you are unlikely to have come across one.

Ronald Belsey (1910-2007) was one of the great thoracic surgeons of the post world war two period and established the South West Regional Thoracic Centre initially based at Frenchay Hospital Bristol. Surgeons came from all over the world, in particular the United States, to study under him although he was not an easy man. From the outset he worked on the principle (to put it in his own words): *'you cannot make friends and at the same time get things done'*. True to his word, he went ahead and made several enemies¹. He is however particularly remembered for his expertise in oesophageal surgery and his operation, the Belsey MkIV was the standard anti reflux operation in many centres for decades.

One of the essential components of the operation which was performed then through a transthoracic incision was to suture the crura of the diaphragm behind the oesophagus giving a snug fit. To protect other structures when inserting these stitches Belsey utilised a modified spoon. Folklore has it that it was purloined from the Navy, Army and Air Force Institutes (NAAFI) canteen. It was placed between the diaphragmatic crura with the concavity forward to enable curved needles to be passed through the crura while the back of the spoon protected vital structures. The spoon had notches either side to stop the crura sliding off it.



Ronald H Belsey 1910-2007



The British Oesophageal Group (BOG) was an informal group of oesophageal surgeons which met annually to discuss the problems of oesophageal surgery. Many members of that group, conceived in 1974 by the late Hugoe Matthews, have retired but some still meet under the title of 'Old Bogggers'. In memory of his mentor Ronald Belsey, Professor Anton Lerut of Leuven University presented the Old Bogggers with beautiful replica Belsey spoons (fig 1). However, while decorative and of historic interest they are of little use to retired oesophageal surgeons.

One Old Bogger (the author) has a keen interest in cookery and realised that the spoon was ideal for skimming broths and stocks. Depressed gently into the liquid the scum floats through the notches enabling it to be removed easily (picture below). It is now a treasured possession, both as a memento of a past surgical era, and as a very useful tool in the kitchen armamentarium,

References

1. Plarr's Lives of the Fellows Online 7 Feb. 2008
<http://livesonline.rcseng.ac.uk/biogs/E000447b.htm>



Looking for an adventure?

Sail across an ocean!

Leslie Hamilton

Cardiothoracic surgery has its challenges and excitement but is it time to step out of your comfort zone? Why not sail around the world (or at least across an ocean). The Clipper Race offers you that opportunity. Never sailed before? – 40% have not been on a boat before applying. In 20 years from now you will be more disappointed by the things you have not done, rather than those you have.

I stopped clinical practice in June – I was beginning to dread my on-call nights and weekends (we are a transplant unit). But I needed a goal for my retirement. I went along to a presentation about the race with my daughter (a keen sailor) out of interest. I had no notion of taking part. However I brought the brochure home. I began to think I dropped it into the conversation at home. My kids were enthusiastic; my wife was not sure I would be fit enough. I was unsure (I get sea sick). I applied. And was accepted. I am doing leg 8 (the last) of the 15/16 race, starting next June: New York – Londonderry – Holland – London.

The Clipper Race was started in 1996 by Sir Robin Knox-Johnston, the first man to sail solo non-stop around the world (1968). He wanted “ordinary” people to have the chance to do what he had done. Eight 60 foot yachts left Plymouth in 1996 to do a circumnavigation. The 15/16 race (the 10th) left St Katherine Dock in London on 30 August on route to Rio de Janeiro – 12 identical 70 foot racing yachts, each with a crew of 20 and a professional skipper. Each boat has a sponsor (I am on Team GB).

They will arrive back in London on 30 July next year, having gone via Cape Town, Sydney – Hobart, Viet Nam, China, Seattle, Panama, New York (and then my leg 8).

About 40% of the crew do the full “round the world” – the rest do 1 or more legs. So 690 crew in total for the 12 boats. An amazing range of people, aged 18 to 74, from all over the world, all with different motivation for doing it. Training is excellent. The training fleet is based in Portsmouth / Gosport (you can also do your training in Sydney). They assume no previous experience. Using the 68 foot boats from the previous race, over 4 one week “levels” they take you to ocean racer! A model for competency based training and developing teams (even an “ARCP” at the end of each week!).

It is not cheap (though they do say the best way to make a small fortune is to start with a big fortune and buy a yacht). It is £5000 for the 4 weeks of training (includes your “ocean foulies” and some other gear) and about £5000 for each leg. It takes 11 months for the full “round the world” with each leg being about 6 weeks (? a sabbatical).

Quite a number of crew are already signed up for the 2017/18 race and some even for the 19/20. Time to set yourself a challenge. See <http://clipperroundtheworld.com/>

In the meantime, you can have your own virtual boat in the current race and you can follow progress of the real boats on “The Race / race viewer” on the website (Team GB is the navy blue boat).



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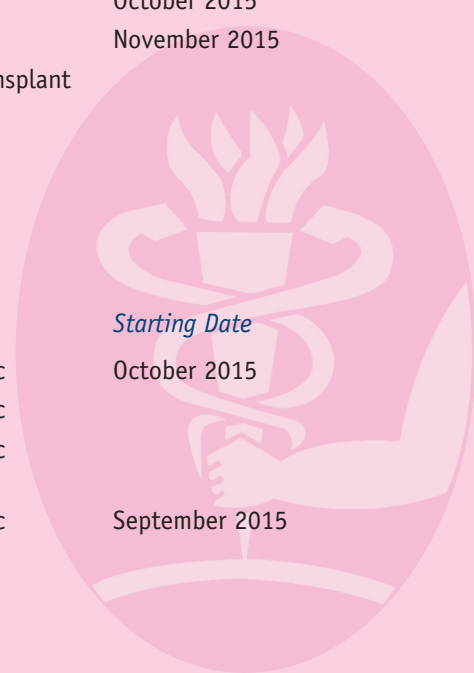


New Consultants

<i>Name</i>	<i>Hospital</i>	<i>Specialty</i>	<i>Starting Date</i>
Neil Cartwright	Northern General Hospital	Adult Cardiac	October 2015
Govind Chetty	Northern General Hospital	Adult Cardiac	November 2015
Balakrishnan Mahesh	Golden Jubilee National Hospital	Cardiac & Transplant	
Ed Peng	The Royal Hospital for Children Queen Elizabeth University Hospital, Glasgow	Congenital	

Other appointments

<i>Name</i>	<i>Hospital</i>	<i>Specialty</i>	<i>Starting Date</i>
Suvitesh Luthra	Derriford Hospital	Locum Cardiac	October 2015
Zahid Mahmood	Golden Jubilee National Hospital	Locum Cardiac	
David W Quinn	Golden Jubilee National Hospital	Locum Cardiac & Transplant	
Mesbah Rahman	University Hospital of Wales	Locum Cardiac	September 2015



Definition of a “Case” for Trainees

Simon Kendall

The SAC in Cardiothoracic Surgery has done a thorough piece of work clarifying the definition of a ‘case’ for the purpose of trainees and trainers recording it as such.

Mr Joel Dunning and Ms Clare Burdett have collated all the opinions of the definitions (for Lobectomy, CABG and AVR) and then refined those opinions to a consensus view using a ‘Delphi Process.’

These definitions have now been sent to all trainees and training programme directors in the letter attached below.

All trainers and trainees are now requested to use these definitions for logbooks and CCT applications,

Please find below the definitions of a ‘case’ for the most commonly performed procedures. These definitions should be applied when completing logbook entries and for CCT. They will also apply to the Matrix for entry into the Specialty.

We hope you find them useful - they have been specifically introduced to help guide you and make the recording of cases fair and accountable for all trainees. The definitions have been chosen after consultation with both trainees and trainers (through a Delphi Process) to ensure they are workable and based on consensus.

Coronary Artery Bypass Grafting:

- Majority of Bottom & Majority of Top Ends

Aortic Valve Replacement:

- Aortotomy + Valve Excision + Suture in Valve & Tie Down + Aortotomy Closure

Lobectomy:

- Majority of Vessels & Bronchus + Hilar Dissection

If you perform less than the above definition, please record the individual parts that you performed (i.e. top end) but do not record it as a case.

As you can see, definitions for all 3 procedures focus on the ‘central part of the operation’. Please use the same philosophy when recording other procedures not defined here.

For more complex operations such as AVR & CABG, if you complete only one of the two, you can record it as such (e.g. AVR Case if you do the AVR part only).

For an Independent Case, the definition is: -

- Consultant not scrubbed entire case - but can be in theatre

You should use these definitions from the date of this publication. Modifying previous logbook entries is at your own discretion.

Price Thomas Travelling Fellowship

awarded by the Travelling Surgical Society of Great Britain and Ireland

This prestigious bursary is open to surgical trainees at ST7 or more senior by May 2016 and to Consultants within 10 years of appointment.

The award holder will travel with the TSS to Toronto 3rd-12th June 2016. All expenses including travel, accommodation, organised meals and course fees will be met by the society (a value of some £2,000). The award holder will deliver two talks during the trip.

The award is open to surgeons in the following specialties: General surgery, including any of the subspecialties (Breast, Colorectal, Upper GI, Hepato-pancreatico-biliary, Endocrine), Vascular, Cardiothoracic, Plastic, Urology, General Paediatric, Transplantation, Trauma or Military Surgery.

Details about the Travelling Surgical Society can be found on the web site (www.travellingsurgeon.org).

The application form can be found on the web site at www.travellingsurgeon.org/about-us/bursaries/



SCTS CUP 2015

Dincer Aktuerk

The Society of Cardiothoracic Surgery in Great Britain and Ireland in partnership with Medela hosted the second annual SCTS CUP 2015 in Manchester.

The 5-a-side tournament is held 'traditionally' the day before the annual meeting and saw ten teams from all around the UK representing deaneries, cardiothoracic units and corporate groups. This year's teams were Real Sociable CardioSolutions, Medela Sucks, Real Mad Leeds, Sternum United Scotland, Wolvey Wizards, Ethicon United, CPR Midlands, Manchester Royal Infirmary, Welsh Dragons and London Town. The defending champions Medela Sucks vowed to return to retain the trophy, which they won in a closely fought final in 2014. There was a cracking atmosphere pitch-side with all the other teams and spectators lining the touchlines during the entire indoor tournament. The players had an opportunity to enjoy a buffet and network with other participants. After 25 games of football it came down to the most important of them all. London Town and Medela Sucks had to summon one last burst of energy to ensure they would be picking up winners and not runners-up medals. The hard fought final found its epic conclusion in a penalty shoot-out, which was decided in favour of London Town thanks to their defending and scoring goalkeeper Khalid Mujahid. The award ceremony took part during the annual SCTS/ACTA dinner.



We have great pleasure in inviting you to participate in the **3rd Annual SCTS Cup** to be held in Birmingham on **Saturday 12 March 2016** before the Annual Meeting commences. The 5-a-side contest is a fantastic way to kick off next year's meeting and enjoy an afternoon of competitive and exciting football. We are looking forward to welcoming mixed teams from various cardiothoracic surgery departments and corporates. A mixture of surgical, anaesthetic, nursing, SCP and perfusion staff encourages collaborative working, and offers a team-building experience. Alternatively, a direct competition between professional groups for bragging-rights in the hospital or around the country is another perk. To participate, please contact your regional trainee representative or create a full team from your institution. If you are not able to assemble a team, but would like to take part just email the SCTS Organising Committee and we will accommodate you in one of the teams. Fans are warmly invited!

Looking forward to seeing you in Birmingham.

Dincer Aktuerk (ST7)

Queen Elizabeth Hospital, Birmingham

EACTS 2015

Football Tournament

Stuart Grant and Joe Zacharias

The 2015 EACTS meeting was full of great scientific content and educational opportunities but will perhaps best be remembered by some for the drama that unfolded on the football pitch in Amsterdam. The United Kingdom team sponsored by Heart Valve Voice made the trip to Amsterdam with cautious optimism. Pre-tournament preparation had been far from ideal. Conditions on the day were good and the squad were ready to face the best that Europe had to offer.

The team was led by Joe “the finisher” Zacharias due to a last minute injury to long-time player manager Neil “dodgy knees” Moat. The “boys” arrived at the stadium allowing enough time for the team to down a few beers and sign autographs for the waiting crowd. The Heart Valve Voice team had been drawn in the group of death along with pre-tournament favourites Italy and a tough looking Russian side. The other group included Holland, Switzerland and a combined European team. After a comprehensive warm-up, the Heart Valve Voice team lined up against a very fresh and well kitted out Italian team in their first game. The starting five were Joe Z, Ralph ‘Wreck em’ White, Max ‘the cat’ Baghai, ‘Mighty’ Mick Murphy and ‘Super’ Stuart Grant with Heyman ‘Lucky’ Luckraz, Adrian ‘Chopper’ Carrol, ‘Nippy’ Nitesh Shah and Andy ‘mad dog’ Coane on the bench.

The opening 5 minutes were played at a frantic pace and the clearly well drilled Italians took an early three goal lead. However after some in game tactical changes the Heart Valve Voice team started to get back in to the game and pulled it back to 3-3 with some cool finishing from Grant, Luckraz and White. The Italians were starting to look worried and it was only through an unfortunate goal keeping mishap that they found a way back in to the game. Despite some good play in midfield from Baghai, Shah and Carrol the Italians extended their lead and ran out 6-4 winners.

The Heart Valve Voice team knew that the next game was now a must-win game if they were to make it through the group stage. However they had little chance to lick their wounds and immediately lined up against the formidable looking Russian side. With the rousing words of JZ ringing in their ears and the boost of Coane arriving after a delayed flight the Heart Valve Voice team made an inspired start and were quickly 3-0 up thanks to a hat trick by White. With Baghai now in goal and the enforcers Murphy, White and Carrol keeping things solid at the back the lead was extended to 5-1. Goals from Grant, Zacharias and Shah added to the Russians misery and despite a couple of late consolation goals the Heart Valve Voice boys ran out comfortable 8-3 winners and qualified for the semi-finals.

The semi-final draw pitted our men against a young Holland team, who as host nation and winners of their group were favourites with the bookmakers to progress to the final. The early exchanges were tense and evenly matched as the two teams

looked to assert their dominance. Murphy and White were commanding in defence and a number of tough challenges clearly had the Dutch team rattled and

allowed a 2 goal advantage to be opened up with a brace from Grant. However despite good work in the midfield from Zacharias, Baghai, Carrol, Coane, Luckraz and Shah the Dutch team played their way back into contention and the scores were level at 3-3 at the end of normal time. This meant a penalty shoot out to decide the winner. “Mad dog” Coane was put in goal to rattle the young dutch strikers. Grant calmly put away the first penalty with Zacharias perfectly placing the second to level the scores after two penalties each. The Dutch forward then scored their third penalty but was adjudged to have broken the one-step penalty rule and Coane made a fantastic save to deny the re-taken spot kick. White stepped up to take the third penalty, knowing a goal would send his side through but was incredibly unlucky as he saw his penalty clip the bar on its way high in to the watching crowd. This meant sudden death penalties. The fourth Dutch player stepped up and missed leaving Carrol with a chance to send the boys through to the final. The atmosphere in the stadium was palpable as he smashed the ball into the back of the net, ensuring that the UK team would be in the final of a major football tournament for the first time since 1966.

The final saw a repeat of the first game against Italy. Determined to avenge the result in the first game, the Heart Valve Voice boys made a promising start playing some great football, however the Italians were too strong and eventually ran out 5-1 winners. Many of the Italian team did not look old enough to have got through a tough cardiac surgical program!! Player manager JZ said ‘we gave it our all and I am really proud of what we achieved on our first time together, we will head to next year’s tournament in Barcelona full of confidence and determined to go one better’.





VACANCIES FOR MEMBERS OF THE SPECIALTY ADVISORY COMMITTEES (SACs) – 2016

The JCST is looking for practising NHS Consultants who are committed to surgical training and would like to make a real contribution to the following surgical specialties:

Cardiothoracic Surgery - General Surgery - Neurosurgery - Oral & Maxillofacial Surgery - Otolaryngology - Paediatric Surgery - Plastic Surgery - Trauma & Orthopaedic Surgery - Urology - Vascular Surgery.

The work undertaken by SAC members includes amongst other areas:

- Setting quality indicators for the training of surgeons, on behalf of the certifying authority, the General Medical Council (GMC);
- Recommending trainees for the award of the CCT/ CCST (Irish trainees)/ CESR (CP) (Combined Programme);
- Assessing other ad-hoc trainee applications such as OOPT/OOPRs, etc;
- Developing and maintaining the curricula and assessment development for surgical training;
- Providing advice to Postgraduate Deans and Schools of Surgery including:
 - acting as SAC Liaison Member for a designated region in the UK and Ireland;
 - attending their respective Specialty Training Committee meetings and ARCP meetings on a regular basis (see outcome of SAC review and its recommendations here);
 - providing advice and guidance to trainees and trainers;
 - supporting the network of Training Programme Directors (TPDs) by liaising with them and Training Committee Chairs on matters to do with training;
 - making recommendations regarding training posts/programme;
 - bringing to the attention of the SAC any relevant matters concerning individual trainees or training posts;
- Evaluating CESR applications on behalf of the GMC for those who wish to be considered for Specialist Registration.

All those appointed should have the following skills and experience:

- A strong personal commitment to the NHS;
- Active or very recent experience as a surgical trainer;
- Experience of administration/management of training at regional committee level or equivalent;
- Excellent knowledge of the StR (ARCPs and ISCP) surgical training system;
- Have attended a Training the Trainers course;
- Have attended an Equality & Diversity training course (you will be required to attend a JCST in-house E&D training session).

Full job description and person specifications can be found here.

PLEASE NOTE:

All new SAC members will be required to attend an SAC Induction Day at RCSEng – SAC liaison duties cannot begin until this has taken place. Induction Days usually happen in March/June/October – future dates are available here.

SAC meetings are held in London (3-4 times per year) and **travel expenses are paid by the Hospital Trust or Health Board where the member works**. Membership of the SAC is for a period of five years. If you are interested and would like to find out more please visit the JCST website here or phone 020 7869 6252.

CLOSING DATE: 15 January 2016

World Society of Cardiothoracic Surgeons 2015 Report

Andrew Brazier

Held in the historic grounds of Edinburgh's Royal College of Surgeons, the 25th annual congress of WSCTS promised to be a fantastic event. In four conference halls across four days, 26 sessions were held.

Hundreds of surgeons, students and clinicians of every level came from across the globe to attend and discuss their work from all the diverse areas cardiothoracic surgery has to offer.



Royal College of Surgeons, Edinburgh

It seemed that a special effort had been made to ensure there was opportunity for practitioners from all areas to present. Well-established techniques such as on and off pump bypass grafting were discussed, as well as rapidly evolving procedures such as transcatheter valve implantation and robotic thoracic surgery. These talks were well received and debate was constructive. For me, it was this inclusive environment that made WSCTS such a successful conference.

The congress began with a welcoming session in the Playfair main hall.

Here, the invited speakers talked about the history and future development of cardiothoracic surgery. Throughout, a clear message was conveyed: it is through training and sharing of expertise that our specialty will move forward. As a trainee I was pleased to see such a strong emphasis being placed on training, both in the

UK and abroad. I was lucky enough to be selected to present my work on Sunday afternoon. The subject of my presentation, TAVI, is often a small area in cardiothoracic surgery conferences, so it was gratifying to be able to present in front of an international panel of specialists in the field. It was also heartening to receive positive feedback and advice following my presentation, and later between sessions. The remainder of the conference passed in a similarly encouraging fashion with some extremely high quality presentations from both invited speakers and those with selected abstracts. The nature of questioning and discussion was equally positive.

The evening of the penultimate day of the conference held the gala dinner, with the Playfair library of the University of Edinburgh playing host. This event allowed attendees to socialise in a more relaxed environment. I talked with several distinguished surgeons, who were more than happy to share some invaluable career advice with me. The pinnacle of the evening was the honouring of Mr Bill Walker with a lifetime achievement award; a first for the society. The kind words of current colleagues and former trainees highlighted the important role that he had played, not only in the progression of thoracic surgery, but also the progression of training. This summed up my overwhelming feelings about WSCTS 2015: a commitment to ensuring the future of the speciality through protecting and improving training, and encouraging those trying to improve our specialty for the future. I already look forward to WSCTS 2016 and hope I can again produce work of a high enough quality to be accepted for presentation. If the Cape Town organising committee can do as good a job as this year's, then it's guaranteed to be an event worth attending.



For me, it was the inclusive environment that made WSCTS such a successful conference.

Cardiology

in a Heartbeat

A. Vaswani
H. J. Khaw
S. Dougherty
V. Zamvar
C.C. Lang

Cardiology in a Heartbeat couples a comprehensive overview with an attractive design and student-friendly layout, resulting in a title that is accessible, relevant and current. Written by an experienced author team, it covers all the cardiology a medical student should know.

Each section of the book starts with an 'In a Heartbeat' box which provides a useful summary of what you need to learn, these also act as excellent exam revision tools.

The book is interspersed with a variety of additional features to help you understand the subject:

- Exam Essentials boxes tell you what you must know about the topic
- Pro-tips give you key extra knowledge to further improve your understanding
- Why? boxes explain the pathophysiology and rationale behind certain decisions and processes
- Guidelines summarise the recent recommendations from key bodies to ensure you are up to date with best practice.

Cardiology in a Heartbeat will help you understand and appreciate the subject, succeed in your exams, and serve your patients to the best of your ability.

A portion of the proceeds from sales of this book will be donated to the British Heart Foundation.



Edited and produced by EUCVS www.scionpublishing.com

BOOK REVIEW

'Key Questions in Thoracic Surgery'

Henrietta Wilson

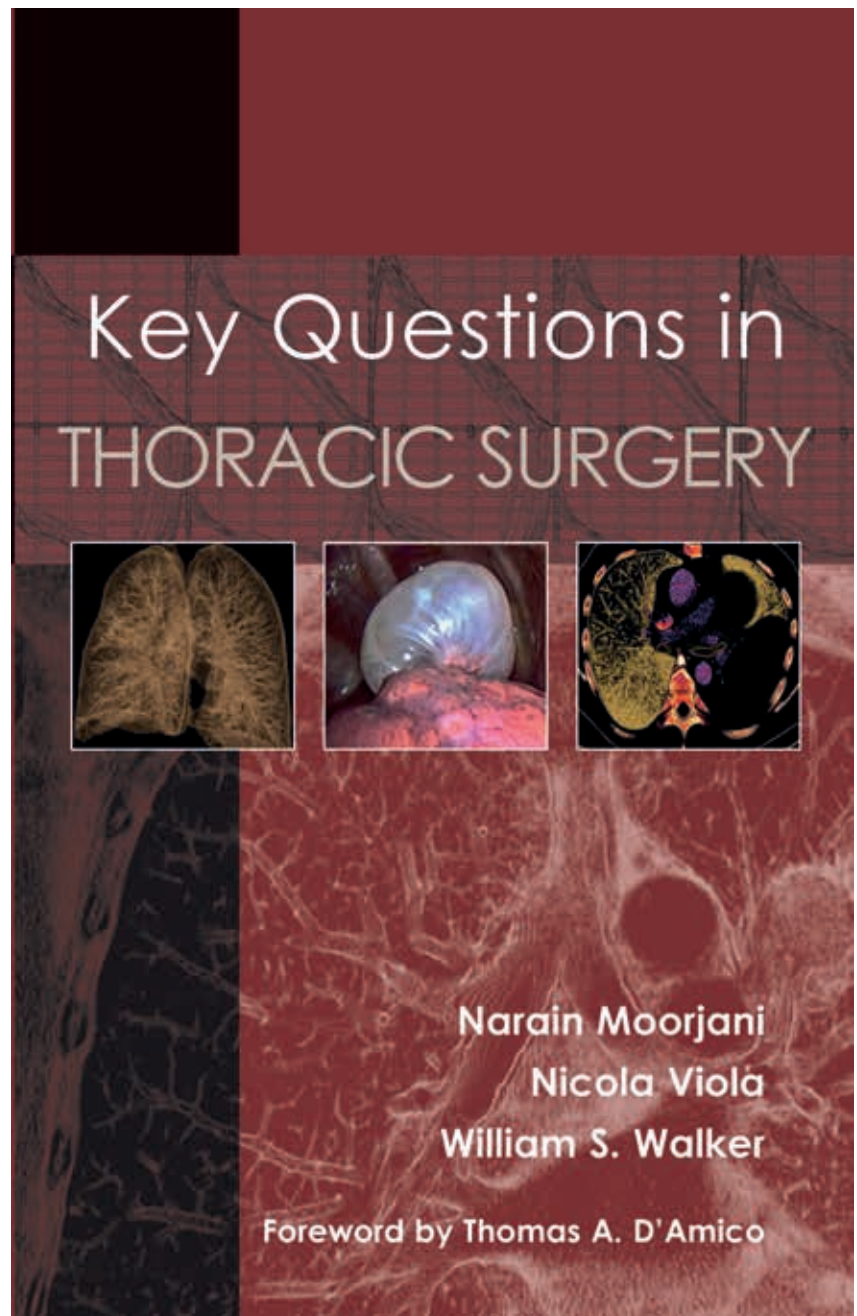


This textbook provides a comprehensive review of all of the core topics in thoracic surgery. The opening chapters outline areas such as anatomy, physiology, pharmacology and radiology, while the later sections cover a wide range of pathologies facing the thoracic surgeon. Also included are sections on thoracic anaesthesia and common surgical procedures.

I think that this textbook will be useful for individuals at all stages of specialty cardiothoracic training. For those trainees just starting out it offers a good grounding in the basic topics of thoracic and oesophageal surgery and can be used as a reference guide as new pathologies are encountered. For those approaching the FRCS (CTh) or American Board examination this book gives a thorough and up to date overview of thoracic surgery and is therefore a very valuable revision guide.

'Key Questions in Thoracic Surgery' is well presented. The question and answer structure throughout the book makes it easy to read and comprehend. In particular, there are a large number of radiological figures and operative photographs which provide an excellent adjunct to the written text. Following each chapter there is also a complete list of references to allow further evidence based reading.

To summarise, this textbook should be core reading material for all cardiothoracic trainees and for other healthcare professionals involved in the management of thoracic patients. The structure and layout make the information easy to absorb and the large number of topics gives good value for money. A must have for anyone approaching the fellowship exam.

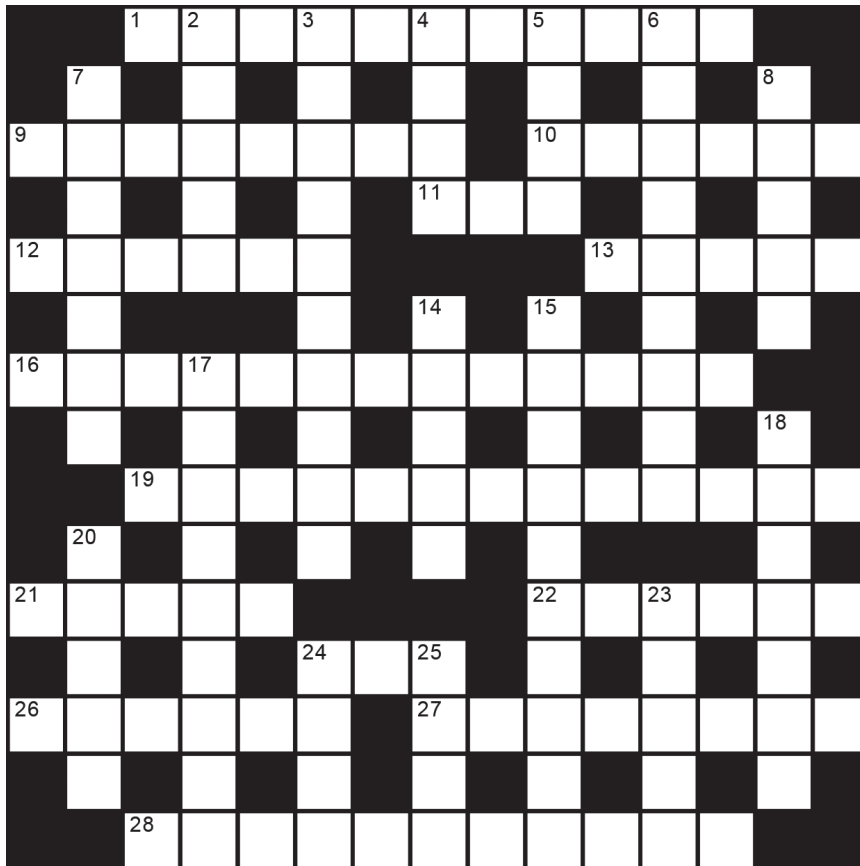


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The Crossword

Send your solution by 31 July 2016 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.



Across

- 1 Before closure, he secured a majority, unchanged (11)
- 9 Media initially unaware regarding education being good for 1 (8)
- 10 Initially, an upset stomach can end in fall (6)
- 11/13 Slur on Papworth, being worthless in cancer screen... (3,5)
- 12 ... that's good for 1 (6)
- 13 See 11
- 16/20 At home, a missionary perhaps got Jude in trouble on the bench (2,1,8,2,5)
- 19 Savage is able to point italics out (13)
- 21 Poet with gold needs a place to hide (5)
- 22 Arrows provide a thrill (6)
- 24 See 4 Down
- 26 Bright? With ten as mental age perhaps? (6)
- 27 Diminished theologian went ahead, securing victory (8)
- 28 Think to make sandwiches? (3,4,4)

Down

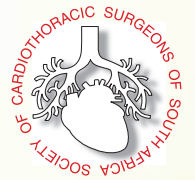
- 2 Nearly 20 donkeys (5)
- 3 French writer's mother winning 1 of 2, chased by social worker (10)
- 4/24A Leak indicating another position in the text (7)
- 5 Like dad to come up without delay (4)
- 6 Lining set up for friends (9)
- 7 Good for 1 member of the working class on Tyneside (7)
- 8 Capital of Vietnam made up (5)
- 14 Ends objection raised on board (5)
- 15 Covering unfinished leave, played all cool and informal (10)
- 17 Slept late, perhaps? That's good for 1 (9)
- 18 Made a comparison, having told stories about Barbie's friend (7)
- 20 See 16 Across
- 23 Home help up country (5)
- 24 "Bullets" (4)
- 25 Side advantage (4)



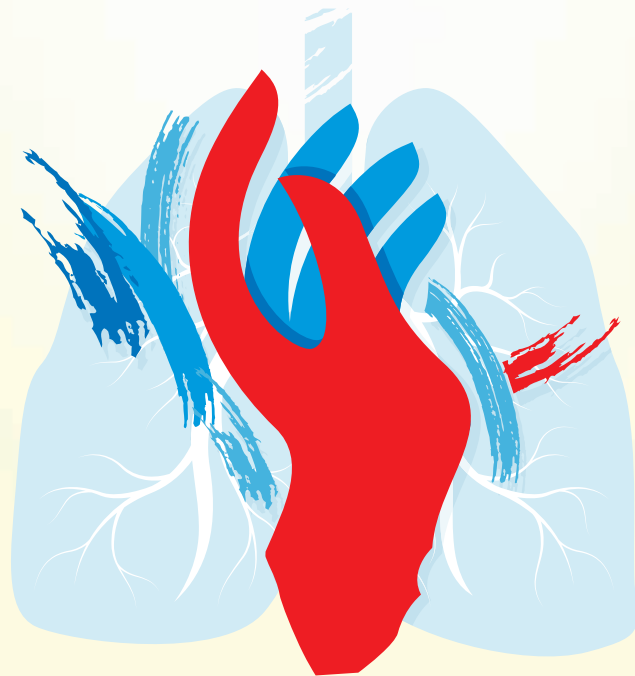
Cape Town, South Africa



THE 26TH ANNUAL CONGRESS OF THE WORLD SOCIETY OF CARDIOTHORACIC SURGEONS



Hosted by the Society of Cardiothoracic
Surgeons of South Africa



Incorporating the 17th Annual Congress
of the South African Heart Association

8 – 11 September 2016
Cape Town International Convention Centre
Cape Town, South Africa

General Information
Please contact Helene Uys
Email: info@wscts2016.co.za
Tel: +27 31 303 9852

www.wscts2016.co.za





SCTS ANNUAL DINNER

Monday 14th March 2016
Bollywood themed

Drinks reception at Museum & Art Gallery, Chamberlain Square
Dinner - served at the Council House, Victoria Square, Birmingham

Entertainment

Dress code: Black tie or Bollywood smart

Tickets £65

Limited half price tickets available for non medically qualified delegates



Contact: Isabelle Ferner • sctsadmin@scts.org • 020 7869 6983 • www.scts.org

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Society for Cardiothoracic Surgery
in Great Britain and Ireland

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