

the bulletin



Society for Cardiothoracic Surgery
in Great Britain and Ireland

July 2016

***Surgical teams are the key to mitigating
risk averse behaviour***

***Risk averse cardiac surgeons,
please stand up!***

***Audit and outcome reporting in
cardiothoracic surgery***

***Medical Student Engagement –
what do the students think?***

An SCTS Fellowship Journey

The story of the Belsey Spoon

***Training outside of the workplace:
The value of the pioneering SCTS Ethicon
curriculum aligned training programme***

www.scts.org
www.sctsltd.co.uk



ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW



**Intercollegiate Specialty Boards
and
The Joint Committee On Intercollegiate
Examinations**

**Panel Of Examiners Recruitment:
Cardiothoracic Surgery**

The Intercollegiate Specialty Board in Cardiothoracic Surgery is looking to recruit new examiners to join its Panel. The Board would welcome applications from interested and motivated Consultants who have significant previous examining experience (e.g. MRCS or University undergraduate) or formal trainee assessment experience.

Applications are invited from surgeons who hold a substantive (minimum 5 years) Consultant post in the National Health Service/Public Health Service (Ireland) wishing to be considered to join the Panel of Examiners in Cardiothoracic Surgery in all of the following areas:

- Cardiac
- Thoracic
- Cardiothoracic

The Criteria for Appointment and an application form are available to download from www.jcie.org.uk. Please note that there has been a change to the Criteria for Appointment in regards to examination experience.

Or for further information please contact Eleanor Lynes, Specialty Manager enquiries@jcie.org.uk

Tel: 0131 662 9222

**International Examinations Office
2 Hill Place Edinburgh EH8 9DS UK
Tel: 0131 662 9333 Fax: 0131 662 9444**

enquiries@jscfe.co.uk

www.jscfe.co.uk



Contents

President's Report	4
Surgical teams are the key to mitigating risk averse behaviour	6
Risk averse cardiac surgeons, please stand up, please stand up!	8
Update on audit and outcome reporting in cardiothoracic surgery	10
Nursing & Allied Health Report	12
SCTS Historian: The Development of Closed Heart Surgery (A Tale Of Two Presidents)	17
Presidential Address SCTS Annual General Meeting 2016	18
SCTS 80th Annual Meeting	21
Medical Student Engagement – what do the students think?	22
An SCTS Fellowship Journey (2015-16)	24
The story of the Belsey Spoon(s)	25
Ionescu Nursing & Allied Health Practitioners Fellowship Award 2015 My Experience	26
Patrick Magee Medal 2016 Report	28
The Cardiothoracic Trainees Research Collaborative	30
Training outside of the workplace: An update on the value of the pioneering SCTS Ethicon curriculum aligned training programme	32
There is no 'I' in the word TEAM	34
Making cardiothoracic surgery attractive to medical students	37
SCTS Student Engagement Day Report	38
SCTS Education Tutors Report	40
Developing Non-Technical Skills	43
3rd National Cardiothoracic Surgery Careers Day London 2016	44
Obituary: Professor Geoffrey Smith	46
SCTS Education Professional Development Programme	47
New Consultants	47
Other Appointments	47
The 2015 SCTS Ionescu Scholarship for non-NTN doctors	48
Obituary: Iain Mackay Breckenridge	49
The Crossword	50



Editor: **Vipin Zamvar**
Publishing Secretary
Contact:
zamvarv@hotmail.com



President's Report

Dear All

As I write this, although England seem to be on top in the 3rd One Day International against Sri Lanka, it is gloomy here. There is talk of rain in Bristol on Test Match Special, in Sheffield it is raining, yet again.

So I will start by lamenting the deaths of Mr Iain Breckenridge and Professor Geoffrey Smith. Both were senior and respected figures when I was a trainee. Indeed I owe much of my progress in the specialty to the support of Geoff Smith. I was one of many consultants who were privileged to have worked for him. I can still hear his voice as he strode into theatre; "Cooper, is the mammary taken to your complete satisfaction?" I never worked out how to answer that and of course there is no satisfactory answer. Geoff was President of our Society in 1992 and 1993.

Annual Meeting

Our Annual Meeting has made significant strides since Geoff Smith gave his Presidential Address to the meeting in Llandudno. Cliff Barlow, as Meeting Secretary, led the team that organised our last two Annual Meetings; a joint meeting with ACTA in Manchester in 2015 and possibly our most successful meeting ever in Birmingham this year. Cliff took over at a time of considerable difficulty and I would like to take the opportunity to pay tribute to him for making the 2015 Meeting as successful as it was.

Enoch Akowuah takes over as Meeting Secretary, Carin Van Doorn takes over from David Barron as Chair of the Congenital Committee. David has put an enormous effort into first 'Safe and Sustainable' and now the 'New Congenital Heart Disease

Cliff Barlow took over at a time of considerable difficulty and I would like to take the opportunity to pay tribute to him for making the Annual Meeting as successful as it was

Review' on our behalf. David Jenkins' term as an elected Trustee has ended but he remains as Chair of the Audit Committee as a co-opted Trustee. His role as Chair of the Adult Cardiac Committee is taken by Andy Chukwuemea. The key personnel on the Committees are shown in the table. If any member wishes to make contact please do so with one of the co-chairs.

Rajesh Shah and Mike Lewis have, as Education Secretaries, led the development of SCTS Education are also both moving on. Mike is now the Chair of the Intercollegiate Specialty Board in Cardiothoracic Surgery and Rajesh will be taking over as Chair of The Specialty Advisory Committee in Cardiothoracic Surgery in the autumn. Their achievements for SCTS are evident.

I have been pleased to be a member of Faculty for the ST3a and ST8a courses in the past year. I hope I have made a useful contribution but the contribution made by the other members of Faculty of these and all the other courses are crucial to their success. I have also been impressed by the attitude of the delegates who, in my experience, have all shown commitment to the courses and their educational objectives. It is disappointing to learn that this has not always been the case. We all have to remember that in this sort of arena our behaviour reflects not only on us personally but also the wider specialty.

Outcomes

Since we started publishing outcomes, the environment in which we practice has changed significantly. Over the years, we have published mortality, and now survival, by hospital and by surgeon in various formats. These changes in format of presentation over the years have been in response to various external pressures. These external pressures have never been related to patients' requirements.

The way data is currently presented does not meet the needs of patients. When I showed the outcomes data to the Patient Liaison Group of the Royal College of Surgeons of England, an intelligent and interested group of patients, they did not find the data easily comprehensible. Nor did they consider the publication of survival rates only anywhere near comprehensive enough. The following comments were typical:

- knowing the surgeons' areas of strength
- links to SCTS' webpages on patient information on the different cardiothoracic operations
- it would be helpful to have a search function that would allow the patient to tailor their search to take into account the following factors:

Graham Cooper



- the particular operation they will undergo (this would be very useful)
- where you live in terms of postcode (i.e. not just region)
- information available on which surgeons carry out different procedures
- PROMs information
- a lot of the outcomes that patients are interested in are not clinical so wider forms of data would be useful
- the inclusion of narrative text explaining what the data means in practice
- more labelling of the graph and the dot to explain what they mean

To meet the needs of patients we need to develop the way we publish information and outcomes. Especially, we need to understand the range of information patients want to see and how we can present the outcomes data so that it is comprehensible to a lay audience. Accordingly the Trustees and wider Executive agreed last month to commission Picker Institute Europe to undertake a piece of work on our behalf to explore these issues. We hope to have this completed by the end of the year and be in a position to take a step forward in providing patients information that they want to see in a meaningful way.

Well, they are off for rain in Bristol but a hint of the weather clearing here, let us hope it continues and I wish you all the best for the summer.

Committee Structure							
Committee	Meetings Team	Audit Committee	Adult Cardiac Committee	Thoracic Committee	Congenital Committee	Education Committee	Professional Standards Committee
Trustee Members	Meeting Secretary (Chair)	President Elect (Co-Chair)	President (Co-Chair)	President Elect (Co-Chair)	Honorary Secretary (Co-Chair)	President (Co-Chair)	President Elect (Co-Chair)
		David Jenkins (Co-Chair) (Co-opted Trustee)	Andrew Chukwuemea (Co-Chair) (Elected Trustee)	Juliet King (Co-Chair) (Elected Trustee)	Carin Van Doorn (Co-Chair) (Co-opted Trustee)	Rajesh Shah (Co-Chair) (Co-opted Trustee)	Andrew Owens (Co-Chair) (Elected Trustee)
		Shyam Kolvekar (Elected Trustee)			Prakash Punjabi (Elected Trustee)	Prakash Punjabi (Elected Trustee)	
Other Members	Clinton Lloyd Chrissie Bannister Isabelle Ferner Tilly Mitchell Helen Munday Sunil Ohri						Lay Member Sarah Murray

Surgical teams are the key to mitigating risk averse behaviour

(Cardiac, Thoracic and Congenital)

The Naked Surgeon by Sam Nashef is a superb book written by a cardiac surgeon with an in depth knowledge of measuring surgical outcomes. His account of doing an audit as a medical student on survival after abdominal aortic aneurysm surgery is an immediate reminder where our profession has come from: his discovery that the non-vascular surgeons had better outcomes was not a welcome message and thankfully had only a short term negative impact on Sam's stellar career progression.

His book reminds us of all the pressing reasons why we measure what we do and why we share the results to improve outcomes – and he also touches on the unintended consequences such as risk averse behaviour.

What is this behaviour in relation to surgery?

Could we define it as any decision made by a surgeon or surgical team that places the performance measures of the surgeon / team over and above the interests of the patient?

To strengthen his message in the book Sam conducted a poll of UK cardiac surgeons (with the support of SCTS) to get some measure if this behaviour was widespread. He had a response from 115

Such headlines would suggest to patients and their relatives that our very own majority view of our own colleagues is that we are not upholding the GMC standards

surgeons, 84% of whom had witnessed such behaviour in their colleagues and 35% admitted that they had at some point behaved in a similar manner.

This is not a good reflection on our specialty and a Daily Telegraph reporter from the Literary Hay Festival seized on this aspect of the book with the headline "One in Three Heart Surgeons Refuse Difficult Operations to avoid Poor Mortality Ratings – survey shows".

Is this another example where, as a professional group, we are aware of poor behaviours and not finding solutions?

The GMC in 2013 has clearly defined the behaviours expected in "Good Medical Practice" and in one of the very first headings under "Knowledge, Skills and Performance" they state that we 'Make the care of your patient your first concern'. Clearly any decision that is influenced by our personal agendas will not meet this standard.

Such headlines would suggest to patients and their relatives that our very own majority view of our own colleagues is that we are not upholding the GMC standards.

Professionally we are continually battling our human frailties that challenge our delivery of the excellence expected. Risk averse behaviour is understandably in the spotlight as the decision to operate is so clear cut, but there are plenty of other examples where we might not attain the perfection expected of us – being late to clinic or theatre, cancelling a case because of another commitment, influencing a patient to use private insurance etc etc.

On top of that we have responsibility to several patients at any one time, trying to balance ALL of their interests and make them our primary concern – the patient on the table, the emergency just referred to us, the first patient back on ITU bleeding, or a colleague who wants

to prioritise a patient that has been postponed once already.

So – back to Risk Averse Behaviour.

This hasn't just appeared since the publication of outcomes. The referring physicians always knew which surgeons to approach to get the decision they wanted for their patient, but now MDTs, generic lists and larger surgical teams make it more difficult for the physicians to make such personal referrals. This leads to differences of opinion – is an operation indicated? If so, which one? And if so who's going to do it and when? And are colleagues giving opinions influenced by their risk aversion?

As doctors / surgeons we possibly remain quite paternalistic – and we have a failing where we assume we know what is best for our patient without sharing the choices, risks and benefits with the patient themselves – this is typified when an MDT makes a decision rather than a recommendation in the absence of the patient. The right decision is the one the patient chooses after the consent process, but this too can be influenced by risk aversion. The choices need to be presented in a non-biased way, which immediately leaves the physician and surgeon exposed to conflicts of interest in the subtle ways they present the data - all of which should exclude any personal agendas. The complex risks need to be considered as well as trying to give some measure of expected quantity and quality of life to a patient who is often sick, scared and struggling to understand the complexity of the situation.

And of course those medical / surgical opinions on risks and benefits will have further variance depending on our current knowledge, anecdotes and recent experiences (positive and negative).

Because of all these variances high risk patients would benefit from multiple

Simon Kendall



surgical and medical opinions – when these all align the patient may find the decision easier, but where there are differences of opinion the complexity of the situation becomes more evident to the patient and relatives, and hopefully they appreciate the deserved extra care and attention they are receiving. Occasionally it might even be indicated to ask another unit for an opinion.

Seeking other opinions should be seen as an indication of humility and pursuing the best interests for the patient, although it can be misinterpreted as a weakness due to a lack of decisiveness or risk aversion.

Once the decision to operate has been made then who best to do it?

The days where the individual surgeon is expected to accept any patient referred to them from an MDT, clinic or during their on call duties should be an out dated concept? And equally should any individual surgeon be telling a patient that an operation is inappropriate without offering to arrange a second opinion? When the surgeon recognises the complexity of the case or their own lack of experience with the proposed procedure they should be supported by a structure and team where such cases can be considered to answer the pertinent questions:

- Is the referral appropriate?
- Can any of the team do it?
- Is there a sub specialty interest such as VATS surgery or mitral surgery?
- Is the patient best referred to another unit?
- Is that colleague performing well at the moment?
- Should two of us double scrub to help the patient?

Is this how the highly functioning team work? Which looks to provide the right care for the patient and support each member of the team? This sort of team will recognise and respect the strengths

and weaknesses of each other and prevent the colleague from situations not in the patient's best interests nor their own. From the patient's perspective they experience a functioning service that works in their interest, and they are not exposed to individual variance.

For extreme cases that have been referred by other units or are especially high risk, Papworth Hospital has developed its 'Star Chamber' approach where the team agree if the referral is appropriate and which surgeon (s) are best suited to help the patient. This may be a model that other units may well adopt, and through NICOR we have asked HQIP to consider endorsing this as best practice.

In all of this is a desire to get the right surgeon (s) doing the right operation on the right patient. Every team will have a variety of skills within its group and it is inappropriate for the patient to undergo an operation by a surgeon who does not believe it to be in the patient's interests, adhering to another GMC mantra 'Do no harm'. Risk aversion because the surgeon believes the surgery will cause harm should not be confused with risk aversion due to performance gaming. If the patient is undergoing a procedure then they deserve a surgeon utterly committed to the procedure, and it will be the underlying functioning team structure that enables this to happen.

In such a functioning team risk averse behaviour may be minimised as each surgeon in the team prioritises the interests of the patient, and the surgeons who previously had a tendency to risk aversion will know they are supported to perform to their strengths. Conversely risk aversion by individuals may be a symptom of a poorly functioning team.

However, there is also danger of institutional risk averse behaviour. Organisational reputation is very important not only in influencing referrals from physicians and the associated income, but also in giving patients confidence in their treatment. Although we have become reasonably good at measuring what we do we still

don't collect any comprehensive data on the cases we don't do. In lung cancer we have some measure of resection rates but no such measure in cardiac surgery. Is it possible for an organisation to protect its reputation by being risk averse and is only suspected when neighbouring units start receiving referrals that have been surprisingly turned down? This requires further research looking at equality of access for the different conditions that we treat.

This is such a complex topic, which starts with the simple aim that the patient receives the right treatment. But from there on it all gets complicated:

- The patient's expectations
- The family's expectations
- The physician's expectations
- The surgeon's opinion – and all the associated influences
- The support of the team
- The support of the organisation

Of these perhaps the two most important factors are the patient's expectations and the support of the team. This largely avoids conflicts of interest and makes the patient the primary concern. The challenge now is to get all of our teams to be functional.

How do we take this forward? It is for us all to learn from the good practice that already exists. And from there we can continue to develop our teams and our behaviours.

Risk averse cardiac surgeons, please stand up, please stand up!

As a group of surgeons involved in Cardiac surgery we have been hearing a lot of talk of the possibility of risk averse behaviour in our midst over the past years. Sam Nashef has covered it well in his recent book and this was reported in the press in the past month which led to a response from our society. At every national meeting this is rumoured but it appears to be a very difficult subject to deal with. There was even a recent letter from a Royal College president that suggested that if anyone was aware of risk averse behaviour in our midst, we must report it immediately.

I have been a consultant surgeon for 12 years, nearly all of it in the era of public scrutiny. After 9 years of having, a mortality, around the 2% mark, year on year, in my 10th year I took on some difficult cases and had a run of bad results, that led my mortality to jump to 5% in one year. As I was closely watching my performance, I was aware of this “bad run” quickly. So what did I do the following year? Did I look at ways to improve my performance? Did I go and watch better surgeons? Or did I just get risk averse?

I decided to take more of my complex cases to an MDT. There I found strength in numbers to be more selective. I was surprised to find that at an MDT there was much more support to offer interventional options than to force high risk surgical solutions. So I did not get risk averse, I just got more selective and once more have my mortality in the 2% area for the last 16 months.

So, this brings me to the thorny topic of how do we define risk averse behaviour. Early in my career I was told by a highly regarded mentor of mine that “you learn quickly when to operate and you spend the rest of your career learning when not to operate”. As surgeons we are always walking a fine line between being accused of being a “maverick” if you take on cases deemed by peers to be high risk, or “risk averse” if you are seen to be more selective in offering your services. As every surgeon has his or her own idea of what can be safely done

You learn quickly when to operate and you spend the rest of your career learning when not to operate

within their confidence levels, there is no clear definition of a risk averse surgeon and may never be. So does it matter that we cannot define this behaviour? Yes it does. Because if we cannot measure it, we may be affected by the Dunning-Kruger effect.

Student Rating

Some of you might be aware of the work of psychologists, Dunning and Kruger who published their work on university students. When students are asked to rate themselves as to how good they were on aspects that cannot be easily tested on, most students rated themselves in the average to above average category. On testing them it was more obvious that a proportion of these students, were below average and had rated themselves higher than their abilities. A few rated themselves lower than their ability too. This has been reproduced in many different groups and is possibly best seen in action while watching a live audition of a reality show on TV where people with below average talent for singing might still believe that the talent show judges are wrong not to put them through to the next rounds. This effect is possibly the explanation in our group that nearly all surgeons have seen risk averse behaviour among their colleagues but no body owns up to it themselves. If we cannot test for something then, we are more likely to be wrong in our self assessment.

Could there be risk averse behaviour in the current system? In the NHS, cardiac surgeons are on a contract that is time based in most institutions. The number of cases expected is not stipulated and if so needs to correct for case complexity and so cannot be easily determined. Add to this the fact that there is close scrutiny of any adverse outcomes following surgical intervention but no obvious penalties to surgeons, when patients are turned down for surgery. So when faced with a high risk case, a surgeon can offer to take this case on. It will involve some amount of work to optimise the patient for surgery, followed by a longer procedure due to possible anatomical or physiological challenges. Likely more input in the post-operative care in both intensive care and on the post-surgical ward. If the patient does well you as a surgeon will feel the satisfaction of having taken on the challenge and getting the patient through. If something does go wrong during or after the procedure there will be colleagues who will question your ability and judgement. If the patient does not survive, the coroner will be interested in the details. And if these unexpected outcomes occur frequently, by chance, to happen together, you will be an outlier both in your institution and nationally with the consequences that comes with that situation.

Joseph Zacharias
 Consultant Cardiothoracic Surgeon
 Blackpool Victoria Hospital

If when faced with a high risk case you suggest that surgery is too risky a strategy, then your cardiology colleague may go ahead and offer a PCI solution on the basis that surgery was turned down or send the patient down the route of medical management. There are no comebacks at the surgeon who made the decision. Cardiologists rarely push for second opinions as they are happy to provide a PCI solution even if it's only targeted at part of the problem.

Avoiding Pain

It has been shown in rats, that over time, the tendency is for animals to develop a coping strategy where pain is avoided and the path of ease or pleasure is followed. The current system, where the decision to operate can be punished more severely than decisions not to, leads to a group of individuals who learn to work this system to their advantage. We as intelligent individuals trapped in this system need to be aware of its effect on us and our colleagues. I don't believe that any of us are risk averse by nature, but we must all agree that we work within a system that encourages risk averse behaviour. And until we find a system that can either measure it or test for it we will all continue to suspect each other while not owning up to it in our own practise.

So if we cannot test for risk averse behaviour, the next best thing is to look at activity levels based on population. It has been established that generally for a population of one million

people there should be about 500 to 600 cardiac surgery cases done. Of course there are many variables that can influence this number. In countries where surgeons are incentivised per procedure the number, rightly or wrongly, is even higher as seen in America. It would be interesting to look at units that serve large populations and still do small number of cases as an easy surrogate for appropriate provision of surgical services. The other option is to believe our cardiology colleagues who unanimously claim to seeing this behaviour increasing with each passing year. The final option is to measure the conversion of referrals made to surgical out-patients to operations performed, as this may give a crude denominator of cases turned down. All these suggestions have in built flaws that are beyond this piece, but as a group we do need to look to find one or a combination of more than one way to define and measure possible risk averse behaviour.

To conclude, the current system in the NHS encourages a culture of risk averse behaviour. We as a society need to do something urgently to protect the surgeons who take on high risk cases in each institution from either ending up as outliers over time or worse still, with burn out, with a constant barrage of high risk referrals. If we do not act soon, a new norm will be set that will be difficult to reverse. It may be bad for some surgeons, but it will be worse for our speciality and the people who pay the highest price, will be our employers the tax payers, who when in greatest need of our help, may be denied life extending options.

**the
bulletin**

Advertise in the Bulletin

If you would you like to advertise in the next issue of the Bulletin.
 Please contact Tilly Mitchell for full details and costs.

Tel: +44 (0) 20 7869 6893

Fax: +44 (0) 20 7869 6890

Email: sctsadmin@scts.org

Website: www.scts.org

Full Page A4 and Half page advertising space available.



Update on audit and outcome reporting in cardiothoracic surgery

Following the presentations and discussions at the last board of representatives and annual business meetings, I thought it would be useful to update colleagues about the current status of our audits and outcomes publication.

I should start by congratulating the data managers and audit leads for adult cardiac surgery on submitting all the validated data for 2012-15 to NICOR, for the first time without Ben Bridgewater's help and guidance. I am very pleased to announce that there are no alarm 'outliers' at unit or surgeon level in this audit cycle. It is the first time since outliers have been reported in the public domain and is a massive achievement for our specialty. The congenital heart disease audit has already published the 2012-15 audit cycle in April, with no hospitals performing worse than predicted.

Doubts

Whilst I understand that some still have doubts about the value of publishing surgeon specific data, it is important to realise that the decisions governing the publication of outcome data are not made by the SCTS executive, but by NHS England and submission of our data to the audits is not voluntary. For units governed by NHS Eng, consultant level publication of risk-adjusted survival following adult cardiac surgery is compulsory. In response to concerns from membership, Tim Graham wrote to NHS Eng in 2015 and the reply was very clear that Consultant Outcome Publication (COP) was not optional. The letter and reply were copied to all members at the time.

Over the last 3 years, SCTS has also responded to membership questions about data publication in other ways. Due to the lack of statistical discrimination and perceived possibility of 'risk-averse' behaviour, all emergency surgery (Grant et al. *Circulation*; cardiovascular quality and outcomes. 2013;6:178-85.), surgery on a ventilated patient, and more unusual procedures eg pericardiectomy

It is important to realise that the decisions governing the publication of outcome data are not made by the SCTS executive, but by NHS England and submission of our data to the audits is not voluntary.

have been excluded from outcome reporting in NACSA. As practices develop, other procedures eg aortic debranching will also be examined. These important advances should reduce the concerns about high risk patients having surgery denied because of risk-averse behaviour from surgeons. We have also updated the advice on the SCTS website about monitoring performance internally at a local level, so that changes can be made before alarms are triggered at NICOR. I would urge you all to read this best practice document and use it for your local audit meetings: www.scts.org/_userfiles/pages/file/Professionals/Resources/Governance%20v4.pdf

As many of you are aware, Ben Bridgewater has changed career after

devoting much of his professional life to this field. Originally he chaired the database committee as a member of the SCTS executive, and then joined NICOR and became the NICOR clinical audit lead for adult cardiac surgery. He also held posts at HQIP and was director of outcomes publication for the new COP agenda. His enormous contribution to this field will be missed. In 2014, the SCTS executive reformed a new clinical audit committee and David Jenkins was asked to chair, with Doug West representing thoracic surgery and David Barron congenital. David Jenkins is a member of the professional liaison group at NICOR, chaired by the BCS president, but remains independent to represent SCTS interests and is not paid by NICOR. I am pleased to announce that Andrew Goodwin has been recently appointed to the NICOR audit lead post as Ben Bridgewater's replacement, and SCTS were

involved in the selection process. David Jenkins' three year period as a SCTS trustee was completed in March, but he has been co-opted to continue his audit role on the executive as we continue to think that this 'two person model' has important advantages for membership.

Some have questioned why our three audits report different outcome measures. This is due to important differences in the case mix, risk adjustment mechanisms and maturity of the audits. Adult cardiac surgery will continue to report in-hospital risk-adjusted survival at consultant and unit level, along with many other audits in the COP programme. Thoracic surgery started reporting in 2014; the individual outcome chosen for surgeons was the

David Jenkins

Chair of the audit committee SCTS executive



resection rate for the MDT for which they were core members. Unadjusted 30 and 90 day mortality was reported at Unit level only. These outcomes will continue for the 2016 report, but it is likely that in the near future individual consultant surgeon risk-adjusted 30 and 90-day mortality will be required to fit with other COPs. Congenital cardiac surgery remains a special case because of a large number of different low volume operations, and will report risk-adjusted survival by unit only.

Differences

In 2014, it became apparent that there were differences in the interpretation of some fields in the adult cardiac surgery audit, and this affected risk scoring. The most obvious example was the 'unstable angina' field and this was important as it contributed to the EuroSCORE calculation. This was subsequently changed and updated to take into account modern practice. David Jenkins chaired a specialist group in July 2015 to review the dataset, modernise for current practice, redefine the risk factors and provide objective guidance to improve the uniformity of reporting. NICOR are developing a user guide based on this work and the new definitions will be circulated and go live for data collection in April 2017. Unlike some of the newer audits, adult cardiac surgery only reports one outcome measure (risk adjusted survival) and patients/commissioners are demanding more information. Later in 2016, we will lead a group to critically examine potential measures for additional outcome reporting, as expected by HQIP and NHS England. The adult cardiac audit has been too focussed on survival / mortality when there are so many other outcomes that are relevant to patients. Other audits

have overtaken the adult cardiac audit by reporting multiple measures and the executive feel we need to divert attention from the important but blunt single outcome of in-hospital survival. We are aware that the data quality for other outcome measures is less certain and untested. Therefore, NICOR have agreed with us that we should not proceed with reporting other outcome measures at consultant level, but start comparing anonymously at unit level to properly understand the ranges and data variations.

Challenges

In response to challenges from one unit, there was a further external review of the statistics used to identify outliers in the audit. There have been two reviews of the statistical methodology in the last two years – the first by Professor Nick Black and then by Professor Spiegelhalter. Their findings were largely positive and supportive of the methodology used by NICOR. The latest review by Professor Spiegelhalter resulted in a responsible report from NICOR – 'NACSA false discovery rate analysis', that for the first time identified the chance that a surgeon or unit could be identified as outlying, but was in fact performing within the chosen 'control limits'. We now understand that because of the larger number of surgeons, this false discovery is greater for surgeons than for units. At alarm level, assuming that all actually have an acceptable performance, false identification would be expected to occur once in 26 years for units and once in 3.5 years for surgeons. Thus, the chance that those published as alarm outliers in the last round were true outliers was 86% for surgeons and 98% for units. At alert level, it means that only 50% of the 14 surgeons identified

in the last round were true outliers. This important new understanding reinforces our belief that alerts should not be published, but should precipitate internal review and reflection. The NICOR/SCTS letters to outliers have been updated to appropriately reflect this new understanding of the uncertainty.

We acknowledge that the understanding and experience of outcome reporting is more developed than the structures in place to deal with identified outliers. SCTS has contributed to improving this anomaly with Simon Kendal and David Jenkins representing SCTS on the joint cardiac societies group that produced 'Maintaining good clinical practice – handling of potential consultant outliers', published at: https://www.bcs.com/documents/7F8_Handling_of_Outliers_v_final_approved.pdf.

I think that the future will deliver more useful data for patients, but also be fairer to surgeons. Publication of outcome data from individual consultants is expected to continue, but in the latest update from HQIP, COP has been renamed 'Clinical Outcomes Publication', some of you may feel that this is a further step in the right direction?

Nursing & Allied Health Report

Cardiothoracic Forum at the SCTS Annual Meeting – Birmingham March 2016

The 2016 annual meeting was held at the International Conference Centre, Birmingham. This gave 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. The 2016 forum focussed on revalidation and assessed practice; we 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 had an international faculty participating with professionals from Nursing and Allied Health backgrounds attending



from the United States, Europe and the UK. Once again we offered discounts on registration with one free registration for every five booked.

The meeting in Birmingham ran 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 year's 1st Ionescu University stream we again had a full practical day planned. The University day was split into a half cardiac / half thoracic day, which enabled 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 Austin and his team from WetLabs provided us with an array of hearts and lungs, and it proved to be an exciting and educational session for all participants. I would like to thank all the company representatives who worked with us, CardioSolutions, Covidien, Maquet and Stryker and also the surgical faculty that took time to teach the nurses, allied health practitioners and all other participants. We look forward to working with you



again in Belfast and hope that through increased nursing and allied health participation we will have another successful University day.

The CT Forum abstract committee worked hard selecting the papers to be presented during the main meeting. Unfortunately we only had 13 abstracts submitted this year, from advanced nurse practitioners, SCP's and theatre nurses, whereas we normally receive about 20-30. However with a number of abstracts selected from surgical trainees and Consultants we were able to examine in-depth all aspects of care related to cardiothoracic patients, and looked at service development and improvements across the UK, Europe and the USA.

In Birmingham we had a number of fascinating plenary sessions. The President of the RCN, Cecilia Anim, once again gave us an up-to-date nursing perspective within her opening remarks and Andrea Spyropoulos, the past RCN President, also attended. Both provided some lively discussion points and food for thought. As already mentioned revalidation for nurses commenced in April this year. In relation to this we welcomed Anna Crossley from the RCN who gave a talk on demystifying the process of revalidation for nurses and JP Nolan who presented Advanced Nursing

Christina Bannister

SCTS Nursing & Allied Health Professional Representative



Practice in the UK. We thank both for their insights and all were appreciative of the opportunity to ask questions on revalidation, and understand the process more fully. Personally, I came away from the presentation a great deal wiser and have been able to start my revalidation portfolio based on the NMC downloads. Jill Ley, Clinical Nurse Specialist from San Francisco, followed these two fascinating presentations with an American perspective, focussing on Revalidation Practices in the US. All three then took questions from the floor and answered any concerns the nursing community had.

Jill stayed for the entirety of the meeting and participated in the Ionescu University day; we all able to chat to Jill and discussed global nursing and allied health issues with her, especially from an American perspective.

At this years' CT Forum meeting we filmed all presentations which are now available to view on the nurses & AHP



Pages of the SCTS Education website: <http://sctsed.org>. We have also created a short advertising film, and are going to send this to all units for nurses and AHP's to see the exciting opportunities they can gain from attending the annual meeting. Once this film is circulated please send it on to all within your units to view, and encourage nurses and AHP to participate.

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.

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 has gained insight into the Aortic Aneurysm pathway and is working towards creating 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 is completing her

focussing on delirium in cardiac surgery; she visited John Hopkins Institute in Washington, USA where they have specialist teams and units dealing with post-operative delirium. Daisy is creating a risk assessment model which could be used in all centres in the UK and Ireland based on the knowledge she has gained. Both Fellows presented their experiences within the CT Forum plenary session at the annual meeting in Birmingham. They also are planning on sharing their experiences by writing a paper for the SCTS website and Bulletin.

The 2016 Ionescu Nursing and Allied Health Practitioner Fellowship was advertised, but unfortunately no applications were submitted. The Fellowship is an excellent opportunity for nurses and allied health practitioners to expand their practice, and develop not only their role but that of 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.

continued on next page

Nursing & Allied Health Report continued

Further details from the Ionescu Fellows can be found in their Bulletin Articles.

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 WetLabs and all the other companies and faculty that participated. We would also like to thank Cardiosolutions 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 in December 2015 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, the Nursing & AHP Education Sub-Committee members have created a Cardiothoracic Nursing Clinical Development Course 'Core Principles of Cardiothoracic Surgery and Care of the Patient following Surgery.' This course is aimed at Band 5/6 nurses and a framework of core competencies for ward based nurses that will underpin a 1-4 day programme have been created. The course is composed of small group teachings and wetlab practical sessions that utilise the resources of formal 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. During 2016 we have already run two courses, the 1st in Manchester and the 2nd in Glasgow. We have had excellent participation from

nurses across the UK on both courses, feedback has been positive and the course reviewed after each session to make enhancements. We are planning further courses later in the year in London and the South of England.

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

SCTS / St Jude Medical Surgical Anatomy Course

On the 14th and 15th July 2016, we are commencing a joint venture with St Jude Medical and SCTS. We have the first theatre nurses' surgical anatomy course at the St Jude Medical Head Office in Stratford. The objectives of the course are to improve anatomical understanding of cardiac structures, to acquire the skills and knowledge to assist in cardiac theatres and to increase knowledge to be able to help and support the physicians during the procedures.

Details of the course are on the SCTS website and I look forward to providing feedback within the next SCTS Bulletin. Our thanks go to St Jude Medical for their support with the course, and the entire surgical faculty who have given up their time to participate.

Surgical Care Practitioner Update

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

Throughout 2016 there have been a number of Master Classes in Cardiothoracic Surgery held at the Manchester Surgical Simulation Centre, Manchester in collaboration with SCTS Education and Ethicon. 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 in 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 was awarded to Carly Mills at the annual meeting dinner.

CTNet Allied Health Portal

The Allied Health Portal is now live on the portal section of CTNet. This has been created by nurses, perfusionists,

physicians assistants and allied health practitioners from the US, UK and Europe. Throughout 2015 we have been having regular meetings to establish the 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. These are now available for all to view and we encourage all nurses and allied health practitioners to log on and use the information on the site. 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 and Allied Health Practitioner day at EACTS is currently being planned by nurses and allied health professionals from the UK, the Netherlands, and Denmark. The 2016 postgraduate day is planned for Sunday October 2nd 2016 in the Centre Convencions Internacional de Barcelona (CCIB), Barcelona.



The SCTS CT Forum top marking presentations are invited to present at this meeting, and we are also planning plenary talks from Specialist Nurses and Allied Health Practitioners from across Europe. We look forward to sharing knowledge and experiences with other nurses and health care professionals from across Europe during the day.

Once again, the presentations will be peer reviewed and EACTS will provide an award for the best presentation. The 2015 award was given 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. We hope to match this in 2016 and keep the award in the UK. Our thanks go to EACTS for their continued support.

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 collectively review new research and national initiatives as to reduce the incidence of surgical site infections. We have been able to discuss from a national perspective issues around wound surveillance and surgical site infections, and have linked with the National Cardiac Benchmarking Collaborative (NCBC) to create national definitions and data collection. 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

The patient information pages for Aortic Valve surgery are now published on the SCTS and Bupa websites. These pages have both written information and videos from patients, surgeons and nurses detailing pre and post surgery information, and experience undergoing surgery. We have created a central repository of Quality Assured information which provides accurate information regarding cardiac surgery for both patients and their relatives; and also provides a resource for nurses and allied health practitioners working with cardiac patients.

We are planning to expand this information to other areas of cardiac surgery, and wish to create some aortic surgery information. 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

SCTS Nursing & Allied Health Professional Working Group

At the end of the SCTS Annual Meeting in Belfast, March 2017, I will be standing down as Nursing & Allied Health

Nursing & Allied Health Report continued

Professional Representative. After five years within the role I am going to focus on enhancing patient involvement within the society and improving the cardiothoracic surgical information they receive. I will miss organising the CT Forum and meeting all the participants from across the UK, Ireland, Europe and the US.

At the 2016 meeting in Birmingham we held the interviews for the new lead, and were greatly impressed by the applicants knowledge, passion and commitment not only to cardiothoracic care but to the expansion of the CT Forum, and education of nurses and allied health professionals throughout the UK and Ireland. Following discussions with the surgical leads for the SCTS we have decided to create a Nursing and Allied Health Professional working group to promote Nursing and AHP working within all aspects of the speciality. This shows the commitment of the surgeons to work collaboratively and each sub-committee within the society now has a nurse or allied health professional connected. From March 2017, when I step down this group will be led by Helen Munday, Trust Matron at Papworth, and I'm sure she will continue to do a fantastic job, and continue the integration of nurses and AHP's within cardiothoracic surgery. Congratulations go to Helen Munday (Papworth), Bhuvana Krishnamoorthy (UHSM), Amanda Walthew (LHCH), Heather Wyman (Harefield), Julie Quigley (Papworth), Julie Sanders (Barts Health) and Melissa Rochon (Royal Brompton). Tara Bartley and I look forward to working with them all throughout the coming year and with future endeavours.

National Nursing & Allied Health Developments

This year the Royal College of Nursing celebrates its centenary. In 1916 Dame Sarah Swift, Matron-in-Chief of the British Red Cross, was supported by Sir Arthur Stanley MP and matrons of several leading hospitals to found a



College of Nursing. The Colleges aims were to champion a consistent curriculum for nursing education, a standard examination, and a register of qualified nurses. Over the past 100 years the RCN has expanded exponentially, and has made many changes to nurses working lives and for those, the patients they care for. Throughout 2016, the RCN is celebrating its centenary with many events across the UK, one event for each year of the RCN's history, and we urge all nurses to be involved in the celebrations.

These events are going to culminate in an International Centenary Conference on the 22-23rd November at the QE11 Centre in London. The conference aims to reflect on nursing developments, and look towards the challenges and opportunities faced by the profession. The five core themes cover a broad scope of topics, from technology and innovation to society, communities and relationships. Keynote speakers include Maureen Bisognano, President Emerita and Senior Fellow at the Institute for Healthcare Improvement; Dr Phumzile Mlambo-Ngcuka, United Nations Under-Secretary-General and Executive Director of UN Women who will talk about the role nursing staff can play in promoting opportunities for women; and Dr Jim Campbell, Director of the Health Workforce Department at the World Health Organization, who will share his vision of the future nursing workforce.

We encourage all nurses to join in these events and 100yr celebrations. Please link to the RCN website for details of all the events and also for the Congress in Liverpool in May 2017.

SCTS CT Forum Contacts

The SCTS Website – the Nursing and Allied Health Professionals page, has 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. Please also link to the SCTS Education website, again on the Nursing & AHP page for further information.

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 as follows, please pass these details on to as many nurses and allied health professionals that you all know and encourage everyone to participate.

Follow us at Twitter - [@SCTS_CTForum](#)

Join the Facebook Group - [SCTS CT Forum](#)

If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out, then please forward their name, address and title to me at Christina.Bannister@uhs.nhs.uk or chrisiebannister71@gmail.com or direct to Tilly Mitchell at tilly@scts.org

Chrissie Bannister

Nursing & Allied Health Professional Representative

SCTS HISTORIAN

Philip Kay

The Development of Closed Heart Surgery (A Tale Of Two Presidents)

My first article chronicled the development of closed mitral valvotomy with Russell Brock (Guys) and Oswald Tubbs (St Barts) building on the pioneering work of Sir Henry Souttar.

It is interesting to note that though they also both worked at the Brompton Hospital they had a largely different surgical approach to mitral stenosis. Brock, in a report of 100 cases, used a valvotome in only 22 patients, preferring his index finger via the trans-atrial route. Tubbs was greatly influenced by a visit to Edinburgh where Andrew Logan used a dilator inserted through the left ventricle. In the five years after 1954 Logan used this method in 82% of 537 cases.

The late 30's to the early 50's were innovative times for other developments in cardiac surgery, and again Britain remained in the forefront. On 26 August 1938 Robert Gross performed the first successful ligation of a Patent Ductus Arteriosus at the Boston Children's Hospital. A year later Os Tubbs claimed fame by performing the first ligation of an infected ductus successfully treating the sepsis.

Dwight Harken, who had worked as a RSO at the Brompton Hospital under Tudor Edwards, was recalled to the United States shortly after the declaration of War. He returned to the UK in 1944 to be in charge of the American Surgical Chest Centre with the 160th General Hospital of the US Army in Cirencester. There he carried out 134 operations for the removal of foreign bodies of which 56 were within or directly related to the heart. The remarkable feature of this series was that there were no deaths.

The 1940's became a time when great surgeons visited the UK to demonstrate their skills. On 19 October 1944 Clarence Crafoord performed the first resection of a coarctation with end to end anastomosis in Stockholm. Sir Clement Price Thomas arranged for him to demonstrate this operation at the Westminster Hospital in 1946.

On 29 October 1944 Alfred Blalock working at the Johns Hopkins Hospital in Baltimore performed the first subclavian to pulmonary artery anastomosis (Blalock-Taussig shunt) on a patient with Fallots Tetralogy. In

September 1947 Brock invited him to demonstrate the operation at Guys Hospital. The pioneering work of Gross, Crafoord and Blalock lead to further approaches on intracardiac pathology. O'Shaughnessy, in the text of a Hunterian Lecture, was the first to suggest that congenital pulmonary stenosis could be corrected by a valvotome inserted through an incision in the right ventricle. Sadly he died during the evacuation of the British Army from Dunkirk before he could deliver the Lecture. Sir Thomas Holmes Sellors was the first to apply this technique on a 20 year old man with Fallots Tetralogy. The operation was performed on 4 December 1947 at the Middlesex Hospital. His report was published on 26 June 1948.

On 12 June 1948 Brock reported three successful pulmonary valvotomies performed through the right ventricle, the first in February 1948. Brock was to develop this technique using graded valvotomes, sleeve punch forceps and expanding dilators in patients with Fallots Tetralogy. This approach was considered superior to the Blalock procedure as it lead to better development of the often hypoplastic pulmonary vasculature. The combined procedure of pulmonary valvotomy and infundibular resection became known as the Brock procedure and enjoyed some popularity until it was superceded by one stage total correction.

Thus it is clear that interpersonal and interhospital rivalry in London is not a new phenomenon. In the "race" to publication Holmes Sellors (Uncle Tom) was gracious in his article adding that Brock's paper was admirable and dealt with the subject more thoroughly. Indeed Brock's introduction was inspirational; "The day must surely come when direct operations on the substance and structure of the heart will be as firmly established and successfully conducted as those on the lungs and brain. We must attack the problem and begin the development of a technique for intracardiac operations, for unless begun the task can never proceed." It was clear that direct vision of the intracardiac structures would be required.

Such research was already underway. Bigelow in Toronto carried out the basic experiments on hypothermia showing that a reduction in body temperature to 30 degrees Centigrade prolonged the safe period of cerebral anoxia from three to ten minutes. This was time enough for repair of simple intracardiac defects such as ASD closure and aortic and pulmonary valvotomies. In Denver Henry Swan used an ice bath for total immersion of the patient. Holmes Sellors was one of the first to adopt this method in the UK and reported a series of over 200 cases of ASD closure in 1960.

Though successful the hypothermic bath technique was cumbersome and messy and the rewarming process slow. The ultimate goal was a still and bloodless field with no time limit. This required a device to take over the essential function of the heart and lungs.

This was indeed a golden era of Cardiac Surgery in the UK. It was the tale of two Presidents of The Royal College of Surgeons of England; Lord Russell Brock who served between 1963 and 1966 and Sir Thomas Holmes Sellors from 1969 to 1972.

The day must surely come when direct operations on the substance and structure of the heart will be as firmly established and successfully conducted as those on the lungs and brain.

Russell Brock. 1948

Presidential Address

SCTS Annual General Meeting

Birmingham, 14 March 2016

“Whither Cardiothoracic Surgery In 2016?”

Over a year ago on 50th anniversary of his death I was given a present of a series of books regarding Winston Churchill. In seeking inspiration and similes for the Presidential Address I was able to find an abundance in the life of the man previously polled as the greatest British person of all time – Sir Winston Leonard Spencer Churchill.

He was born in 1874 at Blenheim Palace. Following an undistinguished school career at Harrow, he went to military school at Sandhurst and then saw active service in India and the Sudan. As a newspaper correspondent in the Boer War he was captured as a Prisoner of War. He became a Conservative MP in 1900; becoming Home Secretary in 1910 and then First Lord of the Admiralty. In 1915 he was dismissed from this post following the failures of the Gallipoli campaign and he then went to France to take command of an infantry battalion on the Western Front. In 1924 he then served as Chancellor of the Exchequer for five years. He then went into his “wilderness” years in the 1930s (during what should have been his productive 50s) without office in government. From the back benches he warned of the dangers of Germany and war. After a vote of no confidence in the administration Churchill became Prime Minister, forming a coalition government.

Then followed Churchill’s great leadership and statesmanship to maintain inter-allied co-operation with America and Russia and defeat the AXIS powers. Ironically he was not to share the final triumph of WW2 as Prime Minister as in the General Election of July 1945, two months after Germany’s surrender, the war-weary British people voted the Labour Party into power under Clement

Attlee. Imagine how disappointed and let down Churchill must have felt at that time by the people he had led and supported.

He remained an untiring Leader of the Opposition. In 1951, aged 77, he became Prime Minister again, resigning in 1955 due to ill health. He died in 1965 at the age of 91 and received a full state funeral with honours.

He had a most remarkable life with great professional highs and great lows. He knew both failure and success and created admirers, friends and many enemies along the way. He had other great qualities. He was an innovator, largely responsible for the invention of the tank. He was an excellent painter and a great writer, winning the Nobel Prize for Literature – famously saying “History will be kind to me for I will write it”. He also experienced great personal tragedy with the death of a young child and he had a dysfunctional family and he battled with ill health as he grew older.

Many of these themes of success and failure are familiar to all surgeons during their professional and personal lives. Churchill had major qualities which characterised his greatness – a positive and combative attitude which clearly made a big difference. He had confidence that his course of actions were right. But to my mind a great quality was perseverance in purpose of action in spite of great difficulties and his greatest strength was that of resilience – to adapt to both the considerable stresses and adversities that he encountered – as he famously said “When you are in hell, keep going”.

How might these qualities of confidence, perseverance and resilience which so defined Winston Churchill’s successful

life and career be considered from the perspective of the Society in order to continue and maintain its future success? We can reflect on what has been achieved in the past 4 years.

We should have confidence in the next generation of surgeons and the surgical team; the education of this generation and all members of society; the potential for innovation and the direction of travel of our clinical audits. We should continue with the on-going beneficial joint working with the SAC.

The Next Generation

Considering the next generation – how many surgeons of my vintage would have achieved the A-level success that is now required to get into medical school? These are the brightest and potentially most motivated young people. We were the first specialty to introduce national selection in 2008. Following the initial bulge of ST3 applications following reduced recruitment from 2003 – 2007, there has continued a ratio of applications to appointments of around 6:1. The number of posts has been reduced since 2013 as ST1 selection was introduced and there continues to be an 8:1 ratio of applicants to appointees and the impression from the SAC is that these are a strong good group of trainees – despite recruitment across the board in all surgical specialties declining for non-specialty specific reasons.

So with good seeds we need to consider the soil into which they are placed so that they can flourish and grow. Previously training has been with a large case load exposure with non-structured training; little feedback; and often self-taught – a sink or swim approach. Now with improved selection there is the

T R Graham

development of core talents, there is structured training with feedback with ISCP education and training processes and in early consultant practice there is support and development. SCTS in partnership with the SAC is contributing strongly with bespoke courses and subspecialty fellowships. The workforce planning we have undertaken is now regarded as reasonably accurate.

The next generation of consultants are and will be different – working in a different environment. Matching the two is the challenge with a key factor being the support for new consultants with professional development courses; mentorship; fellowship; good governance with the introduction of new techniques and better team structure and dynamics. With regards to education this has been transformed over the past 4 years. The SCTS Education Committee has developed a strong vision and delivered quality education across all the specialty. Of particular note has been the development of curriculum aligned courses for NTN with an industrial partnership potentially in excess of £1 million investment – the envy of surgery in the UK and our specialty internationally. There has been continuation of the coveted NTN fellowships towards the end of surgical training and also the development of non NTN education. The Society has also benefited considerably from the philanthropy of Mr Marion Ionescu with whom the Education Committee and the Meetings Team have developed

his legacy – the annual funding of the Ionescu SCTS University at the Annual General Meeting which is set to continue in perpetuity; consultant clinical fellowships and recently the facilitation of the appointment of an education administrator. Mr Ionescu has transformed SCTS's ability to deliver education to the surgical team now and in the future.

Innovation

Innovation is challenging within the NHS environment and has recently been a theme of the STS meeting in January where the qualities required for innovators were considered. We have many individuals, particularly more recently appointed consultants and current trainees who have these qualities in abundance. We anticipate this will be led by the recently commissioned Research Committee. The Society aim to bring together these bright individuals and industry to have a positive impact on the development of innovation and have taken this forward with a recent showcase event at the Annual General Meeting in Birmingham.

Audit Confidence

We should have increasing confidence regarding our clinical audits due to the perseverance of the SCTS Executive and more recently in particular David Jenkins and Doug West. All the three clinical audits are becoming increasingly



harmonised with the emphasis on survival not mortality. The congenital audit is possibly the strongest clinical audit in the world and the thoracic audit is now progressing at a pace. We have been able to achieve further understanding and clarity with review of the statistical methodology in the adult cardiac surgery audit and we hope to be able to remove the outlier control lines on plots for individual surgeons in the public domain. Our relationship with the other audit agencies have improved and we are having increasing influence on policy. We have worked to improve the definition of risk factors and there is going to be a period of stable analysis from year to year. We are developing a staged approach to other useful outcome measures and there are future projects such as a new “blue book” of 15 years of UK Adult Cardiac Surgery planned with NICOR.

The next area for SCTS to consider is resilience which is the ability to adapt to stress and adversity. Cardiothoracic

The Board of Representatives' meeting in December 2015 focussed on wider professional issues and behaviours - 15% of the potential workforce has either been dismissed or suspended.

The take home message was that, even though external data could not confirm that there was more of a problem in cardiothoracic surgery than in the other specialities, we needed a good look in the mirror.

Presidential Address 2016 continued

surgeons need to have this, both in their personal and their professional lives. In our personal lives we will know great periods of personal stress such as bereavement, divorce and illness and other personal difficulties. We are a self-selected group of doctors – high achievers who also need to deal with death and complications in the patients that we treat and operate on. The need for this resilience has recently been brought into focus, both for myself and the hospital within which I work following a CQC visit related to unit and individual outcomes released by HQIP on data up to March 2014 and then the subsequent interactions between the Trust and the CQC and the media.

Resilience

As a professional society SCTS needs to demonstrate resilience together in several areas with its members. The NHS is complex and currently in a degree of crisis. Hospital budgets are in deficit of over £2 billion, targets for healthcare are being missed and there is a major unresolved doctors' dispute. The Department of Health may fail to balance the budget with possible consequences for our political leaders. Donald Berwick from the Institute for Health Care Improvement has recently undertaken an "Improving Quality in the NHS in England Review" and his early conclusions were that the NHS is a highly conflicted environment with a demoralised workforce not likely to reach its capabilities and he questioned the ability of the NHS to continue to survive in its current form on funding of only 7% of the GDP. There may be some respite in that the Department of Health are funding a clinically led Quality and Efficiency programme to support the delivery of the "NHS 5 Year Forward Review" which has been proposed to improve efficiency and to contribute to closing the budget deficit gap in each specialty. SCTS are contributing to the

appointment of a potentially important funded post in cardiothoracic surgery for this project in the near future. The other area for a need for resilience is to maintain the training environment. The junior doctors' (which I believe is an inappropriate term) dispute has caused

Stress in the NHS environment is clearly a major factor and there appears to be a disconnect between the external agencies' data and activity and our experience within the specialty.

conflict between the government and the medical profession and has the potential to impact on the future of the NHS. The junior doctors and their training should be supported at this time as they are the future of the specialty and of future patient care and also rather selfishly because the consultants and then all the other sectors of the health service will be next in the spotlight. This consideration of the training environment in the specialty of cardiothoracic surgery however is not unique to the UK with the prevalence of depression amongst residents and interns worldwide being reported at around 30% by the AATS – a concerning figure. There are challenges for our trainees and as a consequence the future of the specialty which are well known but need to be faced up to. These include the publication of surgeon specific data; adequate operating experience; maintaining a satisfactory work/life balance and the development of subspecialist practice and the ability to innovate within the NHS.

The NHS is generally accepted to be becoming an increasingly difficult environment for doctors to work in.

There are now courses being developed and run for managing doctors in difficulty and difficult doctors which is a clear barometer for this issue. Consultant dismissals and suspensions occur and the impression has been in our specialty that these have been increasing. Why is this and what evidence is there that this is the case?

National Clinical Assessment Service

The National Clinical Assessment Service is a body whose purpose is to achieve the resolution of concerns about professional practice. They are the body to whom trusts report and refer individual consultants. There are over 7000 consultant surgeons in England and Wales of which cardiothoracic surgery over the past 5 years has made up 4%. In the 6 year period from 2009 to 2015 there were 42 referrals to NCAS in relation to cardiothoracic surgical consultants. As a percentage of all the referrals for the whole of surgery, cardiothoracic surgery made up 4% of the NCAS referrals, a proportion apparently in keeping with the number of cardiothoracic surgeons. The Professional Standards Department of the Royal College of Surgeons of England has developed an invited external review mechanism which trusts can use to obtain external opinion advice on their services. 20 reviews have taken place in cardiothoracic surgery since 2008. These numbers from the external agencies do not seem to fit with the incidence of issues being discussed by the wider membership. In view of this, as President I undertook a rather crude survey of cardiothoracic surgeons who have been in difficulty since 2009. There is no mandatory reporting mechanism available for this and it is a very sensitive area. The methodology of this survey could be criticised. It has been through a series of personal conversations and discussions held at meetings, in restaurants and bars and

SCTS 80th Annual Meeting

**13-15 MARCH 2016
BIRMINGHAM**



over the telephone – but to the best of my knowledge I have been able to triangulate this information. There have been 10 consultant cardiothoracic surgeons dismissed and over 55 have been suspended, had restriction of practice, taken early retirement or felt the need to emigrate to another post due to issues in the UK. Over 85% of these dismissals and suspensions were in adult cardiac surgery. From 2009 to 2015 there were a possible 400 cardiothoracic surgeons workforce in the UK and 65 out of this possible 400 – that is 15% of the potential workforce – has either been dismissed or suspended. There has been a variety of reasons for this but surgical outcomes and the publication of surgical outcome data has been specifically cited in less than 20% of cases. Other reasons have been cited in more than 80%. Stress in the NHS environment is clearly a major factor and there appears to be a disconnect between the external agencies' data and activity and our experience within the specialty.

Review and reflection

In view of this the Board of Representatives meeting in December 2015 focussed on wider professional issues and behaviours. There was a series of presentations and the take home message was that even though external data could not confirm that this was more of a problem in cardiothoracic surgery than in the other specialities, that the specialty needed to look in the mirror. With this in mind SCTS are developing a strategy considering professional behaviour and one of the first parts of this has been to commission a Professional Standards Committee. During the coming year SCTS plan to further engage with external agencies including "Action against Medical Accidents"; NCAS; the

Royal College of Surgeons of England Professional Standards Group and 360 feedback providers. You may not consider that this direction of travel is appropriate for the Society, however it is worth reflecting on examples of unprofessional behaviour that we may all be guilty of and that we may have observed in our colleagues such as criticising and undermining colleagues; inappropriate interactions with the media and use of social media; providing inaccurate professional references, holding personal conversations in front of patients; making disparaging comments about patients, relatives or staff on the ward rounds; or even being rude to a manager!

I would like to sign off with two final thoughts. The question I have been asked on several occasions is what are the benefits of membership of SCTS and what do members get for the membership fee. I could talk about the Annual General Meeting, the Universities, the excellent educational package and developing website and even the expenses and sandwiches at the BORS meetings! However I would like you to consider this in a different light. SCTS really provides the only concerted voice in our specialty for advocacy and lobbying on cardiothoracic surgical issues in the UK and Ireland. To paraphrase President Kennedy – ask not what the SCTS can do for you but what you can do for the SCTS – this is your specialty and your society and your patients. We have an excellent example of this in that we now have over 130 consultant surgeons who are education faculty members. Please continue this engagement and involvement.

Currently the strapline for SCTS is as the Society for Cardiothoracic Surgery in Great Britain and Ireland. I was recently impressed at the STS meeting when it was clear to me that their mission was to enhance the ability of their members – cardiothoracic surgeons – to provide the highest quality patient care through education, research and advocacy. Although these are the same core values as SCTS, to me this represented a move towards acknowledging the STS as a membership organisation principally funded by membership subscriptions and possibly SCTS should consider returning more towards this ethos.

Conclusion

SCTS and its members should be confident and see the opportunity in the difficulties of our specialty and environment. There will always be patients who require our care and consideration. SCTS and its members should also persevere and be resilient to keep a sense of purpose and not be distracted by the difficulties that will inevitably be encountered, both professionally and personally.

It has been a privilege to be the President-Elect and then President of the Society for the last 4 years. Thank you to the membership for electing me. It has been interesting times. I am confident that I am leaving the Society now in the capable hands of Graham Cooper and subsequently the recently appointed President-Elect Richard Page, both of whom have Yorkshire connections. Good fortune to them both and to SCTS in the future – and "wither" not cardiothoracic surgery.

T R Graham

22 March 2016

Medical Student Engagement

– what do the students think?

ENGAGING WITH MEDICAL STUDENTS and trainees is vital if we are to ensure we recruit the best young doctors into cardiothoracic surgery. This has been recognised by the SCTS Education committee and Aman Coonar has been leading on this agenda. Much progress has been made over the last few years in this area, including an Annual Cardiothoracic Careers Day (in collaboration with the RSM), bursaries for specific cardiothoracic placements and the formation of a network of medical students who share and disseminate information (including a facebook page). One area that I feel must not be neglected is interaction at a local level with medical students. Whilst Cardiothoracic Surgery is not specifically on many undergraduate curricula, we are all able to make small inroads such as inviting a student who may be

on a cardiology placement to observe in theatre, or getting involved in medical school surgical society events. It is often these chance encounters that can lead to a student's interest being sparked or confirmed. We are all potential role models and a few words of encouragement (as well as help with practical information and guidance) can go a long way, not to mention being rewarding.

In order to gauge how the above strategies are being perceived, I asked two medical students who are aspiring cardiothoracic surgeons to share their thoughts on their experiences of cardiothoracic surgery to date. Nicole Asemota is a 4th year medical student at Nottingham and Jeesoo Choi is a third year student in London. I met them both at the SCTS annual meeting in March.

Nicole Asemota

Although only in fourth year, I already know that I want to specialise in cardiothoracic surgery. Being the practical type, I always knew I wanted to do surgery. So, combined with great interest in logical, yet mind-blowing physiology and anatomy of the heart and lungs, cardiothoracic surgery seemed perfect.

Cardiac and thoracic surgery are two distinct fields, and within each, there are a variety of different operations - this excites me. Further sub-specialising means, you can operate on the children as a specialist paediatric surgeon, or perform rare heart and lung transplants as a specialist transplant surgeon. You can be the 'go-to' person on mitral valves or involved in developing minimally invasive surgery. The opportunities are endless, and as the fields develop further, I foresee many more sub-specialties becoming available.

Having decided early, I am using my time at medical school to get exposure to the field. I've held a beating heart, I've helped remove a very large cyst in the thorax, and I've watched the repair of a large thoracic aortic aneurysm. I've met some amazing surgeons, who have each encouraged me further into the field. I made my final decision when I spent 4 weeks with some great cardiac and thoracic surgeons at Nottingham City Hospital where I assisted in many operations. Active participation has helped me to understand and get a greater desire to be part of this specialty.

I was able to present at and attend the 2016 SCTS Conference, where my understanding of the operations, training pathways and future developments grew exponentially. There I met Mr Michael Lewis, with whom I organised a great week in the Sussex Cardiac Centre and Professor Bhatti who is the only female cardiothoracic surgeon I know; it is inspiring to know that a woman can make it in the specialty.

Cardiothoracic Surgery is one of those specialties where every operation can genuinely add tens of years to someone's life and I would be honoured to be able to give that gift to someone in a few years time.

Jeesoo Choi

I first became interested in cardiothoracic surgery during the cardiothoracic rotation in my third year at medical school, where I was taught by Mr Michael Sabetai (Consultant Cardiac Surgeon). It was the first time I was in theatre observing him perform a coronary artery bypass when I realised how much of a privilege it is to open your patient's chest, and be able to hold and fix their heart. I have continued to work with Mr Sabetai, who has both taught me an immense amount in theatre and has kindly mentored me.

Our study on patient awareness of surgeon-specific and hospital-specific mortality data, conducted at St Thomas' Hospital, was accepted for presentation at multiple national and international conferences this year, including the SCTS Annual Meeting and the Association of Surgeons in Training conference. These have been incredible opportunities that have opened my eyes to the wider surgical world. As well as really enjoying the chance to present our study, there have been several inspiring speakers, interesting studies and opportunities to network with cardiothoracic trainees and consultants. It has also been a chance to discuss issues current and future surgical trainees are and will be facing.

The SCTS Careers Day held last November, was a very enjoyable day during which there were talks on thoracic, cardiac, paediatric and transplant surgery and intensive care, with wet labs in the afternoon. It was valuable to get a taste of what the subspecialties involve and specifically to gain insight into the possible career pathways. With cardiothoracic

Farah Bhatti
with **Nicole Asemota**
and **Jeesoo Choi**

surgery recruiting at ST1 level, it is vital for interested medical students to be made aware of what is required, early on. I am currently organising the next Careers Day with Mr Aman Coonar, which is to be held in November 2016, and I would strongly urge all trainees and consultants to encourage the medical students that they are teaching to attend. I am sure I am right in saying that we appreciate all the effort consultants and trainees have put in towards students engagement. I hope to see many more students involved in these activities in the future!

Finally, despite being constantly (and dishearteningly) informed that cardiothoracic surgery is "the toughest specialty", "a dying field" and "not women-friendly" by several doctors, I have received encouragement and support in even greater proportions. I am very lucky to have positive role models such as Professor Farah Bhatti and Mr Michael Sabetai, who are always interested in encouraging me to follow this career.



Society for Cardiothoracic Surgery
in Great Britain and Ireland



Association of
Cardiothoracic
Surgical Assistants

YOUR SPECIALTY NEEDS YOU



Keen cardiothoracic (cardiac and thoracic) surgeons...

...Who have passed the FRCS (CTh) exam

...Who want to add to the achievements section of their appraisal portfolio

...Who need a good source of cpd

...Who want to contribute to an exciting new educational project

The new exam for cardiothoracic surgical care practitioners.

Training for the role will be provided.

Please get in touch

Norman.Briffa@sth.Nhs.Uk

An SCTS Fellowship Journey (2015-16)

Daisy Ezakadan Sandeman
Clinical Nurse Practitioner
Royal Infirmary of Edinburgh

I was awarded 'The Ionescu scholarship' following the SCTS annual meeting in Manchester in 2015. It was surreal and exciting but the most overwhelming feeling was that of pride. I was the joint first awardee of this scholarship bestowed on nursing and allied health professionals. I wanted to reciprocate this honour by making the journey most valuable to me and aspirational to others.



I am doing my PhD and my area of research is "Delirium in Cardiac surgery". I knew from the outset this scholarship would be used to enhance my PhD. I attended the European Delirium Association meeting in London in September 2015. The interactions with

national and international leaders in this field increased my understanding of delirium management. Networking at this meeting also helped me plan my Ionescu trip to Canada. I visited the Peter Munk Cardiac Centre in Toronto, Canada. It has a proactive, enthusiastic and delightful group of people who form their Delirium steering committee. The team comprises of nurses, doctors, educators, project managers and patients who provide testimonials during 'Delirium awareness week' They also help create educational materials. This group work tirelessly motivating staff, spreading awareness, ensure staff interest and maintain an environment which promotes optimal delirium care.

I spent a week in the PMCC understanding the various mechanisms set in place to treat delirium as 'acute brain injury'. I observed that the staff are trained in applying measures to prevent delirium along with routines for early diagnosis, established order sets in treatment and effective follow up.

The centre emphasises on 'Partners in care' in delirium prevention and management. This means delirium care is everyone's responsibility from staff looking after the patients to the relatives who attend to their loved ones. The resources provided for delirium care in the PMCC appears to be primarily focussed on prevention. This has been shown to reduce the incidence of delirium and other associated complications.

Take home messages:

1. Delirium is common especially where there is high vulnerability.
2. The interaction between vulnerability and precipitant is the key to understanding the pathophysiology of delirium.
3. The pathophysiology is poorly understood but opportunities are many.
4. Focus on the basics: Prevention is better than cure.

5. Get like minded people together, you will see results.
6. Delirium care is everyone's business.
7. Keep awareness programmes going throughout the year.

I would like to extend my appreciation to the SCTS & Mr Ionescu for granting me this esteemed fellowship. It has been a unique and rewarding experience. I feel very privileged and hope to continue on my journey with the support of SCTS. I also take this opportunity to urge others to apply for this award. However big or small your project, this scholarship can facilitate and bring your vision to fruition.

daisy.ezakadan@luht.scot.nhs.uk

d.v.sandeman@ed.ac.uk

Twitter: [@daisy_varghese](https://twitter.com/daisy_varghese)



The Delirium team:
Peter Munk
Cardiac Centre
(PMCC) Toronto
Dr Sanjeev Sockalingam
Dr Rima Styra
Ms Sandra Li-James
Mr Arsalan Hamidi
Dorina Baston
Jeanne Elgie-Watson
Dr Katie Sheehan
Joanna Lynch

The story of the Belsey Spoon(s)

Toni Lerut

Honorary Fellow of SCTS of Great Britain and Ireland

I read with great pleasure, and with some nostalgia, the introduction to the thoracic community of a new use of the Belsey spoon by Mr. Jules Dussek in the December issue of the Bulletin.

As one of the very last registrars to Mr. Belsey (1974) I had the privilege to learn from the Master himself the Mark IV anti reflux procedure.

The Belsey spoon comes into the picture when the distal 4 cm of the oesophagus surrounded by the 240 – 270 ° fundoplication will be reduced underneath the diaphragm and fixed to it (fundopexy). The spoon i.e. a modified teaspoon is introduced underneath the diaphragm (fig 1). The two carved notches stabilize the spoon at the hiatal border and by compressing the diaphragm against the concave part of the spoon hapless puncturing of abdominal viscera will be avoided (fig 2).

The spoon was made by a technician at Frenchay Hospital who, in order to obtain a correct length (approx.35cm), interposed a stainless steel rod in between the top end (the handle) of the spoon and the bottom end (the small bowl) and carving out in the latter a notch, or indentation, at each side.

A commercially made model of the spoon featured, if I remember well, in the Pilling instruments catalogue but at, for a registrar, an exorbitantly high price. So every single registrar considered it as a personal trophy to obtain a genuine hand made Frenchay brand of the spoon (a tip was very helpful to speed up the process).

As pointed out by Jules Dussek I had invited the older members of BOG (British Oesophageal Group) for once to come over to “the continent”, to hold the annual meeting in Leuven.

For the dinner I wanted to surprise my guests and I had made a deal with the chef of the restaurant that he would serve a soup called “The Belsey Soup” so called because it was served with a special spoon but now modified into the BOG version that I had ordered from the technician in my Hospital.(fig 3).

Just imagine every one trying to bring the soup up to the mouth with a spoon having two carved notches on the sides!!

I am sure that quite a number of ties (in those days wearing a tie was obligatory in restaurants!) after a while had been covered with spots of soup!! Fortunately I never received a bill.

The day after, on Sunday, we all visited the trenches and war cemeteries in Flanders fields closing the day with an impressive Last Post ceremony under the Menen Gate.

But the end result of that meeting is that still today many of the attendees have a specimen of that spoon at home and on a regular base the story comes up at the occasion of the Old Boggers meeting.

The Mark IV anti reflux procedure, although in my opinion the most “physiological” and elegant anti reflux procedure, has disappeared from the operating theatres since the introduction of laparoscopic surgery.

But it is great to see that through the inspiration of Jules Dussek the future of the Belsey spoon continues to look bright.

And all who have known Ronald Belsey will remember that he was a great epicure enjoying the pleasures of exquisite gastronomy and oenology. So I am sure that when looking down from, as he used to say, “The orbit” he will smile at Jules with great contentment.



Fig 1 Belsey spoon the Frenchay version

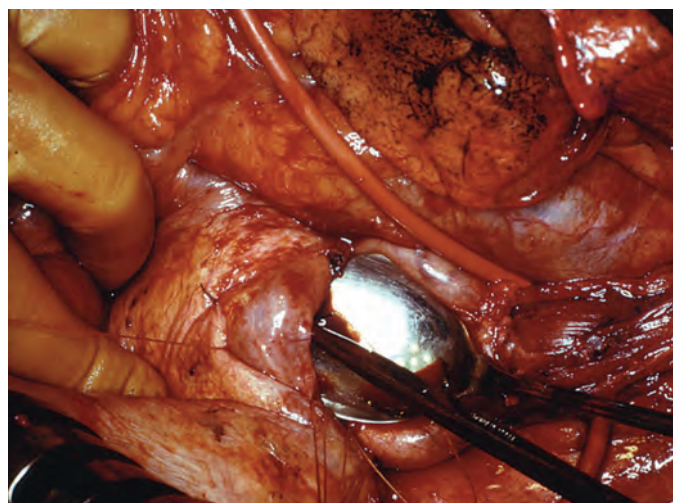


Fig 2 Peroperative view



Fig 3 Belsey spoon the BOG version

Ionescu Nursing & Allied Health Practitioners Fellowship Award 2015

My Experience

I was delighted, not to mention a little surprised, when I found that I had been awarded the inaugural Ionescu Fellowship Award for Nursing and AHPs following an interview at the SCTS Annual Meeting in Manchester last year.

My application for the award, was based around my work with the Complex Aortic MDT at University Hospitals Southampton (UHS). We had established an Aortic Service in 2014, which at the time of my application was still very much in its infancy. I was keen to visit other centres to see how they had developed and were running their Aortic Services, but as is usually the case, it's difficult to find funding, as well as the dedicated time necessary to do so. Chris Bannister drew my attention to the award, so I applied, and the rest, as they say, is history!

The £2500 Award is to pay for travel, accommodation and living expenses to enable you to visit your chosen centre, or centres in my case. Being able to visit somewhere for a longer period such as a week or more, enables you to truly see every facet of the service in action, rather than the snapshot which would only be achieved when visiting for a day. The purpose of my visits was to observe all aspects of the service in action, in order to see what ideas I could bring back to Southampton and implement in order to move our Aortic Service forward. Because I wanted to visit somewhere with a similar patient demographic and health service set up, I opted to stay within the UK for my visits. I primarily chose Liverpool Heart and Chest Hospital (LHCH) as it has a well established dedicated Aortic Service, with 4 surgeons, who not only treat all elective patients undergoing aortic surgery, but also cover all emergency dissection cases. As a stipulation of my award, the panel asked me to also include another hospital, and so Queen Elizabeth Hospital (QEH) Birmingham was also selected

In view of my working in a small team, I had to split my visits up into weekly blocks, to avoid my colleagues having to cover too much of my work. Firstly, I visited LHCH for a

This has been a great experience and I would recommend any nurse or AHP to apply for it if they have an interest they wish to pursue. I can assure you it is well and truly worth the effort.



week in September 2015, and again for a week in December. From the outset and in fact even before I arrived, everyone was extremely welcoming. At LHCH, they have an Aortic ANP, so I based myself with her (the wonderful Tracy Hutson) and attended daily ward rounds with her and the doctors. I learned about her role, spent time in theatres, and am very grateful to Prof Aung Oo and Ms Debbie Harrington who both took the time to explain to me, the intricacies of the procedures they were performing. In addition, I spent time in their outpatient clinics, attended the monthly MDT, met with the people responsible for planning and coordinating operating lists, and generally spoke to as many people as I could about aortic surgery and the Aortic Service. I had a fantastic two weeks at LHCH, and came away not only feeling that I'd experienced every facet of the service in action, but also having made some new friends.



Emma Hope
University Hospitals Southampton NHS Foundation Trust



is that one day people are coming to visit us at UHS because it's a centre of excellence for aortic surgery.

I would like to thank Mr Ionescu for kindly funding this award and the SCTS for awarding it to me. This has been a great experience and I would recommend any nurse or AHP to apply for it if they have an interest they wish to pursue. I can assure you it is well and truly worth the effort.

March 2016, I made my way to QEH to spend time with Mr. Jorge Mascaro and the team involved with their complex aortic surgery. There is no Aortic Specialist Nurse there, so I based myself in theatres with the SCPs and was well and truly looked after by Chrissie Birkett. Once again, I spent time in theatres with Mr Mascaro, who like the surgeons in Liverpool also spent a lot of time talking through the various procedures with me. As I had done at LHCH, I also spent time in outpatients and talking to the surgical coordinators. Prior to visiting QEH, I had warned them that LHCH had set the bar very high in terms of how welcoming they'd been, so that I had high expectations! They rose to the challenge and more than met it, and once again I was made to feel very welcome and left with invitations to return any time.

So, what did I learn? Having been able to spend time away looking at other teams at work, to my surprise, I realised that we're actually already doing a pretty good job in Southampton and that there isn't any need to make any huge changes. What is required, I discovered, is a bit of tinkering here and there. Most importantly for me is the role of a dedicated Aortic Specialist Nurse. Currently I'm in the process of putting a business case together to present to management to try and change my role to that of Aortic Specialist Nurse. Since my visits, I'm also working towards forming a patient support group – I have a small number of patients who are happy to speak to pre-op patients on request, and I'm gradually recruiting more. I'm also working on compiling a patient information booklet. As a direct result of my visits, I have now secured the services of a Geneticist to become part of our team. I realized that this was the one person we didn't have on our team, who both we, and the patients would benefit from having on board.

Although my Fellowship year has come to an end, my journey hasn't. Currently I only work with elective patients, but I would like to extend my role further to be involved in supporting patients who have had Type A dissections, both in hospital and in follow up. I still plan to make a few more visits and continue to build up my network of contacts through the SCTS. My aim

Forthcoming Meetings

International VATS Symposium 2016

Date	14th & 15th October 2016
Venue	Royal College of Physicians, 11 St. Andrews Place, London, NW1 4LE
Contact	L.R. Associates – Ms. L. Richardson 58, Kiln Close, Calvert Green, Buckingham, MK18 2FD.
Tel	01296 733 823
Fax	01296 733 823
Mobile	077 111 32946
Email	lorrainerichardson1@btinternet.com
Web	www.internationalvats.com

Birmingham review course in cardiothoracic surgery

Date	22nd – 24th September 2016
Venue	Education centre, Birmingham Heartlands Hospital, Bordesley East, Birmingham, B9 5SS.
Contact	L.R. Associates – Ms. L. Richardson 58, Kiln Close, Calvert Green, Buckingham, MK18 2FD.
Tel	01296 733 823
Fax	01296 733 823
Mobile	077 111 32946
Email	lorrainerichardson1@btinternet.com
Web	www.Birminghamreviewcourse.Co.Uk

Patrick Magee Medal

2016 Report

The 2016 Patrick Magee Medal enjoyed great interest internationally. Forty-three abstracts were presented by undergraduates. Work originated from 22 UK medical schools combined with international entrants from Brazil, Bulgaria, China, Ireland, Italy, Russia and the United States of America. The abstract titles are listed below.

It is a fitting tribute to Pat's legacy that in 2016, there were over 50 undergraduate students present at the Annual SCTS Conference with full participation in all aspects of the meeting. Informal feedback highlighted their enjoyment of the academic sessions. Many remarked on the beneficial experiences of speaking to surgeons and trainees. The recently formed student sessions were a tremendous success with inspirational talks from Aman Coonar, Jonathan Unsworth-White, Jonathan Afoke and Farah Bhatti.

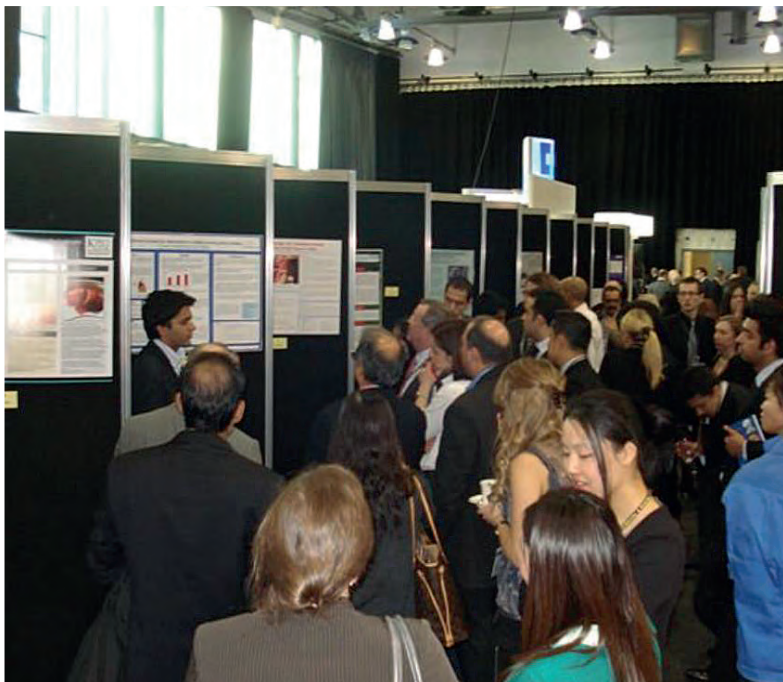
Pat was central to creating the SCTS Undergraduate Poster Prize. We are deeply honoured that the extremely worthwhile initiative lives on in his name and confers his educational values to future generations. As a tradition, we ask that one of his friends or colleagues says a few words to describe Pat's values and actions. In 2016, Mr Graham kindly spoke to describe the wisdom and charity of Pat.

Tim described the enduring mentoring role that Pat afforded so many colleagues in the UK and abroad.

The speech was both moving and inspirational. Norman Briffa (Sheffield Teaching Hospital), Neil Roberts (Barts Heart Centre), Donald Whitaker (King's College Hospital) and Tim Graham (President SCTS) served as the panel of judges.

Ultimately the winner of the 2016 Patrick Magee Medal was Samuel Schnittman from Mount Sinai Hospital, New York. He presented an abstract titled: "Long-term outcomes following bioprosthetic versus mechanical aortic valve replacement in patients aged 18 to 50 years."

This year's competition has been a further step forward in the Patrick Magee Medal. It continues to act as a centre-point for undergraduate activity in the SCTS Annual Meeting and the society as a whole.



This year's entrants add to the 253 posters presented in preceding years. I have every confidence that through the competition the positive influence of Pat will continue to permeate the SCTS for many generations to come.

It is a fitting tribute to Pat's legacy that in 2016, there were over 50 undergraduate students present at the Annual SCTS Conference with full participation in all aspects of the meeting.



Patrick Magee Medal (2016) – List of Posters

Early outcomes of mitral valve replacement performed by residents on high-risk patients (A single centre experience)

Selective in Advanced Medical Practice (SAMP); a model for increasing medical student exposure to surgical specialities

The efficacy of Coronary artery bypass grafting (CABG) surgery

A comparison between mitral valve replacement and repair in the surgical treatment of ischaemic mitral regurgitation

Audit of Postoperative Pain Management in Cardiac Surgery Patients

A literature Review on Pain and Pain Management Following Cardiac Surgery

Is there a volume outcomes relationship for patients undergoing surgical management of acute aortic dissection?

Acute aortic thrombosis following a Stanford type A aortic dissection

Are Two better than One? – In patients undergoing coronary artery bypass surgery, is the use of 2 arterial conduits associated with improved patient outcomes?

Thoracic Aortic Dissection in a normal height patient: a family with Thoracic Aortic Aneurysm, Dissection and ACTA2 mutation

Post-operative aortic valve competence following valve sparing aortic root replacements (VSARRs)

The safety and efficacy of immediate, pre-emptive platelet transfusion in patients undergoing coronary artery bypass graft surgery: a retrospective cohort study

A Case of Quadricuspid Aortic Valve with Three Independent Coronary Ostia

Complex lung resection for cancer increases the incidence of post-op atrial fibrillation: A single centre study on incidence of AF

Struma cordis

Metastatectomy of a solitary lung melanoma of unknown primary in a patient with type 1 Neurofibromatosis

Much Ado About Nothing - Are Patients Aware of the Mortality Data Published by the Society of Cardiothoracic Surgeons?

An audit of adherence to SAC case definition guidelines for isolated coronary artery bypass graft surgery

Outcomes in End Stage Renal Failure (ESRF) Patients Undergoing Cardiac Surgery

Thoracic Surgery – An Essential Adjunct to ECMO services – A Tertiary Referral Centre Experience

Intraoperative Epicardial Pacing Wires in CABG patients; Propensity matched analysis of short and long term outcomes including requirement for permanent pacemaker

Successful conservative management of a pustulant peri-aortic root graft collection using irrigation and antibiotics

An updated analysis of hemiarch versus total arch replacement in acute type A dissection: A meta-analysis of 1860 patients

Impact of patient factors on length of hospital stay following VATS lobectomy

The use of platelet rich plasma (PRP) and platelet poor plasma (PPP) to aid haemostasis in a Jehovahs Witness patient undergoing emergency aneurysm repair

Management of lower limb ischaemia during operative repair of acute Type A aortic dissection by distal cross over grafts

Patients survey of their awareness and use of information published on the SCTS website on surgeon's specific and unit specific mortality results

On-Pump and Off-Pump Coronary Artery Bypass Grafting

What is the best surgical option for managing prosthetic aortic valve endocarditis with root abscess?

Long-term outcomes of bioprosthetic aortic valve replacement

Review of Coronary heart disease in South Asians: early assessment and management

Microparticles – endothelium interaction after transfusion in cardiac surgery patients

Pain Management using PCA in Adults post Nuss Procedure: An analysis with respect to patient satisfaction

Long-term outcomes following bioprosthetic versus mechanical aortic valve replacement in patients aged 18 to 50 years

A Rare Case of Massive Thymipoma in Pregnancy

A review of the efficacy, safety and cost-effectiveness of endobronchial valves in patients with severe emphysema

Surgical Intervention for Kawasaki's Disease

Long Term Outcomes of Coronary Artery Bypass Grafting in Comparison to Percutaneous Coronary Intervention for the Treatment of Coronary Artery Disease

Atherosclerosis of the Left Internal Mammary Artery: Histological Analysis of a Case and Literature Review

Long-Term Patency of Saphenous Vein and Left Internal Thoracic Artery Composite Graft: a Case Report

Outcomes of Valve- in-Valve Percutaneous Aortic Replacement: A Systematic Review

Postoperative Bridging of Anticoagulation in Mechanical Valve Replacement

The Cardiothoracic Trainees Research Collaborative

The Cardiothoracic Trainees Research Collaborative (CTRC) is the national research group for Cardiothoracic Trainees in Great Britain and Ireland. We aim to promote research amongst trainees by facilitating their involvement and leadership in research projects, provide inspired research training and by fostering an environment of collaboration between cardiothoracic units.

The collaborative approach

Cardiothoracic Trainees are spread throughout Great Britain and Ireland. This large geographical area can provide a significant amount of data, which is representative of the population we serve. The SCTS National Adult Cardiac Surgery Audit¹ has been a major advance and inspiration, but there are still so many clinical questions to be answered. Good research questions are frequently generated, but their data collection and analysis is often confined to the local hospital or a small group of 'friendly' centres. As a result patient numbers are low, statistical power is compromised and generalisability is called into question at every stage from journal review to the end user – the Cardiothoracic Surgeon who hopes the paper can inform their practice. The size of the specialty lends itself well to collaboration on a national scale and CTCRC has set out, since its foundations, to exploit this great geographical network that we have available to us as Cardiothoracic Trainees. There is no "I" in team. If we can work together so that research questions are considered within this framework, large patient numbers will increase applicability, strengthen results and support more convincingly the conclusions drawn.

The model

At a trainee research day, held at the Royal College of Surgeons of England, presentations from Neurosurgery, Plastic Surgery and General Surgery were delivered. The results of these studies were outstanding in terms of the numbers of patients, the production of robust results and the clear collaboration that had occurred. Conference presentations and publications in quality journals have been achieved. The first randomised controlled trial organised by a trainee collaborative came from General Surgery – The Rossini Trial². It was commended for recruiting ahead of target across 21 centres and named all those who collaborated in the eventual paper. This demonstrates that trainees can not only manage high quality research projects, but also make collaboration work to everyone's advantage.

1 <http://www.scts.org/intro.aspx>

2 Pinkney, TD, Calvert, M, Bartlett, DC, et al. 'Impact of wound edge protection devices on surgical site infection after laparotomy: multicenter randomised controlled trial', *BMJ* (2013); 31: 347.

Trainees

We are a very welcoming group and anyone under the 'trainee' banner is welcome to join us. This includes clinical fellows, junior doctors (yet to get a training post) and medical students interested in

pursuing a career in Cardiothoracic Surgery. To facilitate this, we have regional links (see table below for your local contact) and a medical student link.

You can contact us at cardiotrc@gmail.com, sign up to our newsletter and/ or follow us on Facebook.

We have already published³ and have presented at both national and international conferences, but are always looking to expand. The group offers the chance to engage with (and learn about) research, even when in a clinical (non academic) post. There are opportunities to join an existing study or propose your own.

Consultants

We would value your involvement.

This may appear contradictory for a trainee research group, but actually it is vital. To develop as good researchers, we need good consultant mentors. Our projects allow trainees to take ownership and be involved at every stage of the research process, but each project still requires guidance and mentorship from a Consultant Supervisor. By pairing with a trainee, consultants can use the collaborative's network and support research training. We have already benefited from good senior support in reviewing our protocols, data collection and analysis - in particular, we would like to thank Professor Treasure whose kind help in the early stages has allowed the group to flourish. We have also had excellent training provided by Consultants at our meetings and we run a regular feature in our quarterly newsletter where Consultants can share their research wisdom.

3 Lang, P, Manickavasagar, M, Burdett, C, et al. 'Suction on chest drains following lung resection: evidence and practice are not aligned', *Eur J Cardiothorac Surg* (2016); 49 (2): 611-6.



Please be supportive when a trainee asks to collect data at your hospital, as the projects are multi-centre and require co-operation to succeed.

In Summary...

The research ethos in surgery is gaining momentum, with an increasing emphasis on developing research skills amongst trainees. The Royal College of Surgeons (England) has promoted trainee involvement in research and, specifically in Cardiothoracic Surgery, SCTS has established an Academic and Research Committee (led by Professor Gavin Murphy), which encourages research endeavour in the specialty and supports our initiative.

So there has never been a better time to get involved – and all are welcome.

Alan G. Dawson
Academic Clinical Fellow & East Midlands CTRC Rep
Urszula Simoniuk
Specialty Trainee & CTRC Meetings Secretary
Clare Burdett
Specialty Trainee & CTRC Lead
cardiotrc@gmail.com
<http://www.ctrc-uk.com>



Figure 1: Our Collaborative Committee 2016

REGION	LOCAL LINK
East of England	Daniel Sitaranjan
East Midlands	Alan Dawson
Ireland	Open to applications
London (2 posts)	Amir Sephehpour & Duncan Steele
Mersey	Thomas Theologou
Northern England	Mohamed El-Saegh
Northern Ireland	Open to applications
North West	Ana-Catarina Pinho-Gomes
Scotland	Peter Lang
South West (2 posts)	Udo Abah & Rick Karsan
Wales	Tom Combellack
Wessex	Danaï Karamanou
West Midlands	Yassir Iqbal
Yorkshire & Humber	Azar Hussain
Medical Student (National)	Shruti Jayakumar

Training outside of the workplace:

An update on the value of the pioneering SCTS Ethicon curriculum aligned training programme

The detrimental effect of European Working time Directives on training surgeons has been well vocalised in recent years, with a responsive surge of simulation, technology and intensive 'bootcamp' programmes to bridge the gap. However naturally talented, the surgeon's craft requires time, practice, repetition, directed feedback and evolution of skill for each individual trainee to learn muscle memory and build appropriate patterns within their practice. European legislation has led to reduced exposure in the workplace, and the requirement of additional means of training to reach competencies.

Cardiothoracic surgery in the UK has led the way in bridging this gap with integration of a robust, curriculum-oriented programme of continuous learning, delivered over the 6 years of speciality training. SCTS Education under the guidance of our SCTS tutors offers trainees the opportunity to attend two fully funded, stage-appropriate and SCTC accredited training courses per year with full support of the SAC and Training programme directors.

The delivery of each course is multifaceted including simulation, wet-lab, case studies, group and lecture based teaching. Importantly, the focus is to augment knowledge obtained in personal study, and develop skills which are required in the daily practice of a competent cardiothoracic registrar at that level. As such the ST3A course covers the introductory anatomy, physiology, pathology and clinical scenarios alongside wet-lab skill practice of chest opening and closing, mammary harvest, cannulation, wedge excisions, bronchoscopy, tracheostomy and chest drain management expected of a first year registrar.

Does it work?

Simulation and wet-lab training is a big bucks business in the current climate with investment in facilities and equipment across all surgical specialities. The challenge faced by educationalists and surgeons, is demonstrating its usefulness within clinical practice. Assessment of candidates in simulated circumstances following a simulated educational event, shows little more than an improvement in the candidate to simulate. While one might anticipate a transfer of skills to the work place, there is little evidence to show ability in a wet-lab equates to a better surgeon.

We sought to establish objective assessment of the impact of the ST3A course on return to clinical practice using the current ST3 year group as the focus of a single-subject design research project.

The project

Objective assessment of all 20 candidates was undertaken by a consistent clinical or educational supervisor before and after ST3A course attendance. The direct observational procedure forms (DOPS), while not formally validated were based on the widely accepted UK and USA work-based assessments for the cardiothoracic skills : Video-assisted thoracoscopic pulmonary wedge resection and cardiopulmonary bypass management.

Both of these skills were felt to be relevant to ST3 level trainees, and were taught in theory and practical sessions on the ST3A course.

Alongside the forms, supervisors were asked to complete a rapid online questionnaire regarding their overall response to the trainees involvement in the educational programme.

And?

The initial analysis shows a significant improvement in the surgical skills of the trainees. The simple breakdown of the positive impact within the operating theatre is clear.

Candidates showed improvement in each and every component of both skills between the two assessments, which were on average a week before (Pre ST3A) and four weeks after the course (post ST3B).

Furthermore, supervisors were asked their overall impression in four domains (knowledge,

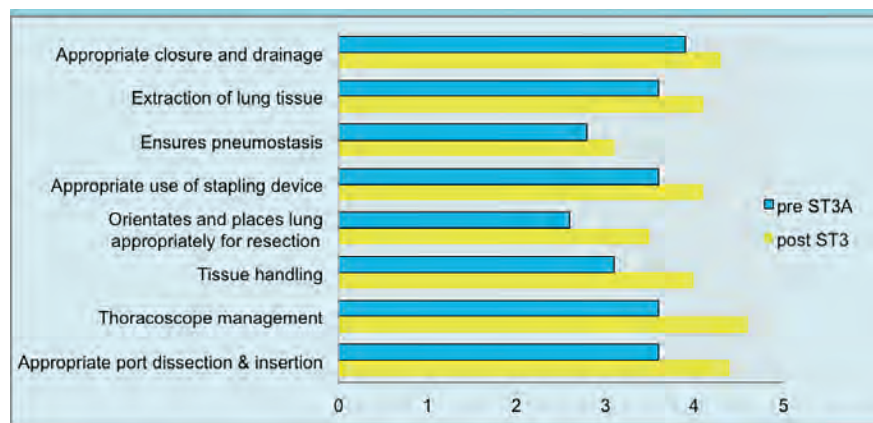


Chart 1: Objective supervisor assessment of pulmonary wedge resection before and after ST3A course.

Louise Kenny

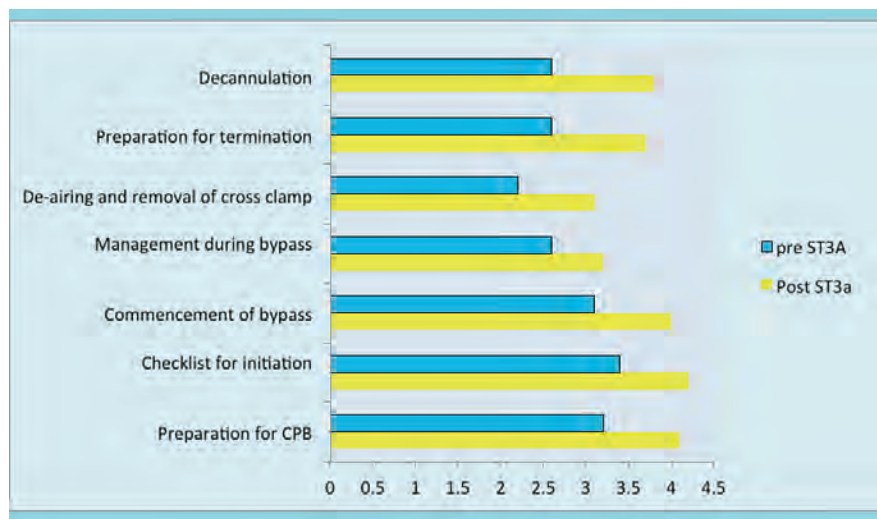


Chart 2: Objective supervisor assessment of CPB management before and after ST3A

This evaluation of the impact of SCTS accredited ST3A training course shows huge promise in skill development when assessed objectively within the normal professional working environment. Importantly, the study revealed that participation in this simulation and wet-lab based course improved confidence in both trainee and trainer, resulting in a subsequent increase in trainees participation in technical aspects.

clinical decision making, technical skills and confidence in the OR) specifically in relation to attendance to the ST3A course.

The majority of supervisors reported noticeable improvement across all four domains of confidence in the OP, technical skills, clinical decisions and knowledge.

As the final assessment of impact of the course on the trainees clinical practice, surgeons were asked their level of agreement with the following statement:

"I felt more confident to allow the trainee to perform more of the technical aspects of subsequent operations"

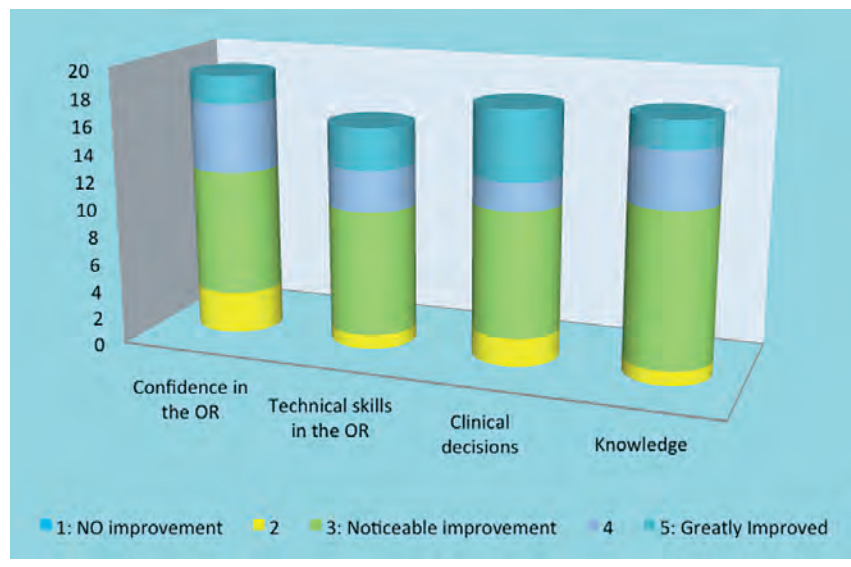
70% of supervisors either agreed or strongly agreed with the above statement, suggesting the course not only has an impact of the actual skill of the surgical trainee, but on the conceived competency by their supervisor, confidence in their ability and subsequently on their daily training activities.

Where next?

The generation of surgeons trained through endless and exhaustive hours can often be quick to dismiss training courses outside of the workplace, perhaps through a misunderstanding of content or a frustration of registrars missing days at work. In the current climate of prescriptive training years and reduced hours, which may, in light of recent events, be teetering on a EWTB brink, innovative and exciting ways of progressing trainees must be integrated and accepted.

ST3B, the second course over the training year has just completed, with data currently being returned. We are hopeful that the overwhelmingly positive trend continues, and analysis of DOPS alongside case and part-case numbers for each trainee will show incremental improvement related to the courses. We implore trainees and supervisors to engage thoroughly with this process, in order to secure the involvement and dedication of faculty and funders for future years of training.

With great thanks to all faculty, the Sorin National Wetlab Centre in Gloucester and Ethicon and Sorin for supporting the project.



There is no 'I' in the word TEAM

The main stay of our business is in the title National Health Service. It is a "service". We are all here to serve our patients. The dictionary definition of service highlights the importance to render help, to aid and to be useful. It includes the words duty or work of public servants. We work in a privileged service industry. No other profession works with total strangers, counsels them, brings them into hospital and then interferes with their most vital organs. The relationship between a patient and the surgeon is special. It is defined by an indelible scar that is an emblem of our labour. It means we are remembered for life by our patient as an individual, as a surgeon, as a leader and as part of a team. Performance is defined, not only by what we say as an individual, but what we do as team. The complexity and knowledge required to deliver a comprehensive service is beyond the capability of the lone individual.

The SCTS and its membership deserve a lot of credit for their transparency and leading the way with surgeon specific mortality. Despite the publication of results, the mortality for the procedures we offer has fallen against a background

The first principle of a service industry is to front load with the expert, ie the consultant. Much of our service is already consultant led and delivered.

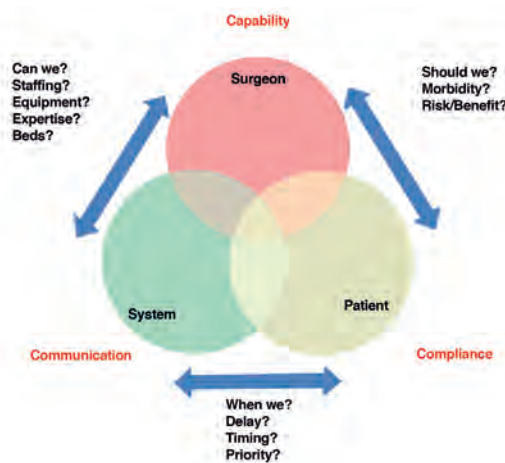


Figure 1 The outcome⁴ of the patient is dependent on the surgeon, the system and the patient. This typology offers the questions: Can we? Should we? When We?

of increasing co-morbidities. We are all familiar with the arguments for and against producing surgeon specific data. This has been eloquently debated at a recent international meeting. We all understand that the outcomes are dependent on many factors related to the surgeon, the system and the patient – it is multifactorial as shown in Figure 1.

The first principle of a service industry is to front load with the expert, ie the consultant. Much of our service is already consultant led and delivered. There is tension implicit in the system as we are dependent on a lot of people to deliver the service, yet it is our name above the bed and we are held accountable. 'The Captain of the Ship' argument holds although this has somewhat different legal interpretations in different parts of the world. No matter what our interpretation, we cannot abrogate our responsibility to lead and participate in a team delivered service.

Customers and Markets

It is well recognised in business literature that perceptions and expectations of the 'customer' market change over time especially if base line criteria are met. Survival is now expected and almost assumed by the patient coming to our

outpatient department. They are now, however, enquiring about other aspects of their care including efficacy, experience and quality; wound infection, stroke and delays predominate their thinking about hospitalization and these parameters are affected by the whole system. We will not be able to put the 'cat back in the bag' as far as mortality is concerned but we can certainly change the focus conversation from the individual to the team.

The function and cohesion of a team are paramount to delivering safely and quality. The individual art can be practiced but high quality is not guaranteed and comes at a high cost. A more reliable, sustainable and effective standard of quality can be only achieved by rigorous application of evidence based medicine and standardised operating protocols (SOPs) figure 2.

But there is a problem. Firstly, SOPs are often frowned upon and are seen as an anathema to most surgeons and an affront to what is commonly perceived as a well-earned autonomy concomitant with the consultant status. Secondly, it is well documented that doctors make decisions predominantly on experience and not evidence. The biases and heuristics generated by surgeon specific data certainly will influence decision making especially in the high risk patient and impact on compliance with SOPs.

Team participation demands other skills that to date have not been fully appreciated. Non-technical skills of surgery are recognised and taught, but are we really addressing the issues of attitude and behaviour? Culture is often cited as the cause or solution to organisational/team success or failure. It is loosely defined as the 'way things are done around here'. Edgar Schein, a professor at Massachusetts Institute of

David J. O'Regan
Leeds General Infirmary

Technology in Boston - USA and guru on the subject, best described culture as 'A+B=C' - attitude plus behaviours equal culture (personal communication).

It is our attitudes and behaviours as team members that contribute to local cultures. These are subject to increasing accountability and scrutiny. It transpires that most the reports to the GMC are centred on this very issue. Staff are quite rightly empowered to challenge and hold each member of the team to account, as it is this shared responsibility that ensures that the care we deliver is dignified and safe.

control. We are all guilty of leaking our frustrations and it is very easy for this to be used destructively rather than an opportunity to coach and learn through mutual respect.

We all need to be cognisant of the fact that consumerist society values, beliefs, are changing expectation and entitlements. The workforce is likewise subject to significant socio-demographic changes including age, gender, and multiculturalism. All this brings richness to the way we deliver care and the necessary diversity of opinion required when seeking a better way. But, have we changed as a profession and are

our own attitudes and behaviours congruent with the time? The autocratic surgeon is, in many respects, being left behind and potentially exposed through an evolutionary mismatch figure 3 overleaf.

The expectation and the responsibility goes far beyond to operate and deliver a safe service as we participate in high performance teams with an inherent natural interdependence.

Performance does not just happen; it has to be rehearsed, practiced and coached. How can we assess this at an interview and why are we not assessing this throughout training? The SCTS flirted with the idea of having mentors to support the newly appointed consultant but what are we doing about teams that are dysfunctional? Why are we not

encouraging consultants to move around to find best fit? A consultant job is for life but does it have to be in the same place?

In order for the SCTS to meet the challenges of the future we do need to re-consider the appointment process and reinforce the attributes of team playing. We also need to think through the implications of having a more migrant consultant workforce and the social, domestic and financial impact. It is pleasing to see the establishment to a governance lead but is it going to be possible to establish a code of conduct and will the SCTS be able to apply this in a fair, transparent and consistent manner that enables us to maintain standards of professional conduct as well as capability that reassures the patients and our employers? Perhaps the role should be extended to examine attitudes and behaviours of troubled teams with a SCTS directed governance agenda focused on advice and coaching that can mitigate political and personal agendas?

'IMSAFE' is an acronym used by the airline industry as a process of self-calibration: Illness, Medication, Stress (personal, financial, time pressures), Abuse (alcohol or recreational substances and hangovers) Fatigue (physical and mental including sleep deprivation) Emotion (anger, aggression, depression, personal grief/loss) Eating (hypoglycemia and hydration). How are often are surgeons working when feeling below par and what support is on offer? Psychomotor skills of the experienced surgeon are generally preserved in times of difficulty but cognitive skills are attenuated. Do we see a future where the surgeon can exercise self-calibration without feeling guilty or under pressure? The decline in cognitive function can be ameliorated by having the team on board but this is conditional on a level of self-governance and a supportive team. A declaration and request for help in times of difficulty

	Individual	Mass Customisation
Art	<ul style="list-style-type: none"> • Professional autonomy • High cost /high quality 	<ul style="list-style-type: none"> • Conflict over autonomy versus efficiency • High variable quality
Science	<ul style="list-style-type: none"> • High cost • High variable quality • Conflict over autonomy versus efficiency 	<ul style="list-style-type: none"> • Evidence based medicine • Best practice • Low cost / high quality

Figure 2: Relationship between the delivery mode and degree of disease management. Adapted from the paper by McLaughlin and Kaluzny. All the consultant surgeons deliver independent practices and are very defensive about their professional autonomy. The service provided is of an extremely high standard but, as outlined in the rubric, it is of high cost. Improvement and change could be affected, as shown by the blue arrow, by adopting an evidence based best practice and moving towards mass

Down side

There is a down side. We, not infrequently, find ourselves asserting the need for improved performance but this assertion is defended with accusation of 'bullying'. Yes, this is an easy defence for the person who is not delivering to standard but it is a difficult balance that requires a mindfulness and self-

continued on next page

There is no 'I' in the word TEAM continued

Evolutionary mismatch...

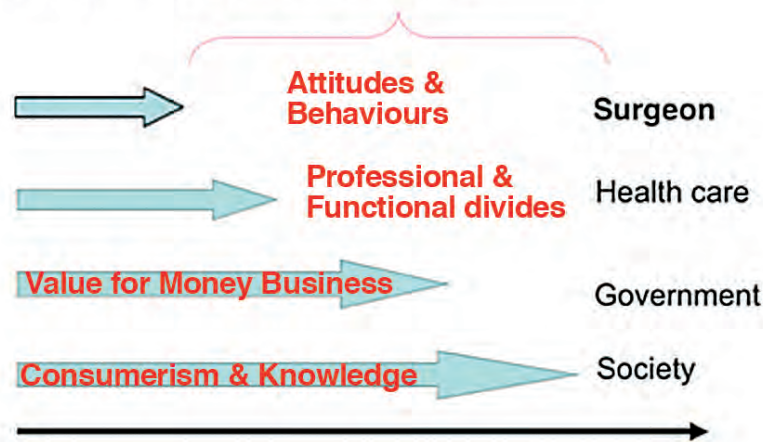


Figure 3: Society expectations are changing and challenging the system at multiple levels. The surgeon is potentially exposed

included in the team brief will go a long way - after all we are human!

We also need to consider the collegiality of our profession. We are all fellows of a college of surgeons. Implicit in the word fellow is support and respect for one another. This does not necessarily mean friends but more a recognition and acknowledgement of an individual's roles, responsibilities and contributions to the team. Negative behaviours and derogatory comments about colleagues can and do erode at a person's emotional wellbeing. This should not be tolerated at any level. The first response to a colleague in difficulty should be supportive and in kind. James Reason proffered a simple clear algorithm to use when faced with doctors in difficulty. Sanction and exclusion are really last resort and should only be taken when presented with irrefutable evidence. We do seem to be in a culture of 'shoot first and then ask questions'? The SCTS can and should position itself to offer wise counselling for the individual, teams and employers alike in order to bring some common sense and calm to situations that appear to be getting out of control - perhaps we could even offer a help line?

The job is difficult enough as it is and is getting tougher. The SCTS is in a good position to consider the nuances of the appointment process, team playing and doctors in difficulty. We do need to examine our own and collective attitudes and behaviours. Change will not come from top down control but from within ourselves and our profession. If we can do this then it becomes a tool, however if left to other authorities it most certainly will become a stick! We have to want to do it. We need to support each other through thick and thin. We need to foster team playing, drive quality through standard operating protocols and above all respect each other's roles and contributions to this amazing and privileged specialty.

References

McLaughlin, C. P. & Kaluzny, A. D. 2000, "Building client centred systems of care: Choosing a process direction for the next century", *Health Care Management Review*, vol. 25, no. 1, p. 73.

Human Error; James Reason: Cambridge University Press; 1990

**David J. O'Regan MBA MD BM
FRCSEd C-Th. FFSTEd**

Room 146, E Floor, Jubilee Building
Leeds General Infirmary

Email: davidoregan@nhs.net

Twitter [@david-ukan](https://twitter.com/david-ukan)

Making cardiothoracic surgery attractive to medical students

Over the last couple of years cardiothoracic surgery has remained the most competitive of surgical specialities. With an ST1 entry point, exposure to cardiothoracic surgery as an undergraduate has become increasingly important. Despite this, one of the problems voiced locally was that it was a difficult specialty to gain experience of with very few clinical attachments available. Over recent years the SCTS has worked hard to involve medical students in cardiothoracic surgery. The annual meeting provides opportunities to present research and audit and has become highly regarded by medical students. Other opportunities have been made available such as a clinical attachment in Middlesbrough – something I have been told provides outstanding clinical experience. In Sheffield, with excellent consultant support, we have been able to get numerous medical student initiatives going with good success.

Presentations provide an easy opportunity to connect with large numbers of medical students. There is not a great deal of emphasis placed on careers counselling and students value any information that will make them competitive and improve their CV. A talk on the life of a surgeon can be extremely effective and can provide a stimulus for students to seek further experience in the specialty. Medical schools are extremely grateful when doctors show interest in teaching and mentoring and will support any teaching efforts.

Basic science courses with wet tissue skills stations are used heavily in postgraduate surgical training and we have found them to be useful when teaching medical students. The teaching programme we use begins with anatomy teaching using porcine tissue and builds up throughout the day to basic clinical skills such as knot tying. It focuses on delivering teaching with an emphasis on mentorship. If students are able to leave the course confident that they can contact someone from within the specialty it can greatly increase their motivation. We have run numerous undergraduate courses and seeking support from medical schools can improve the quality and relevance of teaching provided.

Cardiothoracic surgery does not have any significant presence in undergraduate medical curriculums. With increasing emphasis being placed on producing doctors who are able to work in primary care this is something that will not change. Surgical attachments are always popular with students but are being reduced. A positive way of dealing with this is for units to create high quality attachments that can be chosen as student selected components (SSC). Organising a teaching programme over a couple of weeks is easy and effective – students can spend dedicated time on cardiac and thoracic wards, in theatre and in ITU. It can be an opportunity to get involved in audit and research and again can help students identify a mentor.

Michael Gooseman
Yorkshire and the Humber



In Sheffield, with excellent consultant support we have been able to get numerous medical student initiatives going with good success.

SCTS

Student Engagement Day Report

After a very successful event in Bristol last year, the SCTS student engagement day was run this year by Cambridge University Medical Students and Papworth Hospital.

The event took place on Saturday 21st November 2015 where 60 delegates from all over the UK and visitors from Brazil and Ireland truly enjoyed a fantastic experience in the field of cardiothoracic surgery.

The day started with TEDx-like lectures in Cardiothoracic intensive care (Dr Nicola Jones), Adult Cardiac surgery (Miss Farah Bhatti), Cardiothoracic Transplant surgery (Mr Stephen Large), Thoracic surgery (Mr Aman Coonar), Paediatric Cardiothoracic surgery (Mr Shafi Mussa) and the Cardiothoracic training scheme (Mr Phil McElnay).

In addition, a 40-minute post-surgical emergency simulation was led by trainee cardiothoracic surgeons with the involvement of students. This demonstration was a great way to get students involved in a typical emergency situation and illustrate the role of each healthcare professional.

The afternoon session consisted of four practical stations: aortic anastomosis, chest drain insertion, thoracoscopic skills and suturing. This provided a greater exposure to students in getting involved with common skills utilised in cardiothoracic surgery. Practical stations were truly enjoyed by all students. Furthermore, it provided fantastic opportunities for medical students to engage with each other and collaborate with cardiothoracic trainee surgeons and Consultants.

At the end of the day, certificates of attendance were handed out. Speaking to quite a few students, a very positive response and feedback was provided with "excellent and inspiring teaching" and "great hands-on practical sessions". Everyone gained more experience and exposure in the field of cardiothoracic surgery. The organising committee learnt new skills and we all made professional connections.

Cambridge University medical student committee:

Oliver Brewster, Vinci Naruka, Rob Piper, Millie Ngaage, Saigeet Eleti, Charlotte Cardus, Elena The and led by Mr Aman Coonar.

Surgical trainees demonstrating a resuscitation scenario



At the wetlab!



Vinci Naruka
5th year Medical Student
University of Cambridge



Suturing session and laparoscopy station



Thoracic anatomy and chest drain insertion



SCTS Education Tutors Report

Portfolio of training courses

Since being appointed a cardiac and thoracic surgery tutors for the Society of Cardiothoracic Surgeons of Great Britain & Ireland, we have set up a portfolio of cardiothoracic surgery training courses for nationally appointed cardiothoracic surgical trainees. It has taken a fantastic team effort with support from the Society Executive, Cardiothoracic Surgery Specialty Advisory Committee (SAC), Training Programme Directors and most importantly, the members of the faculty, whose time and effort have enabled us to deliver a fantastic programme of education to complement the training that occurs in the workplace. The complete portfolio has now been delivered, with the successful running of the recent ST8A Cardiac Surgery and Thoracic Surgery Pre-Consultant Courses. This course taught senior trainees the important principles of becoming a Cardiac or Thoracic Surgery Consultant, allowing them to practise the skills of emergency surgery in a live operating model, such as repair of an acute aortic dissection, post-infarct ventricular septal rupture or bronchial tear. Consistent with previous courses, the programme was very well received by the trainees with excellent feedback. The feedback also allows us to continually evolve the courses to meet the changing needs of the trainees. To the best of our knowledge this is the only portfolio of courses that has been designed to mirror the specialty ISCP curriculum and that is provided free of charge to all trainees. This is made possible by fantastic financial and logistical support from our industry partners, principally Ethicon.

The boot camp venture of SCTS was presented in the ASiT meeting and won the best prize award.

Training courses for Core Trainees & Foundation Doctors

In addition to the portfolio of courses for nationally appointed cardiothoracic surgical trainees, we also have set up introductory courses for core surgical trainees and foundation doctors. This year both will be run at the West Midland Surgical Training Centre in Coventry, which has fantastic facilities, including access to cadaveric materials for simulation teaching. The ST2 course is also run free of charge with financial support from Ethicon for all nationally appointed ST2 trainees on a run-through programme, as well as for other core trainees interested in cardiothoracic surgery, with support from their core surgical training programme directors.

The Foundation Year Course is aimed at those exploring Cardiothoracic Surgery as a career choice and allows trainees to get hand-on experience at performing cardiac and thoracic surgical procedures, such as a coronary anastomosis or a lobectomy. This course is run with great financial support from Medtronic.

SCTS Education Operative Video Prize

Over the past year we have also successfully ran the SCTS Education Operative Video Prize. The premise behind this is to empower cardiothoracic surgical trainees to actively participate in their own education. It involves the trainees creating a short 5 minute video of a surgical procedure or part of a procedure from a list of 120 cardiothoracic procedures or operations, with the view over the next few years to create an SCTS quality approved library of videos, accessible by trainees so that they can for example review a new procedure before performing it in the operating room. The 6 best cardiac and thoracic surgery videos were viewed and voted on by the trainees at the SCTS Annual Conference during the Trainee meeting. The winners

were Nur Ismail (Thoracic Surgery), with her robotic thymectomy video, and John Taghavi (Cardiac Surgery), with his valve sparing aortic root replacement video. The shortlisted videos are available to view on the SCTS Education website. We would encourage all cardiothoracic trainees to submit at least one video per year, in a similar manner to producing a manuscript and an audit, as it will be discussed at the annual review of competency progression (ARCP).

Professionalism

Recently, issues of professionalism have occurred at the recent training courses in Hamburg with trainees either turning up late or absent from the last day of teaching following effects from the night before. Unfortunately, as well as reflecting poorly on the individual trainees involved, it does not send out a good message on the value that the trainees place on this unique educational opportunity and may affect funding for the programme as a whole. It is important to stress that trainees are expected to attend the course completely and abide by the standards of behaviour expected in the work place set out by the General Medical Council (GMC), as well as the professionalism expected of a SCTS member. Where issues of professionalism arise, a report is sent back to the training programme directors for further discussion at the annual review of competency progression (ARCP). We would encourage all trainees to make the most of these educational opportunities and to treat them with appropriate respect.

Quality assurance

Finally we have been working with the Education Department of Royal College of Surgeons of Edinburgh to inspect and quality assure our programme. Dr Hurst, the head of the department, has visited our courses and has given valuable feedback. It was very gratifying to learn that we have been delivering the courses in keeping with educational standards.

Narain Moorjani
SCTS Cardiac Surgery Tutor

Sri Rathinam
SCTS Thoracic Surgery Tutor

We wish Mike Lewis all the very best in his role as the Intercollegiate Board Chair. Mike and Rajesh as Education secretaries have been greatly supportive in our role as tutors.

We thank our entire faculty and course directors who made this programme a success.



Forthcoming SCTS Education Courses

21st – 22nd July 2016

Non-Operative Technical Skills for Surgeons (NOTSS) Course (ST5B)

Advanced Patient Simulation Centre, St George's Hospital, London

Course Directors: Tim Jones / Mike Lewis / Ian Hunt / Gianluca Casali

23rd Sept 2016

Introduction to Cardiothoracic Surgery for Foundation Year Doctors & Core Trainees (ST1)

West Midland Surgical Training Centre, University Hospital, Coventry

Course Directors: Heyman Luckraz / Karen Harrison-Phipps

10th – 11th Nov 2016

Professional Development Course (ST8B)

J&J Pinewood Campus, Wokingham

Course Directors: Stephen Rooney / Mike Lewis

14th – 16th Nov 2016

Introduction to Specialty Training in Cardiothoracic Surgery Course (ST3A)

J&J Pinewood Campus, Wokingham

Course Directors: Ravi De Silva / John Pilling

28th – 30th Nov 2016

Essential Skills in Cardiothoracic Surgery (ST2)

West Midland Surgical Training Centre, University Hospital, Coventry

Course Directors: Mobi Chaudhry / TBC

5th – 7th Dec 2016

Core Cardiac Surgery Course (ST4A)

J&J Pinewood Campus, Wokingham

Course Directors: Joseph Zacharias / Ishtiaq Ahmed

Aberdeen Royal Infirmary: Locum Consultant Cardiothoracic Surgeon Needed

The North of Scotland Cardiothoracic Surgery Unit are currently looking to recruit a Locum Consultant Cardiothoracic Surgeon at Aberdeen Royal Infirmary effective from 1st August 2016 or soon afterwards.

If you have any interest in this post please contact Mr El-Shafei's secretary, Sandra Adam on **01224 555907** or email **sandra.adam2@nhs.net**





The Association of Surgeons in Training

**T-Log.co.uk / ASiT Surgical Education and
Training Prize 2016**



Winner

GROUP - SCTS Education

Miss Rhiannon Harries
President, ASiT

Mr Dev Mittapalli
Director of Education, ASiT

ASiT – *the pursuit of excellence in training*

35-43 Lincoln's Inn Fields, London, WC2A 3PE
Telephone 020 7869 6681 | info@asit.org | www.asit.org
Registered Charity Number 274841

Developing Non-Technical Skills

G Hardman, AH Walker

Traditional health-care education and training is discipline specific and focuses on clinical knowledge and technical skills but up to 80% of errors in healthcare are consequent on failures of non-technical skills. Cardiothoracic surgery accounts for some of the most common and technically challenging procedures performed in the UK today. The cardiac operating theatre is a highly demanding, high-risk environment, reliant on multiple interactions between subspecialist individuals and complex technologies to provide safe care for patients with severe cardiac disease and multiple co-morbidities. The contribution of human factors to patient safety in the cardiac operating theatre is well recognised¹.

In January 2015 funding was secured from Health Education Northwest Enhanced Learning Environments for the introduction of an innovative interprofessional learning (IPL) programme, using simulation and technology enhanced learning for the delivery of non-technical skills training to the cardiac surgical team. Training an existing multi-disciplinary team, who are established in working practice was a novel proposal. By training the MDT together, our aim was to improve working relationships, aid understanding of individuals' roles and their value within the team, and to allow direct application of learning outcomes to everyday practice, ultimately improving patient safety.

Prior to course development, all staff members in our department were invited to participate in 2 online questionnaires; Safety Attitudes and Safety Climate questionnaire and the Team STEPPS Team work attitudes questionnaire². The results of this needs analysis highlighted an awareness of the importance of non-technical skills, but a perceived difficulty in achieving this within the department. 45% of respondents felt that "communication breakdowns are common" and 21% disagreed with the statement, "Doctors and nurses work together as a well-coordinated team". Staff satisfaction was low and the consequent effects of poor communication and poor collaboration between team members on patient safety culture within our department was recognised.

A working group of representative parties convened to design a curriculum based on learning needs specific to our department, identified from local incident reporting, along with local and national serious incidents, with a focus on communication, team-working, situational awareness and decision making.

The pilot programme commenced in June 2015 with 9 individuals from the existing cardiac operating and intensive care teams participating. The programme curriculum was delivered over five 2-hour sessions, with simulated scenarios followed by video-assisted facilitated de-briefing. Between

each module reflective practice is facilitated using an online discussion forum and participants are encouraged to apply their learning within the working environment.

Between each module Modified "awareness of patient safety" and "attitudes to team working" questionnaires were distributed within the department along with post-course questionnaires to candidates completing the course.

Using a Likert scale (1=poor, 5=excellent) the course increased knowledge of non-technical skills (2.6 pre-, 4.4 post-course, $p=0.005$) and their impact on patient safety (3.2 pre-, 4.2 post-course, $p=0.0077$). The course also provided tools to enhance participants confidence (2.8 pre-, 4.0 post-course, $p=0.0003$) and skills (2.6 pre-, 4.2 post-course, $p=0.001$) in non-technical skills within their work environments.

The provision of protected time for teaching across all disciplines within a busy service has been challenging but through this work we have embedded an improved patient safety culture within the team and the practice of all professional groups within our department.

All staff members in our department will ultimately participate in this programme. We aim to extend the programme to a second Cardiothoracic unit in late 2016, with regional expansion through the Northwest School of Surgery in early 2017.

References

1. Wahr JA et al. Patient safety in the Cardiac Operating Room: Human Factors and Teamwork: A Scientific statement from the American Heart Association. *Circulation*. 2013;128:1139-1169
2. Colla JB et al. Measuring patient safety climate: A review of Surveys. *Qual Saf Healthcare* 2005;14:364-366

G Hardman

ST4 Cardiothoracic Surgery, Health Education Northwest

AH Walker

Consultant Cardiac Surgeon, Lancashire Cardiac Centre, Blackpool Victoria Hospital

3rd National Cardiothoracic Surgery Careers Day London 2016

ST1 application means decisions are better made in medical school

ST1 selection was recently introduced for cardiothoracic surgery. The first batch of successful applicants is still early in training. Limited training spots at both ST1 and ST3 and the stringent selection process make it important for aspiring students to express interest and build their competitiveness for their chosen specialty earlier than before. This is the situation in many other countries.

In the current medical curricula, exposure to cardiothoracic surgery is often scarce. There is also some negativity about career opportunities. Basic suturing techniques and surgical skills are sidelined and are not a compulsory part of the academic timetable. Hence, there is a need to offer information, experience and our

positive and innovative culture to medical students elsewhere.

SCTS sees this as an opportunity to nurture students from an early stage by providing access to the specialty and also a framework to help committed students build their portfolio of skills so they can succeed in national selection.

This builds on and is complementary with the work of partners including the RSM, ASIT, student societies and Royal colleges.

The Cardiothoracic Surgery Careers Day

Realising the need to make up for the lack of surgical exposure at the primary medical degree level, Society of Cardiothoracic Surgery (SCTS) Education and team want to inspire the next generation of surgeons who will lead the nation's cardiothoracic service. The National Cardiothoracic Surgery Careers Day serves as a platform for the delegates to get a personal insight into the life as a cardiothoracic surgeon. The delegates hear about the life of a CT surgeon in different subspecialties, getting into the specialty and training. This is combined with skills sessions.

TED - style talk by Steve Large, Cambridge on transplant progress

"It can be very daunting when you get these accomplished people talking to you about their amazing careers as you listen with envy but having them tell you about the road they took to get on top of this 'huge mountain' is so useful and inspiring!" – medical student

This event also serves as a platform for the delegates to clear their doubts on possible barriers that might hinder their career in cardiothoracic surgery. Current issues like women in cardiothoracic surgery are addressed a successful women cardiothoracic consultants themselves.

The first two meetings

Two successful events were hosted in Bristol and Cambridge, in 2014 and 2015 respectively, earning highly positive feedbacks from the participants. Moreover, the events were run by a full committee of medical students. They managed to organise surgical workshops in the afternoon session, which were very popular amongst the delegates as well. The workshops were led by trainees and consultants in cardiothoracic surgery and with the high number of volunteers, many of the delegates were able to obtain personal attention from the tutors.

Last year, the Cambridge team opened their doors to 6th form students. It was a major success and it managed to fulfil the initial dream when the event was first introduced, which is to foster the interests in cardiothoracic surgery. This event will continue to be an outreach event to inspire budding cardiothoracic surgeons in coming years.



Cambridge 2016



Bristol 2014

David Tang Chuk, Barts & London
Jeesoo Choi, Kings
Aman Coonar, SCTS Lead for student engagement

"As a Sixth Form student I found the experience to be extremely valuable and one which I contributed to the success of my application to Medical School. I was able to speak to experienced surgeons, surgical trainees and medical students - all of whom were more than happy to offer me advice with regard to my University application and particularly the interview skills which I would need, in addition to offering me a realistic understanding of what it is like to study and work in the field of Medicine and, more specifically, Cardiothoracics. Furthermore I found being in a room full of like-minded individuals extremely encouraging, while the practical surgical skills sessions simply further fuelled my passion for surgery and my desire to study medicine."
 6th form student

"The workshops are also very hands on, ... we did chest drains on sheep necks and sutured pig aortas together - there are very few opportunities like this out there and I cannot recommend this more for someone who wants to pursue a career in surgery - even if you are not sure, you will get a pretty good insight!"
 medical student 2016

This year, students from Barts and the London School of Medicine

and Dentistry and King's College London will be hosting the 3rd National Cardiothoracic Surgery Careers Day in St Bartholomew's Hospital, in London on the 5th of November 2016.

Save the date - 5.11.16

Widening access to 6th form students

This year, 6th form students will also be given a chance to obtain advice for medical school application, anatomy demonstration using animal models and a tour in the historic Barts Pathology Museum. We have partnered with various schools including those from less affluent areas as we wish to open the doors to cardiothoracic surgery ever wider.

More information on the event can be found on the event website. www.cardiothoraciccareers.co.uk/ and on facebook <https://www.facebook.com/cardiothoracicsurgerycareersday/>

We also run an event at the main SCTS annual meeting and publicise any courses we hear about.



TED style talk - Steve Large



Inovus low cost VATS simulator

Obituary

Professor Geoffrey Smith

11 November 1937 - 24 January 2016



I am sure all members of the society are aware of Geoff's untimely death in January of this year due to metastatic colonic cancer. Speaking on behalf of the family it was a great comfort to see so many colleagues attend the funeral service and I would like to thank members for their many messages.

Geoffrey Harry Smith was born in Derby and educated at Derby Grammar School. He was admitted to medical school at St. Mary's, Paddington qualifying MB.BS with Honours.

As a student he moved from a flat in Hampstead to 'mixed' accommodation at Fellowship House in Holland Park. There he met his wife to be Brenda and so began a long and happy journey together. In 1960, they married in Kensington and soon had three daughters. He later became a proud grandfather of four grandchildren.

He was Senior Registrar at the London Hospital of Diseases of the Chest and moved to Sheffield to further his training and was appointed Consultant in 1969 along side Desmond Taylor and Alan Norman the latter performing mainly thoracic and oesophageal surgery.

Cardiac surgery in the late sixties and seventies was still evolving and Geoff was instrumental in taking the specialty forward in Sheffield and creating a skilled team at the Northern General Hospital. The unit grew and Geoff was a catalyst in the development of the Chesterman Unit amalgamating the service from the Royal Hallamshire Hospital. This unit has now become a major teaching centre for both cardiac and thoracic surgery.

My first emergency operation as a 'Thoracic surgeon' was a ruptured abdominal aortic aneurysm and had to put in a bifurcation graft as cardiothoracic surgeons in those days also did all vascular surgery. Older members will recall the society was called the Society of Thoracic and Cardiovascular surgeons for several years. With his charming smile he also asked if I could help with the cardiac programme! He was a great supporter for thoracic and oesophageal surgical development in Sheffield.

Geoff's achievements were many and his principle interests were in valve surgery, postgraduate education and the delivery of cardiac surgical care with accurate reporting of results. Latterly,



Geoff was particularly impressed with the book 'The Naked Surgeon' by Sam Nashef. This book should be mandatory reading for all surgeons whatever their discipline. Sam Nashef's experience in Sheffield ignited a passion for honest reporting and analysis of patient outcome data.

In collaboration with Sheffield University and the British Heart Foundation, Geoff competed with other centres to have heart transplantation in South Yorkshire.

He was appointed Professor of Cardiac Surgery in 1987 and with the help of Richard Cory Pierce and Gianni Angelini set up a transplant service. I assisted Geoff on the first transplant in Sheffield in October 1989. The patient was a young teacher who had a further 10 years of good quality life. Geoff enjoyed medical politics and Chaired the National advisory group on the reconfiguration of medical specialties in London 1993. There were many news headlines and public outcry about reconfiguration particularly the proposed closure of Harefield. He was on the Education committee for the European Association of Cardiothoracic Surgeons Hospital and through the EACTS made many International friends.

A highlight of his career was when he became President of the SCTS 1992-1994. He was a popular president of the society and at his Presidential address to the society in Bristol there was a standing ovation for his speech on "Investment and Reinvestment" in the specialty. This was well received and a subtle reminder that all senior experienced surgeons should give something back to the specialty and not be seduced by the yellow brick road of private practice. He had a unique talent to motivate, empower and get the best out of his trainees and staff.

After retirement in 1993 he kept active. He was Chief of Cardiac Services in Abu Dhabi. Visiting Professor at Umea, Sweden. Vice Chancellor at the Asian Institute of Medicine in Kedah Malaysia 2009. He also acted as Medical Advisor to the British Council.

At home he was fond of opera particularly Mozart, bread making, wine and golf. He was very fond of his time in Ulverston in the Lake District, was a keen hill walker and many colleagues have witnessed Brenda and Geoff's hospitality there.

There have been many tributes to Geoff since his death and here I quote some of the many comments.

"Always entertaining to talk to"

"Kind and supportive"

"Great trainer"

"Still owes me a fiver"

"Few people influenced me more in my career than Prof Smith"

"Great Mentor"

"Compassion for family life"

"A true professional and family man"

Andrew Thorpe, Leeds

SCTS Education Professional Development Programme

In challenging times it becomes harder to lead and develop services. On top of that, we work in a pressurised and time-consuming specialty. SCTS recognises this and to support our members we have set up a rolling programme of 1-day small group sessions each focussing intensively on a particular topic. Our educational partner is Academyst a leading healthcare management educator. Over a five year period each day will be repeated at least twice. Attendance at these courses will assist with revalidation and also help consultants and senior trainees in their professional roles. Currently these courses are run in central London.

The course benefits from a huge subsidy so that there is only a nominal charge for SCTS members who attend! Non-SCTS members can attend but are charged the full price which is typically £250-300/day.

Feedback from our most recent course: **'Healthcare transformation'**. May 2016. *'Outstanding. Very helpful to discuss with colleagues in our specialty. Eye-opener.'*

Next SCTS courses

Leading Successfully in the Complex Healthcare Environment

13th September 2016

Effective Influencing & Negotiation Skills

4th November 2016

Aman Coonar

SCTS Education lead for professional development

Andrew Vincent

Academyst LLP

New Consultants

<i>Name</i>	<i>Hospital</i>	<i>Starting Date</i>	<i>Specialty</i>
Alan Soo	Galway University Hospitals	May 2016 C	ardiothoracic
Amit Modi	The Royal Sussex County Hospital	August 2016	
David McCormack	Nottingham University Hospital	October 2017	

Other Appointments

<i>Name</i>	<i>Hospital</i>	<i>Starting Date</i>	<i>Specialty</i>
Suvitesh Luthra	Derriford Hospital, Plymouth	August 2015	Locum Consultant Cardiac Surgery
Paul Whitlock	John Radcliffe Hospital, Oxford	December 2015	Locum Consultant Adult Cardiac Surgery
Daniel Robb	Royal Victoria Hospital, Belfast	February 2016	Locum Consultant Adult Cardiac Surgery
Sunil Bhudia	Harefield Hospital, Middx	February 2016	Locum Consultant Cardiac Surgery
Syed Suhail Ahmed Qadri	Castle Hill Hospital, Hull	April 2016	Locum Consultant Thoracic Surgery
Andrew Selvaraj	John Radcliffe Hospital, Oxford	June 2016	Locum Consultant Adult Cardiac Surgery
Selvaraj Shanmuganathan	Nottingham University Hospital	September 2016	Locum Consultant

The 2015 SCTS Ionescu Scholarship for non-NTN doctors

Vivek Srivastava

The 'SCTS Ionescu scholarship' for non-NTN doctors was introduced by the Society for Cardiothoracic Surgery in 2015. The application process required a CV, two references and a plan. There was no restriction on how the funding could be utilised but this also made it more difficult as there was no precedent. I have a developing interest in minimally invasive cardiac surgery (MICS) and therefore, following discussions with my mentors/referees, I proposed to use the funding as a 'travelling fellowship'. The main aim was to improve my understanding of the variety of these procedures especially mitral valve surgery and also the functioning of some of the large centres providing these as a routine. Broadly, my proposal included a course on MICS and three separate observerships with eminent surgeons at centres of excellence.

1. Re-Evolution Summit - course on MICS. It is organised by the Methodist Hospital, Houston, Texas, USA at their Methodist Institute for Technology, Innovation & Education (MITIE), a fantastic facility for training through simulation. It included training on all varieties of MICS and robotic procedures including CABGs, aortic valve procedures and mitral valve procedures through didactic teaching and demonstrations on cadavers and simulators. The faculty included prominent surgeons from all over USA and it was a delight first-assisting experts with the entire range of procedures covered over three days.
2. The first observership aimed at minimally invasive mitral surgery was with Prof. Jean-François Obadia at Hopital Louis Pradel at Lyon, France. The application/ approval process was simple - an email to him requesting the observership and a prompt welcoming reply from him. The four days there were spent learning valuable tips from Prof. Obadia and watching him perform the procedure with amazing slickness. He made sure I gained as best from my time there as possible - so I also watched some fantastic off-pump CABGs (Prof. Farhat) and valve sparing root replacement (Dr. Robin).
3. The next leg was a week-long trip to the Leipzig Heart Centre, Germany. Leipzig Heart Centre is, of course, well known for introducing several new minimally invasive techniques in cardiac surgery under the leadership of Dr. Friedrich Mohr. The centre has visitors throughout the year and I was warned it could be difficult finding suitable space. Luckily for me, I could find a slot which allowed me to follow up the observership with the 'Latest techniques in Cardiac Surgery' meeting (famously organised by Prof. Mohr and Dr. Michael Mack of USA). The department is fully geared to receive observers, even providing on-site accommodation and discounted meals. It is a huge centre - nine theatres spread over two floors and constantly at work. Over five days, I saw several minimally invasive operations - AVRs, MV repairs, CABGs (including MIDCABs and multivessel grafting through

thoracotomy) as well as routine cases. It was impressive that such a large facility functioned so smoothly, but then it's all been routine to them for several years now.

4. The last project was the visit to Mount Sinai Hospital, New York. This did require some advance planning and organisation - from finding an appropriate time-slot to completing a significant amount of paperwork. I needed immunity tests and supplemental immunisations and one extra on-site day solely for security clearance and training on various policies. But once cleared to visit theatres, it was just a treat observing Dr. Adams operating, making it all worth it. His is a mitral valve reference centre with repair rates of 99%! Over 4 days, I saw a glimpse of why - three simultaneous theatres with diverse MV pathologies repaired with a variety of techniques including redo repairs and not one replacement.

Overall it has been a busy year juggling schedules to fit travel plans into work commitments. But it has been a thoroughly enriching and rewarding experience. I have gained a deeper understanding of surgical procedures and have also learnt to some extent how large centres function and how smaller individual-led practices can deliver superior outcomes based purely on a commitment to excellence. I have met and seen some brilliant surgeons at work and it has been an inspirational journey.

This initiative of the SCTS in recognising the contribution of non-NTN doctors is a very refreshing and welcome move and I am grateful to Mr. Marian Ionescu and the 'Society' for instituting this scholarship. I will remain indebted to my mentors and referees who supported me for the scholarship and to the Society tutors who judged me worthy of this opportunity. And finally, through this forum, I would encourage all non-NTNs to take advantage of the scholarship for furthering their professional development and growth.

Vivek Srivastava, Clinical Fellow, Department of Cardiothoracic Surgery, The James Cook University Hospital Middlesbrough, U.K.



Obituary

Iain Mackay Breckenridge

26 March 1934 - 23 January 2016

It is about 18 years since Iain retired from cardiac surgery after an extremely successful consultant career spanning some 25 years working his entire consultant life at the University Hospital of Wales (UHW), doing "missionary work" as he put it away from his native and beloved Scotland.

Iain had an unorthodox entry into the cardiac surgical world. Originally at the Hammersmith Hospital in the 1960's Iain was a cardiology trainee. He became involved with the cardiac surgical programme through his involvement in running the heart-lung machine and almost accidentally became involved with the cardiac surgical programme developed by Professor Hugh Bentall at the Hammersmith. Iain went on to train at the Brompton Hospital and Great Ormond Street working with Jarda Stark and many of the leading figures in UK cardiac surgery of the time. It was during this period that Iain met his beloved late wife Elizabeth working as a nurse.

At the end of his training, Iain undertook what was something of a pilgrimage to undertake a fellowship in Birmingham, Alabama with John Kirklin. At the time Birmingham was the leading centre in the world for cardiac surgery and in particular for paediatric cardiac surgery and many outstanding surgeons from that era worked or spent time with John Kirklin. After a successful fellowship Iain was appointed Consultant Cardiac surgeon at the UHW in about 1972. At the time he was one of the first fully trained truly modern cardiac surgeons ushering in the modern era. With cardiologists like LG Davis he immediately set about developing a programme of paediatric cardiac surgery and performed some of the first complex repairs in infants

in Wales. This was challenging and demanding work and set the scene for Iain's intense focus and commitment to clinical work and the best interests of his patients.

The 1970's and 1980's were periods of massive expansions in adult cardiac surgery with the development of coronary artery surgery. Iain working with his long time consultant partner Eric Butchart set about expanding both the activity and the scope of cardiac surgery at the University Hospital of Wales. They developed effective programmes of coronary artery surgery and prosthetic valve replacement eventually reporting on one of the largest series of Medtronic-Hall valves in the world.

Iain was an outstanding doctor, academic heart surgeon and senior colleague. He was meticulous in assessing patients for surgery. He was a careful and extremely effective surgeon. His methodical and systematic approach was hugely beneficial to trainee surgeons and he was extremely popular with his trainees. He cared for his patients any time of the day or night on the intensive care unit and this was the time before full time intensive care specialists when the surgeons had a major role in the care of their patients. He was keen to adopt new techniques and when colleagues had been away to learn new techniques he was always eager to see these integrated into his practice. Iain was never afraid to support his registrar or senior registrar to undertake new procedures with him if he had confidence in the individual.

Although on occasions a fearsome figure Iain was loved by nurses, and trainee surgeons alike. He always supported his team and was generous in his praise when things went well. Iain was also very committed in his support in the



development of young surgeons both in terms of their practical development but also supporting their research. In addition, his wide circle of professional contacts meant he was able to send his trainees to successful careers elsewhere in the UK and across the world.

Every one of these surgeons will have fond memories of working with Iain, excellent clinical training, lots of abuse, a rich vein of professional stories, some sad stories but mainly professional success and a fondness and respect for Iain. Iain loved a drink whether beer, wine or malt whisky, always entertaining and hospitable.

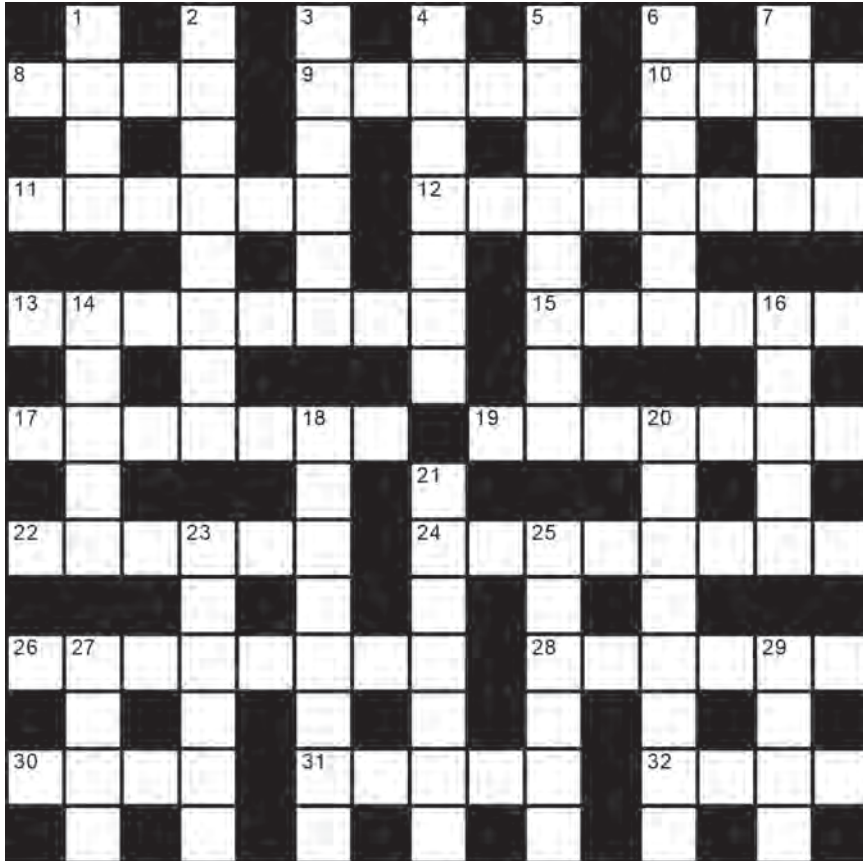
Even in retirement Iain maintained his links with colleagues at UHW and colleagues were delighted to welcome him as an honoured guest to the inaugural meeting of the Welsh Cardiothoracic Society in the Vale of Glamorgan as recently as November last year.

Iain was predeceased by his wife Elizabeth in 2007 and leaves 5 children and 9 grandchildren. Iain died in UHW, the hospital where he had spent his whole consultant career, after a short illness.

**Alan Bryan
Indu Deglurkar**

The Crossword

Samer Nashef



Send your solution by 31 December 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

- 8 Musical creatures (4)
9 Arouse woman to secure consent (5)
10 Return of number 1 lord (head, of 17?) and one of the big 8 (4)
11 B14 like 32 (6)
12 Most perverse family that is in Grand Street (8)
13 Only bit I represented is the aristocracy (8)
15 Like 7 in African inefficiency (6)
17 Dig monk out of this country, say (7)
19 Like 1,9 like 4 (7)
22 The Spanish in penalty like 8 (6)
24 Broadcast secure, without loopholes (8)
26 How his personality welcomes rumours (8)
28 Pennies evolve (6)
30 They are quiet in church, our fellow planners (4)
31 They are easily led in quiet backwater (5)
32 Stock bullies (4)

Down

- 1 Dressing from the county clinic (4)
2 Hoping for drug note (8)
3 The old blokes and one Arab (6)
4 Their (y)ears are long (7)
5 Yet their collars may be blue! (8)
6 No bail out for this country (6)
7 Follows setters, perhaps (4)
14 Love grape bearer, like 31 (5)
16 Final life for 8: the next one (5)
18 Eggs may be too simple (4,4)
20 Pest annoys us and 15 (8)
21 Dutch Amsterdam's pet (7)
23 Cell groups topped the subjects under discussion (6)
25 Ready essential cooking instruction providing excellent easy starters (6)
27 Welcome precipitation (4)
29 Garment that's good to have (4)

A guide based on experience – by surgeons, nurses *and* patients

Having heart surgery?

Learn more >

Nervous? Anxious? Uncertain? A little bit squeamish?
Here you will find out as much as you want to know.
Put yourself at ease knowing you are in good hands.

Surgery options for your heart condition

Want to know more ?

Seeing your surgeon

Want to know more ?

Preparing for surgery

Want to know more ?

The day of your operation

Want to know more ?

The first three days after surgery

Want to know more ?

Side-effects and complications

Want to know more ?

Going home after surgery and continuing your recovery

Want to know more ?

Cardiac rehabilitation programme

Want to know more ?

Visit

www.scts.org/patients/having_heart_surgery



Society for Cardiothoracic Surgery in Great Britain and Ireland

This information has been created by Bupa and the Society for Cardiothoracic Surgery. It is designed to provide you, your family and carers with the information you need at each stage of heart surgery, from your initial appointment with your surgeon all the way through to recovery.



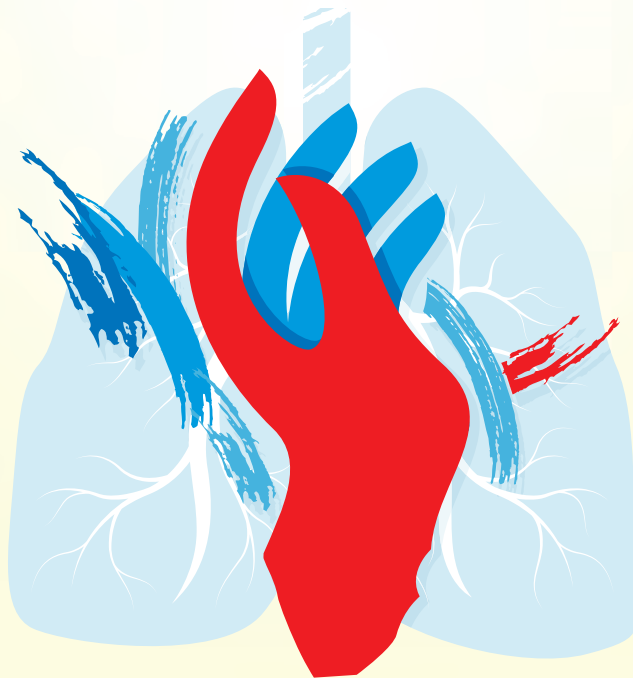
Cape Town, South Africa



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

