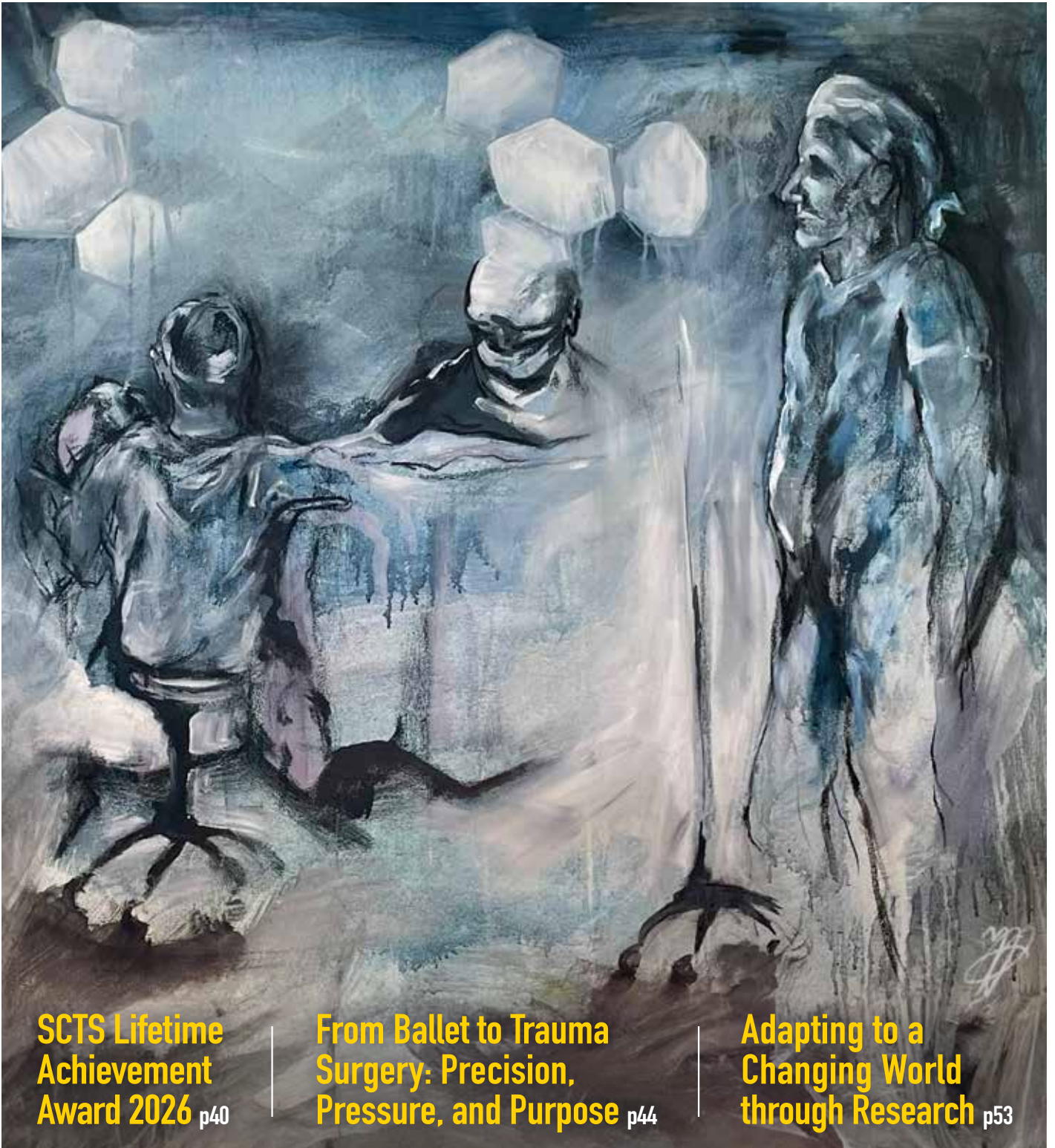




Issue 20
August 2026

the *bulletin*

*Society for Cardiothoracic Surgery
in Great Britain and Ireland*



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Award 2026** p40

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in Great Britain and Ireland*

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On the cover ...

Yuvraj Juttla is a medical student at University College London and aspiring Cardiothoracic Surgeon with parallel interests in fine art and installations, particularly in exploring the intersection between art and surgery. The cover piece (created using acrylics and compressed charcoal) explores the luminosity and intensity of the operating theatre, capturing the quiet chaos and concentration of the surgical environment.

Whilst every effort is made to ensure the accuracy of the advice given, we cannot accept liability for loss or damage arising from the information supplied. We wish to emphasise that the opinions expressed are the responsibility of the individual contributors, and are not necessarily the views of the Society.

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Find out more using the QR codes above. Together, we can ride further, achieve more, and make a lasting difference.



From the Editor

Dionisios Stavroulias, Publishing Secretary, SCTS



Writing an editorial in the middle of my holiday by the sea is both a challenge and a blessing.

I apologise in advance for any mistakes or omissions. It is never easy to capture the essence of each article without becoming too lengthy. For this edition, the task is accompanied by the delightful distraction of watching my daughter play along the shoreline.

At a time when wars, political instability, and uncertainty dominate headlines, both abroad and at home, it is difficult to write about cardiothoracic surgery without acknowledging the wider context in which we practise. Medicine does not exist in isolation; the pressures affecting society inevitably shape healthcare systems and the care we deliver.

NHS waiting lists remain extensive, with ongoing shortages of staff, beds, theatre capacity, and ageing infrastructure limiting the system's ability to meet demand. Nearly 100,000 patients are still waiting over a year for treatment. These challenges are familiar in cardiothoracic surgery, where timely delivery of complex care depends on our ever stretched resources.

I found myself reading the late David Hockney's work, *Secret Knowledge: Rediscovering the Lost Techniques of the Old Masters*. In it, he suggests that Renaissance artists may have used optical devices such as the camera obscura and camera lucida to achieve their extraordinary realism. His point is compelling: great advances depend not only on talent, but also on the tools available to realise them.

The same is true in modern surgery. Excellence depends not only on surgeons and multidisciplinary teams, but also on infrastructure, equipment, and investment. The challenge for our specialty is therefore not simply one of effort or reform, but whether we possess the tools required to meet patient need.

In "The Future We Choose," Aman Coonar presents the achievements of the Society for Cardiothoracic Surgery (SCTS), emphasising the importance of collaboration, mentorship, and a strong organisational culture in driving success. Drawing on experiences from the SCTS Annual Meeting and the Toronto General Hospital Thoracic Surgery Refresher Course, he highlights how inspiring teachers and supportive environments can shape careers and improve patient care. Like Hockney's embrace of new artistic technologies, Coonar argues that cardiothoracic surgery must adapt to

rapid technological advances, including artificial intelligence, robotics, and novel implants, while ensuring that healthcare systems can evaluate and adopt these innovations efficiently.

Under the leadership of Co-Chairs Karen Redmond, Doug West, and now Rory Beattie, the Thoracic Subcommittee has continued to make progress across research, service development, and national collaboration. Babu Naidu led the Thoracic Priority Setting Partnership which published the key research priorities in March. The National Pectus MDT has now reviewed over 700 patients. Nathan Burnside, Kandadai Rammohan, and Josh Lodhia have enhanced national thoracic data collection, including the re-launch of a national database in conjunction with Epic. The subcommittee has also contributed to national guidance on rib fracture management and thoracic endometriosis pathways.

From the Adult Cardiac Surgery Specialty Committee, the most striking development for me was the work on acute aortic emergencies. Dr Dawn Adamson is leading a second aortic dissection toolkit in partnership with multiple societies, expanding its remit from Type A to include Type B dissection and the broader management of aortic disease. Marcus Brooks and Collin Bicknell have proposed a National Confidential Enquiry into Patient Outcome and Death review of acute non-traumatic aortic emergencies, including ruptured aneurysms and acute dissection, building on work involving the Vascular Society, the Royal College of Emergency Medicine, and the Association of Cardiothoracic Anaesthesia and Critical Care. The focus is on improving diagnosis, referral pathways, patient transfer, and access to specialist multidisciplinary care. I find the close integration of vascular and cardiothoracic expertise truly reflects that the best outcomes are achieved through collaborative care.

Ali Ansarpour and Mohamed Sherif's report on behalf of the National Cardiothoracic Surgery Trainee Committee emphasises trainee engagement across scientific sessions, workshops, and wet labs at the 2026 SCTS Annual Meeting in Belfast. The SCTS-NTCCTS Training Excellence Awards received 51 nominations recognising outstanding trainers. Trainees were also well represented at ASiT, with numerous abstracts, national prizes, and an Introduction to Cardiothoracic Surgery course. This sustained enthusiasm is such good news for the future of our specialty!

The Trust Appointed Doctors (TADs) report showcased new awards recognising departmental support and individual excellence. In thoracic surgery, the award went to the University Hospital of Wales, and in cardiac surgery to Plymouth Hospital, emphasising the importance of supportive training environments and the contribution of TADs across the UK.

Finally, the impressive article by Lauren Dixon, National Lung Cancer Audit Clinical Research Fellow, demonstrated encouraging improvements in lung cancer care across England and Wales. There has been an increase in diagnosis at an early stage, a rise in the percentage of patients eligible for curative surgery and the highest national average resection rate to date at 22%. However, variation between providers still exists, as does mounting pressure on surgical capacity and waiting times. Ensuring timely and equitable access to surgery remains a key challenge. Nevertheless, these promising figures are the cumulative efforts of clinicians, researchers, screening programmes, and multidisciplinary teams over many years.

Since March, I have been reading a remarkable philosophical work, *The Game of the World* by Kostas Axelos. Often regarded as his magnum opus, the book presents the world not as a fixed system but as an open, dynamic "game" in which human beings, technology, history, nature, and thought are all participants. As I ponder upon the many developments across our specialty this year – from advances in artificial intelligence and robotics to improvements in patient pathways and multidisciplinary collaboration – I have found Axelos' perspective becoming ever more relevant. The future of cardiothoracic surgery will not be shaped by any single innovation or individual, but by how we engage with a complex and interconnected world, adapting, learning, and working together to refine care for our patients.

There are many other interesting articles and reports in this edition, including personal reflections from our members, and I hope you will enjoy reading them.

As I often say, the year truly starts in September; please make time to rest over the summer, even if only briefly. Stay positive, read a good book, and I look forward to seeing you in the new academic year at the BORS meeting.

Please send any comments to my email:
dionisios.stavroulias@ouh.nhs.uk ■



Save
the
Date

SCTS Annual Meeting 2027

21-23 March

Registration Opens 1st December



ICC Birmingham
scts.org

ICC
Birmingham

From the President The Future We Choose

Aman Coonar, SCTS President, Consultant Thoracic Surgeon, Royal Papworth Hospital, Cambridge



I want to start by thanking all those who have contributed their time, energy and efforts to the work of SCTS. The highlight was the very successful Annual Meeting in Belfast, as well as the progress we are making across our four clinical areas because of the work of our revitalised committees, members and collaborators. Those projects are discussed by their committee leads later in this Bulletin.

As I write this, I am returning from a whirlwind trip to participate in the *50th Toronto General Hospital Thoracic Surgery Refresher Course*. It was a great honour to represent SCTS and, as a former fellow and graduate of their programme in lung transplant and thoracic surgery, it was humbling to share the podium with former teachers. Meeting the current Programme Director, I was also immensely touched when she reminded me that as a medical student she had accompanied me on her first donor lung retrieval, and that experience was one of the factors that inspired her to become a thoracic and lung transplant surgeon!

For me, a pivotal moment was when as a cardiology SHO, the late Pat Magee, a warmly remembered past President of SCTS, invited me to his theatre and talked me through the steps of the surgery as it happened. The memorable words, “Go on bypass”, and watching the blood drain out and return, had an impact that was career-realigning. Taking time for our students matters; sometimes more than we realise.

The course’s academic content and setting were outstanding. Watching the Canadian World Cup football squad go by the hotel, by chance, was a bonus. The course was a combination of pragmatic guidance with cutting-edge

surgery viewed through a critical scientific lens. The culture of humanity, operative excellence, developing individuals and the team, and scientific rigour continues to inspire me. When units have such a culture, remarkable things can happen through collective and collaborative effort.

That approach informs many of my values, and when I do not see it, I am surprised. When units succeed, it is because they do things together, share responsibility and think about the longer term. When they do not, it is human factors that often explain some of the problem.

Moving back to SCTS, the Honorary Secretary’s article mentions how our secretariat has been strengthened. I want to highlight that our voluntary business coach has been a very successful addition, and we are now transitioning that role into a voluntary Chief Operating Officer position. The willingness of people to give their time to support SCTS speaks volumes about the goodwill that exists towards our Society and work.

That same principle underlies **Friends of SCTS**, which we will be developing further over the coming months. As surgeons, we spend our careers looking after patients, but we do not always hear enough from them once their treatment is complete. Friends of SCTS aims to bring patients, families and supporters closer to the Society. Their experiences can help us better understand our impact and can help amplify our voice and mission in an increasingly busy healthcare landscape.

This is a hugely transformational time in human history. As we enter this next phase of technological change, we must find ways to adapt, evaluate and improve new technologies rapidly and iteratively.

The pace of change is such that older methodologies of evaluation will be overwhelmed if traditional approaches alone are relied upon.

For example, we need to be using AI daily to augment our various activities. As I have said before **‘AI will not replace doctors, but doctors who use AI will replace those who do not’**.

To enable this, and other technological advances such as novel implants, robotics and precision medicine, we must ensure that the whole care pathway is fit for purpose. Funding for technologies that improve patient experience and outcomes will come through improved efficiency, shorter lengths of stay and faster recovery.

Much of that will come from a focus on prehabilitation and enhanced recovery. Work in these areas is teaching us about the holistic and system factors that improve outcomes, particularly the steps we can take to reverse sarcopenia and frailty.

As cardiothoracic surgery increasingly becomes a specialty of repeat short-stay precision procedures combined with longer-term care, with redo surgery becoming more common, it will become increasingly important for us to advocate for and insist on the processes that help our patients recover faster, stay fitter for longer and thereby reducing ITU and hospital stay. We need to guide the administration to direct the resources accordingly.

Then we can justify the expense of innovation and new technology by appropriately **reducing the money cost of the high-quality years added**.

On that note, I hope to see many of you participating in the **SCTS London to Brighton bike ride** on the 13th September 2026 (use our dedicated booking link at www.scts.org). ■

Honorary Secretary's Report

Doug West, Consultant Thoracic Surgeon, Bristol Royal Infirmary



This summer marks the end of my first year as Honorary Secretary. We have seen many significant changes in our professional and secretariat teams since then, and I already feel like an old hand.

Mark Jones has come to the end of a very successful term as Treasurer. He brought order to our finances and dealt with a significant issue with our restricted funds. Karen Redmond has now taken over after a handover period, bringing new insights from her experience with the Irish Thoracic Society.

Sunil Bhudia has moved on from Meetings Secretary, delivering an excellent Belfast meeting at the end of his tenure. Carol Tan has now taken over. Lastly, Sri Rathinam is coming to the end of his

term as Communications Secretary and will be handing over to former Bulletin Editor Indu Deglurkar. Sri has done an enormous amount for the Society and deserves our gratitude.

We've also seen new leaders in all the clinical subcommittees, with Hari Doshi in adult cardiac surgery, Rory Beattie in thoracic, Atillio Lotto in congenital cardiac and Stephan Scheuler at transplantation. The need for clinical transformation across cardiothoracic surgery is clear, and we have a strong new team to deliver this now. It was also good to see a broad geographical spread of new appointments from across the UK nations and in the Republic of Ireland.

Trustees are vital to the governance of the Society. Congratulations to

Shyam Kolvekar, Adrian Marchbank and Maninder Kalkat who have recently been elected as new trustees.

In the secretariat, we have created a new role of finance coordinator and were fortunate to appoint Sophie Khan. This has allowed us to be more proactive with our financial controls, to work more effectively with our external auditors and take better charge of our finances. We've also welcomed Nadia Little in as Society Administrator while Emma Piotrowski is on maternity leave. John Cowx has been with us as voluntary business coach now for several months and is helping us to further modernise our administration.

The Board of Representatives Meeting will be held on Friday 25th September, at the De Vere Grand Connaught Rooms in London. We had a very productive meeting last year with speakers including Col. Nigel Tye from the Ministry of Defence. If you are a unit representative I hope that you can join us in September.

Lastly, we've been looking at how the executive functions. Recent years have seen a large expansion in our subcommittees. This has brought real expertise from our members into the Society and allowed many members a chance to serve. It does create a challenge at the Executive to ensure that there is enough time for discussion. We are trialling a new format of longer sessions in the morning to focus on some topics in depth, with shorter presentations to give all subcommittees a chance to report in the afternoon. This allows time for a trustees meeting, recognising the central role of the trustees in our governance and decision making. If you are a subcommittee chair, please submit your written reports in a fortnight before so that colleagues can read them beforehand; it really helps.

Thank you all for your hard work for our Society. I look forward to seeing many of you at the executive and trustees' meetings in London in October. ■



“The need for clinical transformation across cardiothoracic surgery is clear, and we have a strong new team to deliver this now. It was also good to see a broad geographical spread of new appointments from across the UK nations and in the Republic of Ireland.”

Stewardship, Sustainability, and Purpose: Reflections from the Treasurer

**Karen Redmond, Honorary Treasurer, Consultant Thoracic Surgeon,
The Mater Hospital, Dublin**

Sophie Khan, Finance Coordinator, SCTS



As Treasurer of the Society for Cardiothoracic Surgery in Great Britain and Ireland, I have quickly come to appreciate that financial stewardship within a professional non-profit organisation is both rewarding and challenging. The role extends far beyond reconciling accounts and overseeing budgets. It involves ensuring that the Society remains financially sustainable, professionally independent, compliant with the expectations of the Charity Commission's guidance, SORP reporting requirements and wider governance obligations while remaining firmly aligned with its charitable mission of advancing education, supporting research, patient advocacy, and serving its members.

One of the greatest misconceptions about charities and professional societies is that "not-for-profit" means "without financial pressure." In reality, sustainability is essential. Like many organisations, we face increasing operational costs, growing regulatory expectations, and the need to continue delivering high-quality educational meetings, trainee opportunities, digital resources, and support for our members.

A particular challenge for all charities is the balance between restricted and unrestricted funds. Restricted funds – often linked to fellowships, research grants, or educational projects – are critically important and usually easier to secure because donors understandably wish to support visible initiatives.

Whilst grants and donations tied to specific projects are always appreciated, unrestricted funds are vital and give us the freedom to support the infrastructure and day-to-day running of the Society. This financial security helps fund governance, compliance, communications and digital platforms, while also enabling us to respond where the need is greatest. It allows us to plan with greater confidence, invest in new opportunities and remain resilient in more challenging periods.

By continuing to strengthen this type of income through fundraising, partnerships and regular supporter engagement, we can help ensure the Society remains sustainable, flexible and able to make a greater difference.

Our annual meeting also remains tremendously important, not only scientifically and educationally, but financially and professionally. It creates opportunities for collaboration, trainee engagement, networking and partnerships while reinforcing the identity and visibility of our specialty. From a financial perspective the annual meeting also provides an important source of income, through registrations, sponsorship and industry support, helping to strengthen the Society's unrestricted funds and support its wider educational, professional and operational activities throughout the year.

Without these strong operational foundations, it becomes difficult to deliver the educational and professional activities that define the Society.

This means we must continue to think creatively about sustainable income streams that remain fully aligned with the values and branding of the Society. Educational activities offer one of the strongest opportunities. Conferences, webinars, simulation training, online educational resources, and collaborative programmes can simultaneously support our members, improve patient care, and contribute to the Society's long-term sustainability.

Alongside this, I would like to sincerely thank our sponsors and industry partners for their continued support of the Society and its activities. Their contributions help make possible many of the educational initiatives, trainee opportunities, and patient-focused projects that we deliver throughout the year. These partnerships must always remain transparent, ethical, and aligned with our professional standards, as they are an integral part of supporting the work of the Society.

There are also opportunities for members themselves to contribute directly to the future sustainability of the Society. I would encourage colleagues to support and share the Friends of SCTS fundraising campaign and donation pages:

scts.org/patients/donate.aspx

www.justgiving.com/charity/s-c-t-s

Even modest contributions, when shared widely amongst colleagues, friends, and supporters, can make a meaningful difference in supporting the broader charitable and educational work of the Society.

Following great success last year, I would also encourage participation in this year's London to Brighton Bike Ride fundraiser on 13th September. It is a fantastic opportunity to support the Society, raise valuable unrestricted funds and come together as a community:

scts.org/london_to_brighton_cycle Ride.aspx

Events such as this not only raise valuable funds, they also strengthen collegiality, wellbeing, and engagement across the Society. They remind us that supporting our profession can also be enjoyable, visible, and community-focused.

Taking on the role of Treasurer has given me a new appreciation of the complexities involved in leading and sustaining a modern professional society. It is both a privilege and a responsibility to help ensure that the Society remains financially secure while continuing to evolve and grow. I am enormously grateful to colleagues, members, sponsors, and volunteers whose ongoing commitment makes this possible. With continued engagement, innovation, and shared purpose, I am confident that we can continue to strengthen the Society and support future generations of cardiothoracic surgeons – and ultimately the patients we serve. ■

SCTS Meetings Report

Transformation in Cardiothoracic Surgery

**Sunil Bhudia, SCTS Meeting Secretary, Consultant Cardiac Surgeon,
University Hospitals Birmingham NHS Foundation Trust**

Rosalie Magboo, SCTS Associate NAHP Lead, St Bartholomews Hospital, London



The SCTS Annual Meeting 2026 returned to Belfast, hosted at the International Conference Centre from 15th to 17th March. Straddling both Mother's Day and St Patrick's Day, the meeting carried a distinctive energy from start to finish, welcoming over 1,200 attendees across the three days. Most delegates attended the full programme, with others taking advantage of single- and two-day registration options.

University Day

In keeping with previous years, the Sunday University Day drew strong attendance, with lecture-based sessions delivered by national and international experts generating lively and substantive debate. Operative technique demonstrations were equally well received.

The NAHP University achieved a record number of delegates, with sessions covering Building a Culture of Evidence-

Based Care, Crafting Better Researchers, Innovations Reshaping Thoracic Surgery, and Multidisciplinary Team Involvement in Cardiothoracic Surgery. Medical students with aspirations in cardiothoracic surgery heard first-hand accounts of life as a thoracic surgeon, cardiac surgeon, congenital cardiac surgeon, and trainee. They had the opportunity to submit high-quality abstracts for the Pat Magee Prize, pose questions directly to experts, and attend wet-lab sessions, which proved particularly popular.

The Thoracic Surgery University addressed the Management of Early-Stage and Locally Advanced Non-Small Cell Lung Cancer, Surgery on the Thymus Gland, and Chest Wall Conditions. The Cardiac Surgery University Day covered Aortic Dissection, Mitral Valve, and Coronary Revascularisation, alongside well-attended sessions on Minimally Invasive and Robot-Assisted Cardiac Surgery. For the first time,

a dedicated session on Challenges in Tricuspid Valve was introduced, and the perennially popular session on Mechanical Cardiac Support and Cardiothoracic Surgery again drew strong interest.

The focused wet lab programme for trainees, introduced at last year's University Day, was significantly expanded this year, with growing support from consultants, trainees, and industry. Trainees practised coronary artery bypass grafting, aortic valve procedures, and the highly popular heart and lung transplantation wet lab. The NAHP wet lab and dry lab sessions ran across the day, with the dry labs proving especially popular. Industry partners also ran their own wet lab sessions across multiple days of the meeting.

Industry and Society Collaboration

The Meeting Team extends sincere gratitude to all industry partners for their continued

support. This year the number of sponsored lunchbox sessions was deliberately limited to four, each offering strong educational content and well-attended by delegates. The exhibition hall, though slightly more compact than at some previous venues, was fully supported by partners, providing excellent opportunities for networking and engagement. New catering arrangements were introduced to improve efficiency, and provision was made for colleagues observing the holy month of Ramadan.

Collaboration with partner societies continued to strengthen. Representatives from the European Association for Cardiothoracic Surgery attended with a presence in the exhibition hall, with a reciprocal arrangement planned for their next



annual meeting. A similar agreement is in place with the American Association for Thoracic Surgery. CTSNet, a long-standing collaborator, will again showcase selected University Day lectures on their platform and promote the meeting to the wider international cardiothoracic community.

Presidential Plenary and Afternoon Session

Monday 16th March opened with the Presidential Plenary, beginning with President Aman Coonar setting out his vision for the SCTS. This was followed by Emile Bacha, President of the AATS, speaking on the future of education, and Pierre Emmanuel Falcoz, President of the European Society for Thoracic Surgery, addressing quality in modern lung cancer surgery. Past President Simon Kendall then introduced the Lifetime Achievement Award, presented this year to Professor Sir Bruce Keogh – a moment that was met with a well-deserved standing ovation.

The afternoon plenary, themed around Transformation, was one of the highlights of the meeting. Kamran Abbasi, Editor in Chief of the BMJ Group, explored transformation in science and data. Muhammad Mohiuddin, Director of the Xenotransplantation Programme at the University of Maryland, delivered the Heart Research UK Lecture on transformation in cardiac surgery. Jean Colombel of Dassault Systèmes offered a compelling look at virtual twins for precision medicine. The session concluded with Enoch Akowuah introducing the five centres selected in the first wave of the Minimally Invasive Cardiac Surgery and Enhanced Recovery Programme. Liverpool, St Bartholomew's, South Tees, Bristol, and Royal Brompton Teams, presented their vision for driving the programme forward.

Parallel Sessions and Research Focus

The congenital programme ran as a parallel session on Monday, with Professor Emile Bacha featuring prominently, and included discussion of joint research projects. The NAHP parallel sessions focused on MDT collaboration and quality improvement, with an innovative international session on Digital Technology – The Good, The Bad, and The Ugly, drawing speakers from the US, Republic of Ireland, and UK in an



interactive format well received by delegates.

Tuesday 17th March featured a particularly strong research focus, with two dedicated sessions: Role of Research in Speciality Sustainability, and a Research Priority Setting Partnership and Hackathon partly organised by medical students. Smaller dedicated meetings also took place across the three days, covering trials including AFFECT and PRV. Abstract-driven sessions and quick-fire moderated poster presentations ran across both Monday and Tuesday, showcasing the best national and international research. Delegates were able to rate presentations through the significantly improved SCTS 2026 App, with prize-winner selections based on a weighted combination of programme committee marks, app reviews, and session chair rankings.

Wellbeing, Networking, and Social Events

Several elements of the meeting reflected a genuine commitment to delegate wellbeing. Women in Cardiothoracic Surgery held their networking event during Monday afternoon's coffee break, and the Equality, Diversity and Inclusion team hosted a well-received session on Tuesday. Pet therapy, which proved a great success at the Edinburgh meeting, was brought back during lunch breaks on both Monday and Tuesday. Sincere thanks

go to Assistance Dogs Northern Ireland, whose volunteers and their dogs provided a genuinely calming and popular presence.

The social highlight of the meeting was undoubtedly the Gala Dinner at the Titanic Museum on Monday evening. Guests explored the world-famous museum before ascending to the dinner venue, where a three-course meal was followed by awards and a spectacular performance from traditional Irish dancers. A night that left a lasting impression.

Looking Ahead

The Meetings Team is keen to hear from consultants on how to make the meeting more attractive and fruitful to increase attendance. We feel that the meeting will be elevated by more consultants attending and marking it as a "FOMO – fear of missing out" event in the calendar.

After a rewarding journey with the Meetings Team, Nisha Bhudia and I conclude our tenure with this meeting. It has been an amazing journey and honour to contribute to the Society. Amit Modi joins as Associate Meetings Secretary and Jean-Paul Evangelista as Associate NAHP Lead.

Save the date

SCTS Annual Meeting 2027
21st–23rd March, ICC Birmingham ■

SCTS EXECUTIVE COMMITTEE

President: Aman Coonar

President-elect: Enoch Akowuah

Honorary Secretary: Douglas West

Honorary Treasurer: Karen Redmond

Communication Secretary: Indu Deglurkar

Lay Representative: Sarah Murray

Trainee Reps.: Mohamed Sherif, Ali Ansarpour

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Meeting Secretary: Carol Tan

Education Sec.: Deborah Harrington, Michael Shackcloth

Nursing & AHP Rep: Amanda Walthew

Perfusion Rep: Gianluca Lucchese, Betsy Evans

Fundraising Co-Leads: Cha Rajakaruna, Giuseppe Aresu

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Thoracic Surgery Co-Chair: Rory Beattie

Congenital Co-Chair: Attilio Lotto

Audit Co-Chair: Uday Trivedi

Research Co-Chairs: Mahmoud Loubani, Babu Naidu

Transplantation Co-Chair: Stephan Schueler

Equality, D & I Co-Chair: Vipin Zamvar

Women in Cardiothoracic Surgery

Co-Chair: Ralitsa Baranowski

SAC Chair: Mark Jones

RCS Council Rep: Rana Sayeed

Exam Board Chair: Elizabeth Belcher

Cardiothoracic Dean: Nizar Asadi

Surgical Tutor: Mahmoud Loubani

SCTS Administration

Mara Banuta

Isabelle Ferner

Sophie Khan

Nadia Little

Tilly Mitchell

Emma Piotrowski

Adult Cardiac Surgery	Thoracic Surgery	Congenital Cardiac Surgery	Transplantation	Audit	Education	Research
Co-Chair: Hari Doshi Executive Co-Chair: Enoch Akowuah Deputy Chair: Giovanni Mariscalco Appointed Members: TBC Audit Leads: Uday Trivedi Education Lead: Deborah Harrington NAHP Representative: Ana Alves Trainee Representative: TBC Co-opted Members: Uday Trivedi (NICOR) Michael Sabetai (UK Aortic Surgery) Peter Bradley (NHS Commissioning)	Co-Chair: Rory Beattie Executive Co-Chair: Douglas West (NCIP/GIRFT) Deputy Co-Chair: TBC Appointed Members: Joel Dunning Gerard Fitzmaurice Leanne Ashrafian Mark Jones Syed Qadri Malgorzata Kornaszewska Nizar Asadi Mathew Thomas Doug West Maninder Kalkat Edward Caruana Audit Leads: Kandadai Rammohan TBC Education: Nathan Burnside Michael Shackcloth NAHP Representative: Hemangi Chavan Trainee Representatives: Jeesoo Choi Joe McLoughlin Co-opted Members: Emma O'Dowd (BTS) George Tsaknis (BTOG) Guillermo Martinez (ACTACC) Aman Coonar (NHSE) Babu Naidu (PSP)	Co-Chair: Attilio Lotto Executive Co-Chair: Aman Coonar Unit Representatives: Tim Jones Natalsha Khan Barnabe Rocha Giuseppe Pelella Branko Mimic Fabrizio De Rita Audit Lead: Serban Stoica Co-Deputy Audit Leads: Phil Botha Branko Mimic Education Lead: Shafi Mussa NAHP Representative: TBC Trainee Representatives: Shubhra Sinha Nabil Hussein	Co-Chair: Stephan Schueler Executive Co-Chair: Aman Coonar Deputy Chair: Karen Redmond Lay Rep: Sarah Murray Appointed Members: Marius Berman Aaron Ranasinghe Asif Shah Vipin Mehta Hari Doshi Espeed Khoshbin Giuseppe Aresu Pradeep Kaul Mohamed Osman Aravinda Page	Co-Chair: Uday Trivedi Executive Co-Chair: Aman Coonar Deputy Audit Lead: Sunil Bhudia Adult Cardiac Surgery Leads: Uday Trivedi Dimitrios Pousios (Deputy) Regional Deputy Adult Cardiac Surgery Leads: Indu Deglurkar (Wales) Zahid Mahmood (Scotland) Alastair Graham (Northern Ireland) Thoracic Surgery Leads: Kandadai Rammohan Nathan Burnside (Deputy) Congenital Cardiac Surgery Lead: Serban Stoica Co-Deputy Audit Leads: Phil Botha Branko Mimic NAHP Representatives: TBC Co-opted Member: Andrew Goodwin (NICOR)	Co-Chairs: Deborah Harrington Michael Shackcloth Executive Co-Chair: Aman Coonar Surgical Tutors: Mahmoud Loubani (Cardiac) Nathan Burnside (Thoracic) Congenital Cardiac Surgery Lead: Shafi Mussa Transplant Surgery Lead: Espeed Khoshbin NAHP Representatives: Kathryn Hewitt TBC National Trainee Representatives: Mohamed Sherif Ali Ansarpour Trainee Representative: Michelle Lee Trust Appointed Doctors Leads: Anas Boulemden (Cardiac) Mohammad Hawari (Thoracic) Student Leads: Jason Ali (Cardiac) Shilajit Ghosh (Thoracic) Accreditation Lead: Shafi Mussa Website Development Lead: Pasan Witharana	Co-Chairs: Mahmoud Loubani Babu Naidu Executive Co-Chair: TBC Adult Cardiac Surgery: Gianluca Lucchese Thoracic Surgery: Babu Naidu Congenital Cardiac Surgery: Attilio Lotto NAHP Representatives: Rosalie Magboo Zainab Khanbhai Hemangi Chavan Nisha Bhudia Trainee Representative: TBC Medical Student Leads: Niraj Kumar Gokul Raj Krishna Co-opted Members: Rana Sayeed (National Cardiac Surgery Trials Prog Steering Comm Rep.) (Cardiothoracic SSL) Babu Naidu Luke Rogers (aSSL) Ricky Vaja (aSSL) Akshay Patel (aSSL) Jacie Law (aSSL) Ann Cheng (aSSL) Brianda Ripoll (aSSL) Moslem Abdelghafar (aSSL) Hind Elhassan (aSSL)

Professional Standards	Meetings	Equality, Diversity & Inclusion	Nursing & Allied Health Professionals (NAHP)	Women in Cardiothoracic Surgery (WICTS)	Communications	Patient Safety Working Group
Co-Chair: Sarah Murray Executive Co-Chair: Indu Deglurkar NAHP Lead: Amanda Walthew Appointed Member: Attilio Lotto Training Trainee Rep (Senior): Mohamed Sherif Trainee Rep (Junior): Ali Ansarpour Education Trainee Rep: Michelle Lee	Meeting Secretary: Carol Tan Executive Co-Chair: Sri Rathinam Deputy Secretary: Gianluca Lucchese Associate Secretary: Amit Modi NAHP Meeting Lead: Rosalie Magboo NAHP Associate Meeting Lead: Jean-Paul Evangelista Conference Organisers: Tilly Mitchell Emma Piotrowski	Co-Chair: Vipin Zamvar Executive Co-Chair: Aman Coonar Appointed Members: Giovanni Mariscalco Nicole Asemota Nikhil Sahdev Jeevan Francis Sathyan Gnanalingham Anoop Sumal	Co-Chair: Amanda Walthew Executive Co-Chair: Sri Rathinam Meeting Leads: Rosalie Magboo John-Paul Evangelista (Associate) Cardiac Lead: Ana Alves Thoracic Lead: Stacey Stockdale Audit Lead: TBC Education Lead: Kathryn Hewitt Pharmacy Lead: Nisha Bhudia Critical Care Lead: Matthew Petty Perfusion Lead: TBC Physiotherapist Lead: TBC Research Leads: TBC Surgical Care Practitioner Lead: ACTSCP President – Nisha Nair	Co-Chair: Ralitsa Baranowski Executive Co-Chair: Aman Coonar Cardiac Surgery Rep. (Scotland): Rashmi Birla Trainee CT Surgery Rep. (Wales): Rhian Allen Trainee CT Surgery Rep. (England): Georgia Layton Trainee Academic CT Surgery Rep: Nicole Asemota Thoracic Surgery Rep: Leanne Ashrafian Research CT Surgery Rep: Laura Clark Core Surgical Trainee Rep: Alice Copperwheat Medical Student Reps: Augusta Paulikaite Heen Shamaz	Co-Chair: Indu Deglurkar Executive Co-Chair: Douglas West Bulletin Editor: Dionisios Stavroulias NAHP Representative: Jeni Palima Consultant Living Text Book Co-Leads: Bilal Kirmani Jeremy Smelt Perfusionist Representative: Lee Clark Education Website Development Lead: TBC Trainee Members: Hanad Ahmed Raisa Bushra Maria Comanici Francesca Gatta Georgia Layton Rohith Govindraj	Co-Chair: Andrew Parry Deputy Chair: Vanessa Rogers Executive Co-Chair: Sri Rathinam Appointed Members: Ismail Vokshi Ruhina Alam Jane Dickson Jody Stafford Branko Mimic Sarah Murray



SCTS Annual Meeting 2027

Call for Abstracts

Abstract Submission

Opens 1st September

Deadline 5th November

Registration

Opens 1st December



ICC Birmingham
21-23 March
scts.org

ICC
Birmingham

SCTS Nurses and Allied Health Professional Update

Amanda Walthew, SCTS NAHP lead, Thoracic nurse consultant, Liverpool Heart and Chest Hospital



It was wonderful to see so many nurses and allied health professionals at our annual meeting this year in Belfast. It emphasised the importance of innovation, collaboration, continuous learning, research, advances in clinical practice and adaptability as essential qualities for modern healthcare. Importantly, it brought us all together nationally, reinforcing that we need teamwork, skilled, knowledgeable NAHP teams who share ideas, encourage and motivate each other; all vital in the drive to achieve high quality patient care and outcomes.

Amazing Achievement – Daisy Sandeman



Daisy is the Advanced Practice Lead at Lothian NHS. She was awarded the inspiring excellence nursing innovation and research award at the Royal College of Scotland Nurse of the Year Awards 2026. Her PhD work on delirium has led to a reduction of incidence from 40% to 18% improving recovery, length of stay and patient experience. She is a valued member of the SCTS NAHP family, and we are so proud of her amazing achievement.

Awards Winners

Rising star Charlotte Bateson, Clinical specialist physiotherapist for cardiac surgery, Glenfield hospital, Leicester. Charlotte has been in post for two years and is a motivated physiotherapist who is a passionate about cardiac surgery. Her leadership skills have had a huge impact on service development and improvement.

Inspirational Star Rebecca Boyles Senior Thoracic Nurse UHL

Rebecca is a Research Nurse who is an Inspiring Role Model and has had a phenomenal impact. She was crucial in us being the largest recruiter for TOPIC-2 trial. She has managed the HARP-2, and MARS trials. She currently supports the RESTORE, SPORT, Fit4Surg, and ERASER. She was also a vital member in Research into the Covid-19 Pandemic.

Innovation – Cardiothoracic Advanced Practitioners; Liverpool Heart and Chest

The ward attender pathway – the management of patients who require short-term follow-up. Rather than extending their inpatient stay, these patients are discharged home earlier with a clear plan for review in an ACP-led ward attender clinic within a safe time frame of two weeks. This reduces patient stay and enhancing support for patients and helps to prevent readmissions.



Thoracic Team of the Year – Thoracic team Middlesbrough



The Thoracic NAHP Team at South Tees has transformed postoperative thoracic surgery care through an innovative Community Thoracic Service and Day-1 Discharge Programme. Led by Advanced Nurse Practitioners and Specialist Thoracic Physiotherapists, the team delivers expert, patient-centred care that safely shifts recovery from hospital to community settings. Their work has reduced length of stay and readmissions, improved patient experience and increased surgical capacity across the region.

Cardiac Team of the Year – Cardiac Surgical Team – Harefield

The team has transformed the elective cardiac surgery admission pathway, delivering one of the highest DOSA rates in the country, with over 90% of elective cardiac surgery patients admitted on the day of surgery. This achievement reflects not a single initiative, but a culture of excellence, flexibility, and continuous improvement embedded across the multidisciplinary team.



The NAHP Advanced Cardiothoracic Education two-day course

Education Update

The NAHP Advanced Cardiothoracic Education two-day course in Derby was specifically designed to support professional development in cardiothoracic care. Bringing together multidisciplinary staff from across the UK, the programme focused on advancing clinical knowledge, sharing best practice, exploring innovation and strengthening collaboration within thoracic and cardiac services to improve patient outcomes and enhance workforce development. NAHP teams from eighteen different hospitals attended with over thirty attendees on both days. A huge thank you must be said to Kathryn Hewitt ACP Birmingham and to Lynn Calvert and the wonderful team at Getinge for their help and support. This will certainly go ahead again early next year.

SCTS NAHP Research and Audit Update May 2026

The SCTS NAHP-Led Research Group is launching a National Ambulatory Chest Drain Audit to develop a standardised care pathway for patients discharged with ambulatory chest drains following lung resection surgery. This national collaborative project will evaluate variation in current practice, improve patient safety, reduce hospital length of stay, and inform SCTS-endorsed best practice guidance.

Participating thoracic centres will be asked to nominate a local lead and submit

retrospective data using a standardised dataset during the audit period. Guidance on methodology, governance, data submission, and timeline will be provided during project setup. The audit is scheduled to commence in August 2026.

We thank the thoracic units that have already expressed interest and look forward to collaborating with colleagues across the UK and Ireland on this important project.

For further information or expressions of interest, please contact SCTS NAHP Research Lead Dr Hemangi Chavan at hemangi.chavan@nhs.net

SCTS Represented at Joint Cardiology and Genomics Conference

Rosalie Magboo and Nisha Bhudia represented the SCTS at the Joint Cardiology and Genomics Conference held in London on 15 May 2026, alongside representatives from 11 other organisations.



SCTS at the Joint Cardiology and Genomics Conference

The event was organised by the South-East Genomics Medicine Service.

The conference aimed to provide foundational knowledge in cardiovascular genomics and explore its practical applications in everyday clinical practice through a case study-based approach. Rosalie and Nisha presented a case study of a Marfan syndrome patient with multiple aortovascular surgery. The programme brought together professionals from across healthcare disciplines to discuss developments in genomics and their growing role in cardiology/cardiac surgery services.

Congratulations

I must congratulate all SCTS NAHP committee members for their amazing work in the strive for excellent patient care and outcomes this year.

If you are a nurse or allied health professional interested in becoming more involved in collaborating with us and educating others nationally, please contact amanda.walthew@lhch.nhs.uk

We have a national WhatsApp group for members to join. This is used for collaboration, advertising events and general updates.

Please encourage your teams to join us. The current fee (NAHP) is a one off £10 admin fee and £30 per annum. ■

SAC Chair Report

Mark Jones, SAC Chair, Consultant Cardiothoracic Surgeon, Royal Victoria Hospital, Belfast



It has been a busy and exciting few months since I became Chair of the Specialty Advisory Committee in Cardiothoracic Surgery. The General Medical Council (GMC) contacted us in February to grant their approval of the update to the Cardiothoracic Surgery Curriculum and the Congenital Cardiac Surgery Curriculum. The implementation date for these revised curricula will be August 2026. I am very thankful to the SAC Trainee Representatives, Mr Sherif and Mr Ansaripour, who welcomed Professor Loubani, Ms Belcher, Mr Tim Jones and me at the Trainee Meeting in March, where we were able to discuss these issues and address questions. In addition, I would like to thank Mr Bhudia and the whole organising committee for the opportunity to deliver an address about the updates to these curricula during the Annual Meeting of the Society for Cardiothoracic Surgery (SCTS) in Belfast. Further details regarding the updates to the curricula are available at <https://www.iscp.ac.uk/iscp/curriculum/cardiothoracic-surgery-curriculum/1-introduction/>.

Recruitment and national selection were overseen this year again by Mr Woolley supported by Mr Roberts and many others including the team at the Wessex deanery. Offers have been made for both ST1 posts and ST4 posts following the national selection process. As published in 2025, the pilot ST4 posts, introduced as a temporary measure a few years ago, is due to end after this recruitment round (<https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/person-specifications/person-specifications-2026/thoracic-surgery-st4-2026>). However, we anticipate expansion at ST1 level consistent with the SCTS-SAC Cardiothoracic Workforce Report 2025 (https://scts.org/_userfiles/pages/files/workforce_report_18032025_44.pdf).

During this year's recruitment process the Medical Training (Prioritisation) Act 2026 was passed. We will continue to review the impact of this new legislation and work with the statutory education bodies to confirm the recruitment process for 2027 supported by our lead dean, Professor Jo Szram.

Quality Assessment is led by Mr Cartwright along with the team at the Joint Committee on Surgical Training (JCST). We have just come to end of the period for completion of the GMC National Training Survey. We would like to thank everyone who has completed this and encourage continued support for this and the JCST Quality survey.

Many will be aware that there is now a waiting list for the specialty fellowship examination in cardiothoracic surgery. The impact on those waiting to sit the examination, as well as on training programmes, needs to be addressed. I have discussed this with Ms Belcher as Chair of the Intercollegiate Specialty Board in Cardiothoracic Surgery and we are also raising it though the JCST. In addition, we are collaborating to ensure that the updated curriculum is appropriately reflected in the Intercollegiate Examination in Cardiothoracic Surgery.

The National Online Training Programme and educational portfolio delivered in conjunction with SCTS is an excellent opportunity. I have enjoyed participating in this programme and meeting trainees at the beginning of their training pathway. I wish them every success as they engage with such educational resources and thank all who help to deliver excellent teaching.

The SAC is keen to enhance the training opportunities within the 7-year cardiothoracic surgery curriculum following appointment at ST1. Mr Stamenkovic and Mr Asadi have been working with me to explore how best to develop Phase 1 of training. For many ST1/2 cardiothoracic doctors in training

it is likely that they will benefit from more than the minimum six months of cardiothoracic surgery in these years, as long as they meet the goals of the core surgery curriculum. These goals should be achieved by completion of ST2.

We are keen to ensure that posts most beneficial to training in cardiothoracic surgery are allocated to these doctors as they prepare for the completion of Phase 1 of cardiothoracic surgical training at the end of ST3. We are exploring how best to conduct the Annual Review of Competence Progression (ARCP) during ST1/2 years of cardiothoracic surgical training. I have been invited to discuss this further at the Confederation of Postgraduate Schools of Surgery (CoPSS).

The Portfolio Pathway allows doctors who have not completed a formal training programme within the UK and Republic of Ireland to demonstrate the knowledge, skills and experience for specialist practice in the UK. The high-level learning outcomes of the curriculum, or Capabilities in Practice (CiPs) are reviewed. Various factors including a greater number of applications, have led us to increase the number of surgeons assessing Portfolio Pathway applications which now includes all SAC liaison members. In view of the update to the Cardiothoracic Surgery Curriculum we are currently reviewing the Specialty Specific Guidance which the GMC will publish to assist those submitting Portfolio Pathway applications.

The SAC values the on-going collaboration with SCTS President Aman Coonar and President-elect Enoch Akowuah, as well as the whole team at SCTS. I would like to thank the members of the SAC for their highly valued work in ensuring continued quality in cardiothoracic surgical training as we continue to work with the other bodies involved in medical education. Further information about membership of the SAC can be found at the JCST <https://www.jcst.org/>. ■

SCTS Education Secretaries Report

**Debbie Harrington, Co-Chair SCTS Education Committee,
Consultant Cardiac Surgeon, Liverpool Heart & Chest Hospital**

**Michael Shackcloth, Co-Chair SCTS Education Committee,
Consultant Thoracic Surgeon, Liverpool Heart & Chest Hospital**

**Nathan Burnside, Thoracic Surgical Tutor,
Consultant Thoracic Surgeon, Nottingham City Hospital**

**Professor Mahmoud Loubani, Cardiac Surgical Tutor,
Consultant Cardiothoracic Surgeon, Castle Hill Hospital, Hull**



SCTS education continues to provide a comprehensive portfolio of courses aligned to the curriculum for all our trainees, allied health care professionals and medical students. The ethos of SCTS Education remains rooted in professional integrity, inclusivity, and a steadfast commitment to training the next generation of cardiothoracic surgeons to the highest standards.

Thanks to all our subcommittee members, course directors, and faculty in all our education streams, who continue to provide excellent training opportunities in an increasingly challenging financial environment.

SCTS Fellowships and Collaborations

The final round of three ACT-Michael Warburg SCTS Fellowship, is due to be announced shortly after a very competitive round of applications.

Amer Harky has completed his post as Liverpool Aortic Post-CCT Fellow, accredited jointly by SCTS and RCS Edinburgh.

He has now commenced in post as a Locum Consultant Cardiac Surgeon in Blackpool. Andrew Brazier has been appointed as a Locum Consultant Cardiac surgeon in Liverpool, to commence at the end of his Fellowship, and two new Fellows have been appointed, Mohamed Sherif from the Yorkshire Deanery and Mostafa El-Badry from Brighton, both due to commence in post soon. SCTS Post-CCT Fellowships provide high-quality, high-prestige, and quality-assured advanced training in Robotic Thoracic Surgery, Complex Aortic Surgery and Complex Mitral Surgery.

NTN Education

The ST3.2 NOTTS Course ran successfully at the end of February in Bristol, supported by Corza Medical. The ST6 Revision and Viva Course ran again this year as a hybrid model with two days online and then two days face-to-face at Ashorne Hill. The course was run slightly later this year in order to accommodate all candidates due to sit the May diet of the FRCS CTh Part 2 examination.

We are extremely grateful to Edwards Lifesciences for funding this vital course for both NTN and Trust appointed doctors.

The ST5.2 Critical conditions course was again delivered successfully at Ashorne Hill at the end of April. The course was well organised by Neil Cartwright, Consultant Cardiac Surgeon Sheffield, and Jon Rosser, Consultant Anaesthetist, Sheffield. It provides small group teaching and lectures on this important element of the curriculum.

We are immensely grateful to J&J Medtech for their ongoing support of SCTS Education. Thanks to them we were able to successfully run the ST3.1 course as a live operating course again at Medizin im Grünen, near Berlin. The feedback from our live operating courses remains unsurpassed demonstrating the vital importance of this most realistic of simulation models. We are hugely grateful to our faculty led by Course Directors Amit Modi and Apostolos Nakas, and in particular the team of UK perfusionists who made this course possible.



We would like to express our thanks to Meril who have again generously supported the ST5.1 course this year due to take place at Medizin im Grunen near Berlin in June.

Looking forwards, we have made the decision to cancel the planned ST4.2 Core Thoracic Course due to poor uptake amongst trainees. For a combination of logistical and financial reasons, we are planning to run a combined ST4 Cardiac and Thoracic Course at Ashorne Hill in the Autumn. Trainees who missed out on the cancelled ST4.2 course will be offered a place for the Thoracic component.

Trust Appointed Doctor Education

Anas Boulemden and Mohammad Hawari continue to lead the TAD Portfolio.

Unfortunately, due to poor uptake, the TAD Wetlab due to take place at the J&J Pinewood Facility in June, has now been postponed. Further updates to come in due course.

National Online Cardiothoracic Training Programme

The National Online Cardiothoracic Surgery Education platform is ongoing, delivered by Mike Shackcloth and Georgia Layton. It is open to NTN, TADs, and NAHPs. Live webinars are at 8am every

Thursday morning, and there are videos of over 50 talks on the PGVLE platform.

You can sign up for a log in to the platform by scanning the QR code.



Medical Student Education

Thanks to Jason Ali and Shilajit Ghosh, our SCTS Student Education leads.

NAHP Education

Led by Kathryn Hewitt, the NAHP portfolio continues to grow. A face-to-face cardiac and thoracic course ran in January at the Getinge Facility in Derby. This course was extremely well received and attended with excellent feedback. We are grateful to Getinge for their support and look forward to the start of a successful partnership with them going forwards.

Industry Partnerships

We are extremely grateful to J&J MedTech for their ongoing support of SCTS

Education. They continue to fund several courses including ST7.2, ST7.1, ST3.1. They allow free use of their Pinewood Facility, at which the TAD Wetlab and TAD Curriculum Review courses are organised, which will be closing in the Autumn. We look forward to seeing their new Facility in Maidenhead due to open in late 2026. They have also contributed to the ST7.1, ST1 and ST2 courses. Meril continue to fund the ST5.1 course in Berlin. We are also grateful for the support of Edwards, Atricure and Pulmonx, without whose support we would not be able to run our courses.

Finally, special thanks to Mara Banuta, our SCTS Education Administrator, for her invaluable support, dedication and commitment to ensuring courses run smoothly and efficiently despite the numerous challenges involved.

Please ensure that your contact details are up to date and that when you are invited to a course, you respond as quickly as possible. If courses are not filled with at least six weeks' notice they risk being cancelled.

We look forward to seeing many of you at our courses later in 2026, further details to follow soon. ■

SCTS Transplant Education Lead Report

**Esped Khoshbin, Education Lead, Transplantation,
Consultant Transplant Surgeon, Harefield Hospital, Middlesex**



SCTS University, Belfast

This year's SCTS University in Belfast was a resounding success for transplant education. A strong cohort of enthusiastic consultant transplant surgeons stepped up to lead hands-on training for the next generation, with delegates spanning the full spectrum – from medical students and allied health professionals through to junior and middle-grade surgeons. Among the student representatives were colleagues from Imperial College London, University College London, and the University of Wales. The transplant sessions at the annual meeting were both highly informative and generated some excellent discussion. Long may that continue.



National Advanced Cardiothoracic Transplantation (ACT) Fellowship

Many of you will recall the Peri-CCT Fellowship, which was originally designed for transplant surgeons recruited exclusively through the national training programme. Recognising the need for broader accessibility, the fellowship has been redesigned to welcome surgeons from the portfolio pathway and nationally registered applicants alike. It has been reborn as the **Advanced Cardiothoracic Transplant (ACT) Fellowship**.

Following SAC accreditation, the first of two ACT Fellows was appointed to Harefield Hospital in late 2025. A second position was advertised early this year and, following competitive interviews conducted by representatives from the SAC, SCTS, NHS England and NHSBT, a fellow has been appointed to the Royal Papworth Hospital for an 18-month tenure. Negotiations for a third position are currently underway with NHS England.

Fellows are formally assessed by an assigned Educational Supervisor, and the SAC is exploring refinements to the assessment and accreditation process, potentially through ISCP. In addition to NHS England funding, industrial support is available to each fellow for developmental activities, including the possibility of an overseas observership during the fellowship period.

Recruitment into Transplantation

From personal experience, engaging future transplant surgeons early – ideally from medical school – makes a real difference. Surveys consistently show that cardiothoracic transplantation ranks highly as a career aspiration among students and junior doctors. Yet the perceived demands of the lifestyle continue to deter some, and the UK remains short of transplant surgeons at a national level. Senior colleagues are leaving the specialty faster than we are replacing them.

The ACT Fellowship is guided by workforce development surveys intended to forecast how many fellows are needed, but that forecasting is becoming increasingly difficult to rely upon. A fresh workforce prediction survey is therefore in preparation to close this audit loop.

Addressing this pipeline will require a lead-in time of at least 18 months beyond completion of cardiothoracic surgical training. Without a genuine commitment to the subspecialty – and a more attractive career proposition – the struggle will persist. The onus is on all of us to kindle enthusiasm early.

There is, however, real cause for optimism. New organ preservation strategies and the **Sustainability and Certainty in Organ Retrieval (SCORE)** project aim to transform transplantation into a daytime undertaking – a shift that would meaningfully improve the work-life balance of transplant surgeons. This project is expected to launch within the coming year.



Transplant course, directed by Espeed Khoshbin (centre), with Professor Sir Magdi Yacoub (l) and Professor Ashar Khaghani (r)

SCTS-Endorsed Transplant Courses and Wet Labs

Now in its fourth consecutive year, the Harefield Core Cardiothoracic Transplantation Course continues to go from strength to strength. The two-day face-to-face course welcomes a broad audience – from foundation doctors and core trainees to transplant fellows, donor practitioners, transplant nurses, surgical care practitioners, theatre nurses, ODPs, physiotherapists and other AHPs. Each year a handful of places are taken up by international visiting consultants, which enriches the programme considerably.

The faculty is predominantly drawn from Harefield Hospital, with keynote contributions from Professor Sir Magdi Yacoub and Professor Asghar Khaghani. The course is directed by Espeed Khoshbin and co-directed by Sophia Wang.

Building on this success, a second course has been developed at the same venue – the STaR Centre, Harefield: the **Harefield Mechanical Circulatory Support Course**, co-directed by Chris Bowles. This launches in **September 2026**, funded by industry and therefore free to SCTS members. Both courses carry **10 CPD points** for two days, are approved by the Royal College of Surgeons of Edinburgh, and are endorsed by the SCTS. Registration is via the SCTS website.

The new Transplant course will also feature a substantially expanded wet lab, offering hands-on experience in ECMO cannulation, BiVAD, surgical Impella insertion, durable LVAD, and total artificial heart (TAH).

Looking Ahead: Innovation in Transplantation and Education

Transplantation remains one of the most dynamic corners of our specialty. The relative scarcity of donor organs in the UK – a consequence of improved road safety, reduced violent crime, tighter drug enforcement and better public health education – sits in stark contrast to a growing demand driven by advances in diagnosis and increasingly accessible referral pathways, such as shock calls and joint thoracic MDTs.

The race to develop surgical alternatives to homograft transplantation is accelerating. Advances in organ procurement and preservation, genetic repair, stem cell regeneration, xenotransplantation, and biological organ engineering are all gathering pace. On the mechanical side, progress in right ventricular support and total artificial heart technology offers genuinely exciting research opportunities.

Our surgical trainees are now entering a world shaped by minimally invasive and robotic surgery, exoskeletal support systems, and AI-enhanced operative environments. For those with a curiosity and appetite for research – whether in clinical innovation or surgical education – the opportunity has never been richer. ■

Adult Cardiac Sub-Committee Report

Harikrishna Doshi, Co-Chair SCTS Adult Cardiac Surgery Subcommittee,
Consultant Cardiac and Transplant surgeon, Golden Jubilee National University Hospital, Glasgow

Giovanni Mariscalco, Deputy Chair SCTS Adult Cardiac Surgery Subcommittee,
Consultant Cardiac surgeon, Glenfield Hospital, Leicester



Engagement with NICE

SCTS, via the ACSSC has engaged with NICE as stakeholders on various guidance and technology assessments.

Ongoing: Interventional Procedure: IP2042: ACSSC is currently involved with NICE for providing Professional Expert Advice for Insertion of a catheter-based intravascular microaxial flow pump for cardiogenic shock (IP2042).

Engagement with Health Technology Wales Request for expertise

Health Technology Wales (HTW) is an independent, government-funded health technology assessment organisation that issues authoritative guidance to health and care providers in Wales. As part of their appraisal process, HTW invites field experts to critically review draft Evidence Appraisal Reports and provide comment on specific uncertainties or overall robustness. HTW is currently reassessing Transcatheter Aortic Valve Implantation (TAVI) for patients with severe symptomatic aortic stenosis at intermediate surgical risk, and undertaking a new appraisal for those at low surgical risk. SCTS via ACSSC is providing the expert review.

Type B Aortic Dissection and Aortic Toolkit

Dr Dawn Adamson, is a National Speciality Advisor for Heart Disease NHS England, and Chair of NHSE Heart Attack and OOHCA Expert Advisory Groups. She is currently finalising the NHSE/combined societies second toolkit for aortic dissection designed to address the management of Type B aortic dissection, but to then go forwards into the wider scope of aortic pathology. This includes surveillance of post op patients, the management and surveillance of aortic dilatation including that that was found incidentally on other scans etc. SCTS via ACSSC is involved in reviewing the toolkit and provide feedback.

NCEPOD Investigation into 'Aortic Catastrophes'

SCTS has been approached by colleagues from Imperial College to support a proposed NCEPOD (National Confidential Enquiry into Patient Outcome and Death) investigation into 'Aortic catastrophes'. The proposal

aims to improve emergency care for patients presenting with acute non-traumatic aortic emergencies – ruptured aneurysm (rAAA) or acute aortic dissection (aAD) – by examining referral pathways, timely transfer, and access to specialist multi-disciplinary teams. The investigation would build on existing work by the Vascular Society, RCEM and ACTS, and seek to identify areas of best practice and where improvements are needed. SCTS via ACSSC has reviewed and supported the proposal.

Aprotinin Project

Following a request from the MHRA, SCTS via ACSSC has reviewed current practice in the use of Aprotinin during cardiovascular surgery. Aprotinin was suspended in 2007 due to safety concerns and reinstated in 2013 under restricted indication, with participation in the Nordic Aprotinin Patient Registry (NAPaR) a mandatory condition of supply. NAPaR findings show that 52% of Aprotinin use across nine European countries occurred in the UK, with 80% of UK cases involving high-risk procedures such as aortic surgery, valve surgery and treatment of endocarditis. SCTS via ACSSC has produced a statement on current practice, submitted to Execs in January 2026.

RAMP Discussion

RAMP (Reception Arrangements for Military Personnel) ensures timely NHS care for repatriated military and eligible personnel. The importance of preparedness has been re-emphasised in the recent Strategic Defence Review. Joint NHS-MoD planning exercises were conducted throughout 2025, with further activity planned for 2026. Future planning requires consideration of how cardiothoracic surgery and wider teams would contribute to a higher-volume response. SCTS is leading the discussions with ACSSC providing support.

Endorsement of SDCEP Antibiotic Prophylaxis Against Infective Endocarditis Implementation Advice

Mr Rana Sayeed and Mr N Moorjani represented SCTS on the SDCEP (Scottish Dental Clinical Effectiveness Programme)

Short Life Working Group, convened to revise the Antibiotic Prophylaxis against Infective Endocarditis Implementation Advice supporting NICE CG64. The updated guidance applies across the UK and has been endorsed by SCTS.

Job Description Review

In accordance with the 2005 NHS Good Practice Guidance, the Royal college of Surgeons (RCS) helps NHS trusts in appointment process of a new Substantive Consultant Surgeon by helping in creation of a high quality job description (JD), providing constructive comments to ensure issues are addressed before the document is finalised and the post is advertised. This role is undertaken by the College Regional Specialty Professional Advisors (RSPA) and Specialty Associations (SA). For Cardiac surgery, this work is undertaken by SCTS through ACSSC. During last year, ACSSC has been involved in review following upcoming Substantive Consultant's post across UK

- University Hospitals Coventry and Warwickshire NHS Trust
- Guy's & St Thomas' NHS Foundation Trust
- Oxford Heart Centre, John Radcliffe Hospital
- Royal Sussex County Hospital
- University Hospital of Wales
- University Hospitals Plymouth NHS Trust
- Barts Health NHS Trust
- Hull University Teaching Hospitals NHS Trust
- Humber Health Partnership, Hull University Teaching Hospitals

Change in the Working of ACSSC & Future Directions

Following a full committee meeting in Belfast, ACSSC has restructured its working arrangements, establishing a Core Group and wider committee. Four Core Members were appointed at interviews held on 2nd June 2026. Monthly Core Group meetings will be held alongside twice-yearly full committee meetings. ACSSC has also agreed to develop a repository of adaptable template documents covering key operational topics such as job planning, Surgeon of the Week, and Surgeon of the Day models, to support consistency and best practice across units. ■

Thoracic Surgery Sub-Committee Report

**Rory Beattie, Co-Chair SCTS Thoracic Committee,
Consultant Thoracic Surgeon, Royal Victoria Hospital, Belfast**



I took over from **Karen Redmond** as Co-Chair earlier this year as she stepped into the Treasurer Role. Her drive, vision and admin skills have left big shoes to fill! **Doug West** remains as Executive Co-Chair.

The Thoracic Subcommittee continues to meet on a monthly basis via Teams, with work progressing on numerous fronts.

Babu Naidu launched the work of the Thoracic Priority Setting Partnership at the Annual Meeting in March. Collaborating with the James Lind Alliance, they have worked with patients, carers and clinicians to identify the top priorities for research in benign and malignant thoracic conditions. They are creating working groups for the various themes, planning how the UK and Ireland can design trials to answer these questions.

Joel Dunning has taken over from Karen as lead for the Pectus Working Group. The National Pectus MDT

has just celebrated its third birthday, with a database being used to record discussions. They have discussed over 700 patients so far! With RESTORE recruitment complete, the group are now discussing the vision of how pectus should be managed nationally in the future.

Kandadai Rammohan and **Nathan Burnside**, along with **Josh Lodhia** have been driving the data working group. Prior

to moving to his role in education, Nathan sent each unit their thoracic returns. He's managed to collate data from 35 of the 38 centres, with over 11 000 procedures. This represents 21% growth from 23/24! The mortality from minimally invasive lobectomy is now around 0.5%. Ram and Josh now have a fully-fledged national thoracic database built in collaboration

“Thoracic surgery is in the midst of a period of growth and innovation, with outcomes continuing to improve. The Pectus Working Group is a great example of surgeons generating momentum, gathering evidence and driving change. The Priority Setting Partnership gives us key areas to focus on, with the national database a very exciting resource to answer future research questions.”

with Epic. The final details on data storage are being finalised, likely to be very similar to our cardiac colleagues, with the database being open for business later this year. Work will be ongoing with data leads and managers in each unit to map to local database fields and processes for submitting data. Units submitting data will be able to put forward proposals for studies using the national level data stored.

The subcommittee have been participants in the multi-speciality **Delphi consensus on the management of patients with rib fractures**, final drafts are being completed and it should be available later this year.

SCTS has been working with British Society of Gynaecologists, Endometriosis UK and NHS England

on how best **thoracic endometriosis** should be managed. A GIRFT elective and non-elective pathways are being created using the best available evidence. This should aid planning for which patients need care in expert centres.

The committee is exploring the development of patient derived Key Performance Indicators for a thoracic unit, and **Doug West** is leading a Thoracic Surgery State of the Nation Report using the NCIP data-watch this space.

Thoracic surgery is in the midst of a period of growth and innovation, with outcomes continuing

to improve. The Pectus Working Group is a great example of surgeons generating momentum, gathering evidence and driving change. The Priority Setting Partnership gives us key areas to focus on, with the national database a very exciting resource to answer future research questions. If there are other avenues you would be keen for the subcommittee to explore, please do reach out. ■

Reviewing the Path and Planning for the Future

Sri Rathinam, SCTS Communication Secretary, Consultant Thoracic Surgeon, Glenfield Hospital, Leicester



I was appointed as Communications Secretary in 2022. This post was created to assist the Honorary Secretary with their ever growing workload, as well as to redefine the role and importance of communication from the SCTS. The SCTS has always valued communication with its membership and endeavours to cater to its needs.

As well as overseeing the various communication strands of the SCTS, the communications secretary and the sub-committee would help with the SCTS Annual Report, Annual BORS report and Unit Engagement events. I look back at the last four years of how this role has evolved and the committee's success as I hand over the reins to Prof Indu Deglurkar who will be the new SCTS communication secretary by the time this issue is printed.

Committee Members

A big thank you to all the committee members during my time leading this subcommittee. We have made progress with various plans, however, there are still projects which are a work in progress. All of this would not be possible without the support of the committee members, as well as the secretarial staff in the office.

Terms of Reference

We created a term of reference for the Subcommittee in 2024; the Committee still has the founding members with a recent call to refresh the committee. We have had a few meetings in the last year but still have delivered on our communication strategy.

Communication Strategy

I think as a team we have delivered most of the strategic objectives set in 2022:

- Oversee all aspects of communication of the organisation
- Interact with the various co-chairs of the committees of SCTS

- Ensure members and public are kept up to date with the developments in the Speciality
- Newsletter and monthly updates
- To streamline the content in the weekly updates
- To offer a monthly focused communication "From the Chest"
- Bulletin: Review arrangements with publishers regarding tariff and revenue from advertisers
- Create a single focused brochure highlighting sponsorship & strategic partnership opportunities for industry
- Engage with a journal to publish SCTS Abstracts: JTCS
- The Living Textbook of Cardiothoracic Surgery: Archive all the SCTS university

Bulletin

We have reduced the number of print copies with an electronic offering to be more sustainable. Dio has taken over from Indu as Editor. We continue to engage with Open Box as our publishing partner and have extended the current contract with them. We changed arrangements with them to only paying for the production process whilst generating advertising revenue for SCTS and thereby making a profit.

From the Chest

The FTC has highlighted the softer side of our members as well as highlighted the heritage of various units. The Escapists Club offers insights into Surgeon's passions, inspirational stars and various articles as a soft edition complementing our SCTS Bulletin.

Publishing SCTS Abstracts in JTCS

We have negotiated an arrangement with JTCS which allows us to publish our annual meeting abstracts as a supplement. There

are ongoing discussions to resurrect the Perspectives in Cardiothoracic surgery, the monologue of best lectures of the SCTS University.

BORS and Executive Reports

The SCTS will not deliver on its charity charter and vision if we don't engage with our members. The Unit Representatives act as a conduit between the Executive and the individual units and the communication committee has been integral in coordinating the board of representatives' report. We have highlighted and shared best practice and have also surveyed unit practise on sustainable surgery.

The fantastic work which all the committee chairs deliver for the SCTS is collated in the annual report.

Social Media

Our social media presence has significantly improved over the last few years, including the media wall and juicer which brings all social media posts by SCTS on to our website. Our social media platforms have proved to be integral to the London to Brighton ride promotion and raising the profile of the SCTS.

Website

The website is about to undergo an overhaul as it has been nearly five years since we last did a major reorganisation. We have, however, in the last few years added various new sections to the website.

Tribute Boards

It is really sad when we lose very valuable senior colleagues and we have created profile pages for colleagues, peers and the public to leave kind words about deceased members. It is staggering to see how many we have lost in the last few years.

Member Wellbeing

We have created sections for members well-being on our website, including resources support and guidance on dealing with Bullying and Harassment.

Position Statements

SCTS has maintained itself as the main advocate to our patients with disease of the chest, heart and lungs. There have been issues and challenges which have faced our specialty both in terms of professionalism as well as patient care, and this has prompted the SCTS to have guidance documents and position statements which are hosted on our website in a dedicated section.

Change is the Only Constant

In my time with the SCTS executive over two decades I have been associated with excellent, motivated individuals in the senior leadership team and the executive. It has significantly changed and evolved for the better. As various surgical societies and organisations



talk about an inclusive culture, our charity leads by example, as reflected in our current senior leadership team and executive.

External collaboration

One of the responsibilities of the Communication secretary is liaising with other organisations and promoting collaborative working. I had the privilege of representing SCTS in the Stake holder meeting organised by the Royal College of Surgeons of England to explore a Collaborative International Strategy to support training, education and professional standards in the international arena. SCTS

has signed a Memorandum of Understanding with the European Society of Thoracic Surgeons to work in close collaboration. We have worked closely with international partners in India, Egypt and ESTS for collaborative ventures and shared learning.

“Every beginning has an end and every end is a new beginning.”

After spending nearly 10 years as SCTS Tutor and Education secretary, the Communication Secretary role was a new challenge which I embarked on four years ago. I have completed many of the strategic points which we planned, but there are still some in the process. But every journey has to come to an end and to hand the portfolio to someone who will build on and make things even better. I wish Indu, the new Communication Secretary all the very best in her tenure as the Communication Secretary and I am sure she will make a grand job of it. I thank all of you for your support and feedback which has allowed me to deliver the role. ■

Congenital Sub-Committee Report

**Andrew Parry, SCTS Congenital Cardiac Surgery Co-Chair,
Consultant Congenital Cardiac Surgeon, Bristol Royal Hospital for Children**



The work of the congenital subcommittee over the past year has focused on three particular areas; surgical workforce, PICU capacity and the FRCS examination.

Surgical workforce

The surgical workforce in UK has been under considerable change over the last 10 years. A large number of consultant surgeons (52%) have left the profession in the UK for various reasons, with 39% of new appointees having been through UK training.

There has therefore been a widespread discussion why this has been happening, and having gathered data and opinions from all units a ‘document’ has been written and

endorsed by every unit that sets out a framework of what the surgeons believe a ‘Good Unit Looks Like’. This document is supported by the SCTS Executive and it is anticipated that it will be submitted to central NHS authorities within the next month. It is intended that the model can be used for local Trusts to develop a working environment that will retain consultant congenital surgeons as they are able to provide the quality of care that they aspire to.

At the other end of the career pathway it has been difficult to recruit into the specialty recently and training days have become less well attended. Efforts have been made to encourage recruitment and ‘Taster Days’ have been set up but it has proven difficult for trainees to attend. In response, approaches have been made to all units seeking a ‘champion’ to step forward to

ensure quality and consistency of these ‘Taster Days’ though there has been limited uptake so far. More encouragingly, there is a large cohort of very eager medical students and F1/2 stage doctors training currently, and the subcommittee are developing ways to maintain the enthusiasm of these young doctors.

PICU capacity

One of the major concerns expressed by congenital consultants remains the availability of enhanced care facilities, with Cardiac Surgery competing with all other specialities for general PICU resources. The answer is not just an increase in bed base, as demonstrated by one centre where the number of beds has increased

significantly, but this has not been reflected by any increase in cardiac surgical throughput. The sub-committee is exploring how access to this valuable resource can be improved for congenital cardiac surgical patients so that their care can be provided within a clinically appropriate time scale and multiple cancellations can be minimised. This has been an ongoing issue for many years and it is recognised that there are no magic solutions, but it is hoped that working through the framework proposed in the aforementioned document significant progress can be made.

FRCS CTh examination

There have been concerns raised that currently the final assessment of a surgeon's factual knowledge is an examination in Cardiothoracic surgery in its generality, with sub speciality interests of acquired cardiac or thoracic. For a candidate wishing to pursue a career in congenital cardiac surgery there is no formal examination in this specific sub-speciality, which could lead to challenges. The subcommittee is working through the complex issues of achieving validation of an examination sat by a small

number of candidates in a sub-sub-speciality, and will be providing a draft recommendation to the FRCS Examination board shortly.

NICOR

Recently, Serban Stoica has taken over the role of lead for NICOR (congenital) nationally marking the first time this role has been held by a surgeon. The Society congratulates him on this achievement and recognises the help this offers in ensuring that surgical data are appropriately interrogated. ■

Intercollegiate Speciality Board in Cardiothoracic Surgery

Elizabeth Belcher, Chair, Intercollegiate Specialty Board in Cardiothoracic Surgery, JCIE, Consultant Thoracic Surgeon, John Radcliffe Hospital, Oxford



ISB Specialty Board in Cardiothoracic Surgery

Miss Elizabeth Belcher	Chair
Professor Farah Bhatti	RCSEng
Mr Neil Cartwright	Leader, Panel of Question Writers [S1]
Mr Mark Jones	SAC Chair
Miss Juliet King	Leader, Panel of Question Writers [S2]
Mr Manoj Kuduvalli	RCPSGlas
Mr Andrew Parry	SCTS
Mr Steven Rooney	RCSEd
Mr Rana Sayeed	JSCFE Lead
Mr Vincent Young	RCSI
Mr Alexander Smith	Trainee Representative
Mrs Elaine McDaid	Specialty Manager

As the Board Chair, I would like to thank the JCIE Panel of Examiners for their commitment to delivering the Cardiothoracic Section 2 examinations despite their clinical responsibilities. Their dedication to the examination has enabled us to deliver a successive 32-candidate diet within our relatively small specialty. Their attendance directly assists in the Section 2 waiting list reduction we have seen over the last year.

Stoke-on-Trent Section 2 Examination

Thanks to Shilajit Ghosh, our host examiner for the Stoke-on-Trent diet in May 2026 and to Lognathen

Balacumaraswami, who assisted with the cardiac component. We are grateful to Elaine McDaid, our specialty manager, and Archie Grey, our administrator.

Sample Questions

New Section 1 sample SBA questions are available on the JCIE website. These sample questions align with the feedback domains. The sample set extends the number of questions previously available from five to 50. Each question has the correct answer available, together with supporting details. Sample questions can be accessed via the link below: www.jcie.org.uk/content/content.aspx?ID=13

Future Examinations

The next Section 2 examination will be held in October in Dublin, and we are grateful to our host examiner, Professor Karen Redmond of the Mater Misericordiae Hospital, Dublin. The next Section 1 examination will be held on the 7th January 2027.

JSCFE

The JSCFE examination will end with the final Section 2 examination in Edinburgh, in November. Candidates who do not complete Section 2 of the JSCFE examination may be eligible to receive a Certificate in Cardiothoracic Surgical Sciences in recognition of their achievement in Section 1.

Examiner Applications

The Panel of Examiners represent all four nations, but not all training regions and Trusts. We welcome applications to the Panel of Question Writers and to the Section 2 Panel of Examiners. Consultant surgeons and Specialty and Associate Specialist doctors may apply to the Panel of Question Writers from the date of their appointment. Consultants who have completed five years in a substantive post can apply to the Section 2 Panel of Examiners.

Criteria for appointment and the process of application can be found in the links below:
www.jcie.org.uk/content/content.aspx?ID=41
www.jcie.org.uk/content/content.aspx?ID=23 ■



SCTS Annual Dinner 2027

SAVE THE DATE



**Monday 22nd March
Birmingham venue TBC**

Supporting Trust Appointed Doctors, Strengthening the Specialty

Ghaith Qsous, Trust Appointed Doctors Lead, Clinical Fellow, University of Nottingham



“Every day you should learn something new.” – M.H., Nottingham University Hospitals

“A department without training and research is a dead department.” –

N.B., Nottingham University Hospitals

“I may not be the best surgeon in the world, but I am the best first assistant.” –

C.L., Plymouth Hospital

This year the SCTS introduced, for the first time, awards recognising the department that best supports Trust Appointed Doctors (TADs) and the Best Trust Appointed Doctor of the Year.

In thoracic surgery, the University Hospital of Wales received the award for the Department Best Supporting TADs, with Nottingham University Hospitals as runner-up. In cardiac surgery, Plymouth Hospital received the Corresponding Departmental Award. Huzaifa Ahmed and Hiwa Sherzad were recognised as Best TAD of the Year in thoracic and cardiac surgery, respectively.

The quotations above come from consultants in the winning units. They reflect the culture, mindset, and leadership that make these departments exemplary models for training and supporting their trainees, without discrimination. These units are not only providing high-quality training and support, but are also helping to shape future leaders, educators, and trainers who will serve the NHS and the specialty for years to come. One of the trainers at the University Hospital of Wales was previously a TAD at Nottingham University Hospitals, illustrating how strong training environments can produce future trainers who carry forward the same values of equality, support, and excellence in other units.

Following my previous article in the Bulletin, I received feedback suggesting that there is still no clear understanding of the TAD pathway. It is therefore important to clarify some common misunderstandings.

First, many TADs arrive in the UK with previous experience in cardiothoracic surgery

and, in some cases, prior independent practice in their home countries. This brings maturity, resilience, and valuable clinical exposure. Many of these surgeons were from the European Union and, before Brexit, could obtain GMC specialist registration without progressing through the CESR pathway or the FRCS examination. The pathway is now more unified.

However, the CESR/Portfolio pathway remains highly demanding. For example, the requirement to achieve 250 cases within six years places significant pressure on applicants, particularly when the formal training pathway spans seven years. For TADs who do not receive appropriate mentoring, guidance, and access to training opportunities, this target can be extremely difficult. If the required number is not achieved within the relevant timeframe, older cases may no longer count towards the application, adding further pressure and affecting mental wellbeing.

In addition, the CESR/Portfolio pathway requires extensive evidence across almost every aspect of clinical and non-clinical practice. Candidates are often expected to complete courses such as ATLS, even though these are not always required in the training pathway. Many of these courses are costly, creating further financial strain.

Even after meeting all the requirements, the process remains onerous. The application itself can take around 18 months to reach a decision. Many TADs who have gone through the CESR/Portfolio route describe it as a painful experience.

For that reason, anyone who succeeds through the CESR pathway deserves considerable recognition and respect. It requires resilience, hard work, and sustained commitment. Unfortunately, it also requires luck: the luck of being in a department that offers the right support, supervision, and training opportunities. The reality is that such departments are often the most competitive. In some thoracic units, a single post has attracted around 80 applicants, while in some cardiac units around 35 applicants have competed for one position. In reality, competition for these supportive posts can be even greater than competition for some national training posts, underlining how essential good training environments are for career progression.

Cardiothoracic surgery is an evolving specialty in the UK. Demand is increasing, driven by factors such as lung cancer screening and an ageing population. The NHS will require more surgeons in the future. TADs and NTN trainees serve the same patients, the same health service, and the same specialty. There should be no divide in how they are valued or supported. Fairness and equality should therefore be central principles of cardiothoracic surgery training.

Success should not be defined only by completing CESR or obtaining a consultant post. Success may also mean maintaining a healthy work-life balance, raising a family well, and building a life in a different country, often far from one's family and within a new culture and language. In my role as a TAD trustee, I have become aware of many success stories, as well as the many obstacles TADs have overcome to reach this stage. Some have lived through war, civil conflict, political instability, financial hardship, and unsafe environments before continuing their professional journeys in the UK. They deserve a fair opportunity to progress, together with appropriate support and equitable treatment. I am proud to be a TAD, proud of my colleagues, and honoured to represent them. TADs in cardiothoracic surgery in the UK are individuals of great quality and potential. They are an asset to the system and can contribute greatly when given the right culture in which to develop.

In conclusion, the winning departments have shown that good training is possible for everyone. They have demonstrated that there is a place for every trainee to develop and progress. What is required is the right leadership, the right mindset, and the right culture. ■

From Local Practice to Shared Evidence: Collaborating on SSI Prevention in Cardiac Surgery

Three practical questions.
One collaborative cardiac surgery community.
Evidence we can generate together.

In every cardiac theatre, small decisions are made at the end of a case. Should the team change gloves before sternal closure? Should a separate set of instruments be used? Should a specialist dressing be applied? Could a local antibiotic strategy reduce the risk of deep sternal wound infection?

These are not abstract research questions. They are practical questions that sit within everyday cardiac surgery. They involve surgeons, scrub teams, surgical care practitioners, nurses, trainees, research teams and, most importantly, patients recovering after sternotomy.

The challenge is that practise varies between centres. Some interventions are already used selectively. Some feel intuitively sensible. Some are supported by evidence from other surgical specialties. But cardiac surgery still needs clearer, stronger evidence.

The ROSSINI-Platform Cardiac Surgery Pillar is an opportunity for the SCTS community to answer these questions together.

This is not simply about opening another trial. It is about building a collaborative cardiac surgery network around practical, deliverable interventions that could realistically change routine care if shown to be effective.

Why these interventions?

The cardiac pillar focuses on three interventions (below) that are simple, clinically relevant and directly applicable to cardiac surgery.

Closed-incision Negative Pressure Wound Therapy

NICE recommends considering negative pressure wound dressings for closed surgical

Mohammed Islam, Senior Clinical Research Practitioner, Guys and St Thomas NHS Trust
Judith Tanner, Professor of Adult Nursing, University of Nottingham
Melissa Rochon, NAHP, Harefield Hospital, Middlesex
Ricky Vaja, Consultant Cardiac Surgeon, Barts Health NHS Trust, London
Luke J Rogers, Consultant Cardiac Surgeon, South Tees Hospitals NHS Foundation Trust
On behalf of the ROSSINI-Platform Investigators Collaboration



incisions because they are associated with fewer surgical site infections and seromas compared with standard dressings. However, this is not routine practise in cardiac surgery, and the available cardiac evidence remains limited. Previous studies have not been large enough to provide a definitive answer on surgical site infection. ROSSINI gives cardiac centres the chance to determine whether this intervention provides meaningful clinical and cost-effective benefit after sternotomy.

Gentamicin-impregnated Collagen Matrix Before Sternal Closure

The second intervention is a topical gentamicin-impregnated collagen matrix placed between the sternal edges prior to closure. The rationale is clinically understandable: deep sternal wound infection can have major consequences, and local antibiotic delivery at the sternal wound is biologically plausible. However, antimicrobial stewardship matters. NICE advises that antibiotic or antiseptic application before wound closure should only be used as part of clinical research because of concerns around antimicrobial and multidrug resistance. Although benefit has been suggested, the

evidence remains limited. The cardiac pillar provides a responsible way to test this intervention properly in the population where the answer matters most.

Instrument and Glove Change Before Wound Closure

The third intervention is instrument and glove change prior to wound closure. This is perhaps the simplest intervention, but it addresses a familiar theatre issue. Cardiac operations can be long, glove perforation risk increases with duration of wear, and contamination at the point of sternal closure may have serious consequences. The ChEETA trial showed that routine glove and instrument change before abdominal wound closure reduced surgical site infection, but this has not yet been adequately tested in cardiac surgery. ROSSINI asks whether this practical, low-cost step should become routine before sternal closure.

Taken together, these interventions reflect the strength of the cardiac pillar: practical changes, grounded in everyday surgical practise, tested at a scale no single centre could achieve alone.

Closed-incision Negative Pressure Wound Therapy	Gentamicin-Impregnated Collagen Matrix	Instrument and Glove Change
Tests whether prophylactic closed-incision negative pressure therapy after skin closure can reduce SSI and seroma risk after sternotomy.	Tests whether local gentamicin delivery between the sternal edges can reduce infection risk while addressing antimicrobial stewardship responsibly.	Tests whether a simple closure-phase change, already promising in abdominal surgery, should be routine before sternal closure.

Why Collaboration Matters

No individual cardiac unit can answer these questions definitively on its own. But across the SCTS community, the answer is within reach.

That is why collaboration is the central focus of the cardiac surgery pillar. Each centre brings something important: clinical experience, theatre expertise, research infrastructure, trainee enthusiasm, nursing leadership, local problem-solving and knowledge of how cardiac pathways really work.

The study will only succeed if it is owned by the whole pathway. Surgeons are central to local leadership and patient identification. Theatre teams are essential to delivering the interventions consistently. Research nurses and practitioners support consent, randomisation and data quality. Surgical care practitioners, ward teams and trainees can help embed the study into day-to-day practice. R&D teams help centres open safely and efficiently.

The aim is not to add unnecessary burden. The aim is to make high-quality research part

of routine cardiac surgery delivery.

Each participating centre will aim to recruit approximately two patients per week. That is a realistic local target, but when repeated across multiple cardiac centres it becomes a powerful national contribution.

We are pleased that **Guy's and St Thomas', Barts Health and South Tees** are currently happy to support the cardiac pillar. Their engagement reflects the collaborative model we hope to build across the UK: centres working together, sharing learning and helping generate evidence that can inform future practice.

An Invitation to SCTS Centres

The ROSSINI Cardiac Surgery Pillar is now moving from awareness to collaboration.

We are keen to hear from centres interested in contributing to this national effort, whether through a local Principal Investigator, Associate PI, trainee lead, surgical care practitioner, research nurse or wider multidisciplinary

team. Centres do not need to have identical infrastructure. What matters is clinical ownership, local enthusiasm and a willingness to work together.

If each centre contributes around two patients per week, the cardiac surgery community can answer practical questions that have remained uncertain for too long.

The interventions are simple. The question is important. The opportunity is collective.

So, the next time your team prepares to close a sternotomy wound, perhaps the question is not only: **"What do we usually do here?"**, but: **"Could our centre help generate the evidence that tells the whole specialty what we should do next?"** ■

To discuss site participation or learn more, please contact: Mohammed Islam, Senior Clinical Research Practitioner,

Guy's and St Thomas' NHS Foundation Trust
Mohammed.islam107@nhs.net



An Update from the SCTS Student Education Committee

The Student Education Committee shares an update across the first half of 2026. Our aim: to widen access to cardiothoracic surgical education, support students across Great Britain and Ireland, and use digital platforms to reach a global audience.

SCTS University Day 2026

A highlight was the University Day at the Annual Meeting in Belfast. Mr Joel Dunning opened the morning with charisma and insights into thoracic surgery. Professor Mark Danton returned to Belfast, where he studied at Queen's, to speak on what it means to pursue a career in congenital cardiac surgery. Mr Rana Sayeed delivered an overview of cardiac surgery for medical students interested in the specialty. Ms Sara Volpi concluded the morning by offering an eye-opening account of the pathway into surgical training.

The Pat Magee student presentation session, opened by Mr Luke Rogers, showcased research from students across the country showcasing early ambition and

Nikan Hoorijani, Medical Student, University of Glasgow
Chai Jin Lim, Medical Student, University of Sheffield
Ethan Alford, Medical Student, University of Southampton
Sarah Guo, Medical Student, University of Cambridge
Donovan Campbell, Medical Student, Queens University, Belfast
Benjamin Chapman, Medical Student, University of Oxford
Jason Ali, Consultant Cardiac Surgeon, Royal Papworth Hospital, Cambridge



initiative. Supported by Ethicon, Edwards, the SCTS team, and surgeons from Basildon Hospital, students participated in dry and wet-lab simulations covering aortic, coronary and mitral techniques. The day concluded with an open Q&A with questions on training, academic surgery and the realities of the specialty. We are grateful to Mr Aman Coonar, Ms Alessia Rossi, Ms Sara Volpi, Mr Doug West and Mr Jason Ali for their generous time

and reflections. We look forward to building on this momentum for Birmingham in 2027.

Digital Events

Our newly established evening webinar programme has quickly gained momentum.

Our Women in Cardiothoracic Surgery evening received 116 registrations globally. Speakers included Heen Shamaz, student in

Celebrating Excellence and Building Momentum in Cardiothoracic Training

Ali Ansaripour, SCTS Junior Trainee Representative, NTN, John Radcliffe Hospital, Oxford
 Mohamed Sherif, SCTS Senior Trainee Representative, NTN, Northern General Hospital, Sheffield
 On behalf of the NTCCTS



The 2026 SCTS Annual Meeting in Belfast was another successful meeting and reflected the continued engagement of cardiothoracic trainees across the UK and Ireland. Trainees were involved throughout the conference, presenting scientific work, supporting practical workshops and wet labs, and co-chairing plenary and scientific sessions alongside consultants and invited faculty. The quality and breadth of trainee contributions reflected the strong academic and educational culture within the specialty.

The annual SCTS Trainee Meeting provided an important opportunity to discuss current training issues and future priorities. Discussions focused on FRCS examination access, developments in Phase 1 (ST1–3) training reform, access to training opportunities, and increasing concerns around study leave and study budget variability across deaneries. One of the recurring themes was that, despite the value of the trainee meeting, it remains the only regular in-person forum where trainees from across the UK and Ireland meet collectively. In response, the NTCCTS has proposed a new annual National Trainees' Summit, intended to bring together trainee representatives, SAC members, SCTS

leadership, and other stakeholders for more focused discussions on training priorities and practical next steps.

A particular highlight of the Belfast meeting was the SCTS–NTCCTS Training Excellence Awards. This year, the awards received 51 trainee nominations, representing the highest level of engagement with the initiative so far. Nominations were submitted across the three categories – Golden Heart, Golden Lung, and Golden Sternum – and reflected how much trainees value supportive trainers and positive training environments. The process remains anonymised, with nominations assessed across five domains, focusing on the quality and impact of the comments rather than the number of nominations received.

This year's winners were:

- **Golden Lung Trainer Award** – Mr Sasha Stamenkovic (St Bartholomew's Hospital)
- **Golden Heart Trainer Award** – Mr Benjamin Adams (St Bartholomew's Hospital)
- **Golden Sternum Trainer Award** – Miss Francesca Gatta (North West Deanery)

The comments submitted by trainees highlighted qualities such as patience, technical teaching, mentorship, approachability, and support during challenging periods of training. The awards continue to demonstrate the importance of good trainers and the impact they have on trainee development and morale.

Cardiothoracic surgery was also well represented at the recent ASiT Conference. The NTCCTS and SCTS jointly delivered the Introduction to Cardiothoracic Surgery Course, which was well attended by medical students and junior surgical trainees interested in the specialty. There was also strong representation of cardiothoracic abstracts throughout the conference, alongside the awarding of three national prizes to future cardiothoracic trainees. The meeting highlighted the continued interest and enthusiasm for cardiothoracic surgery amongst the next generation of surgeons.

Looking ahead, several important developments will continue to shape training over the coming years. The implementation of the updated curriculum, expansion of minimally invasive cardiac surgery and ERACS pathways, development of more structured fellowship opportunities, and ongoing work around workforce planning will all require continued collaboration between trainees, trainers, SAC, SCTS, and national organisations. The NTCCTS will continue to engage closely in these discussions and monitor how these changes impact training on the ground.

Above all, the Belfast meeting reflected the continued willingness of trainees, trainers, and national organisations to engage constructively in improving cardiothoracic training across the UK and Ireland. ■

“A particular highlight of the Belfast meeting was the SCTS–NTCCTS Training Excellence Awards. This year, the awards received 51 trainee nominations, representing the highest level of engagement with the initiative so far.”



UPCOMING COURSES

Course:	Venue:	Date:
Cardiothoracic Curriculum Review Course	J&J Institute, Pinewoods Campus	24 - 25 Sep 2026
The course will review the adult cardiothoracic curriculum. The format will include small-group teaching, simulation and wet lab sessions.		
ST7.1: Cardiothoracic Pre-Consultant Course	Keele Anatomy and Surgical Training Centre	29 - 30 Sep 2026
Pre-Consultant human cadaveric operating course in cardiac and thoracic subspecialties. Advanced complex operating including VSD repair, aortic arch, surgery for AF, double sleeve, carinal resection and more.		
Portfolio Pathway (formerly CESR) Course	Ashorne Hill, Leamington Spa	6 of Nov 2026
One day course aimed at preparation for Portfolio Pathway submission for Trust Appointed Doctors.		
ST1: Introduction to Cardiothoracic Surgery Course	Nottingham Post- Graduate Centre	11 Nov 2026
One day introduction to the speciality of Cardiothoracic surgery, National training programme, SCTS Education and opportunity to meet peers.		
ST4: Core Cardiothoracic Surgery Course	TBC	TBC Nov 2026
Newly redesigned ST4 course covering all core cardiothoracic surgery topics, combining expert-led lectures with interactive small-group learning.		
ST7.2: Leadership and Professionalism Course	Ashorne Hill, Leamington Spa	26 - 27 Nov 2026
Two day course for senior trainees and Trust appointed Doctors – What you need to know as a New Consultant and were afraid to ask!		
ST2: Essentials in Cardiothoracic Surgery Course	Ashorne Hill, Leamington Spa	3 - 4 Dec 2026
Course encompassing broad introduction to both cardiac and thoracic surgery, operative techniques and peri-operative management.		

The National Lung Cancer Audit: Earlier Diagnosis, Increasing Resections, and the Challenge Ahead

Lauren Dixon, Clinical Fellow, Royal College of Surgeons of England



The National Lung Cancer Audit (NLCA) provides a comprehensive national picture of lung cancer care across England and Wales, capturing data on over 39,000 patients annually. It continues to be a key driver of quality improvement, and is becoming increasingly relevant to thoracic surgeons as patterns of diagnosis and treatment evolve.

Earlier diagnosis: A step change in lung cancer care

The 2026 NLCA State of the Nation report highlighted sustained progress in the early diagnosis of lung cancer. In England, 40% of patients are now diagnosed with stage I–II disease, continuing a steady upward trend over recent years. Earlier diagnosis is only meaningful if it translates into treatment. The increasing proportion of stage I–II NSCLC is creating a larger cohort of patients who are potential candidates for surgical resection, and this is placing greater emphasis on timely assessment and access to thoracic surgical services.

Increasing surgical activity and resection rates

The NLCA reports that 7,878 lung cancer resections were performed in England in 2024, and this represents a substantial

increase from previous years. Overall, 22% of people with lung cancer had surgery, the highest proportion recorded to date. It is likely that this demand for surgery will continue to grow as the screening programme is rolled-out. Improvements in perioperative care and wider adoption of minimally invasive approaches may also enable surgery to be offered to a broader group of patients, including older individuals and those with comorbidity.

Persistent variation in resection rates

Despite these encouraging trends, the NLCA observed variation in resection rates across NHS providers. Differences remain evident even among patients with stage I–II NSCLC and good performance status, the group most likely to benefit from surgery. This suggests that some potentially operable patients are not undergoing definitive therapy. The reasons for this are likely multifactorial, including variation in referral pathways, MDT decision-making, and the capacity of thoracic surgical services. From a surgical perspective, this variation represents both a challenge and an opportunity. Increasing resection rates in appropriately selected patients remains one of the most effective ways to improve population-level lung cancer outcomes.

From audit to action: The role of quarterly dashboards

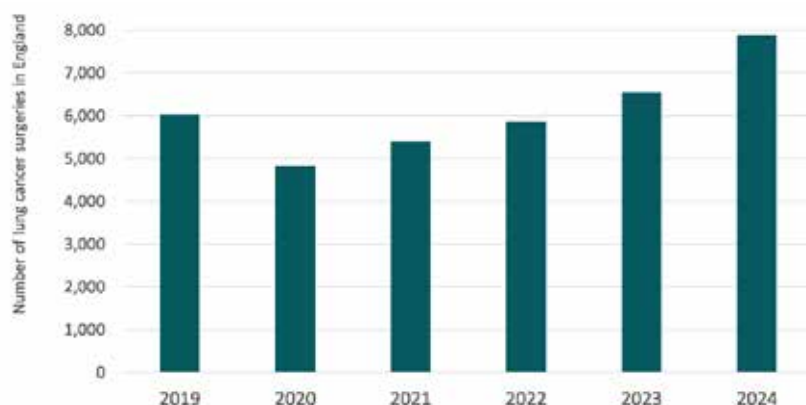
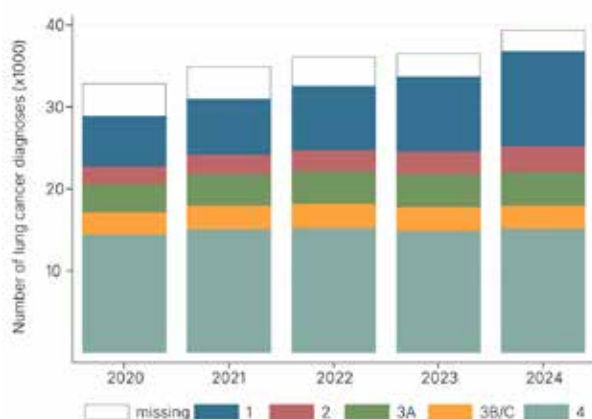
A key development in recent years has been the creation of quarterly NLCA dashboards. Individual NHS providers can now review their own performance, including resection rates in people with stage I–II NSCLC with performance status 0–1. These dashboards allow providers to:

- Benchmark against national averages
- Monitor trends over time
- Identify potential gaps in access to surgery

This represents a significant advance as NLCA results are no longer confined to annual reports; the dashboards make the variation visible and actionable at provider level. For thoracic surgical teams, this makes it easier to interrogate local practice and drive targeted improvement.

Capacity: The key constraint

While earlier diagnosis and increasing surgical activity represent clear progress, the NLCA also highlighted an emerging challenge related to balancing surgical capacity and patient demand. Waiting times for surgery remain prolonged, with the waits for many patients exceeding recommended pathway targets. As the number of patients diagnosed



with early-stage disease grows, the pressure on surgical services is likely to increase further. Without timely treatment, the full benefits of earlier diagnosis may not be realised.

A UK-wide perspective

While these improvements are encouraging, they are not uniform across the UK. Progress in England reflects the implementation of lung cancer screening programme. In contrast, screening programmes are not yet

established across most devolved nations. As a result, the full benefits of earlier diagnosis, and the opportunity to increase access to curative surgical treatment, may not yet be realised across the UK. Ensuring equitable access to both screening and high-quality national data should be a priority across all healthcare systems.

Conclusion

The NLCA documents a clear trajectory of

improvement in lung cancer care: more patients are being diagnosed earlier, more are receiving curative treatment, and surgical activity continues to increase.

However, it also highlights ongoing regional variation and growing system pressure. For thoracic surgeons, earlier diagnosis is expanding the pool of operable patients, and the challenge now is to ensure that all suitable patients have timely access to surgery. ■

The William B Long III, MD, Meritorious Award

John Edwards, Consultant Thoracic Surgeon, Glenfield Hospital, Leicester



Mr John Edwards, Consultant Thoracic Surgeon in Sheffield, has been honoured with the “William B Long, III, MD, Meritorious Award” by the Chest Wall Injury Society (CWIS).

Founded in 2016, CWIS has about 1,300 members in over 40 countries, and is the premier organisation worldwide dedicated to research and improving outcomes for patients with thoracic trauma. Dr Long is held in high regard as the foremost Thoracic Trauma Surgeon of the last 50+ years. He is known indirectly by every trauma team worldwide, as the creator of the Injury Severity Score in 1974, which is in routine use daily. He and Michael Bottlang designed the MatrixRib system for surgical stabilisation of rib fractures (SSRF), which was introduced to market by Synthes in 2006.



Mr Edwards introduced SSRF to Sheffield also in 2006, presenting initial results to the SCTS Annual Conference in 2009. He has been dedicated to educational programmes ever since. As a founding member of CWIS, he led the Rib Fractures Taxonomy project and has served on various CWIS committees. He has a particular interest in surgery for traumatic and functional conditions of the costal margin, as well as non-united fractures and sternotomies.

He has been thoroughly supported by his clinical colleagues and a succession of SMuRFS (Sheffield MULTIPLE Rib Fractures Study): intercalating BMedSci medical students conducting award-winning studies under the auspices of the Sheffield Multiple Rib Fractures Study. ■



John Edwards
with Dr Ron Gross



John Edwards with Dr Evert
Eriksson (CWIS President) and
Dr Tom White (CWIS Chair)

From the Operating Table to an Office Desk

John Cowx, Business Coach, SCTS



My introduction to the world of cardiothoracic surgery was sudden and unexpected.

The COVID pandemic had us questioning our health and wellbeing in general, especially as I also hit 40 that year. When restrictions eased, we spotted a deal at a “full body scan” provider looking to rebuild business after lockdown: having not spent our usual holiday budget that year, we decided to give it a shot.

We weren’t in poor health; no worrying aches or pains, no family history of any major concern on either side. After subjecting ourselves to a full day of scans, jabs, tests, and all kinds of prodding and poking, I was expecting a standard response for a guy freshly entering his fifth decade: watch your diet, do more exercise, the usual.

Instead, I got an “unidentifiable mass”. A shadow between my lung and heart. A “lump”.

I was thrown into a whirlwind of new scans and examinations. The tests went nuclear. Reviews became more thorough. The position of the mass made it hard to fully investigate; after a few months, all they knew was, really, it shouldn’t be there, so it was time to consult an expert. “Don’t worry”, they said. “You’re in Cambridge, so you’ll be heading to the Royal Papworth. There’s a guy there who’ll get to the bottom of this”.

That guy was Aman Coonar. He was the first person to mention the potential of this being “the big C”. His suspicion was a thymoma, but we wouldn’t know for sure without a biopsy – something which, he told me, could activate the mass and kickstart a whole chain of even more unpleasant events.

“Or”, he said. “You’re young, healthy, still have the capability to recover quickly... we could just take it out and be done with it”.

Hearing someone say “cancer” for the first time emphasised serious action was needed. Mr Coonar was proposing major surgery, but his knowledge and reasoning was clear. His confidence in my ability to cope with the procedure made his suggestion the



obvious course of action. Come July 2021, ten months since we, purely out of curiosity, took those tests, I was in the Royal Papworth, undergoing cardiothoracic surgery.

My introduction to the world of SCTS was also sudden and unexpected.

Mr Coonar was correct in both his diagnosis and prognosis for my recovery. Removal of the thymoma was followed by a short stay at Papworth, the staff there quickly helping me to my feet and getting me home after just five or six days. Home recovery was rapid. By the end of the first week, I was comfortably mobile; another week and I was back on the school run, helping with the shopping, picking up and carrying kids and bags as if nothing had happened.

The return of day-to-day normality introduced a new routine: regular CT scans and check ins with Mr Coonar to assess the healing and check for any potential recurrences.

These check ins quickly followed a pattern. Follow up scans showed nothing new: medically speaking, there was little to talk about. We would spend a minute looking at these completely clear scans, then spend the rest of the appointment chatting about family, life, and work.

Mr Coonar – Aman by this stage – took particular interest in my role at the family business, an engineering company we acquired from a passive corporate owner in the mid-00s and had re-established as a successful private company within a relatively niche market.

It was my June 2025 check in that turned to lead me here.

“Do you want to cycle to Brighton with me?”, Aman asked. This was not a standard question, and the easy answer was, “uh... no thank you”. It was my follow up question that unlocked everything: “why on Earth are you doing that?”

It was here I found out about SCTS. Aman, fresh into his Presidency, explained his role in the Society, his drive to introduce new fundraising initiatives, and his wish to find new sources of income. There were many parallels with my work; a niche concern in a highly specialised industry, the need to find new, sustainable income streams. Many of his ideas matched what I had been doing in engineering; many of his challenges were ones I had also faced over the years.



What I hadn't told Aman was we had recently sold our company back into corporate ownership. While I maintained my position there, I was, technically, a free agent. I was as eager for a change to something more meaningful as Aman was for finding someone to help him realise his goals. Our paths had crossed professionally as well as personally; I volunteered to join the Society in January to help the team drive Aman's vision.

Writing this down for the Bulletin, I appreciate the luck that has guided me here, from that operating table in Papworth to this office desk in London.

I was lucky to find this thymoma long before it became problematic. I was lucky to have Papworth on my doorstep. I was lucky to receive Aman as my surgeon and have the excellent support of the team there for my recovery.



I continue to be lucky with no reoccurrences on the CT scans. I was lucky to have gained relevant experience through our company for the role Aman suggested, and I'm lucky to be able to take that role voluntarily following the sale of our business.

Finally, looking around me here, I am lucky to have come into such a friendly, competent team. From the experience of the Annual Meeting in Belfast, to more recently attending the ST3.1 course out in Berlin, I am impressed at how such a small team can make such a large contribution to the success of this Society.

This success goes way beyond luck: it takes the knowledge, experience and dedication of this team to keep the Society running this well. If I can count myself part of this team and help build the Society in any way I can, I will continue to be a very lucky man indeed. ■

A Knife to the Heart: Recollections from the Blunt End of the Scalpel

Tomas Salerno, Professor of Cardiothoracic Surgery, and DeWitt Daughtry Endowed Chair in Cardiothoracic Surgery, University of Miami Miller School of Medicine



In the realm of medicine, few journeys are as profound and transformative as that of a cardiac surgeon. This book, *A Knife to the Heart: Recollections from the Blunt End of the Scalpel*, is a testament to the life and career of Gianni Angelini, a man whose dedication, skill, and resilience have left an indelible mark on the field of cardiac surgery.

From humble beginnings in a small village in Tuscany, Gianni's path was anything but straightforward. His early dreams of becoming an airline pilot were dashed by a congenital eye defect, leading him to pursue a career in medicine. This decision, influenced by his family's modest background and the encouragement of his parents, set him on a journey that would take

him across continents and through some of the most challenging and rewarding experiences in the medical field.

Gianni's story is one of perseverance and adaptability. Moving to the United Kingdom for better surgical training, he faced numerous challenges, from language barriers to the hierarchical nature of the



British medical system. Yet, his determination and skill saw him rise through the ranks, eventually becoming the British Heart Foundation Professor of Cardiac Surgery at Bristol University. His work in Bristol, particularly during the tumultuous period of the Bristol Babies Scandal, showcased his commitment to patient care and medical excellence.

Throughout his career, Gianni has been

at the forefront of surgical innovation. His pioneering work on off-pump coronary artery bypass surgery and his efforts to establish cardiac surgery programmes in Trinidad and Tobago and Hong Kong highlight his global impact. His collaborations with renowned surgeons and scientists and his dedication to research have significantly advanced the field of cardiac surgery.

This book is not just a recounting of surgical procedures and medical advancements. It is a deeply personal narrative that delves into the emotional and psychological aspects of being a surgeon. Gianni's reflections on his mistakes, the lives he has saved, and the personal sacrifices he has made offer a rare glimpse into the human side of medicine.

As you read through these pages, you will be taken on a journey that spans decades and continents. You will witness the evolution of cardiac surgery through the eyes of a man who has dedicated his life to improving patient outcomes and advancing medical knowledge. Gianni's story is a reminder that behind every surgical mask is a person with dreams, fears, and an unwavering commitment to making a difference.

This foreword is an invitation to delve into the life of Gianni Angelini, to understand the challenges and triumphs of a cardiac surgeon, and to appreciate the profound impact one individual can have on the world of medicine. Enjoy the journey. ■

Thoracic Surgical Physiotherapy Network Strengthens National Collaboration and Advances PECTUS Care

**Zoe Barrett-Brown, Team Lead Physiotherapist for Thoracic Surgery,
Royal Papworth Hospital, Cambridge**

**Michelle Gibb, Clinical Specialist Physiotherapist,
Glenfield Hospital, Leicester**

**Lydon Metson, Senior Specialist Physiotherapist – Thoracic Surgery,
James Cook University Hospital, Middlesbrough**



A growing community of specialist Physiotherapy clinicians continues to shape the future of thoracic care through the Thoracic Physiotherapy Network, which recently held its annual face-to-face meeting in February this year, alongside working on key updates for its national PECTUS project. The network was established five years ago by Zoe Barrett-Brown, Lead Physiotherapist for Thoracic Surgery at Royal Papworth Hospital, and Michelle Gibb, Thoracic Surgery Specialist Physiotherapist. It was created in response to feedback from clinicians who identified a need for a dedicated forum to share expertise,

seek advice, and build stronger professional connections within this highly specialised field.

Since its inception, the network has gone from strength to strength. Members now meet annually in person, complemented by three to four virtual sessions each year. These meetings provide a valuable platform for teaching, networking, collaboration, and the exchange of best practice, supporting clinicians to deliver consistently high standards of care.

On Wednesday 11th February, Physiotherapists came together at Royal Papworth Hospital. The day featured a series of teaching sessions delivered by experts from across the MDT. Teaching topics included: chest CT interpretation, focusing on key imaging findings relevant to Physiotherapists after thoracic surgery, lung ultrasound, highlighting the growing need and usefulness of ultrasound in respiratory assessment showcasing how roles within Physiotherapy are evolving, overview of bronchoscopies and a valuable insights into diaphragm anatomy and function, as well as the surgical considerations and impact of diaphragmatic complications. In the afternoon the breakout

sessions encouraged discussion and sharing of experiences between us all. Topics included the development of Advanced Clinical Practitioner (ACP) roles within cardiothoracic Physiotherapy, updates on screening tools used to identify patients requiring Physiotherapy input and Prehabilitation. Delegates shared how different services are integrating preoperative optimisation strategies into their thoracic pathways, highlighting how important it is to get patients ready for surgery and shows why the NHS is heavily investing in prehabilitation.

The network has several virtual meetings planned for the year including sessions on management of air leaks, Physiotherapy after chest wall resection and trauma and benign surgeries and their management.

A major focus of the group's recent work over the past 6 months, has been the development of a national PECTUS resource in collaboration with the PECTUS Matters charity, chaired by Mr Simon Kendall. This project aims to standardise the Physiotherapy information provided to patients undergoing pectus surgery, ensuring clear, consistent guidance both before and after their procedures. Historically, patient information has varied significantly between trusts. By creating a unified, evidence-based approach, the network hopes to improve patient understanding, enhance recovery, and support better outcomes across the country.

As the network continues to expand, its collaborative approach is helping to shape more consistent, patient-centred care on a national scale. If anyone would like to join the network please do get in touch; we would all be delighted to have you on board. ■



“Members now meet annually in person, complemented by three to four virtual sessions each year.”

Delirium in Cardiac ICU: Changing the Conversation

Joan Peralta, Senior Charge Nurse, St Bartholomews Hospital, London



In cardiac intensive care, we excel at managing what can be measured. We monitor with precision, interpret with expertise, and respond with speed. Yet delirium does not always conform to this framework. It fluctuates, it hides, and it is frequently recognised late – if at all. Despite being one of the most common complications following cardiac surgery, its visibility has not matched its clinical significance.

And yet for patients, delirium is often not a secondary issue. It is one of the most distressing and enduring parts of their critical care journey.

Listening to patients describe their experiences – the fear, the confusion, the loss of control, and the lingering psychological impact – was a pivotal moment. It challenged an uncomfortable but long-standing assumption: that delirium is an inevitable consequence of critical illness. Once that assumption is questioned, complacency is no longer acceptable.

From Background Noise to Clinical Priority

As part of the work undertaken by the ACCU Delirium Working Group, we examined practise across our cardiac ICUs in detail. What emerged was familiar across many centres: variation in recognition, variation in confidence, and variation in management. Delirium was present in daily practise – but not consistently or confidently addressed. This was not a reflection of poor care or lack of engagement. On the contrary, it reflected the reality of complex environments, competing priorities, and the absence of a unified, embedded approach. The challenge was not awareness. It was translation – bridging the gap between knowledge and consistent clinical action.

Making the Right Thing Easier to Do

Our initial response, as is often the case, was education. However, it quickly became clear that education alone – particularly when delivered in isolation – does not produce sustained change in practise. We therefore shifted our focus to something more

fundamental: the conditions in which care is delivered. We introduced simulation to allow staff to rehearse complex scenarios and build confidence in a safe environment. We embedded short, regular conversations about delirium into safety huddles, keeping it visible and relevant. We used simple visual prompts at the bedside – quiet cues that support decision-making in real time, when it matters most. We also created structured opportunities for shared learning across teams and sites, reducing unwarranted variation and building a common understanding of best practise.

A particularly powerful influence came through patient involvement. A patient representative was embedded within the ACCU Delirium Working Group, ensuring that lived experience directly shaped our approach. Hearing delirium described not as a clinical condition, but as a deeply personal and often frightening experience, fundamentally changed how teams engaged with the issue. It moved delirium from something we treat – to something we understand.

The Shift That Followed

The changes were not dramatic in isolation – but they were consistent. Staff began to recognise delirium earlier and act with greater confidence. Non-pharmacological strategies became embedded into routine care. Patients were more likely to have access to familiar items that support orientation. Conversations with families became clearer, more structured, and more compassionate.

However, the most important change was less visible, but more profound. There was a shift in mindset. Delirium was no longer viewed as an unavoidable complication to be managed reactively. It became something actively anticipated, prevented where possible, and addressed with confidence when it occurred.

Ownership replaced uncertainty.

Reflections on Leading Change

This work reinforced a principle that extends well beyond delirium: sustainable change is rarely about introducing something new

– it is about making better use of what already exists. We did not need complex interventions. We needed consistency, visibility, and reinforcement.

Confidence emerged not from information alone, but from repeated exposure, shared discussion, and practical application. It grew when staff felt supported, when expectations were clear, and when good practise was both achievable and recognised.

It also highlighted the importance of collective ownership. Delirium does not belong to one professional group. It sits at the intersection of nursing, medical, rehabilitation, psychological, and environmental care. As such, improvement depends entirely on genuine multidisciplinary collaboration.

Perhaps most significantly, it demonstrated the power of culture. Once delirium became an explicit priority – spoken about, measured, and valued – practise began to shift in a meaningful and sustained way.

Looking Ahead

Delirium is, and always will be, complex. There is no single intervention capable of eliminating it entirely. However, complexity must not be mistaken for inevitability. This work has shown that progress is possible – and that it does not require large-scale disruption. It requires consistent, deliberate action applied over time, supported by shared purpose.

As a specialty, we are rightly recognised for our technical excellence. Delirium challenges us to extend that same level of precision, attention, and commitment to the cognitive, emotional and human experience of critical illness. Because recovery is not defined solely by survival. It is defined by how patients think, feel, and remember, their time in our care.

We may not always be able to prevent delirium. But we can decide – individually and collectively – whether we treat it as a secondary complication, or as a core marker of quality in critical care. And in that decision lies the difference between managing illness – and truly delivering care that heals. ■

First International Conference for Future Cardiothoracic Surgeons (ICFCS)

Yuvraj Juttla, Medical Student, University College London Medical School
Laiba Khalid, Medical Student, University of Glasgow



The inaugural International Conference for Future Cardiothoracic Surgeons (ICFCS), held on 11th and 12th April 2026, was a student-led, collaborative initiative bringing together aspiring cardiothoracic surgeons from across Africa, Europe, and North America. As regional leads, closely supported by the Society for Cardiothoracic Surgery Student Education Committee, it was a pleasure to host this two-day event in collaboration with the Association of Future African Cardiothoracic and Vascular Surgeons (AFAC), the Thoracic Surgery Medical Association (TSMA), and VECTOR Netherlands.

The core objectives of this initiative were to provide accessible, high-quality educational sessions delivered by surgeons, fellows, and residents; to foster international collaboration and peer exchange among medical students and trainees; to offer practical exposure to fundamental surgical skills through live and recorded workshops; and to promote



academic excellence through an abstract competition and presentation platform. These aims were reflected in a diverse programme, attended by 175 delegates.

We are incredibly grateful to Mr Sunil Bhudia, our keynote speaker, who spoke engagingly about the global future of cardiothoracic surgery, with a particular focus on developing leadership skills early in one's career. We also extend our thanks to Mr Jason Ali for his comprehensive and highly educational talk on the pathophysiology, classification, and management of aortic dissection. It is also important to recognise Mr Edward Peng, who contributed to our breakout sessions by sharing insight into his role as a consultant congenital cardiac surgeon in the United Kingdom, as well as supporting the judging of our academic oral presentations.

Our international faculty further enriched the programme with topical insight. Professor

Frank Edwin delivered an important perspective on paediatric and congenital cardiac surgery in Africa, while Dr Ghada Shahin explored developments in robotic thoracic oncology surgery in the Netherlands. It was also a real pleasure to have Dr Jason Han (better known as co-founder of The Modern Surgeon) join us across both days to deliver a Virtual Basic Surgical Skills Workshop, which was particularly well received by our delegates.

Beyond the exceptional programme of speakers, it was especially rewarding to bring together medical students from around the world, creating a space for open discussion, collaboration, and the sharing of ideas. The enthusiasm and engagement throughout the conference demonstrated that cardiothoracic surgery remains a specialty driven by highly motivated and forward-thinking individuals.

We hope that initiatives such as ICFCS represent one of many steps towards addressing global inequalities in surgical training and exposure to cardiothoracic surgery. By fostering international collaboration at an early stage, we can begin to bridge these gaps and create more equitable opportunities for future surgeons worldwide.

Recordings of the full programme, alongside supplementary and pre-recorded materials, are available at <https://icfcsconference.org/>. We look forward to building on this momentum in the years to come! ■



Cardiac Surgery Elective as a Medical Student at University Hospital Southampton

Caterina Jaun, Medical Student, University of Southampton

When was the first time you held a beating heart? The first time I held a beating heart was in my acute care placement during my fourth year. I had the privilege of assisting in an organ explantation surgery, where one of the organs removed, was the heart.

Unlike during surgeries I have assisted in previous placements, a sternotomy was performed, letting me see and be able to hold the pumping heart in my gloved hands. I was filled with awe, and it inspired me to pursue further experience in cardiac surgery.

I joined the BM(EU) programme between the University of Southampton (UK) and Kassel School of Medicine in 2021. While I am a medical student at the University of Southampton, I had only been in German hospitals for my clinical placements from 3rd to final year. This meant that while I studied the theory of the NHS healthcare system, I wanted to better understand the system as a whole and see differences that I may have not known about before.

Now, in my final year of medical school, I decided to make that curiosity into reality. I completed my one-month elective in the wonderful Cardiac Surgery department at the University Hospital Southampton under the supervision of Prof S Luthra, Consultant Cardiac Surgeon.

The cardiac surgery department at UHS always welcomed my questions and answered them. Anaesthetists explained transoesophageal echocardiograms to me, surgeons quizzed me on anatomy, and I received many opportunities to practise skills like suturing and even DC cardioversion. Through this, I was given the freedom to explore the specialty closer.

Not having previously been in cardiac surgery, I was amazed at seeing the cardiopulmonary bypass machine work to keep the patient alive. The smooth communication between the perfusionists, surgical team, and anaesthetist team was so well practiced, it felt as though the job of the heart and lungs seamlessly shifted to the machine. This machine gives healthcare professionals the opportunity to improve a patient's life, and it gives me a new appreciation for the technological advancements of our age.

Seeing the beating heart with my naked eye and being able to track its movements with the ECG monitor right next to it was fascinating. It helped me further understand how different ECG patterns form based on what one can see happening on the operating table compared to the monitor.

The organisation and efficiency of the cardiac team was truly notable. In every surgery, I witnessed the surgical safety checklist being completed. This showed me that the team prioritised patient safety and made sure everyone was on the same page.

Not only am I leaving having seen cardiac surgery, but also cardiac anaesthesiology, thoracic surgery, and excellent management in emergencies in theatre.

The unique opportunity of studying medicine in two countries is that I also learned the vocabulary in two languages. The transition between the two languages may seem simple but having only spoken German in surgeries until the beginning of my elective, it took some time for me to adjust hearing English in an environment I have grown accustomed to speaking only German.

Other than the obvious language difference, I also noticed some other differences that seem routine but were new to me. Many surgeons enjoyed listening to music



during surgery, something I had never heard in the surgeries I had attended in Germany.

I noticed that before every surgery, a scrub up (Einwaschen in German) using only soap was performed. This was a difference I observed as in Germany, a scrub up with soap is only used at specific times before surgery, but a chirurgische Händedesinfektion also called surgical hand disinfection is used every time. It makes me curious about the advantages and disadvantages of either choice.

While there are some differences, the processes in theatres were very similar. One can appreciate the similarities between healthcare systems in theatres as this enables them to learn from each other and to improve for the benefit of the patient. It also enables healthcare professionals to visit other systems and bring ideas back that can improve their department at home. During my time at UHS, I witnessed a whole ecosystem of research, development, and training within the department that underpins all the clinical work.

In conclusion, I am thankful for the opportunity to improve my knowledge and for the renewed appreciation I have for the NHS healthcare system. I am grateful to Prof Luthra and the whole department of cardiac surgery at UHS for this opportunity.

I will carry my experiences and impressions from this past month with me. The many new surgeries and an improved understanding of the heart that will accompany me on my future path as a doctor.

The department welcomes enquiries round the year for elective placements from UK and International students. Please contact Asso/ Prof Suvitesh Luthra FACC, FRCS(CTh) at suvitesh.luthra@uhs.nhs.uk ■

SCTS Lifetime Achievement Award 2026

Professor Sir Bruce Keogh KBE FMedSci DSc FRCS FRCP

Simon Kendall, Medical Director for Commissioning, SCTS Past President (2020–2022)
NHS England, North West Region



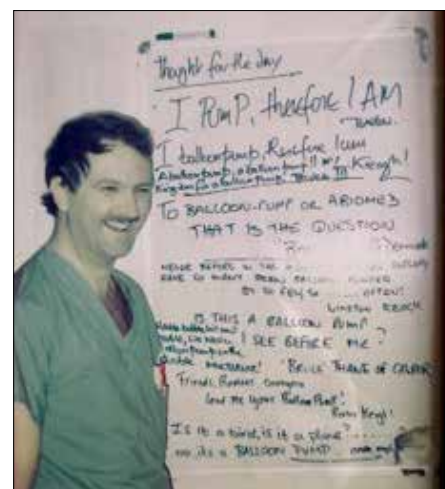
It is no surprise that Sir Bruce Keogh was named the most influential clinician of 2010–2015 by the *Health Service Journal*, nominated by 100 judges. Over six decades his career has shaped national and international healthcare – and the cardiothoracic specialty in particular – in ways that are difficult to overstate. His guiding principle, what he calls the ‘Golden Thread’, has been simple and unwavering: improve clinical outcomes, improve the safety of care, and place the patient at the centre of everything.



From Zimbabwe to the NHS

Bruce was born in November 1954 in Salisbury, Rhodesia (now Harare, Zimbabwe), to parents steeped in public service – his father a senior civil servant, his mother a Hansard parliamentary reporter. Growing up amid a guerrilla war for independence, and after his cousin was injured in a landmine explosion, his father urged him to leave. In September 1973, aged 18, he arrived in England with a rucksack and £250.

His path into medicine was far from smooth. He was rejected by 19 medical schools. He eventually secured a place at Charing Cross Hospital Medical School in 1974 – by chance, through a letter he had written to someone who turned out to be the Overseas Dean of the University of London. At a coffee break in his first days there, he spotted the woman he would spend his life with. Ann qualified in 1979 and they married that year; she went on to a career in paediatrics before raising their four sons.



Building a Surgical Career

Bruce trained in cardiothoracic surgery at the Hammersmith, working with Professor Ken Taylor and completing a British Heart Foundation Research Fellowship, earning his MD in 1989 for work on coronary laser angioplasty. During his West London senior registrar rotation he worked at St George's and Harefield, where he also sought out a full year with Sir Magdi Yacoub.

In 1991 he was appointed British Heart Foundation Senior Lecturer and Consultant at the Hammersmith, moving to Queen Elizabeth Hospital Birmingham in 1995, and then to University College London as a substantive chair in 2004, alongside his role as Director of Surgery at the Heart Hospital. In SCTS he served as Honorary Secretary 1999–2004, President-Elect 2004–06, and President 2006–08.

Data, Outcomes and Crossing the Rubicon

Perhaps Bruce's most consequential contribution to our specialty was forcing a reckoning with outcomes transparency. In the shadow of the Bristol paediatric cardiac

surgery scandal, and with the Freedom of Information Act threatening media-generated league tables, Bruce led SCTS through what he described as ‘crossing the Rubicon’: publishing surgeon-specific outcomes.

He had already co-founded the National Adult Cardiac Surgical Database in 1994, building on work by Sir Terence English and Ken Taylor, and had led the European equivalent as Chair of the EACTS Surgical Database Committee, publishing the first European ‘Blue Book’ in 2003 covering 10 countries. The vote to publish individual UK surgeon outcomes was controversial – many senior figures resisted – but it passed, and the impact was profound. An independent study by the Nuffield Trust and Rand Corporation found data quality improved to near-perfection, and UK cardiac surgical mortality fell steadily over subsequent years despite patients becoming older and sicker. Bruce’s international reach extended to EACTS, where he was Secretary General, and the Society of Thoracic Surgeons in North America, where he served on their Cardiac Surgery Database Committee and twice on their Board of Directors – only the second non-American to do so.



A Knighthood – and a Dilemma

In 2003, returning from holiday, Ann rescued a brown envelope from Bruce’s discard pile. Inside was a letter from the Foreign and Commonwealth Office offering an Honorary Knighthood. Convinced it was a prank, he called the contact number – only to find it was genuine. His first instinct was reluctance: he worried the honour would undermine his credibility with surgical colleagues he was leading through the outcomes transparency debate. Persuaded to accept, he subsequently applied for British citizenship, and in 2004 Mr Keogh became Professor Sir Bruce Keogh KBE.



National Medical Director: a Decade of Transformation

After years of advisory roles in the Department of Health, Bruce was appointed the first National Medical Director of the NHS in 2007 – a remarkable achievement for a practising cardiac surgeon and sitting SCTS President. He served until 2013, then became the first National Medical Director of the newly formed NHS England until 2018: one of eight executive directors overseeing 53 million people and a £97 billion budget.

The breadth of his impact in this period is staggering. His quality framework – built on Safe Care, Effective Care and Good Patient Experience – introduced Quality Accounts with the same legal standing as financial accounts, and the CQUIN payment incentive model. Concrete results included: 22 regional trauma centres delivering a 50% improvement in survival odds for the highest-risk patients; a plan for tackling sepsis in the NHS, an increase in VTE prophylaxis from <40% to 95% for eligible patients; 8 hyperacute stroke units replacing 32 sites of variable care in London; the first major redesign of national ambulance service standards in over 40 years; the formation of HQIP and the initial funding of GIRFT, and the dementia diagnosis rate rising from 40% to 70% and a substantial increase in access to psychological therapies. In 2013 alone he published four landmark reviews: on cosmetic interventions regulation; care quality in 14 hospital trusts; seven-day urgent services, and a new blueprint for urgent and emergency care.

He also invested in the next generation: establishing the National Medical Directors’ Clinical Fellowship Programme in 2011, mandating that final-year medical students

shadow FY1 doctors before starting work, and ensuring junior doctors were embedded in CQC inspections as quality barometers.

By the time he stood down, 99% of eligible patients were receiving primary angioplasty for heart attacks, with 90% having their arteries opened within 90 minutes – a number that encapsulates what he repeatedly demonstrated: the seemingly impossible becoming expected practice.

Birmingham Women’s and Children’s – and the Mantra That Never Changed

Since 2018, Sir Bruce has chaired Birmingham Women’s and Children’s Hospital NHS Foundation Trust – the busiest children’s hospital in the country. His mantra for what makes a hospital excel remains exactly what it was when he was a young consultant: look after and train your staff well; measure and know your outcomes; conduct research; and promote innovation.

A Career That Changed What We Expect

Sir Bruce Keogh’s career has been defined by an extraordinary combination of qualities: unshakeable resolve, genuine humility, warmth and humour – and an ability to bring the most reluctant of colleagues with him. He has transformed what patients, clinicians, and the public expect of healthcare. Thanks to his leadership, our own specialty is internationally recognised for the rigour and transparency of its quality assurance.

It is difficult to remember what healthcare looked like before him. That is perhaps the finest tribute of all. ■

SCTS and EDI in Cardiothoracic Surgery: How We Can All Be Better

Vipin Zamvar, NAHP, Mater Misericordiae University Hospital, Dublin
Emezie Okorochoa, NTN, Southampton General Hospital



With the growing awareness of persistent issues within surgery, including bullying, discrimination and sexual misconduct, how do we collectively reflect and move forward as a speciality?

Following months of discussion and preparation, I thought to answer this question by conceptualising, designing, and delivering the first-ever dedicated Equality, Diversity and Inclusion (EDI) session at the 2026 SCTS Conference in Belfast. I am grateful to Mr Vipin Zamvar, Mr Aman Coonar and Ms Aswani Parmer (EDI Chair, Society of Perfusionists) for their support.

While SCTS and Royal College statements outline organisational strategies, meaningful change also requires understanding lived experiences and fostering safe, open, constructive dialogue. The conference session, “SCTS and EDI in Cardiothoracic Surgery: How We Can All Be Better,” provided a platform to explore how workplace culture shapes professional wellbeing and patient outcomes.

Concept, Aims and Delivery

Moving away from a traditional lecture format, I adopted an interactive panel discussion to encourage engagement and reflection. Using the quiz platform *Slido*, we enabled anonymous audience participation, reinforcing clear aims (Table 2) and a code of conduct that supported honest, respectful contributions. For this first-ever session, we had 43 attendees, of whom 35 actively participated in polls and Q&A.

The esteemed multidisciplinary panel (Table 1) brought personal experiences throughout the session. The inclusion of senior members of the SCTS Leadership, namely SCTS President Mr Aman Coonar, President-Elect Professor Enoch Akowuah, Former President Mr Narain Moorjani and



Chair (on Right) Miss Emezie Okorochoa starting off the session with key definitions to engage and level understanding. Panellists (L-R): Mr Narain Moorjani, Ms Sofina Begum, Ms Daisy Sanderman, Mr Douglas West, Mr Aman Coonar.



Panellists sharing their reflections and personal experiences in the session. (L-R): Prof Enoch Akowuah, Ms Sofina Begum, Ms Daisy Sanderman, Mr Douglas West, Mr Aman Coonar.



Panellists deep in thought in answering the *Slido* quiz questions. (L-R): Mr Narain Moorjani, Prof Enoch Akowuah, Ms Sofina Begum, Ms Daisy Sanderman, Mr Douglas West, Mr Aman Coonar. Chair (Right): Miss Emezie Okorochoa

Panellist	Role
Professor Enoch Akowuah	Consultant Cardiothoracic Surgeon, SCTS President-Elect
Mr Narain Moorjani	Consultant Cardiothoracic Surgeon, Former SCTS President
Mr Aman Coonar	Consultant Cardiothoracic Surgeon, SCTS President
Ms Sofina Begum	Consultant Thoracic Surgeon
Mr Douglas West	Consultant Thoracic Surgeon SCTS Honorary Secretary
Ms Daisy Sandeman	Clinical Nurse Manager in Advanced Practice in Cardiothoracic and Respiratory Medicine

Table 1: The panel members

Aims of the session

- Encourage and increase open dialogue around EDI in a psychologically safe environment
- Encourage reflection on personal experiences, behaviours and professional responsibility
- Explore how workplace disparities may translate into inequities in patient care
- Plant the seed for sustained cultural change within the speciality

Table 2: Aims of the session

Secretary Mr Douglas West, demonstrated the clear importance and drive to improve EDI within the speciality.

To open the session, I shared a personal experience illustrating how workplace culture shapes behaviours, attitudes and ultimately patient care. As the panellists introduced themselves, they each shared a personal story of why EDI is important to them. As a trainee, I was struck by Ms Begum's experience of discrimination during training, the impact on her progression and the realisation of higher systemic issues – calling for individual responsibility to drive change. Ms Sandeman shared her experiences as Lead ANP – how she advocates for her colleagues; reflecting on how, as leaders, we have a duty to care and make a difference.

Given the breadth of EDI topics, the session centred on two main themes to keep discussions focused and tangible:

1. Disparities in the workplace
2. Disparities in patient outcomes

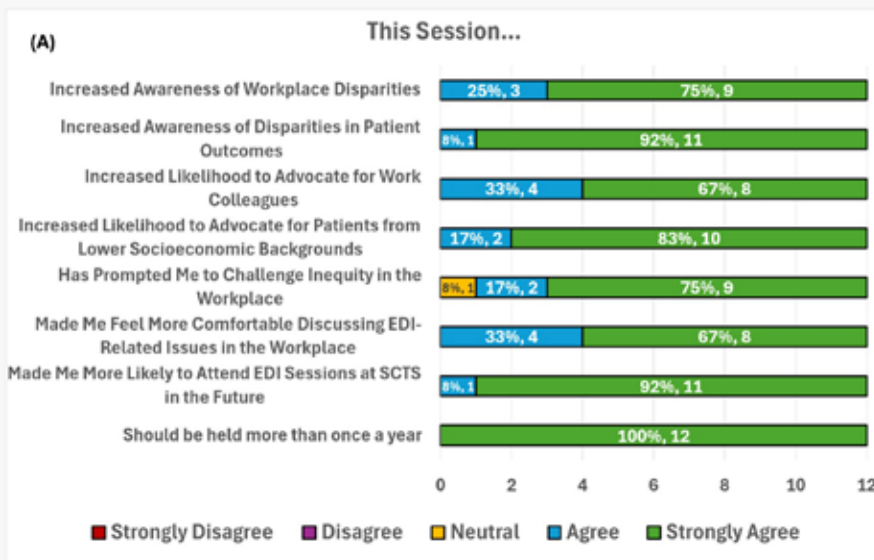
1. Disparities in the Workplace

With a quiz, I presented national EDI data in cardiothoracic surgery (collated by Ms Indu Deglukar). A key finding that prompted reflection was that around 50% of surgeons reported experiencing bullying, many feeling unable to raise concerns; 55% from ethnic minority backgrounds, and nearly 25% had considered leaving the speciality. Both panellists and audience members emphasised the importance of inclusivity, with some attendees sharing how factors such as age had affected their progression and access to support.

Workforce data from 2025 highlighted ongoing disparities at consultant level: 88% are male, only 8% of cardiac surgeons are female, and Black surgeons represent less than 3% of the workforce. This led to rich discussion around representation, visibility ("you cannot be what you cannot see") and widening participation.

The panellists reflected candidly on privilege and allyship, with Mr West boldly describing how hearing diverse perspectives prompted introspection of his privilege. Mr Coonar agreed, noting the impact of both visible and hidden characteristics, whilst recognising the Society's progress towards greater inclusivity. Mr Moorjani highlighted ongoing work to widen access to cardiothoracics as the former SCTS EDI co-chair.

Prof Akowuah drew attention to challenges within research, where underrepresentation persists among both researchers and patients. This was reinforced by an audience member,



- (B)**
- "Very informative and great discussions. Session chair was powerful with excellent knowledge and passion."
- "This was such a lovely session, especially the focus on personal experiences and allowing colleagues to speak in a safe space. Was incredibly powerful, and I feel so honoured to have attended this in this space. Dr Emezie did an incredible job, I hope there will be more of these sessions!"

Figure 1: Positive (A) quantitative (% of respondents), (n = 12) and (B) qualitative feedback received following the session, demonstrating its impact and need for future events.

who shared initiatives to diversify research teams and improve engagement of ethnic minority patients whose uptake in trials is often the poorest.

The clear take-home message was that **workforce culture clearly links to clinical outcomes**. Evidence shows that inclusive, psychologically safe workplaces are associated with fewer clinical errors, reduced burnout, and improved patient outcomes. This led smoothly into the next part of the session.

2. Disparities in Patient Outcomes

This section focused on inequalities in cardiothoracic patient care. Here, I emphasised the central concept underpinning most of the subsequent discussion: **intersectionality**. This key term, coined by Kimberlé Crenshaw, highlights how overlapping identities can compound discrimination.

Within **cardiac surgery**, we focused on a BMJ Open Heart paper by Rice *et al.*: Impact of gender, ethnicity and social deprivation on

access to surgical or transcatheter aortic valve replacement in aortic stenosis, co-authored by panellist member Professor Akowuah. In this paper, for example, Black women from socioeconomically deprived backgrounds are less likely to be referred for AVR or treated promptly, and more likely to have higher in-hospital mortality.

Within **thoracic surgery**, I presented evidence illustrating intersectionality amongst UK lung cancer studies, including results that Black Caribbean, Indian and Chinese female non-smoking patients from deprived areas are more likely to present late and have poorer prognosis. Ethnicity-based personalised and tailored care may help address these disparities. Ms Begum raised the importance of collaborative community and secondary care measures, while a medical student in the audience shared their research on lung cancer health inequalities. They helped reinforce the message that, as clinicians, we all have a role in recognising and addressing these disparities,

including advocating for our patients at every stage of their care.

Feedback and Looking Ahead

The engagement and feedback from the session were overwhelmingly positive (Figure 1), demonstrating a clear appetite for continued dialogue on these issues and the value of open, trusted conversations with balanced panellist perspectives.

This session represents an important first step towards becoming a recurring feature at future SCTS meetings, with potential for wider collaboration and expansion.

Cultural change is complex and cannot happen overnight; workplace disparities influence behaviours, decision-making and ultimately patient care. However, through education, reflection and open dialogue, we can foster a more **inclusive** and **equitable** environment for both colleagues and patients.

A special thanks to all the attendees and panellists for their honest contributions, and conference organisers for their support.

We can all be better – this session is just the beginning. ■

To be involved or contribute to the SCTS EDI Project and Sub-committee, please get in touch with Nadia Little – Nadia@scts.org

From Ballet to Trauma Surgery: Precision, Pressure, and Purpose

How a career in classical ballet shaped my path toward trauma and cardiothoracic surgery

Joana Reis Miranda, Medical Student, Brighton and Sussex Medical School



The moments before stepping onto a stage are surprisingly quiet. Despite the lights, the audience, and the anticipation, there is a brief pause backstage where everything narrows into focus: breathing, posture, timing. Years of rehearsal distil into a few seconds of stillness before performance begins.

I have encountered a similar atmosphere in acute clinical environments. In theatre, in simulation, and in trauma-focused teaching, the same controlled intensity is recognisable: individuals working with precision under

pressure, relying on preparation, discipline, and trust in the team around them.

Before studying medicine, I worked as a professional classical ballet dancer and teacher with the Royal Academy of Dance and the Imperial Society of Teachers of Dancing. At first glance, ballet and surgery appear to belong to different worlds – one associated with performance and artistry, the other with clinical urgency and life-threatening pathology. The more exposure I gain to medicine, however, the more I find that distinction misleading.

Classical ballet is often viewed through the lens of elegance, but behind the curtain, it is built on repetition, technical refinement, and consistency. A single movement may be practised hundreds of times in pursuit of precision. Small adjustments in positioning, timing, or weight transfer can entirely change the outcome of a performance. The process demands humility, attention to detail, and the willingness to continue improving long after fatigue has set in.

Medicine, particularly within high-acuity specialities, demands the same qualities.

What initially drew me towards trauma care was the combination of technical skill and decision-making under pressure. Trauma environments are fast-paced and unpredictable, yet the clinicians leading them remain methodical and composed. There is little room for ego, hesitation, or disorganisation. Effective trauma care depends on communication, situational awareness, and the ability to function cohesively as part of a multidisciplinary team.

As my medical training progressed, this interest increasingly extended towards cardiothoracic surgery. Through clinical placements, trauma education, and exposure to surgeons working within acute care pathways, I became fascinated by the management of thoracic disease and injury. The chest contains some of the body's most vital structures, and cardiothoracic surgeons operate at the interface of technical precision, physiology, and decisive intervention. In cases of severe thoracic trauma, their expertise can be critical in the management of injuries affecting the heart, lungs, and great vessels.

These dynamics were unexpectedly familiar to me.

In ballet, performances are never individual achievements, regardless of who stands in the spotlight. Behind every production is a coordinated team of dancers, teachers, choreographers, stage managers, musicians, and technicians working with shared purpose. Timing matters. Communication matters. Trust matters. A successful performance depends not only on technical excellence but also on the ability of a team to function seamlessly under pressure.

I have seen similar principles in medicine. Watching a trauma team work through a primary survey on an unstable patient – each member moving to their assigned role without instruction, the team leader speaking quietly while the room moves quickly around them – felt strikingly like a corps de ballet executing a complex sequence. The most impressive clinicians I have encountered are rarely the loudest in the room. They bring structure and clarity to situations where both could easily collapse.

The same qualities are evident in cardiothoracic surgery. Whether managing complex thoracic pathology, undertaking technically demanding procedures, or contributing to the care of major trauma patients, cardiothoracic surgeons work in

environments where preparation, precision, teamwork, and calm decision-making are essential. These are qualities I learned to value in ballet long before I encountered them in medicine.

There is also a psychological aspect shared between both disciplines that is rarely discussed openly: the relationship with pressure itself.

Performing professionally taught me how to function despite fatigue, uncertainty, and scrutiny. It taught me that preparation creates confidence, and that discipline matters more than motivation. Most importantly, it taught me that composure is a skill that can be developed over years through exposure to moments that test it. It is not a personality trait. It is trained.

These lessons have shaped the way I approach medicine. Clinical practice requires

lifelong learning, continuous self-reflection, and acceptance that technical mastery is built gradually through repetition and experience. As a mature student who has already trained intensively in one demanding field, I find this mindset deeply familiar – and I think it is a perspective that mature entrants to medicine bring more often than is acknowledged.

Although my path into medicine has been unconventional, I no longer view ballet and surgery as disconnected chapters of my life. They are experiences linked by common principles: precision, resilience, teamwork, and performance under pressure.

Trauma surgery represents a field where these qualities intersect in their most immediate form. It is technically demanding, emotionally intense, and profoundly team-oriented. It requires rapid thinking alongside meticulous attention to detail. Above all, it demands the ability to remain composed when a patient's outcome depends on the next decision.

My growing interest in cardiothoracic surgery stems from many of the same qualities that first drew me to ballet: the pursuit of technical excellence, disciplined preparation, attention to detail, and the ability to perform effectively under pressure. Through my exposure to trauma care, I have become particularly interested in the management of thoracic injuries and the critical role cardiothoracic surgeons can play in the treatment of severely injured patients.

The stage and the operating theatre are different environments. One performs for an audience; the other serves a patient who may never know your name. But both require preparation that begins long before the critical moment arrives, and both reward the people who have learned to do their best work when it matters most.

Years after leaving professional ballet, I still carry its lessons with me. They continue to shape the way I learn medicine and the kind of surgeon I hope to become. As I continue my medical training, I am increasingly drawn to the intersection of trauma and cardiothoracic surgery – fields that demand technical mastery, teamwork, resilience, and the ability to remain calm when the stakes are highest. In many ways, they reflect the very qualities that first shaped me as a dancer and continue to guide me as a future surgeon. ■



A National Strategy to Address Chest and Lung Surgery Priorities

Moslem Abdelghafar, Research Fellow, NIHR Senior Fellow, Hammersmith Hospital, Imperial College Healthcare NHS Trust – University of Leicester

Jacie Law, NTN, Royal Brompton Hospital

Hind Elhassan, NTN, Northern General Hospital, Sheffield

Babu Naidu, Consultant Thoracic Surgeon, Queen Elizabeth Hospital, Birmingham



Thoracic surgery serves a large and complex patient population. Each year, thoracic surgery services across the United Kingdom treat a large number of patients with conditions affecting the lungs, pleura, mediastinum and chest wall, including lung cancer and benign, but often life-changing, conditions such as pleural sepsis, pneumothorax, emphysema and chest wall deformity. Despite this burden, thoracic surgery remains underrepresented in national research activity. Of 1,887 active NIHR funding awards, only two are directly focused on our specialty. This mismatch has consequences: gaps in evidence, variation in practice and outcomes that continue to lag behind comparable healthcare systems.

The Chest and Lung Surgery James Lind Alliance Priority Setting Partnership was established to address this gap by identifying the research questions that matter most to patients, carers and healthcare professionals. The process was deliberately inclusive and national in scope. It brought together patients, clinicians, researchers, charities and partner organisations, including the Roy Castle Lung Cancer Foundation and Pectus Matters. Local champion teams were appointed across thoracic units in Great Britain and Ireland with multidisciplinary representation.

The initial survey, launched at the SCTS Annual Meeting in Edinburgh in March 2025, asked a simple but important question: “What questions would you like future research in thoracic surgery to address, including diagnosis, treatment and outcomes?” Between March and June 2025, the survey received 1,748 submissions from 570 participants. These responses were reviewed, refined and checked against existing evidence to identify true unanswered uncertainties. Separate interim surveys and

final prioritisation workshops were then used to agree two Top 10 lists: one for cancer and one for non-cancer chest and lung surgery.

The resulting priorities were broad, practical and deeply patient-centred. Across both lists, common themes emerged: faster and more efficient pathways, better communication and preparation before surgery, improved pain management, enhanced recovery, psychological support, rehabilitation, management of complications and understanding long-term outcomes. The need for a quicker, easier and more efficient pathway, from diagnosis to timely treatment, was a particularly strong message from patients and appeared as a leading priority across both cancer and non-cancer pathways. Cancer-specific priorities included surveillance for recurrence, the comparative value of wedge resection, segmentectomy and lobectomy, alternatives to surgery, endobronchial treatment for early-stage cancer, management of oligometastatic disease and tumour localisation. Non-cancer priorities included chest drain management, ERAS implementation, risk assessment tools, physiotherapy and the long-term impact of surgery on function, wellbeing and need for further treatment.

The value of the PSP lies not only in defining priorities, but in creating a mandate for action. The Top 10 lists are now being used as the foundation for a national research strategy in chest and lung surgery: one that converts patient-informed priorities into fundable, deliverable and practice-changing studies.

A central component of this strategy is the development of a Thoracic Surgery Research Network. Thoracic surgery is a highly specialised field, with expertise distributed across a relatively small number of centres. The network provides a collaborative structure to develop and deliver multicentre research across the full thoracic surgery pathway.

Patient and public involvement remains central beyond the priority-setting process. A national Patient and Public Involvement group will help maintain perspective throughout the research lifecycle. Patients and carers will contribute to refining research questions, selecting meaningful outcomes, shaping recruitment strategies, and supporting dissemination. This ensures that research remains anchored in lived experience rather than solely in traditional clinical endpoints.

The next phase, focused on translating the PSP priorities into clinically relevant research domains. Three clinical study groups were established, with representation from clinicians, researchers and patient contributors. These groups considered how individual priorities could be converted into specific, answerable studies.

The emerging research questions were then discussed with the wider group and prioritised into early, middle and late phases. This prioritisation considered three practical factors: feasibility, potential impact and the level of resources required to deliver each study. Early-phase studies are likely to include projects that can be delivered using existing networks, routinely collected data, surveys, or pragmatic multicentre designs. While Later-phase work is likely to include complex interventions or studies requiring substantial funding, infrastructure and long-term follow-up.

This phased approach is important; by sequencing the work, the strategy creates a realistic route from priority identification to funded research delivery.

A successful national strategy also learns from other specialties. Oncology and Other surgical specialties have shown how collaborative trial infrastructure can embed research into routine care and deliver practice-

changing evidence, leading to clinical study groups, multicentre research networks and funded programmes of work. Thoracic surgery is now adapting these models to its own context, creating a structured pathway from shared priorities to funded, deliverable research.

Funding alignment is essential, the priorities identified through this process are highly relevant to national funding programmes focused on clinical effectiveness, health service delivery, and patient-centred care. They are also attractive to funders supporting respiratory and thoracic disease. Early engagement with funders, supported

by feasibility data and strong PPI input, will increase the likelihood of success. Studies will add value through embedded qualitative research, translational sub-studies, development of patient-reported outcome measures and standardisation of outcome reporting.

The long-term success of this strategy will be judged by tangible measures: centres engaged, patients recruited, studies funded, publications generated, guidelines influenced, and outcomes improved. Its deeper success, however, will depend on cultural change. Research needs to become part of routine thoracic surgical care, not an optional extra.

Patients need opportunities to contribute to evidence generation as part of their pathway, and clinicians need collaborative research structures that make participation practical and worthwhile.

The PSP has given the thoracic surgery community a clear, patient-informed roadmap. The questions have been asked and prioritised by those who live with, care for and treat chest and lung disease. The next responsibility is delivery, building the partnerships, study groups and funded programmes needed to answer them. ■

The Thoracic Surgical Workforce in the Era of Lung Cancer Screening

Lawrence Okiror, Consultant Thoracic Surgeon, Guy's Hospital, London



The lung cancer pathway in England has changed substantially over the past five years. Screening is finding cancers earlier and in larger numbers, and those patients are now arriving in our clinics and on our operating lists. The clinical case for the NHS Lung Cancer Screening Programme is settled. The question that now faces the specialty is whether the part of the pathway that follows – the surgery – is configured for the volume that is already here, let alone the larger volume to come.

The stage shift is no longer theoretical. The SUMMIT study, the large London screening cohort published in *The Lancet Oncology* last year, found that roughly four in five screen-detected lung cancers were at stage 1 or 2, and almost all of those patients went on to receive potentially curative treatment. National five-year implementation data from the NHS England Lung Cancer Screening Programme, published in *Nature Medicine* in March, told the same story: about three quarters of screen-detected cancers were at stage 1 or 2. This is precisely what international screening trials predicted, and we can now see it in our own NHS data.

The volume has already begun to follow. The most recent National Lung Cancer Audit reports a year-on-year rise of around a fifth in lung cancer resections in England – the largest single-year increase in the audit's history. Every thoracic surgeon in the country will have felt

it: more multidisciplinary discussions, more small peripheral nodules, more requests for early dates. And we are still some way from full national rollout of the screening programme. The audit also notes that nearly nine in ten patients with early-stage cancer waited beyond the 49-day target from referral to surgery. This is not a screening problem. This is what happens downstream of one.

It is worth being honest about what will and will not relieve this pressure. The LungIMPACT randomised trial, reported in *Nature Medicine* in March, tested whether immediate AI prioritisation of chest radiographs could speed up the lung cancer diagnostic pathway. It did what one would expect – radiology reports came out more quickly – but it did not significantly shorten the time from chest X-ray to lung cancer diagnosis. The bottleneck, the authors concluded, lies downstream of the radiology report. Anyone who has worked in this pathway will recognise where: in CT, in PET, in bronchoscopy, in clinic, and increasingly in theatre.

The workforce data describe the scale of what we are working with. The SCTS-SAC Cardiothoracic Surgery Workforce Report 2025 reports 153 consultant thoracic surgeons across the United Kingdom and Republic of Ireland, the great majority of whom practise in England. Eighteen are expected to retire over the next five years against around 25

posts considered for advertisement – a net expansion of approximately seven posts in the period during which national screening rollout is being completed. Of the trainees in the pipeline, about one in three has expressed an interest in thoracic surgery. The most common pattern of operating among consultant thoracic surgeons is two sessions a week – that is, one full day.

The response within existing capacity is well described and is the foundation of efficient practice. Integrated robotic bronchoscopy services allow diagnosis, mediastinal staging and surgical planning in a single admission for the appropriate patient. Robotic anatomical resection, including segmentectomy where clinically indicated, allows lung-preserving surgery for the small peripheral node-negative tumours that the screening cohort generates. Robotic surgery is now the declared primary subspecialty interest of nearly half of consultant thoracic surgeons. These developments have made existing capacity more efficient. They are not, however, a substitute for capacity expansion.

Screening is succeeding because the evidence base behind it is strong, and because patients are turning up. The question now is whether surgical capacity, training pipeline numbers and theatre infrastructure will follow before the gap becomes harder to close. ■

Setting the Standard for Trust Doctor Support

Musab Mohammed, Speciality Doctor, University Hospital of Wales, Cardiff



“One being educated needs three things: natural ability, practise, and time.”

Plato’s observation remains highly relevant to modern surgical training. While natural ability is individual, providing meaningful practise and protected time is the responsibility of the training environment around us. In today’s pressured healthcare systems, these are often the first things to be compromised.

The recognition of Cardiff Thoracic Surgery as the “Best Department for Trust Doctor Support” at the 2026 Society for Cardiothoracic Surgery in Great Britain & Ireland Annual Meeting in Belfast therefore represents an important milestone. Because the award is voted for by doctors themselves, it reflects the real day-to-day experience of the workforce rather than external performance metrics alone. More importantly, it highlights the value of building a culture that prioritises opportunity, mentorship, and inclusion.

Across the UK, the gap between Deanery-appointed trainees and Trust Doctors remains a significant challenge. Too often, Trust Grade roles can become heavily service-orientated, with limited access to structured training opportunities. Cardiff’s experience demonstrates that these distinctions do not need to define professional development or clinical opportunity.

Under the leadership of Miss Malgorzata Kornaszewska, Mr Ainis Pirnieks, Mr Vasileios Valtzoglou, and Mr Tom Combella, the department has developed a culture where education is embedded within service delivery rather than viewed as separate from it. Educational opportunities, teaching sessions, simulation exposure, and clinical mentorship are offered according to engagement and aspiration rather than contract type alone.

A major strength of the Cardiff model is its practical integration of Trust Doctors into

the wider training structure. They are not viewed simply as supplementary workforce members, but as developing clinicians who are given meaningful operative exposure, increasing responsibility, and opportunities to participate in research, governance, and multidisciplinary working.

This approach is particularly important in relation to the Portfolio Pathway (formerly CESR). For many doctors, the pathway can appear complex and isolating. Cardiff has shown that with structured support, clear supervision, and alignment of operative experience with competency frameworks, the Portfolio Pathway can become a realistic and achievable route toward specialist registration.

The wider implications for the cardiothoracic community are significant. At a time of increasing workforce pressure across the NHS, departments that invest

in professional development are more likely to attract, support, and retain motivated clinicians. Creating a culture of inclusion and trust not only strengthens morale within teams, but ultimately benefits patient care and departmental stability.

For the wider specialty, Cardiff’s recognition serves as both validation and reflection. It reinforces the principle that every doctor within the theatre environment is, in some form, still learning. While surgical excellence is often measured through innovation and clinical outcomes, it should also be measured by how effectively departments develop their people.

Cardiff Thoracic Surgery’s achievement demonstrates that supportive training culture is not an optional extra, but an essential part of building the future workforce of cardiothoracic surgery. ■



Cardiff Thoracic Surgery consultants celebrating the SCTS 2026 Best Department for Trust Doctor Support award at the University Hospital of Wales, Cardiff

The Nano-Scalpel in a Student's Mind: A Bachelor's Student Steps Into Surgical Innovation



Ibrahim Almabrook Mohammed Ali, Medical Student, Faculty of Human Medicine, Sabratha University

Imagine standing at a podium at International Surgical Week 2026 and saying: "I am an undergraduate student, and I believe nanorobots may one day navigate human arteries to perform cardiac surgery without a single incision."

That moment reflects my journey – a Libyan bachelor's student who chose to explore ideas early rather than wait for a degree to begin contributing.

A Dream Begins in a Library

While many of my peers focused on exams, I found myself drawn to research. My abstract, "*The Use of Nanorobots in Cardiac and Thoracic Surgery*," was accepted for International Surgical Week 2026 – a milestone that came from curiosity, persistence, and long hours of independent study.

The Moment It All Began

In October 2022, I presented early concepts at the 7th Libyan Conference on Medical Sciences. It was the first time I felt part of a wider scientific community.

Soon after, I received confirmation that my paper had been accepted for the 20th Congress of the Libyan Society of Surgeons. Holding that participant card was a quiet but meaningful reminder that students can be taken seriously when they take their work seriously.

Four Days in Benghazi

I travelled to Benghazi by bus – an ordinary student eager to learn. Over four days, four major international meetings were held as a joint congress:

- AAPS Meeting
- Maghreb Pediatric Surgery Meeting

- Libyan-Tunisian Meeting
- Libyan International Pediatric Surgery Meeting

The world came to Benghazi, and I was grateful simply to be in the room, notebook in hand. Sometimes access begins not with a passport, but with curiosity and the willingness to show up.

A Concept Takes Shape

At the 1st Libyan Exhibition for Scientific Research, Innovation, and Investment, I presented a conceptual design: the **Advanced Surgical Navigation System (ASNS)** – a system imagined to guide surgical tools with high precision and potentially integrate with future nanorobotic technologies.

The judges responded positively, and I received:

- **Innovation Shield**
- **Certificate of Excellence**

These awards were encouraging not because they signalled perfection, but because they recognised potential.

International Recognition

The American Association for Continuing Medical Education (AACME) later acknowledged two of my presentations at Egyptian Society of Surgery meetings:

- "*A Prospective Study on the Use of Nanorobots in Minimally Invasive Surgery*"
- "*The Nanorobotics Surgeon*"

For a student still preparing for bachelor's exams, this recognition reinforced that early ideas can have value when approached with seriousness and respect for the science.

More Than a List of Conferences

Each event represents late nights preparing slides, nervous moments before speaking, and conversations that sparked new directions. I attended not as an observer, but as a student committed to learning – and gradually, others began to see that commitment too.

Looking Ahead

My interest in surgery grows every day. I am still at the beginning of my journey, but I am working toward it with intention. I hope to contribute to the future of nanorobotics in surgery, and I am currently planning:

- Developing a simulation prototype of the ASNS
- Writing a review on the ethics of surgical nanorobotics
- Preparing for medical school or a direct PhD pathway

Conclusion: Starting Before You Feel Ready

Looking back, I feel grateful – not because I have arrived anywhere, but because I chose to start. From a classroom in Libya to International Surgical Week 2026, each step has taught me that:

- You don't need a title to have a vision.
- You don't need a degree to begin researching.
- You only need curiosity, courage, and the willingness to begin.

The scalpel of the future may be a nanorobot – and the person guiding it could be a student who simply decided not to wait. ■

DaVinci Code: The Art of Setting up a New Robotic Thoracic Service – A Counter-Intuitive Journey

Christopher Roche, NTN, University Hospital of Wales, Cardiff

Tom Combellack, Consultant Thoracic Surgeon, University Hospital of Wales, Cardiff

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‘Sonder’ is defined as the realisation that everyone else is living a life as vivid as our own, with their own ambitions, dreams and worries. Arguably, this is an important notion to lean on when embarking on a 7-10 year pathway to establish a robotic programme within a complex field of NHS Wales stakeholders.

As of April 2026, Cardiff has been running a robotic thoracic surgery service. This is the fruit of almost 10 years of work to navigate the various streams necessary to reach this goal. This is a (concise) story giving a flavour of the journey.

The title alludes to some of the headwinds, which were both “counter” to the push to establish robotic surgery and, in a sense, “counterintuitive” (unpredictable and with a tendency to take on a somewhat irrational life of their own).

The initial vision was spearheaded by Cardiff-based consultant, Margaret Kornaszewska, a decade ago. It started becoming reality with a robotic masterclass in one of our centres (the Welsh Institute for Minimal Access Therapy, WIMAT) in 2017. Margaret’s invitation of thoracic surgeons, Robert Cerfolio and Sasha Stamenkovic, to mentor and guide the project was critical. Subsequently, the pathway included (but was not limited to): Health Technology Wales (HTW) business cases, various reviews of robotic systems, navigation of many negotiations under Margaret’s leadership in 2021 (during all-Wales robotic procurement), lobbying (often with no end in sight) directly with NHS Wales Joint Commissioning Committee (NWJCC), engaging the Swansea and Cardiff medical directors (during service modelling for transition to a single thoracic centre, incorporating the robot into that projected service model), moving through rejection from HTW at that time and so on.

In parallel to these endeavours, Sasha Stamenkovic was invited as a visiting surgeon to perform a robotic assisted lobectomy on our *Da Vinci Xi*. Then, five years ago, Tom Combellack undertook a robotic fellowship at Barts under his supervision with the support of SCTS Ionescu funding. In an intense 3-month period he learned robotic skills and performed 23 cases. This was enough to be the lead surgeon operating on our first cases in Cardiff last month, under Sasha’s proctorship. Two cases on the first day passed without issue. Then two more cases on the second day of operating without the proctor present: we were finally ‘up and running’.

Case selection for our first patient was critical. The first case was the only lower lobectomy on our waiting list, an anatomically attractive starting point for lung resections using the robot. However, the patient was also immunosuppressed after a renal transplant (and warfarinised). We agreed that this was not an “ideal” first case but, on balance, would be a great candidate to make the most of the advantages of minimally invasive robotic surgery. Thankfully, the surgery was a success and she was fit for discharge on day two.

This tale is very much a team success story. One of the key supportive steps we took was that the other three thoracic consultants in the unit embedded some flexibility in their schedules and attended at various times to observe. This was to provide a milieu of team support in theatre, which is intangible but supremely valuable when doing first cases for surgical methods less familiar to the surgeon and the whole team. The scrub team, led by our excellent and dedicated colleague, Himali Silva, worked tirelessly to ensure we were ready on day one. Also, a special mention to our anaesthetic team led by Dr Caroline Evans and our SCP first assistant, Anna Luen,

amongst others too numerous to name.

Pressure also came from the knowledge that these initial surgeries in the new service were the result of the many years of meetings, discussions and negotiations (even, on occasion, frank arguments reflecting the passion and frustration that many of us felt). Many gave their time to these processes when it was of benefit to us and none whatsoever to them. We think especially of our urology colleagues, who gave up some of their long-established access to the robotic hardware so we could have that operating time for our specialty. This was amongst many other stakeholders, including other specialties who are also still competing for robotic theatre time. There had been delicate and intricate negotiations at multiple levels of the NHS structures we work within. Ultimately, we were able to demonstrate readiness to deliver clinical benefit at a reduced cost in a way which placed us at the front of the pack.

Lastly, but of course the paramount consideration, are the patients. They gave their consent to the surgery being done robotically and to being the first cases in the new service.

Happily, the establishment of the service went smoothly without complication and with excellent outcomes, demonstrating the advantages of the robotic method: (e.g.) low complications, good oncological quality and short length of stay. A whole team debrief after the first day was essential and revealed a sense of pride and camaraderie, having worked together to achieve what had previously seemed in doubt for our region. We look forward to working in partnership with all those with whom we forged working-relationships and bonds as part of this sonderous journey. We thank the patients and express gratitude to them, without whom there would be no service. ■

Annual SCTS Student Engagement Day

Evie Haigh, Engagement Day Co-ordinator, Keele Surgical Society
Avani Bhalla, Vice President, Keele Surgical Society
Poorva Zope, President, Keele Surgical Society



On Saturday 29th November 2025, the Annual SCTS Student Engagement Day was hosted by Keele Surgical Society at Royal Stoke University Hospital, centred around the theme of “Innovation, Resilience and Progress”. The event welcomed 80 medical students from across the UK and 15 sixth form students from local schools, aiming to inspire students at different stages of training through keynote talks, networking opportunities and hands-on practical sessions. The event sought not only to showcase the technical aspects of cardiothoracic surgery, but also the supportive culture, teamwork and mentorship within the specialty, helping make a competitive career path feel more accessible and achievable.

The morning talks were delivered by four keynote speakers who explored the past, present and future of cardiothoracic surgery. Mr Bil Kirmani opened the day, taking attendees back five millennia through the history and development of cardiothoracic surgery. Professor Ali Zamir Khan provided a glimpse into the future of the specialty, from AI to robotic surgery. Professor Mahmoud Loubani spoke about the importance of resilience, balance and wellbeing within high-stakes careers, reminding students that surgery is about far more than career ambition and technical skill alone. Closing the morning, Dr Juneenath Karattuparambil gave students a fascinating insight into the complex perioperative care of cardiothoracic patients beyond the operating room, highlighting the teamwork that takes place behind the scenes.

During the afternoon, students rotated through a range of hands-on practical workshops led by consultants, trainees and



The four keynote speakers with the co-hosts following the morning talks. Named in order of appearance in image from left to right: Avani Bhalla, Professor Ali Zamir Khan, Evie Haigh, Benjamin Chapman, Professor Mahmoud Loubani, Mr Bil Kirmani, Dr Juneenath Karattuparambil, Poorva Zope

junior doctors, helping students to develop their technical skills. Students could choose between basic and intermediate suturing sessions, and gained hands-on exposure to thoracic and cardiac surgical techniques through VATS, bronchoscopy, coronary anastomosis and valve replacement workshops. The portfolio-building workshop – led by trainees who had recently secured specialty training posts – proved particularly popular, providing valuable guidance on navigating an increasingly competitive and often daunting application landscape. Sixth form students also participated in their own stream of workshops, including anatomy simulations with VRiMS, trauma scenarios, basic life support delivered by StreetDoctors and personal statement guidance, supporting future applications.

The Engagement Day concluded with an insightful talk on medical ethics and the “Battle of the Chest”, a lively and interactive debate showcasing the unique appeal and challenges of both cardiac and thoracic surgery. Attendees were also given the opportunity to present their work through the medical student abstract competition and sixth form essay competition, with winners announced during the closing session.

The success of the event would not have been possible without the invaluable support and guidance of Mr Shilajit Ghosh and Mr Jason Ali, alongside the generous support of sponsors including Johnson & Johnson, Geeky Medics, the BMA, MDU and VRiMS.

As the first SCTS student event hosted in Stoke-on-Trent, the day marked an exciting step in widening engagement within cardiothoracic surgery. By bringing together students, trainees and consultants from across the country, the event celebrated not only the progress of the specialty, but also the future generation who will shape it, reflecting the importance of supporting aspiring clinicians at every stage of their journey. ■



The VATS workshop

The Quiet Architecture of Surgery

Aisha Ahmed, Medical Student, University of Dundee

The Attraction of Scale

What first draws someone towards cardiothoracic surgery? For me, the fascination began with scale. The idea that a surgeon could stop a heart, isolate a lung, or operate within the most protected spaces of the human body seemed almost incomprehensible when viewed from the outside. Cardiothoracic surgery appeared to exist at the furthest edge of medicine where anatomy, physiology, technology, and technical precision converge under immense pressure.

From a distance, it felt defined by spectacle.

Yet after spending time observing cardiothoracic teams at the Golden Jubilee National Hospital, I realised that the true character of the specialty lies not in spectacle, but in restraint.

The Stillness of Theatre

The first thing that surprised me about cardiac theatre was not urgency, but composure.

I had expected intensity to announce itself loudly through rapid instructions, visible tension, perhaps even controlled chaos. Instead, the atmosphere was strikingly measured. Around the operating table, individuals moved with deliberate precision while speaking remarkably little. Anaesthetists adjusted physiology with focused concentration. Scrub nurses anticipated instruments before requests were fully spoken. Perfusionists monitored circulation while the bypass machine prepared to assume the work of the patient's heart and lungs themselves.

Everything appeared purposeful. Nothing appeared wasted.

Watching coronary artery bypass surgery for the first time felt strangely disorientating. Every instinct associates life with the movement of the heart, its rhythm so constant that we rarely notice it until confronted with the possibility of its stillness. Yet in theatre, I watched as circulation was entrusted temporarily to a machine while surgeons operated upon a heart no longer carrying out its familiar work.

What struck me most was not the drama of the moment, but the stillness surrounding it.

The bypass machine hummed softly in the background while physiology was continuously observed, adjusted, and protected by the team around the table. At one point, a scrub nurse placed the next instrument into the surgeon's hand before a word had even been spoken. The movement lasted only seconds, yet it captured something essential about the environment around me: anticipation had become its own form of communication.

Something that seemed unimaginable from the outside became, within theatre, an act of extraordinary discipline.

For a moment, medicine no longer felt purely scientific. It felt almost architectural as though every individual in theatre was helping sustain a structure held together not only by technical skill, but by concentration, anticipation, and trust.

The Orchestra of Surgery

The surgeons stood at the centre of the operation, yet the longer I observed, the more impossible it became to separate their work from everyone surrounding them. Surgery did not feel like an individual performance. It felt orchestral.

While the surgeons operated within the thoracic cavity, the anaesthetic team continuously negotiated physiology in real time balancing pressure, ventilation, oxygenation, analgesia, perfusion, and circulation with extraordinary accuracy. Every adjustment seemed almost invisible unless one consciously searched for it, yet the operation depended upon it entirely.

What unfolded in theatre was not simply technical execution, but collective awareness: multiple disciplines functioning in synchrony under conditions where even small imbalances carried consequence.

That understanding deepened further in thoracic theatre.

Observing lobectomy and lung isolation techniques revealed not only technical

complexity, but the delicacy with which physiology must be negotiated to make surgery possible at all. The clinicians I observed were not attempting to overpower biology, but to work carefully within its limits.

Beyond the Operating List

Outside theatre, outpatient clinics revealed another side of the specialty entirely one less visible, yet perhaps more revealing.

Medical students are often exposed to surgery through operations, where outcomes can appear immediate and decisive. Clinics exposed something quieter: the reality that surgery continues long after the operating list ends. Recovery is rarely linear. Pain can persist unexpectedly. Healing follows its own logic rather than textbook timelines.

Listening to these conversations altered the way I thought about medicine itself. I began to understand that clinical practice often exists not in absolutes, but in approximation a continual balance between intervention and limitation, ambition and realism.

One surgeon expressed this with a sentence that remained with me long after the week had ended: "We can't make it perfect, but we can make it reasonable. We can't fight nature." **Mr NK, Consultant Cardiothoracic Surgeon**

What struck me was not pessimism, but humility.

Before this experience, I viewed surgery primarily as a discipline concerned with correcting pathology. Yet the clinicians I observed approached medicine with something far more nuanced: an understanding that expertise does not eliminate uncertainty. Even the most advanced forms of surgery remain accountable to healing, frailty, time, and biology itself.

Precision and Judgement

Toward the end of the week, I observed robotic thoracic surgery for the first time, including robotic-assisted lobectomy and

bronchoscopy. From the console, the surgeon's movements were translated into motions of extraordinary precision within the thoracic cavity.

The technology was undeniably impressive, yet what stayed with me was not the machinery itself, but the discipline surrounding it.

Despite the sophistication of robotic systems, the atmosphere in theatre remained unchanged: calm, measured, and deeply collaborative. Technology had extended surgical capability, but it had not replaced the qualities that mattered most was judgement,

communication, anticipation, and trust.

And perhaps that is ultimately what deepened my interest in cardiothoracic surgery.

Not simply the technical brilliance of the operations themselves, but the culture surrounding them. The composure beneath pressure. The humility coexisting alongside expertise. The understanding that precision alone is insufficient without restraint.

Carrying Life Through Uncertainty

As students, we are often taught medicine through certainty: diagnoses, protocols,

management pathways, correct answers.

Observing cardiothoracic surgery revealed a far more complex reality one shaped equally by communication, uncertainty, emotional intelligence, and trust.

I arrived fascinated by cardiothoracic surgery because of its complexity. I left fascinated by its humanity.

Because beneath the bypass circuits, robotic systems, and extraordinary technical skill, there existed something far quieter and infinitely more important: the responsibility of carrying another human life safely through uncertainty. ■

Adapting to a Changing World through Research

Gavin Murphy, Consultant Cardiac Surgeon, Glenfield Hospital, Leicester

Enoch Akowuah, Consultant Cardiac Surgeon, James Cook University Hospital, Middlesbrough

Mahmoud Loubani, Consultant Cardiothoracic Surgeon, Castle Hill Hospital, Hull

Sue Page, Project Manager, National Cardiac Surgery Clinical Trials Programme, Glenfield Hospital, Leicester

Sarah Murray, Lay Representative, SCTS



"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change"

This quote is often misattributed to Charles Darwin as a description of Natural Selection, but in fact was coined by Leon C. Megginson, a professor of business management in 1962. However, his description of how services must evolve to adapt to change applies to the current state of adult cardiac surgery.

There are multiple drivers for change

The first is the change in the population who are referred for surgery. They are older with multiple long-term conditions where the balance of risks versus benefits does not always favour surgery over less invasive therapies.

Second, improvements in less invasive treatments have mitigated the long-term benefits of surgery over these techniques. Improvements in percutaneous coronary interventions, such as physiological lesion assessment, intracoronary imaging, and later generation stents have reduced the gap

between PCI and surgery for longer-term outcomes. Percutaneous TAVR has replaced surgical AVR as the most common treatment for severe aortic stenosis, and TEER is emerging as an effective treatment for mitral and tricuspid valve disease.

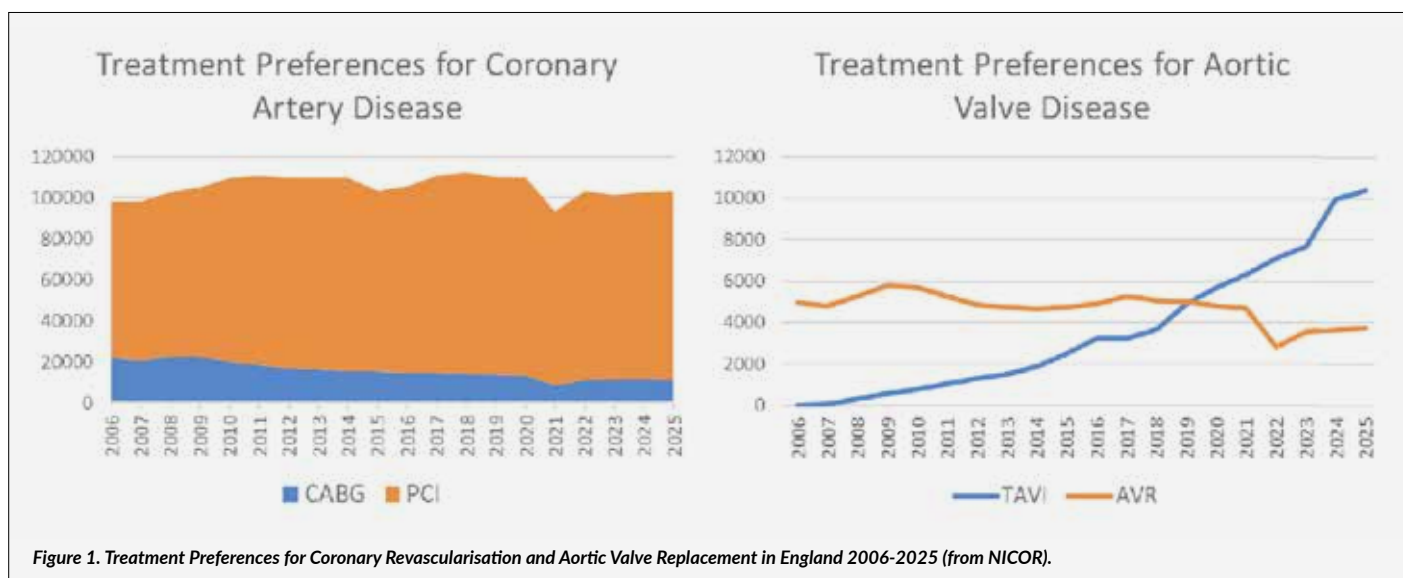
A third consideration is the long-term effect of surgeon specific mortality reporting on treatment decisions by the Heart Team. Initially developed as a tool for surgeons to benchmark the quality of their individual practice against their peers, surgeon specific mortality and unit mortality were subsequently adopted by the NHS as markers of service quality. 96-98% of interindividual and interinstitutional variability in hospital mortality following surgery is attributable to the baseline status of the patient. It follows that the surest way of reducing surgeon and institutional mortality is for patients at higher surgical risk to have alternative, non-surgical treatment. This adversely affects overall survival. A recent study has shown that regions in England with the lowest CABG:PCI rates have the lowest hospital mortality but the highest five year mortality

following multivessel revascularisation for coronary artery disease. Preferences for PCI may have led to as many as 7000 excess deaths in England between 2009 and 2020.

The overall result of these pressures is a decline in the numbers of surgical procedures, which are almost half that when I was appointed as a consultant 20 years ago.

High quality research enables services to adapt to change

Interventional cardiology is one example of how services have reacted to pressures for safer and more effective treatments with high quality research. However, a more appropriate comparison is Vascular Surgery. 20 years ago, in response to NCEPOD reports of unwarranted variation in care and the emergence of effective percutaneous interventions Vascular Surgery underwent a reconfiguration of services and a reduction in the number of centres from 107 in 2012 to 62 in 2026. A key service specification of the newly reconfigured centres was at least six interventional radiologists, reflecting the expected transition to less invasive treatments.



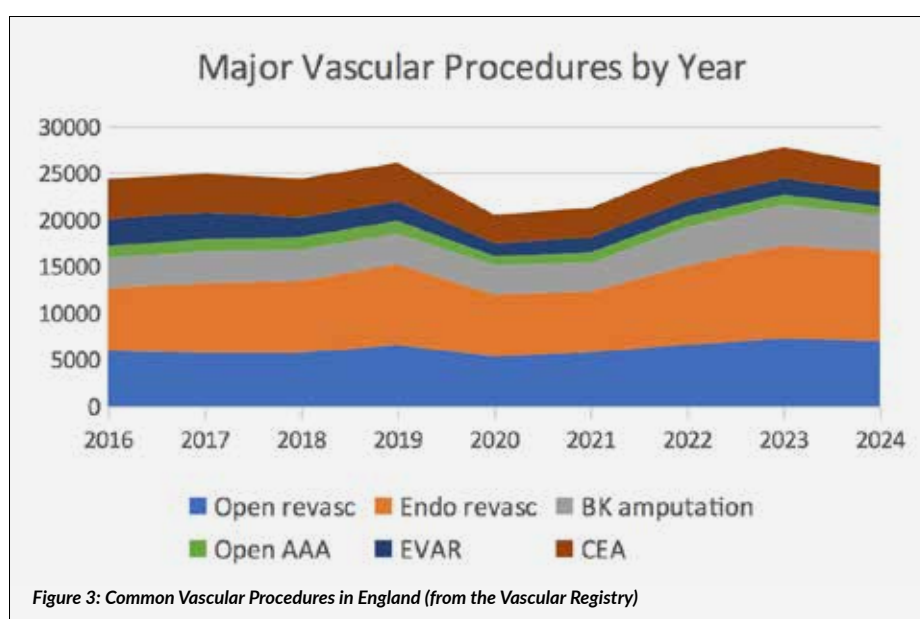
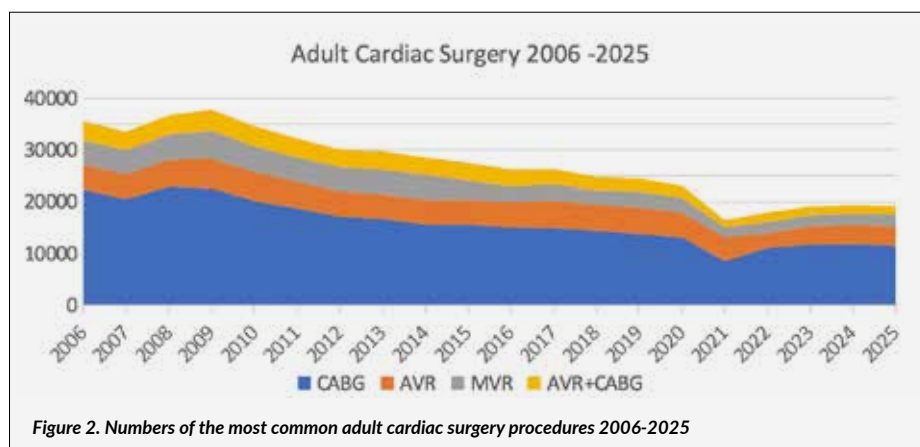
However, Vascular Surgery responded to these changes with high quality research that has more clearly defined the indications for surgery and the limitations of percutaneous therapies. The Vascular Surgery research programme in the UK includes a large portfolio of trials, many of which (EVOCC, RAF, ESTABLISH) are testing whether surgery is *superior* to percutaneous therapies. As a result, the surgical workload is expanding, with UK work force planning indicating that the number of Vascular Surgeons should increase by up to 800 in the coming years.

How has the SCTS Responded to Change?

In 2017, the Society supported the development of a new National Research Programme in Adult Cardiac Surgery, with the appointment of a representative to the RCS England Surgical Trials Initiative and pump priming funds for capacity development.

In 2018 Heart Research UK funded the James Lind Alliance Priority Setting Partnership in Adult Heart Surgery. This attracted over 1000 responses that were reduced to a top 10 list of national research priorities through a modified Delphi process, published in 2020.

Next, in 2020, Heart Research UK funded the National Cardiac Surgery Trials Initiative. The aim was for nine new study groups, co-led by patients and clinicians, to develop research programmes that would address the new national research priorities. A key development was the creation of a National Public Participation and Involvement Group (PPI). Led by Sarah Murray, a public member of the SCTS executive, co-leadership was perhaps the most important enabler of the



whole initiative. Another key enabler was the BHF Clinical Research Collaboration that has facilitated 307 meetings, with 4293 participants of which 1558 were members of the public to develop research funding applications.

By 2026, the Initiative has transitioned to a National Trials Programme with 11 new multicentre trials and two NIHR Programmes for Applied Research. Funded by almost £30M in research grants, the programme

has created two new surgical trials centres in Leicester and Middlesbrough, in addition to existing clinical trials units undertaking cardiac surgery research in Bristol, York, and QMUL. Several trials are co-led by

anaesthesia and cardiology. This reflects the collaborative, consortium approach that is essential for modern research.

The breadth of the portfolio also provides opportunities for every cardiac surgery patient

to participate, with the Trial for Every Patient initiative launched by the Chair of the SCTS Research Committee, Mahmoud Loubani in 2023. Funded by Heart Research UK, this provides key administrative support to ensure that all the trials succeed through collaboration, and not competition, between the participating research groups.

The greatest achievement of the initiative is the participation of every cardiac surgery centre in the UK, across all four nations, with new Principal Investigators leading recruitment to trials in the portfolio, and the recruitment of thousands of patients.

Where next?

Two major developments underpin the sustainability of the initiative.

First, a new generation of researchers has emerged. Supported by SCTS pump priming funds our national trainee leads have been awarded substantial independent research funding. This is the strongest objective marker of progression to research leadership. Several of the trainees lead multicentre trials. This includes Ricky Vaja, an ST8 from London Deanery, and Luke Rogers, a recently appointed consultant in Middlesbrough, who lead the Cardiac Surgery arm of the £13M ROSSINI Platform. Other key developments are the Cardiothoracic Interdisciplinary Research Network, co-led with Julie Saunders, Professor of Cardiovascular Nursing at KCL, and the NIHR Associate PI scheme that supports the wider participation of junior clinical and allied health professionals in clinical trials.

Second, the national research programme has been a key enabler for UK participation in international trials. These include the TRICS IV and PACES trials from the CIHR, the PRIMARY trial with CTSNET, and the ROMA-WOMEN Trial with NHLBI. International trials change practice, and UK representation on multiple international trials consortia helps shape these trials to address the needs of UK surgeons.

Conclusion

As the target population changes and new therapeutics emerge, there is a need to redefine the risks and benefits of surgery relative to other treatments. Research led by non-surgeons will not always reflect this perspective. The Society's approach to change is through leadership, engagement, public partnership, investment in the research leaders of the future, and world class research. ■

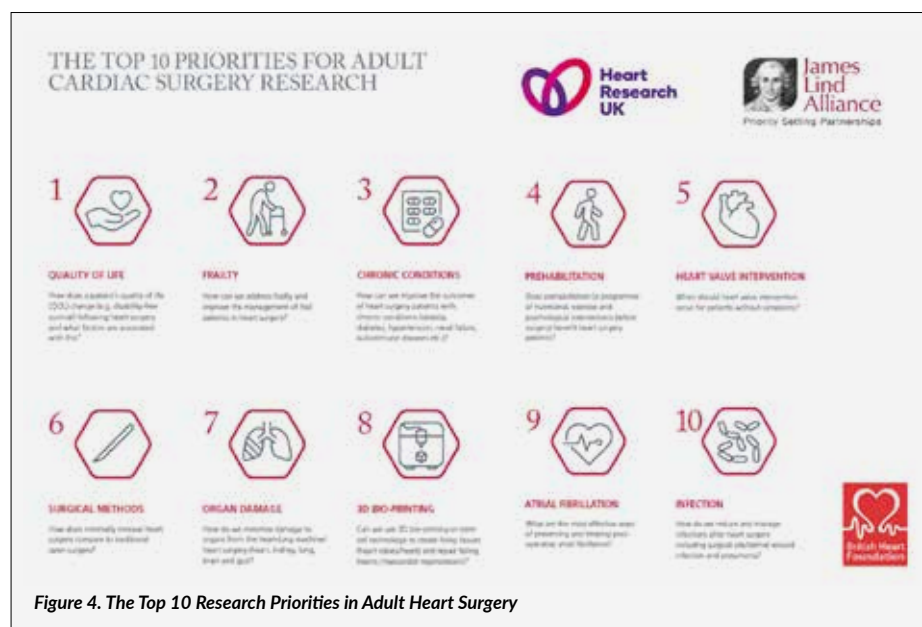


Figure 4. The Top 10 Research Priorities in Adult Heart Surgery

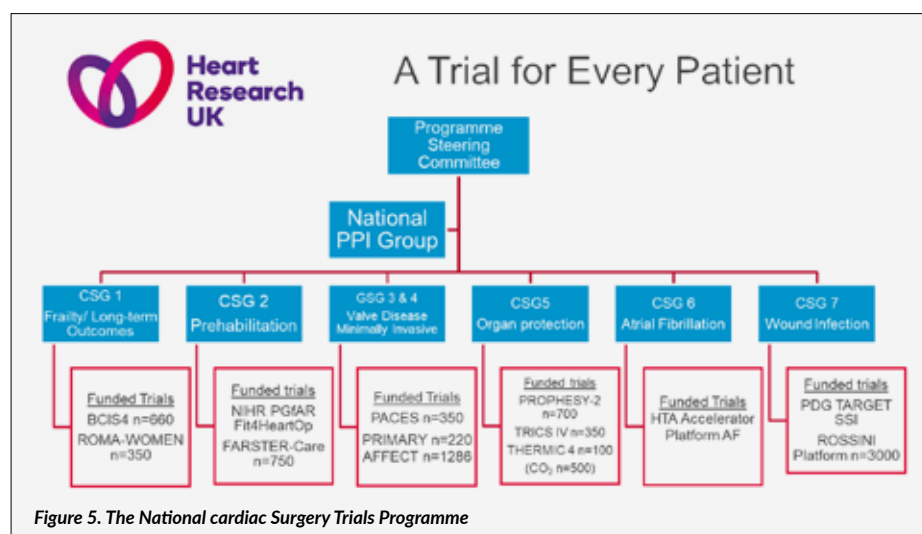


Figure 5. The National cardiac Surgery Trials Programme

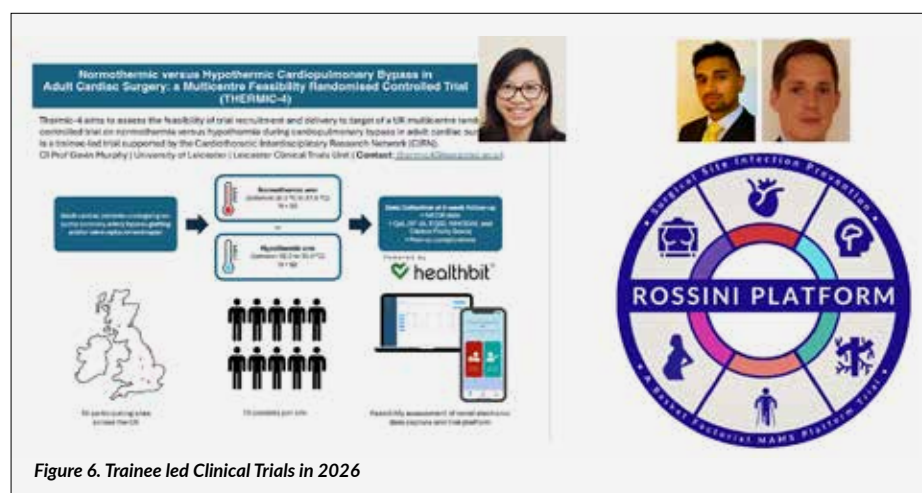


Figure 6. Trainee led Clinical Trials in 2026



Small Teams, Big Ideas: From Concept to Reality at a Hospital Desk

Anna Minasyan, Thoracic Surgeon, Coruña University Hospital, Spain

Nikan Hoorijani, Medical Student, University of Glasgow

**Ishtiaq Ahmed, Consultant Cardiac Surgeon,
Royal Sussex County Hospital, Brighton**



The idea did not begin in a hospital. It began on a bike, somewhere between London and Brighton, then resurfaced in a coffee queue in Copenhagen. For months, Mr Ahmed and I circled one question: how do you take the dense, asymmetric world of mitral valve surgery and make it visible for trainees, who are often asked to build a three-dimensional mental model from a constrained operative view? When I joined him in Brighton for a third-year SSC, we decided to stop talking

and build something. This article is less about what we build than the fact that two people, a student and a consultant, could build it at all.

We first met some months earlier at Mr Ahmed's cardiac cadaver course in Surrey, where conversations had a habit of drifting from the dissection table to the future. By the time the SSC came around, the standard operative attachment felt like an opportunity missed: why not attempt to build something? MitralNexus, is a web-based teaching tool for

mitral valve surgery. Designed to address the cognitive load of an asymmetric procedure trainees often encounter less frequently, and in which three-dimensional anatomy can be difficult to internalise from textbook or off-axis observation. The platform is now a working prototype. Mr Ahmed carried the clinical expertise, supervision and content validation throughout; the parts no AI tool can substitute. The point is that a student and a consultant, working between clinics and weekends, built it in a few months.



This was achievable in the time frame of an SSC, not a multi-year grant, due to the technology that has quietly grown up around projects like ours. Much of the development, from design to back-end logic, API integration, and deployment, was accelerated by AI coding assistants. None of this replaces craft, and none of it removes the need for clinical or technical judgement. But it does collapse the distance between “wouldn’t it be useful if...” and a working build. One moment capture this clearly: deploying the software to Vercel, a cloud deployment platform, would previously have taken me hours of troubleshooting. With Codex, the same process became a supervised, iterative task completed in around twenty minutes, while I studied for OSCEs. That afternoon convinced us that the bottleneck for projects like ours is changing. Infrastructure and technical expertise still matter but are no longer immovable barriers. Increasingly, the limiting factors are the quality of the idea, the judgement of the team, and the willingness to start.

The limitations are real and deserve honesty. AI is impressive at producing code, organising knowledge, and accelerating development. Expert clinical judgement, however, is the ingredient it cannot fabricate; this kind of project does not exist without senior clinical input. The tools also have their moods, particularly around sensitive code or credentials, where what should be straightforward can quietly stall. Intellectual property is a quieter hazard: a novel idea is a vulnerable one, and the road to formal protection is neither short nor cheap. We would not claim that AI replaces a skilled team of engineers; rather, it can extend what a small, clinically led team is able to attempt.

This still leaves why a cardiothoracic surgeon, busy enough already, may wish to take note. We had our thoughts, but we wanted the case made by someone whose work & expertise has been to bring these technologies to wider surgical audiences. We are grateful to Dr Anna Minasyan, Thoracic Surgeon at La Coruña University Hospital, for joining this piece as a co-author.

Dr Anna Minasyan’s Commentary

As this successful example demonstrates, artificial intelligence has rapidly moved from being a futuristic concept to becoming a practical clinical tool, and cardiothoracic surgeons cannot afford to remain passive observers. One of the biggest problems, in my opinion, is that the terminology surrounding AI often makes it sound mystical or inaccessible, when in reality these systems are fundamentally mathematical and computational models trained to recognize patterns in data. We do not need to become machine learning engineers, but we do need enough understanding to critically evaluate these technologies, recognize their strengths and limitations, and understand where they can genuinely improve patient care.

This is becoming increasingly important because AI is beginning to influence almost every stage of cardiothoracic practice: imaging interpretation, preoperative risk prediction, surgical planning, intraoperative guidance, postoperative monitoring, education, and simulation. As these systems become integrated into clinical workflows, surgeons will need to interpret model outputs in the same way we currently interpret imaging findings or statistical analyses. Can the reader imagine a doctor who can’t interpret a chest X-Ray or is illiterate in statistics? I can’t. The same goes for the AI. Without understanding, there is a risk of either blindly trusting unreliable systems or rejecting genuinely useful innovations due to unfamiliarity.

Over the next few years, I hope these technologies enable a more precise, data-driven, and individualized approach to cardiothoracic surgery.

Importantly, AI should not be viewed as a replacement for surgeons, but as a tool that augments human decision-making. The future of our specialty will likely belong to surgeons who combine technical expertise, clinical judgement, and data literacy. Engaging with these technologies now is essential if we want surgeons to actively shape how AI is implemented in cardiothoracic care, rather than simply adapting to decisions made by others outside the specialty.

Tools once requiring institutions and budgets are now within reach of anyone willing to spend a few quiet evenings. Whether you are a student with a notion you never felt qualified enough to build, or a consultant whose teaching question has sat unsolved for a decade, the gap between idea and execution has narrowed in a way that would have been hard to imagine five years ago. So, if there is something you have been carrying around, pick the smallest version of it and give it a weekend. Treat it as a hobby. There is no pressure for it to become a product, a paper, or a platform. The worst that happens is you learn something. We did. ■

Farquharson Award 2025 – The Royal College of Surgeons of Edinburgh

Sri Rathinam, SCTS Communication Secretary, Consultant Thoracic Surgeon, Glenfield Hospital, Leicester

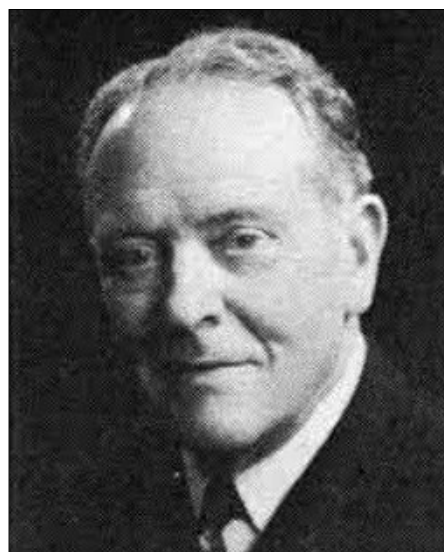


I was humbled and honoured to receive the Farquharson Award 2025. As an aspiring surgical trainee at Madras Medical College, the Royal College of Surgeons of Edinburgh always inspired me.

To become a Fellow, Specialist Fellow, serve as Chair of the Cardiothoracic Specialist Surgical Board, and Regional Surgical Ambassador was a dream realised. To receive an award named after Eric Farquharson – whose textbook shaped my training – is extraordinary. None of this would have been possible without the support of colleagues at University Hospitals of Leicester NHS Trust, the University of Leicester, the Society for Cardiothoracic Surgery in Great Britain and Ireland, and my wife, Dr Gomathi Margabanthu.

The Farquharson Award

Born in Edinburgh in 1905, Eric Farquharson graduated from Edinburgh University in 1928 and gained his Fellowship in 1931. His



celebrated Textbook of Operative Surgery (1954) became an instant success for its clarity, anatomical precision, and conversational style. He served the College devotedly as examiner, Council member, and Vice President until his death in 1970. The award

in his name – endowed by his widow and daughters – recognises excellence in surgical and anatomical teaching, and has evolved to include simulation, operative videos, and distance learning.

From Learner to Trainer

I was taught that learning is a four-way process: you acquire skills, retain them, become an expert, and only truly learn when you pass that wisdom on. A passion for training has run through every stage of my career, from houseman to consultant, shaped further by my trainers in the West Midlands programme. I have always believed a good surgeon must respect the three Ts – Time, Tissue, and Team – and now I add a fourth: Training.

Trainer Journey

Over the years I have held roles as Training Programme Director for the East Midlands, SCTS Thoracic Tutor and Education

Secretary, SAC QA and Simulation Lead, and Cardiothoracic ISB Exam Board Chair.

East Midlands:

I inherited a programme barred from training cardiac trainees beyond ST6. After leading the deanery visit, cardiac training was reinstated. I addressed trainee welfare concerns, created ACF and ACL posts, and made the region a destination for thoracic OOPT. Trainees have maintained a 100% pass rate in Section 2 exams and all have been appointed as consultants.



“The award affirmed what matters most to me: not the structures and committees, but the trainees themselves – watching the next generation of thoracic surgeons develop, flourish, and step into consultant roles of their own.”

SCTS Tutor: Co-creating the SCTS simulation portfolio with Narain Moorjani remains one of my proudest achievements. Twelve structured courses, written objectives, recruited faculty, secured funding – all delivered free to trainees. The programme continues under successive tutors and remains the only comprehensive simulation portfolio offered by a cardiothoracic professional society.

Education Secretary: A defining challenge was liaising with Mr Marian Ionescu, whose exacting standards shaped our collaboration. I negotiated his support for SCTS education,

resulting in the Ionescu Fellowships and the Perspectives publication. Opening portfolio courses to Trainees with Additional Duties helped reduce differential attainment.

SAC: As QA and Simulation Lead I coordinated the SCTS simulation rollout with Ethicon and supported the Wales programme as SAC liaison, helping address local challenges and advocate for trainees.

Exam Board: Taking over the cardiothoracic exam, I oversaw a new format including specialist interest papers and the return of patient volunteers post-

Covid. Inter-examiner variation was reduced from 24 to 2 percentage points during my tenure. I expanded and diversified the examiner pool, increasing female representation and enabling additional exam diets to manage the waiting list.

Receiving the Award

On 14 March 2026, I stood on the podium in the Playfair Hall – a room I had visited many times as ambassador and board chair – to receive the Farquharson Award from Dr Clare McNaught, the first female President of the Royal College of Surgeons of Edinburgh. Hearing Prof Robin Patton read the citation was a moment of quiet reflection on years of investment in surgical education.

The award affirmed what matters most to me: not the structures and committees, but the trainees themselves – watching the next generation of thoracic surgeons develop, flourish, and step into consultant roles of their own. It was a particular honour to meet Mr Farquharson’s daughters at the ceremony. Having my wife Gomathi and sons Akhash and Akilesh beside me made the occasion complete. ■

The Future of Chest Wall Surgery: Beyond Cosmetic Perception

Shyam Kolvekar, Consultant Cardiothoracic Surgeon, St Bartholomews Hospital, London



Chest wall surgery has undergone a remarkable transformation over the past two decades. Once regarded by many as a niche or largely cosmetic area of practice, it is increasingly recognised as a vital component of modern functional thoracic surgery. Advances in imaging, physiological assessment, minimally invasive techniques, perioperative care, and multidisciplinary management have reshaped both patient outcomes and professional understanding of chest wall deformities.

Despite this progress, chest wall disease – particularly pectus excavatum – continues

to be misunderstood by healthcare systems, commissioners, insurers, and sometimes clinicians themselves. Many patients still encounter the persistent misconception that pectus surgery is primarily cosmetic. Yet growing evidence demonstrates meaningful physiological, psychological, and functional consequences associated with significant chest wall deformities. The specialty now stands at an important crossroads: the challenge is no longer simply technical correction of deformity but ensuring that healthcare systems and national pathways evolve alongside it.

Functional Physiology and Exercise Limitation

Historically, patients with pectus deformities were frequently reassured that their condition was unlikely to affect cardiopulmonary function. Many were advised simply to live with it or focus on improving posture. This traditional view significantly underestimated the physiological impact severe chest wall deformities can have in selected patients.

Modern cardiopulmonary exercise testing, echocardiography, and advanced imaging have improved our understanding considerably.

Compression of the right ventricle, impaired venous return, restrictive chest wall mechanics, reduced stroke volume during exertion, and exercise intolerance are now increasingly recognised within the literature.

Importantly, symptoms are often most evident during exercise rather than at rest. Patients commonly describe fatigue, reduced endurance, breathlessness, avoidance of physical activity, and inability to perform at the same level as peers – limitations that can significantly affect quality of life, particularly in adolescents and young adults during formative years.

Chest wall deformities should not therefore be evaluated through static anatomical measurements or cosmetic appearance alone. Functional physiology and patient-reported symptoms must be central to modern assessment.

The Mental Health Burden

Equally important is the psychological burden associated with chest wall disease. Many adolescents and young adults with severe deformities experience low self-esteem, body image disturbance, embarrassment, social anxiety, and avoidance of activities such as swimming or sport. Some describe years of bullying, social withdrawal, reduced confidence, and depression.

While surgery should never be performed solely for cosmetic dissatisfaction, dismissing psychological morbidity as insignificant is equally inappropriate. Mental wellbeing forms a major component of overall health and quality of life. Modern pectus care therefore requires more than technical operative correction alone. Patients benefit from holistic assessment, psychological support, physiotherapy, realistic counselling, and multidisciplinary evaluation. The conversation must continue to move away from simplistic cosmetic labelling toward broader recognition of function, wellbeing, and truly patient-centred care.

Modern Pectus Surgery and Innovation

The development of minimally invasive repair techniques revolutionised the field. The Nuss procedure transformed management by avoiding extensive cartilage resection and allowing correction through smaller incisions. Over time, it has evolved significantly: modern Nuss techniques

now routinely incorporate thoroscopic guidance, sternal elevation strategies, improved fixation systems, multi-bar stabilisation, cryoanalgesia, and enhanced recovery pathways.

Historically, postoperative pain represented one of the major barriers to both referral and patient acceptance. Advances in multimodal analgesia and perioperative care have now dramatically improved recovery. In carefully selected patients treated at experienced specialist centres, minimally invasive pectus repair is considered a relatively low-risk procedure with predictable recovery and excellent outcomes. Many patients mobilise early, return rapidly to education or work, and resume physical activity within a relatively short period.

The emergence of novel techniques such as the Pectus Up procedure reflects the continuing evolution of the specialty toward lower-risk, lower-pain approaches. Pectus Up is an extra-thoracic elevation technique that avoids substernal bar passage and retrosternal instrumentation entirely. Early experience suggests that selected patients may benefit from reduced postoperative discomfort, shorter recovery periods, and potentially lower mediastinal risk while still achieving effective deformity correction. Although longer-term evidence continues to evolve, it represents an important example of how chest wall surgery is maturing toward personalised, minimally invasive, and patient-centred strategies. The future is unlikely to involve a single universal operation; instead, the field is moving toward tailored interventions based on anatomy, physiology, symptom burden, and individual patient expectations.

Why Chest Wall Disease Deserves Specialist Pathways

One of the major ongoing challenges within the NHS remains inconsistent access to specialist chest wall services. Referral pathways and commissioning decisions continue to vary considerably across the United Kingdom. Some patients gain early access to experienced multidisciplinary teams; others face prolonged delays, inconsistent assessment, or outright rejection due to outdated perceptions of pectus disease. The persistent misconception that pectus surgery is cosmetic continues to create significant barriers to funding and specialist referral.

Chest wall disease deserves structured specialist pathways comparable to other complex thoracic conditions. Modern management should involve multidisciplinary team assessment including thoracic surgeons, cardiologists, respiratory physicians, anaesthetists, pain specialists, physiotherapists, psychologists, radiologists, and specialist nurses. Crucially, MDT pathways also improve patient selection, helping identify those who may not benefit from surgery – not every deformity requires operative intervention, and careful assessment remains fundamental. The development of specialist regional and national MDT networks represents an important step toward improving governance, consistency, research collaboration, and equitable access to care.

The RESTORE Trial and the Road Ahead

One of the most significant recent developments has been the emergence of the RESTORE trial, representing a broader effort to strengthen the evidence base surrounding pectus intervention. Historically, chest wall surgery has suffered from limited prospective multicentre data and inconsistent outcome reporting. The RESTORE initiative addresses this directly. It reinforces the principle that pectus deformities deserve robust scientific evaluation, emphasises patient-reported outcomes and functional assessment alongside anatomical correction, and may meaningfully influence future NHS commissioning decisions. Most significantly, it symbolises a broader cultural shift: chest wall surgery is increasingly recognised not as a cosmetic outlier, but as an important component of modern functional thoracic practice.

Looking ahead, the coming decade is likely to bring greater national MDT integration, improved access to specialist services, stronger evidence-based commissioning, and better long-term functional outcome data. Most importantly, there is growing recognition that chest wall deformities affect far more than appearance alone. Patients deserve careful assessment, objective physiological evaluation, psychological support, and access to experienced specialist multidisciplinary teams. With continued collaboration, research, innovation, and advocacy, chest wall surgery will continue its evolution from a misunderstood niche into a recognised and evidence-driven component of modern cardiothoracic surgery. ■

Mr Ngaage

Anupama Barua, NTN, Royal Stoke University Hospital



A tall figure with a dark, dignified complexion, eyes that glowed with quiet strength, and a smile bright enough to soften even the hardest day. His spirit lived in those eyes. Always warm, always alive, always reaching out to others.

He had endured more than most people will ever know. Yet he carried none of that weight when he stood beside others. He lifted people, even when he himself was tired. He gave support to those who had no one. And whenever you called morning, night, or in moments of despair, he answered with kindness.

He believed in you long before you learned to believe in yourself. He told you to hold faith, to keep going, to trust your own strength.

When heartbreak crushed you, when rejection stung, when the workplace turned hostile and cold, he stayed. He stood beside you when others stepped away. Even after you left that place, he continued to guide you, as if your battles were his own.



“Never give up.” Those words were not just advice. They were a lifeline.

In a world where loud voices tried to dominate like demigods in a forest, he remained gentle, steady, and unwavering. He spoke to everyone – from the porter to the cleaner – with the same respect, the same humanity.

He lived with integrity, not as a performance, but as a natural part of who he was.

While many offered **no word**, no comfort, not even the smallest gesture of sympathy, **he offered action**. Where others stayed silent, watching from a distance, unwilling to step into someone else’s pain, he stepped forward without hesitation. Where people who claimed to care disappeared into convenience, he showed up with presence, with effort, with genuine humanity. He didn’t just speak kindness; he lived it. He didn’t write empty sentences; he drove **55 miles** to stand beside you. In a world full of passive observers, he chose to be a man of movement, of compassion, of real, tangible help. His actions became proof of his character. The kind of proof words alone could never give.

His words remain: **“Never give up.”** And so does his name. So does his light. So does the strength he placed in you.

See you again, Mr Ngaage. ■

New Appointments January to August 2026 ...

Name	Hospital	Specialty/Role	Starting Date
Vanessa Rogers	Royal Papworth Hospital	Locum Consultant Thoracic Surgeon	November 2025
Akshay Patel	Guy’s Hospital, London	Substantive Consultant Thoracic Surgeon	February 2026
Faraz Baig	Leicester Royal Infirmary/ Glenfield Hospital, Leicester	Locum Consultant Congenital Cardiac Surgeon	March 2026
Joseph George	Birmingham Children’s Hospital	Substantive Consultant Congenital Surgeon	April 2026
Ashok Kar	Royal Infirmary of Edinburgh	Substantive Consultant Thoracic Surgeon	February 2026
Ahmed El Zeki	St. James’s Hospital, Dublin	Locum Consultant Thoracic Surgeon	June 2026
Federic Derna	Northern General Hospital, Sheffield	Substantive Consultant Thoracic Surgeon	August 2026
Megan Garner	Northern General Hospital, Sheffield	Substantive Consultant Thoracic Surgeon	August 2026
Nader Moawad	Derriord Hospital, Plymouth	Substantive Consultant Cardiac Surgeon	August 2026

What Does One of the Best Cardiac Surgery Fellowships in the World Look Like?

Marius Roman, Advanced Cardiac Fellow/Honorary Lecturer, Waikato Hospital, New Zealand/Leicester



I have been fortunate to complete the competitive Advanced Fellowship in Cardiac Surgery at Waikato Hospital in New Zealand between 2025 and 2026.

Life in Waikato and New Zealand

Waikato Hospital in Hamilton serves the Midlands of the North Island in New Zealand, with a population of 400,000, while the Cardiothoracic unit performs 450-500 Cardiac and 200-250 Thoracic cases annually. Hamilton is strategically positioned close to Auckland, a very diverse and inclusive city, and to amazing hills, mountains, and beaches, all within an hour's drive.

The pace of life in New Zealand, compared to the UK, is slower, while people's general happiness is palpable and physical and mental well-being are embedded as national values. One example is that staff can take breaks to walk/jog around the nearby lake. The Heart team at Waikato Hospital organises regular social events celebrating the successes or progress of team members, as well as casual social gatherings.

The care delivered at Waikato Hospital follows the Te Whare Tapa Wha holistic model, focusing on physical, spiritual, mental, family care, and appreciation for the land. Your salary is the same as an NHS Consultant, with added income from extra activities. You have a relocation package that covers one month of accommodation and car hire, with a generous 13,500 NZD/year and CME hours protected for your education and development.

Exposure

During the fellowship, you are the busiest surgeon in the unit, and the Fellowship's success is one of the Heart Team's key metrics. You feel welcomed by a smiling team from day one, and this never stopped in my time.

As an Advanced Cardiac Surgery Fellow, you work on the Consultant rota and cover all aspects of care associated with this role. You cover one 24-hour on-call shift every week and

a weekend every four weeks on a first/second-tier rota, as eight Consultants. The two-tier rota is designed to cover emergencies and aortic dissections to optimise outcomes.

I performed 130 cases as the primary operator, with 90 cases performed independently, while the remaining 40 were performed as the equivalent of two Consultant cases. 35% of cases were non-CABG/non-AVR, including dissections, major aortic procedures, infective endocarditis, mitral valve repairs/replacements, redo cases, double-valve cases, double/triple procedures, and off-pump total arterial/anaortic revascularisations. I had my own operative list every two weeks, while the rest of the cases were performed on my colleagues' lists. The average Euroscore II for the cases I performed was 2.8. The average hospital stay for all comers is 5-6 days, despite the wide range of pathologies, with a younger and more diverse population when compared to the UK.

In the first three months, you are assessed on your ability to perform safely with good outcomes in low-risk cardiac cases, while in months 3-9, you increase significantly your exposure to intermediate risk cases and in the last three months, the focus is on high-risk cases and cementing new procedures and skills to your repertoire. You will participate in and teach at monthly wetlabs. You can perform Thoracic urgent cases during your on-calls if you have and would like to maintain these competencies. The theatre team has an excellent "can-do" mentality, which focuses on approaching challenges with positivity to deliver great care. This gives everyone the opportunity to be the best version of themselves in a supportive environment. It not only leads to excellent outcomes but also builds long-lasting friendships.

Heart Team approach

As a fellow, you will deliver the highest standard of care and contribute to the High

Risk Valve Clinic (with Cardiologists and Geriatricians you provide a balanced and unified approach to the life-long treatment of valve disease), Dissection MDTs aimed at providing best outcomes of dissections (two Surgeons, Interventional Radiologist, Intensivist, Anaesthetist, Perfusionist determining the management of dissections at point of referral), cover Cath Lab novel and high risk valve insertions (e.g. Sutra Valves or trial Valves). As a fellow, you are active in the Coronary and High-risk MDTs, review new in-house patients, and have your regular new outpatients clinic. The unit uses a pool-based system in which cases are matched to surgeons based on expertise and sub-specialty interests.

Non-surgical Output

As an Advanced Fellow, you are encouraged to take part in the National Meeting, in one Australasian/International meeting and make full use of your education allowance. I used mine to complete the Leading Innovative AI Implementation in Healthcare Certificate Programme at Harvard University, which added new, vital skills that I can bring to future teams. Depending on your academic interests, you are encouraged to publish at least one peer-reviewed article, recruit participants for ongoing trials in the department, present regularly at the monthly departmental research meeting, and deliver formal lectures to medical students from the University of Auckland every two months.

I hope that after reading this, you are convinced that, as an Operative Fellowship aimed at setting you up for success as a Consultant, this Fellowship is as good as it gets. I hope you will have at least as much of a great time as I did completing it! Please feel free to reach out via email or LinkedIn if you would like more information or if I can help you in any way.

I would like to thank the entire Heart team at Waikato Hospital for the amazing year during which you made me feel at home. ■

Demitted Roles

Thank you to the following for the time and commitment they gave to their roles ...

Role	Name
Communication committee	Sridhar Rathinam
Treasurer	Mark Jones
Meeting Secretary	Sunil Bhudia
Elected Trustee 1	Attilio Lotto
Elected Trustee 2	Karen Redmond
Elected Trustee 3	Indu Deglurkar
Cardiac Co-Chair	Manoj Kuduvalli
Cardiac Deputy Chair	Hari Doshi
Deputy Meeting Secretary	Carol Tan
Associate Meeting Secretary	Gianluca Lucchese
Nursing & AHP Representative Meeting Lead	Nisha Bhudia
Nursing & AHP Deputy Representative	Rosalie Magboo
Deputy Audit Lead	Nathan Burnside
Research Executive Co-chair	Sunil Bhudia
NICOR Representative	Andrew Goodwin

New Roles

Congratulations to the following ...

Role	Name
Communication committee	Indu Deglurkar
Treasurer	Karen Redmond
Meeting Secretary	Carol Tan
Elected Trustee 1	Maninder Kalkat
Elected Trustee 2	Adrian Marchbank
Elected Trustee 3	Shyam Kolvekar
Cardiac Co-chair	Hari Doshi
Cardiac Deputy Chair	Giovanni Mariscalco
Deputy Meeting Secretary	Gianluca Lucchese
Associate Meeting Secretary	Amit Modi
Nursing & AHP Representative Meeting Lead	Rosalie Magboo
Nursing & AHP Deputy Representative	John Paul Evangelista
Transplantation Deputy Co-chair	Karen Redmond
Deputy Audit Lead	Sunil Bhudia
NICOR Representative	Uday Trivedi

It's 2026 – Thoracic Endometriosis is Still an Enigma – and We're not Having it!

Aamir Amin, NTN, Wythenshawe Hospital, Manchester

**Felice Granato, Consultant Thoracic Surgeon,
Wythenshawe Hospital, Manchester**



Thoracic endometriosis syndrome (TES) should not still feel like clinical folklore. Yet in emergency departments, respiratory clinics, gynaecology pathways and thoracic surgical units across the NHS, female patients with pneumothorax, chest pain, haemoptysis or breathlessness still describe the same story: repeated presentations, normalised or dismissed symptoms and delayed recognition.

This is not because clinicians do not care. It is because the system has not decided what good care should look like. TES sits in the no-man's-land between specialties. It is a thoracic condition with a complex gynaecological and systemic basis, a surgical disease requiring hormonal strategy, and a chronic illness that can present as an acute emergency. That combination exposes the weakest seams of modern healthcare: siloed referral routes, fragmented imaging, inconsistent MDT access, and no nationally embedded pathway.

The evidence is no longer empty. In a recent systematic review and meta-analysis of 28 studies including 1,182 surgically treated patients, pneumothorax recurrence after surgery was 28.2%, reoperation 14.0%, overall complications 30.8%, and postprocedural air leak 24.2%. Mean chest drain duration was 4.4 days and mean length of stay 6.1 days. These numbers matter because they convert a so-called rare condition into theatre time, ward days, chest drains, readmissions, anxiety, lost work, fertility dilemmas and avoidable repeat harm.

The British Society for Gynaecological Endoscopy and RCOG recognised the problem

in 2022. Their joint statement explicitly supported centralised, multidisciplinary care, better coordination between specialties, and work with patient representatives and funders to develop a centralised pathway for thoracic endometriosis. Four years on, the question for the NHS is uncomfortable but fair: where is the pathway? Where are the referral criteria, the regional centres, the joint MDTs, the agreed imaging protocols, and the outcomes registry?

NICE guidance rightly emphasises earlier diagnosis, referral, individualised support and specialist endometriosis services for complex disease. But thoracic disease remains a practical gap. A patient can meet the spirit of specialist care and still fall between local gynaecology, respiratory medicine and thoracic surgery because no one owns the pathway. That is not a patient problem. It is a design problem.

The economic argument is also stronger than it is sometimes allowed to be. NICE's own resource impact work acknowledges capacity pressures but also notes that earlier diagnosis and treatment should reduce organ damage and subsequent treatment costs. For TES, the same logic is hard to ignore. A planned joint approach is almost certainly better value than repeated emergency admissions, recurrent pneumothoraces, duplicated outpatient appointments and operations performed without the right pelvic or hormonal context.

The patient-care argument is stronger still. Patients with TES need clinicians to ask simple, specific questions: Is the chest pain or pneumothorax menstrual? Is there known or suspected pelvic endometriosis? Has diaphragmatic disease been considered?



Has imaging been timed and interpreted with TES in mind? A national survey of British gynaecological endoscopists found low screening rates and variable management, with most respondents supporting multidisciplinary, centralised care. That was not a minor audit finding; it was a warning.

The solution does not require a new empire. It requires a standard. Every suspected TES patient should have access to: a defined referral route; joint thoracic-gynaecology review; radiology familiar with diaphragmatic and pleuro-pulmonary disease; counselling about recurrence, hormonal suppression and fertility; and transparent follow-up with patient-reported outcomes. Every operation should ask not simply, 'Can we fix this pneumothorax today?' but, 'Are we treating the disease process that will bring this patient back?'

This is a candid column, so let us be candid. In 2026, awareness posters are not enough. Patients have already done too much of the system's pattern recognition for us. They arrive with symptom diaries, online support group advice, screenshots of papers and the same exhausted question: why did nobody join the dots earlier?

Cardiothoracic surgery has a role in changing that. We understand recurrent pneumothorax, pleural disease, air leak, drain burden and the consequences of delayed definitive management. But TES asks us to look beyond the pleural cavity. It asks us to build pathways with gynaecology, respiratory medicine, radiology, anaesthesia, pain services, fertility teams and patients themselves.

Thoracic endometriosis may remain biologically enigmatic. NHS care for it should not. The next step is not another statement of concern; it is implementation. A standardised, commissioned, auditable pathway for TES is overdue. Patients should not need luck, geography or persistence to access multi-disciplinary care. Instead, they should encounter a robust system capable of recognising the pattern – and acting on it. ■

Currents, Shadows, and Storms

Aung Ye Oo, Clinical Lead for Aortovascular Surgery, St Bartholomews Hospital, London
Farhin Holia, Research Fellow, Royal London Hospital



A consultant's career is, among other things, a long observation of teams. You watch them form, settle, fracture, and reconstitute themselves. You watch what they do well, what they cannot do, and what they reveal about the people inside them under the steady pressure of years rather than the brief pressure of cases.

Years of watching eventually teaches that the biggest challenges in surgical teams rarely come from skill. Skill is the easiest variable to address. The harder variable, the one that determines whether a unit thrives or quietly corrodes, is behaviour.

Every team we have worked in, in this specialty and outside it, contains three types of contributors. The steady current. The quiet shadow. The unnecessary storm. These are not labels for people. They are descriptions of a stance towards the work, and the same person can move between them over a career.

The steady current is what actually moves a department forward. Disciplined, focused, aligned with the mission. The senior nurse who knows the kit better than any consultant. The registrar who handles the ward round so the consultant can focus on the difficult case. The perfusionist on her thirtieth aortic case, calm because she has been calm thirty times before. The anaesthetic colleague who raises a concern early, quietly, without drama. These are the people who turn plans into progress. Every strong unit is built on them, and they are almost always undercelebrated, because their work is the absence of crisis rather than the presence of heroism.

The quiet shadow remains present but neutral. Not obstructing, not

accelerating. Doing the job, going home. Every department has a few. They are not a problem in themselves. A specialty cannot demand maximum contribution from everyone at every moment, and there is a kind of stability in colleagues who simply do their work without theatre. The shadow becomes a problem only when a department mistakes its tolerance for endorsement, or assumes its silence means agreement.

The unnecessary storm is the harder phenomenon. It disrupts more than it delivers. It demands attention but resists accountability. It substitutes drama for discipline and confuses visibility with value. Every consultant reading this will recognise the archetype, because every department has produced one, sometimes more than one, over its history. The storm is rarely incompetent. That is part of what makes it tolerated. It is often technically able, sometimes brilliantly so, and the unit convinces itself that the disruption is the cost of the talent.

Years of observation suggest this calculation is almost always wrong. The cost of the storm compounds. It tires the steady currents, who carry the work the storm refuses. It alienates the shadows, who become more shadowed. It teaches the trainees that volatility is a permissible career strategy. It exports the unit's worst behaviour into the next generation of consultants, who learnt what was normal by watching.

The instinct, when faced with a storm, is to manage around it. This is what most departments do, most of the time. The instinct is rational. The storm is loud, and standing up to it costs energy that no one quite wants to spend. But the cost of managing around it is never zero, and it

is paid by the people who can least afford to pay it: the junior staff, the trainees, the steady currents who are quietly exhausted by absorbing what the system will not address.

The encouraging part of this observation is that storms fade the moment standards hold. They are sustained by the ambiguity around them, not by their own force. A unit with clear expectations, firm boundaries, and a culture that values contribution over performance starves the storm of the conditions it needs. Nothing volatile survives in a culture built on real work. The storm either adapts to the standard or leaves, and either outcome is a gain for the unit.

This requires something of the senior consultant body that is rarely spoken about plainly. The protection of culture is not an HR function. It is a clinical leadership function, and it is one of the most important uses of seniority. Naming behaviour, holding standards, and making clear that volatility is not the cost of doing business: these are acts of leadership in the most literal sense. They cost something to perform. The cost of not performing them is higher, and it is paid by other people.

Across the careers we have watched, the pattern has been consistent. The work returns to the steady currents. The shadows remain harmless. And the storms, sooner or later, exhaust themselves, because the things that sustain them, the audience, the indulgence, the assumption that brilliance excuses behaviour, are finite resources that mature systems learn to withdraw.

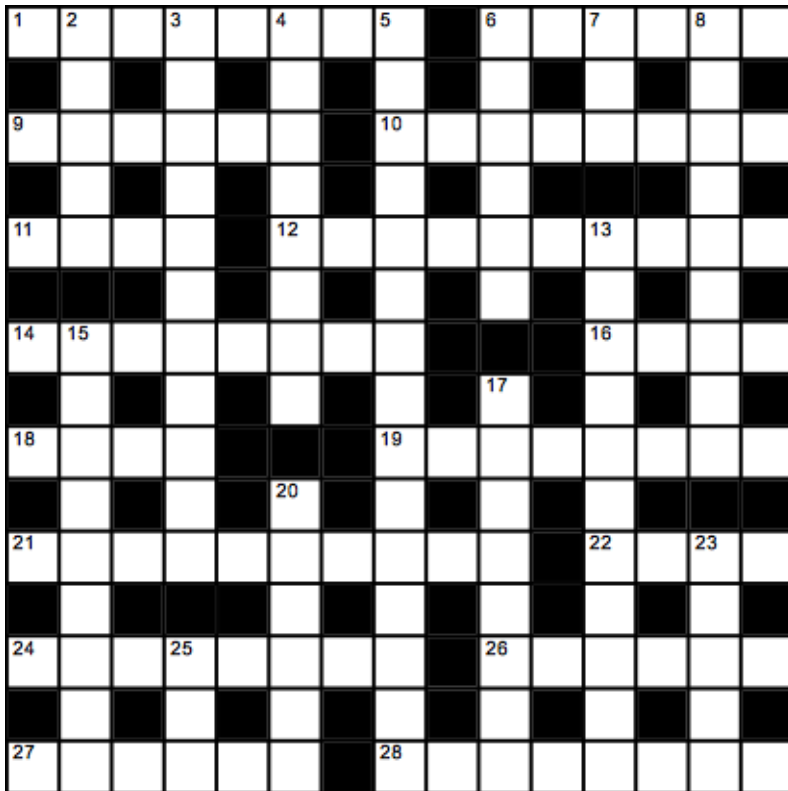
Noise can delay momentum. It cannot decide direction.

The cardiothoracic surgeon's job is, in the end, a long project with patients at the centre of it. Departments are the vehicles that carry the project. The people who keep the vehicles moving are usually the quietest in the room, and they are the ones to whom we owe more recognition than we currently give. The people who keep the vehicles loud do not, in the long run, define the project, even though they sometimes manage to define the meeting. The mission outlasts the storm. It always has. ■

Every team we have worked in, contains three types of contributors: the steady current; the quiet shadow; the unnecessary storm.

Crossword

Set by Samer Nashef

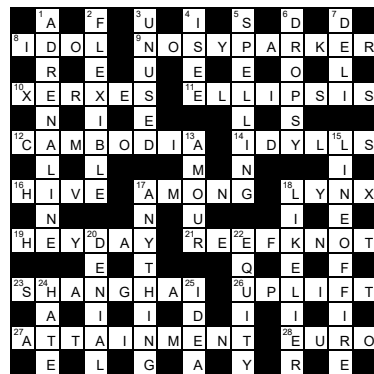


Please email solutions by 09/10/2026 to:

emma@scts.org or send to
**Emma Piotrowski, SCTS, 38-43,
 Lincoln's Inn Fields, London WC2A 3PE**

The winner will be randomly selected from successful solutions and will win either a bottle of 'fizz' or fine olive oil.

Congratulations to Minji Ho for winning the January 2026 Bulletin crossword competition (right).



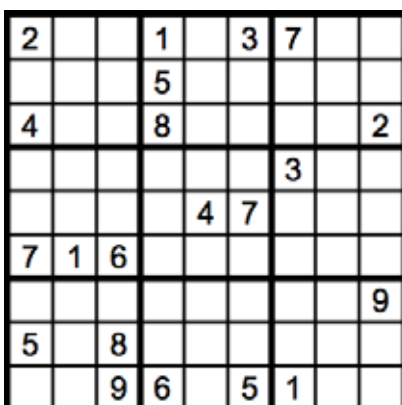
Across

- 1 Our close relations suffering or ill, as to finish third (8)
 6/9/23 We accepted an old idea: advert devised to catch criminals (6,4,2,5)
 10 Hospital road taken in conscious gear (8)
 11 Buzzer loud? Complain! (4)
 12 Previous partner I valued is let off the hook (10)
 14 Papers in evenly backlit Alpine fun? (5-3)
 16 Voice that can cause some mental torture (4)
 18 Promotion of extremely holy place (4)
 19 Switching parts of lens to make tear-resistant implant (5-3)
 21 Having overeaten, hand round back massage? Too much! (3,2,5)
 22/27 Acrobatics in toilets with Eliot's initials (10)
 24 From Memphis to Richmond? That is momentous! (8)
 26 Pretax bill no case for selling (6)
 27 See 22
 28 PM once rocked the chart (not this singer) (8)

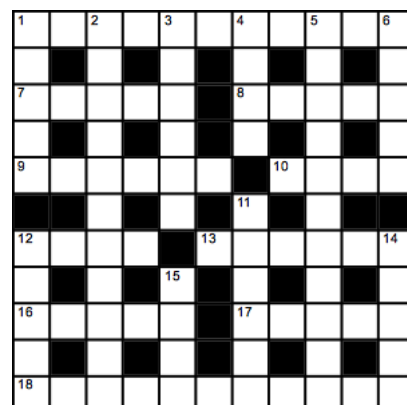
Down

- 2 Big gongs ultimately resonate (5)
 3 Type of music comes across very loud, divided and uncaring (11)
 4 GiftS, they say (8)
 5 15's 9 23 pet (12,3)
 6 Guardian study supporting conflict (6)
 7/25 15 novel written by heavyweight (6)
 8 Seriously, leaving home would be premature (9)
 13 Can hesitate to produce a number (11)
 15 Doctor Ian becoming first scientist (9)
 17 Stalin's secret police chief conceals pretend bugs (8)
 20 First aboard bus, on reaching the station, terminates (6)
 23 See 6 Across
 25 See 7

Sudoku



Quick Crossword



Across

- 1 Time between childhood and adulthood (11)
 7 Flower (5)
 8 Indian instrument (5)
 9 Beer (6)
 10 Challenge (4)
 12 Area (4)
 13 Alpine house (6)
 16 Just married woman (5)
 17 Board (5)
 18 CABG competitor (11)

Down

- 1 Improvise (2-3)
 2 Remarkable (11)
 3 Less difficult (6)
 4 Money (4)
 5 European country (11)
 6 Before time (5)
 11 Small church (6)
 12 Striped creature (5)
 14 Gogglebox (5)
 15 Second operation (4)



APROTININ 10,000 KIU/ml Injection BP

Aprotinin is indicated for prophylactic use to reduce blood loss and blood transfusion in adult patients at high risk of major blood loss undergoing isolated cardiopulmonary bypass graft surgery. Aprotinin should only be used after careful consideration of the benefits and risks, and consideration that alternative treatments are available.¹

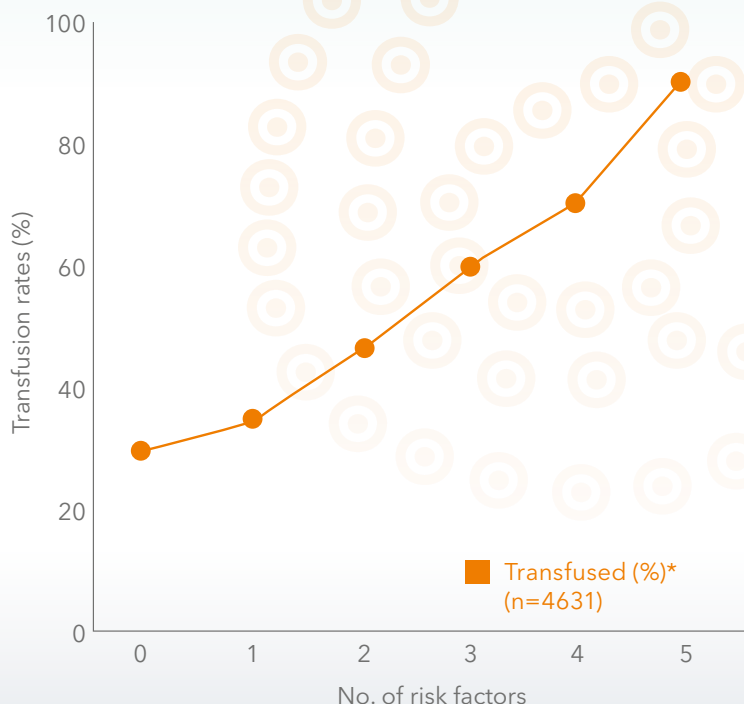
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Red blood cell transfusion is the single factor most reliably associated with increased risk of post-operative morbidity and mortality²

- Blood loss requiring transfusion remains a risk in cardiac surgery, despite the use of blood-sparing agents and blood management techniques³⁻⁵
- The graph below shows how multiple patient risk factors compound to increase the risk of transfusions during CABG surgery^{6,7}

Risk Factors for Transfusion in iCABG Patients:



In a recent study of patients undergoing scheduled coronary artery surgery, a set of pre-defined risk factors were applied.⁶

- Age >70 years
- Female
- Low molecular weight heparin or antiplatelet therapy <5 days pre-operatively
- Estimated Glomerular Filtration Rate <60mL/min
- Insulin dependent diabetes mellitus

Regardless of volume of blood loss, when patient risk factors are compounded, transfusion rates increase⁶

Scan the QR code or visit our website at aprotinin.co.uk to see what other HCPs think of aprotinin and for other useful resources



Adapted from Myles PS *et al.* 2017^{1,2}
^{*} Any transfusion up until hospital discharge

References:

1. Aprotinin 10,000 KIU/ml Injection BP Summary of Product Characteristics. Available at www.medicines.org.uk. Accessed Feb 2026.
2. Koch C *et al.* Crit Care Med 2006 Vol. 34, No. 6; 1608-1616.
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4. Stevens LM *et al.* Major transfusions remain frequent despite the generalized use of tranexamic acid: an audit of 3322 patients undergoing cardiac surgery. Transfusion 2016;56:1857-65.
5. Gombotz H *et al.* The second Austrian benchmark study for blood use in elective surgery: results and practice change. Transfusion 2014;54:2646-57
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7. Supplement to: Myles PS *et al.* Tranexamic Acid in Patients Undergoing Coronary-Artery Surgery. N Engl J Med 2017;376:136-48.

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Clinical data on valves with RESILIA tissue up to 7-year follow-up have been published, with additional follow-up of up to 10 years in process.
Reference: Beaver T, Bavaria JE, Griffith B, et al. Seven-year outcomes following aortic valve replacement with a novel tissue bioprosthesis.
J Thorac Cardiovasc Surg. 2024 Sep;168(3):781-791.

*Edwards Lifesciences Model 11000A (Carpentier-Edwards PERIMOUNT Magna Ease valve with RESILIA tissue)

†Edwards Lifesciences Model 11000M (Carpentier-Edwards PERIMOUNT Magna Mitral Ease valve with RESILIA tissue)

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