Society for Cardiothoracic Surgery
in Great Britain and Ireland

the bulletin

July 2015

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From the Editor

Welcome to the latest issue of the Society Bulletin. We are publishing in a paper form after a gap of two years. We had received positive feedback from the membership, but it is only due to the financial support from Mr Ionescu that this print version has been resurrected.

This edition of the Bulletin is focused on training, and celebrates the culture and state of surgical training in the UK. Simon Kendall (page 8) reminds us of how training was a few decades ago. Though many of us have often rued the passing of the "good old days", Simon's remarkable insight into the comparision of the "good old days" and "the way it is now" must bring home to all of us, why in the case of surgical training at least, change is definitely for the better. The UK continues to be a world leader in the field of surgical training.

Douglas West (Thoracic Audit Lead, page 23), David Barron (Lead Congenital Cardiac Surgery Audit, page 20) and David Jenkins (Lead Adult Cardiac Surgery Audit, page 24) explain the latest developments and future plans in the area of outcomes reporting.

Steve Griffin now works in the Middle East, and he provides an account of his first 18 months in Dubai. Cardiothoracic Surgical practice is so different in different parts of the world, and surgeons learn to adapt. Steve Griffin's account (of work and life) might tempt some us to give a second look to all those recruitment emails, which often get hit by the delete cross.

Sam Nashef has written a book "The Naked Surgeon – The Power and Peril of Transparency in Medicine"; and this has been reviewed by Mark Jones (page 32) for this Bulletin. This book goes some way in explaining the concept of risk and it's quantification to the lay public. The book is available on Amazon, and I am sure surgeons will enjoy reading it.

The majority of the articles in this Bulletin have been written a few days before the (extended) deadline. An editor should have the luxury of sifting through material much in advance, and therefore this is a call for contributions for the next edition. Please do not wait for any deadlines. Please send in your contributions to Isabelle at the Society Office, anytime now.

As usual, Sam Nashef has compiled a crossword for this edition of the Bulletin. It is a cheesy one (now, is that a clue?). There is a prize for the first one to send the completed crossword to Isabelle.

I would like to end with mentioning the World Society of Cardiothoracic Surgeons 25th Anniversary Congress which is being hosted by the Royal College of Surgeons of Edinburgh (19 to 22 September 2015). This is the first time the World Society is coming to the UK, and it will be a good opportunity for all UK trainees to present their work at an international meeting. Consultant surgeons will also be able to network with colleagues across the globe. More details at www.wscts2015.org

Wish you all a pleasant and enjoyable summer.

Vipin Zamvar

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SCTS Lifetime Achievement Award:

Mr Marian Ionescu

By Michael Lewis

Mr Marian Ionescu was awarded the SCTS lifetime achievement award at this year's annual meeting.
The SCTS lifetime achievement award is an award made to recognise outstanding contribution to the field of cardiothoracic surgery. The recent recipients of this award are indeed a roll call of some of the greats of our specialty and include Donald Ross, Terence English, Peter Goldstraw, Magdi Yacoub and Bill Brawn. This illustrious hall of fame has a new esteemed member.

As those of you who know him will understand, trying to summarise such a full and accomplished life in such a short space of time is a major challenge-but here goes!

Marian Ion Ionescu was born in Romania in Sant Giorgio on the Danube on 21st August 1929 and grew up in Târgoviste weathering the storm of World War II as a young man. He attended Med School in Bucharest and qualified in 1954. During Med School he met Christina Marinescu, a budding cardiologist. Such a pairing of a cardiologist and surgeon has been described as "formidable". They make a great team.

Once on the path of cardiac Surgery, Mr Ionescu worked hard to establish and build his career. He was successful in applying for a WHO scholarship that allowed him to work in some of the biggest units in the USA.

Before and after these visits, under the regime in Romania, Marian laboured hard. After years of gaining trust from the authorities, in 1965, he and Christina managed to gain permission to have a holiday in nearby Yugoslavia. Being with friends near the border they (with the aid of their friends having a party with the border guards) managed to fill their small fiat 600 full of fuel and so as not to arouse the guards pushed their little car for kilometres across the border into Italy past the astonished Italian guards. No country would give them sanctuary except France.

Mr Wooler the Chief Surgeon in Leeds subsequently heard of Mr and Dr Ionescu. He was keen to expand the cardiothoracic surgery programme and came to Paris to ask them to join him in Leeds.

Over the years Marian Ionescu has been a true pioneer of our specialty. Alongside an extensive research career (in extracorporeal circulation and deep hypothermic circulatory arrest) he has many surgical "firsts" to his name including the successful surgical correction of a parachute mitral valve, the first correction of a single ventricle circulation, reconstruction of the RV to PA continuity with a fascia lata or pericardial conduit along with several pioneering developments in valve replacement, including creating and implanting the

> *"Over the years Marian Ionescu has been a true pioneer of our specialty"*

continued on next page

SCTS Lifetime Achievement Award: Mr Marian Ionescu

first polyurethane valve, the first use of a porcine valve for mitral valve replacement, creating and implanting the first stented fascia lata valve and the development and implantation of the bovine pericardial heart valve.

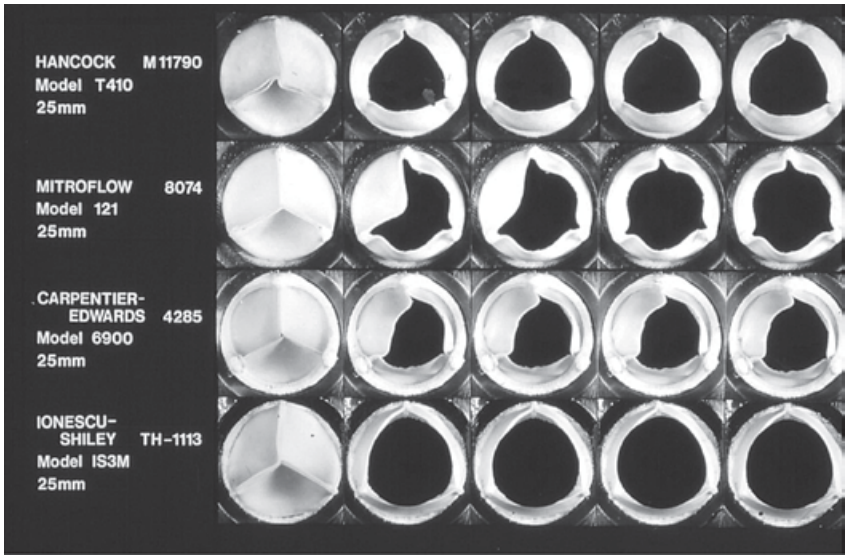
Whilst writing this talk I have spoken to a number people who worked with Mr Ionescu.

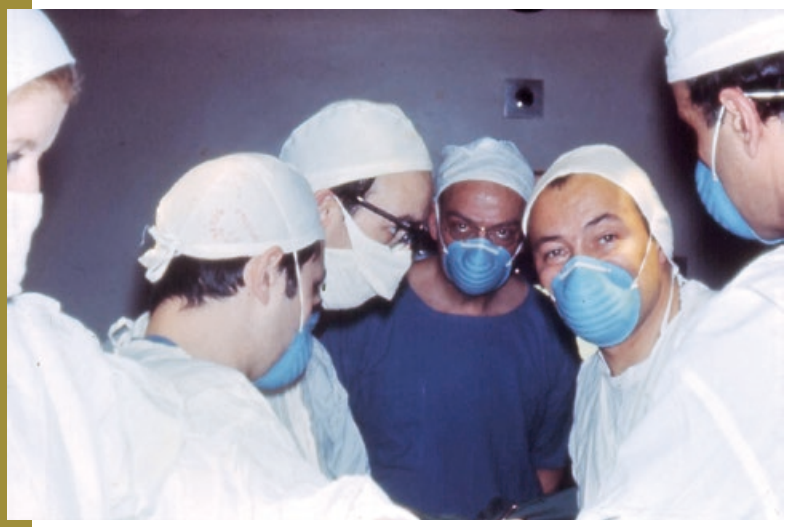
He is always described as being very generous-he took lots of equipment with him when climbing in the Himalyas but always left it behind for the benefit of the Sherpas and guides. This has been borne out in the philanthropic nature of his support for SCTS and SCTS education in particular.

He is a man of wide and varied interests: Poetry, Philosophy, Art, Ferraris and Mountains!

Mr Ionescu has had a life long enthusiasm for education: He has published or edited some eight books. He has brought nine students/pupils to the position of Professor or Chiefs of Department from Palo Alto to Beijing (including Spain, Tunis, Hungary, Italy, Romania, India and Israel).

Mr and Mrs Ionescu's desire to help others is well recognised by all those who meet them - A visitor arrived at their house to hear Marian having a heated conversation on the phone and Christina upset. He realised he was trying to talk to the producer of ITN as piece ran on the news about a man who kept a honey bear at his home where he had reared it from a cub. The man was to have the bear taken away as he could not afford the newly introduced wild animal licence fee. Marian and Christina were arguing for the man's address so they could send him the not insubstantial fee for the licence.





Mr Ionescu has had a life long enthusiasm for education: He has published or edited some eight books. He has brought nine students/pupils to the position of Professor or Chiefs of Department

Unbidden and selfless they saw a wrong and wanted to right it.

In recent years, Mr and Mrs Ionescu have been hugely supportive of a number of projects, in the worlds of Animal Welfare and Education in Cardiothoracic Surgery.

Their support of the education portfolio has allowed the SCTS University to flourish into the state of the art review of our specialty that it now is. The Fellowship programme is going from strength to strength with a wide range of high quality applications this year, delivering real benefits to all members of the team (including, for the first time this year, medical students). The funding of the SCTS course portfolio has allowed us to look at course provision for the whole multidisciplinary team.

This support has been and will be fundamental in allowing SCTS to continue to strive towards achieving the goal of delivering the best care for our patients that we are able to give.

It is an honour and privilege to present Mr Ionescu with the SCTS lifetime achievement award.

President's Report

Dear All

This edition of the Bulletin is dedicated to training issues as for sometime now the Executive have felt that we should be highlighting this area of SCTS endeavour. Due to continuing support from Mr Marian Ionescu we are in a position to fund this issue of the bulletin as a paper published copy which many of us feel may be more widely read and appreciated by the members.

The last President's Report was around the time of the December Board of Representatives' meeting when there was an attendance of over 100 SCTS members. There was lively discussion and debate related to our national clinical audits and in particular how outcomes measures in adult cardiac surgery are being published at individual surgeon level in the consultant outcome programme of NHS England.

> *Over the past 2 years I have been proud to be involved with and very impressed by the achievements and momentum of the Education Committee under the leadership of Mike Lewis and Rajesh Shah*

This issue has continued to be a substantial part of the Executive's work over the past 5 months and David Jenkins, later in the bulletin, reports on the work and progress that has been achieved by the Clinical Audit Committee under his chairmanship. There has been progress on developing a "13 point plan" of action with the NACSA which we are taking forward as we increase our active engagement with NICOR.

This issue has continued to potentially overshadow the other important work and activity that is being undertaken by the Executive on behalf of all its members as we continue to aspire to be the Society for Cardiothoracic Surgery both in Great Britain and Ireland and beyond. I am pleased therefore that we are focusing this edition of the bulletin on some of these other areas.

Over the past 2 years I have been proud to be involved with and very impressed by the achievements and momentum of the Education Committee under the leadership of Mike Lewis and Rajesh Shah. They have placed our specialty association at the forefront of education and training within the UK and Ireland and also on reflection internationally. They have designed and delivered curriculum aligned courses for the UK NTNs with a major industrial partner. They have attracted and delivered clinical fellowships with industrial partners together with the Ionescu Education Fund (for which they have negotiated a substantial increase) for allied healthcare professionals, non NTN middle grade doctors and more recently for medical students. They have strengthened the links and partnerships with the Cardiothoracic SAC and the Joint Surgical Colleges Examination Board which has continued to increase the profile of cardiothoracic surgery in the UK and beyond. As a consequence there has been a significant increase in SCTS membership and they are now planning ambitiously to continue to develop education and training for allied healthcare professionals and nursing colleagues. What has also impressed me has been the willingness of many consultant members and others to be involved as faculty on a pro bono basis in these courses which I have been able to observe directly recently in Hamburg on the Cardiac ST3 course.

AGM

The Annual General Meeting in Manchester in March was very successful from a scientific, professional, social and financial perspective. The Meetings Team delivered an excellent joint meeting with ACTA in difficult circumstances and are to be congratulated. The meeting was well attended and the standard of the scientific sessions was high. There was clearly a lot of enjoyable social interaction and I got a lot of positive feedback from anaesthetists who attended the joint meeting. There was a "Showcase" breakfast meeting with our marketing company Scott Prenn which over 40 potential partners and "friends" of SCTS attended.

Financially, the meeting delivered a surplus which is important for SCTS in order for it to underpin our other areas of activity. The Meetings Team have already met to debrief and are in the process of organising the next meeting in Birmingham which will be on 13 – 15 March 2016. Many of you will know that Birmingham is a great venue to host a national meeting and we are very much hoping to welcome you all to a highly successful meeting in Britain's second city next year !

I was able to reflect on our Annual General Meeting when I recently attended the Asian Society for Cardiovascular and Thoracic Surgery in Hong Kong in the middle of May. SCTS was asked to contribute to a joint session on education and training at which we

Tim Graham

presented on curriculum development, quality assurance of training and the role of examinations. In particular, Tara Bartley presented on the SCTS UK experience of the development of advanced nurse practitioners and allied healthcare professionals. This session confirmed to me that the UK via the SCTS and the SAC in Cardiothoracic Surgery are on the leading edge of these areas internationally. This session was also attended by EACTS and AATS surgeons and I was pleased to be involved in presenting our activities in these areas.

In addition we also contributed to a joint EACTS / ASCVTS / AATS session on clinical audits, outcomes and identification and management of outlier performance. This was an interesting session and once again the UK and Ireland and SCTS were identified to be on the leading edge in this area - indeed international outliers! There was considerable discussion and it is fair to say that the Asian, European and American surgeons viewed our reporting of outcomes at individual consultant surgeon level in adult cardiac surgery with some disquiet. They were unconvinced of the benefits to patients and not in general what they wished or intended to do in the future. There was however consensus and enthusiasm between all parties for international benchmarking of unit and national results in order to improve the quality of care delivered to cardiothoracic surgical patients around the world. I was pleased to be invited to the Asian meeting in Hong Kong which was an exciting and interesting city to visit but I came away feeling proud of our national Annual General Meeting. I felt that in Manchester our meeting had been much more contemporary, vibrant, professional, inclusive and informative. In particular our Ionescu Universities post graduate education day clearly stood out in comparison.

I will not be allocated enough space within the bulletin in order for me to list all the activities and work that are currently being undertaken by the Executive. The minutes of all the Executive meetings are placed on the SCTS website which we are working to improve with Industrial partnership. We have a forthcoming Executive meeting on 5th June following a meeting with the NHS Choices team prior to the publication of the next round of adult cardiac surgical data. The Executive has a busy agenda and in particular we are planning to propose the development of an SCTS research committee and also an SCTS professional standards committee to take these areas forward.

ACCEA

The next round of ACCEA applications is upon us and we have an ACCEA awards committee which will be reviewing applications, both for renewals and new awards and ranking them prior to providing citations to ACCEA, all within a very tight time frame. The process is becoming increasingly competitive as there is no new money or new awards this year and essentially renewals are competing with new award applications.

I hope you enjoy this edition of the Bulletin which is focused on training Concerns are frequently voiced over some issues related to training in the UK, in particular operative experience; case numbers and the European Working Time Directive. My observations however from attending the recent Asian meeting and beyond is that in the UK and Ireland principally through our consultant member trainers we are continuing to produce high calibre, well qualified trainees in cardiothoracic surgery equipped for NHS Consultant practice who compare favourably with trainees from the rest of the world. We should and need to continue to acknowledge and celebrate that considerable achievement.

Finally for consultants please update your personal portfolio on the SCTS website – this is your opportunity to put your details and practice in perspective prior to the release of the next round of clinical audits information.

Lets hope there is some decent summer weather and I hope that you all manage to get a good summer break – we all deserve it !

Tim Graham
President

I felt that in Manchester our meeting had been much more contemporary, vibrant, professional, inclusive and informative. In particular our Ionescu Universities post graduate education day clearly stood out in comparison

Honorary Secretary's Report

Training in Cardiothoracic Surgery

This issue of the bulletin is focussed on training and you will read some fascinating insights from the perspectives of different colleagues.
Training in medicine and surgery has clearly transformed in the last three decades. In the 80's and 90's junior doctors would journey through various posts of various standards accumulating experience. The obstacles to progress were the competition for promotion – from SHO to registrar to senior registrar and then a consultant's post.

In cardiothoracic surgery it was a very pyramidal structure with senior registrar and consultant's posts extremely difficult to achieve. In general the competition for these posts prompted vigorous lobbying (often by phone) to describe the qualities of a candidate. The application would be a curriculum vitae which might have described some rough numbers of activity, but often the main focus was how many papers had been published as a sign of excellence. If a junior surgeon struggled there was no structure to support them, nor the ability to seek remedial actions – very much 'swim or sink'. In particular this would apply to the surgery itself where the 'boss' might have other priorities and on a whim ask the trainee to 'open up the case' or 'would you get on with this one, I'm a bit busy'. If it went well you were allowed to progress – but if the surgery went badly it could bring your career to an abrupt halt.

Therefore it was an 'implicit' system. There was no defined structure, there was no curriculum and the specialist exit exam was in its embryonic stages. The senior registrars came to their consultant's interview only having to prove they had the FRCS exam and that they were in a recognised senior registrar post – the rest of the assessment was very much word of mouth, from the candidate at interview and from the informal conversations about them.

Evidence Based Training

Now training is very much an 'explicit' system: At every stage of a surgeon's progress there is a continual collection of evidence based around a defined structure and curriculum. Medical students, foundation years, core training and beyond are now all based on web based portfolios. These now have:

- Clinical Supervisor Reports
- Educational Supervisor Reports
- Regular multi source feedback
- Evidence of clinical based assessments – case based discussions, observation of clinical skills, procedure based assessments
- Evidence of mandatory training
- Evidence of continued professional development
- Exam certificates
- A specialty exit examination
- Audits
- Research
- The opportunity to document reflection.

Not a single item on this list existed in 1990 !

I am most impressed by the immensely high quality and consistent quality of cardiothoracic surgical trainees that are now progressing through this new system. I feel sorry for them being under such continual scrutiny – it cannot be easy knowing every action counts. They are most professional how they present themselves and in my role on the SAC I am fortunate to participate as a liaison for a Specialist Training Committee. Every trainee in that rotation would be an excellent colleague and an asset to the unit they work in – this is remarkable consistency and quality in training and is a credit to everyone involved. This applies at a regional level and in each cardiothoracic unit, but also for the leadership at a national level: the SAC who over the years have defined the curriculum and structure; the creators of eportfolios and ISCP; the SAC and national selection; the JCIE for developing a quality assured exam – all of which have been huge pieces of work requiring strong leadership.

Many of our trainees have not experienced any other system. It appears to be producing outstanding cardiac and thoracic surgeons and hopefully it is not too onerous and stressful. Certainly when they achieve their consultant's role they will be completely prepared to have their outcomes monitored as well as appraisal and revalidation which have been adopted with various levels of enthusiasm by established surgeons!

Issues

I have a couple of issues issue with the new system, one of which applies to the intervention specialties and the second to all branches of medicine.

My first issue is that we have yet to define the amount of independent operative experience a trainee surgeon should have. The combination of enlarged rosters to comply with the European Working Time Directive and the increased focus of quality outcomes has resulted in the senior trainee not having the independent experience that his trainer was fortunate to have. This results in the newly appointed consultant often needing a period of mentorship and occasional help in the more complex cases – although this is good practice how to support a new consultant colleague we may wish to consider that the newly appointed consultant has achieved minimum numbers of independent procedures with their trainer 'unscrubbed'.

Secondly the term 'trainee' applies to all junior doctors for their entire training.

Simon Kendall

One day they are a 'trainee' and then the next day they are a 'consultant'. To some extent the word 'trainee' is a derogatory term as it infers they are not fit to do the job properly. At present there is no easy way for staff or patients to identify the level of seniority of a junior doctor. Yes, they are training in their specialty but at the same time they are key deliverers of patient care, becoming more and more responsible as they progress. Titles can be pompous and unnecessary but they can also be very useful for identification – it's the Captain and First Officer on the flight deck and you don't hear the captain inform the passengers that the trainee pilot is going to land the plane...

Perhaps the GMC and the Colleges will consider a series of titles for doctors as they progress through their training? It is tempting to suggest the original titles of SHO, Registrar and Senior Registrar – but at the very least something that reflects the seniority of the doctor which gives patients, relatives and staff an immediate appreciation of the level of doctor that they are dealing with?

What we can be certain of now is that the title would be a true reflection of progression through a defined curriculum backed up with explicit evidence - unlike 30 years ago when it was an unknown and variable product!

ST6 Cardiothoracic Course Report

Vijay Joshi (ST6)

Target Audience: ST6 level national trainees with membership to SCTS

Venue: European Surgical Institute, Hamburg, Germany.

Sponsors: Ethicon (Johnson & Johnson)

ETHICON
PART OF THE Johnson & Johnson FAMILY OF COMPANIES

Travel and Accommodation

Fully funded by sponsors. Only thing requiring personal funds is transport to and from U.K. airport. Accommodation is at a nice hotel with food fully paid for as well as an organised dinner outing. There are opportunities for social interaction between candidates and faculty every night.

Venue

The training facilities in Hamburg were of excellent quality. Ample sized lecture theatre and smaller conference rooms for group study. Surgical facilities were above expectations. Fully functional VATS equipment and cardiopulmonary bypass machines were available to aid in a realistic surgical experience.

Organisation

Well organised by sponsors. It was obvious that a lot of planning had gone into this course.

Wet Lab

Operations performed on live anaesthetised pigs. Candidates divided into either thoracic or cardiac groups. Operative experience in VATS lobectomies, chest wall fixation, open sleeve resections, OPCAB, aortic root replacement, and mitral valve repair with surgical consultant scrubbed to provide a step by step walk through. Groups were kept small to maximise experience. All candidates had an opportunity to participate in a congenital wet lab following dedicated lectures.

Overall

This was a great course to improve surgical skills in a realistically simulated environment under consultant guidance. Lectures were focused on topics to improve both clinical practice and for preparation for FRCS exam.

Highly recommended!

Cardiothoracic Dean's Report

For those of you who haven't met me, I took over the role of Cardiothoracic Dean last year from Sion Barnard. It is a post with a 5 year tenure and so I hope I shall meet as many of you as possible during this term.

The role of Dean is to offer a first line point of access for all trainees who are either already in the specialty, or thinking about a possible career in cardiothoracic surgery. I would hope to be able to offer advice and help with any queries in regard to training and the career pathway within the specialty, as well as any other related topics. I can be contacted any time by email, and am always happy to discuss issues on the telephone or in person if you prefer. I like to think that I am easy to contact and will reply straight away to your queries. As Dean, I sit on the SAC and the Exam Board so hopefully I can keep you up-to-date with questions you have related to these areas too. I shall try to offer an easily accessible first port of call, and if I am unable to help you directly, I should be able to help put you in touch with the right people. My email address is jonathan.hyde@bsuh.nhs.uk.

Within this report, I shall briefly update you on what has been going on in training-related matters within the specialty, and then there are 3 reports from individuals who have been through or are currently going through training, and provide very different perspectives.

1. Curriculum

Mr Barnard (SAC Chair) and Mr Anderson (Chair of Cardiothoracic Intercollegiate Exam Board) attended a meeting with the GMC in November 2014 to discuss changing the curriculum to reflect a 1:5 year split for Cardiac surgery and Thoracic Surgery. Thus, a trainee proposing to do Thoracic surgery would spend a year (in their first two years) in Cardiac surgery and then the remainder of their training would be in Thoracic surgery and vice versa for trainees planning on a career in Cardiac Surgery. This would require competency changes to the curriculum and thereafter changes could be made to the examination. The GMC were welcoming of this even though it seemed to run against the spirit of the 'Shape of Training' review. We shall keep you updated as and when things happen, but GMC endorsement is generally not easy.

2. National Selection

The selection process for ST1, ST3 and ST3 (ACF) was again hosted by the Wessex Deanery. The two day process ran very well. There were improvements made to the selection process this year, based on previous candidate feedback, such as the re-introduction of a Portfolio station.

At the end of the process, 13 posts were appointed to ST3, 1 to an ACF (already an NTN) and 8 to ST1. The pilot of the ST1 appointment will continue in 2016 and in the summer of that year a formal review of the 20-25 who have entered at ST1 so far will be carried out to see if continuation of the project is deemed worthwhile. Dr Plint has written to the GMC to extend the pilot into the 2017 round so that there is enough data for valid analysis. One of the reports that I attach below is from an ST1 entrant.

Congenital appointments to a combined London /London consortium and a Liverpool/Newcastle consortium were hoped to be made at National Selection, but it was not possible for logistic reasons. It is still hoped to have these two appointed in the summer, however there are funding issues with the Liverpool /Newcastle bid and it may be proleptically appointed or undergo a separate process in 2016.

In the combined SAC/TPD meeting on 12th June 2015, there will be a discussion about bringing the application process forward so that bids are considered at the September SAC meeting rather than December. This would make web-links to potential posts easier to construct and avoid shortlisting over Xmas/New Year.

Mr Jonathan Hyde

3. Curriculum Aligned Courses

These have now started running following work a lot of hard work carried out in 2014 by the College Tutors, Sri Rathinam (Thoracic) and Narain Moorjani (Cardiac), and details of all courses can be found on the Society website. A very successful ST6 course was run in the Ethicon European Surgery Institute in Hamburg for ST6 trainees. Trainees at all levels from ST3-ST8 can benefit from two courses per year, and they are also very well supported by industry.

4. Workforce Planning

Workforce planning and an updated list of UK/Ireland Consultants with indicative retirement dates continue to be produced. Inspired by the Vascular Surgery Workforce document of 2014 (produced by the Vascular Society), Cardiothoracic Surgery are producing their own document, and an initial draft was presented at the March 6th 2015 SAC meeting by Simon Kendall. It is hoped that the final document will be ready for the combined SAC/TPD meeting on the 11th/12th June 2015.

5. Intercollegiate Examination

The requirements for part III examination continue to be discussed. One of the sticking points is the requirement for an ARCP 1 at ST6. This is obviously reviewed towards the end of the ST6 year, meaning that the Intercollegiate exam is taken at ST7 for practical purposes. This can have effects on peri-CCT fellowships (such as the congenital training mentioned above) and Transplant fellowships which are both well established. It is felt that these are best undertaken when the trainee is not spending time revising for the Intercollegiate Examination. However, as this (ARCP 1 at ST6) is a JCIE rule, there does not seem an easy way around this other than Trainees taking the exam in the early part of any fellowship. Personal specifications of the fellowships need to reflect that the exam may be desirable but cannot be essential as it would exclude this group of Trainees.

> ***A trainee proposing to do Thoracic surgery would spend a year (in their first two years) in Cardiac surgery and then the remainder of their training would be in Thoracic surgery... and vice versa for trainees planning on a career in Cardiac Surgery.***

A Trainee's Journey into Cardiothoracic Surgery

The first thing to say, is that I adamantly did not want to be a surgeon throughout medical school following a ritual humiliation by an esteemed surgeon, after which I vowed never to set foot in a theatre again. Now as an ST5, with a fair bit of operating under my belt, it's been interesting to think back to how I have ended up here, and I thank the SCTS for this opportunity prompting me to do so. My brief was an article of my experience of training in cardiothoracic surgery, and how I prepared through medical school, FY1, national selection, and research.

Early years training

In my foundation years, I was lucky to work at a great surgical unit, with a strong interest in training. I was studying for my MRCP, with career aspirations as an intensivist or physician, when I caught the surgical bug from senior colleagues. I started wheedling my way into theatre, and not only realised how much I enjoyed the technical skills, but also how much more fun surgeons seem to have than physicians! The team took care to nurture my budding interest and I took care to get into every case I could. The deal was sealed when I scrubbed as first assist on a ruptured AAA in the middle of the night, and watched the surgeon, cool as a cucumber, salvage what looked to me to be an irreparable horror. I thought, 'I want to be him when I grow up'.

I started building a logbook, getting audits done, surgical work based assessments, focussing on the system and the competition. I cannot stress enough how important I think it is to engage with the multifaceted nature of surgery and administration early on. At first it felt like hoop jumping and box ticking, but when it comes to charting your own competency and progression, it is so valuable to have a portfolio that shows responsibility for your career.

My other interest within the medical field is international health development, and I had always planned to return to Latin America as a doctor, having worked there after school. After foundation years, I put formal UK training to one side and I worked abroad in Guatemala for a year, as the equivalent of a resident.

A 24-hour on-call could involve machete injuries, necrotising fasciitis, tuc-tuc traumas, strychnine poisoning, electrocution, and almost certainly a delivery or two. There are many stories, but for a different arena. While it was a reasonably well-supported job, with experienced seniors on hand, it gave me the opportunity to be resilient and resourceful, to really test my brain, my clinical skills, management and cultural sensitivity in a resource deplete area.

Much of what I learnt and how my practice changed is intangible and immeasurable. It was an invaluable period of my training, which, with the clarity of retrospect, I can say has shaped me into the surgeon I am today.

I continued dutifully to complete a logbook, and to get seniors to fill out WBAs, much to their confusion – perhaps not surprisingly, the Mini-CEX had not yet reached Guatemala. But it certainly counted when I flew back for my Core surgical training interview. I was a confident, well rounded, and perhaps, dare I say it, an interesting candidate because of the work I had been doing. And of course, I had a portfolio of an F2 with keen interest in surgery, and of the routine, weird and wonderful from my experience abroad.

And so, finally we get to cardiothoracic surgery as my first CT1 job. Straight off the plane and right into the thick of an interesting, exciting fast moving unit. It sounds perhaps minor now, but as a CT1, taking vein felt like doing my own little operation every day. I was taken under the wing of the thoracic team, and I really enjoyed starting to get my hands on small thoracic procedures and parts of resections. The unit was superb for thoracic training, and I started building up case numbers, as well as clinical work out of theatre. Something about the involvement with intensive care, and the medicine, as well as the technical side of the speciality attracted me.

One surgeon told me he had always liked cardiac because it meant he could be 'an operating physiologist', and it struck a chord with me. Having been attracted to intensive care early on, it seemed to fit nicely to be in a speciality which indulged my loved of operating alongside the more cerebral aspects of physiology.

As part of the CT1 job, I spent a month on Cardiac ICU, working with the cardiothoracic anaesthetists and gaining a good basis of physiology and intensive care, which has been invaluable everyday as a cardiothoracic registrar. I am aware, from my own experience and my peers, that ICU is an area where one can feel out-of-depth and caught on the battleground between intensivist and surgeon care. Clearly we are moving away from the cardiac surgical registrar managing ICU in many units, but the experience during my training has given me a robust understanding to provide safe, efficient care, and to be able to communicate effectively in ICU territory. We work so closely as a team, that I believe it is helpful to have trained, even for just short periods, within the discipline of other members of the team.

National selection

Having taken the leap and asked for a CT2 year in cardiothoracic, it became about preparing for national selection. An endless stream of presentations, WBAs, logbook entries, and teaching sessions to fit into the dreaded matrix in everyway possible. Maintaining control of paperwork is a skill in itself that I certainly picked up whilst preparing for selection. I had great support from both

Louise Kenny

consultants and registrar colleagues, with many helping me to prepare for interview and get projects off the ground. Night shifts became the witching hours for abstract writing and muddling through statistics.

National selection itself was stressful for me, not least so because of an arm in plaster. All us budding cardiothoracic surgeons, as competitive and 'larger than life' as we are, crammed in a room together, winding each other up with tales of our expansive experience and two-headed interviewers.

As I often did with OSCES in medical school, I deceived myself it was a tough-mudder obstacle course, with commando rolls and rope ladders. I got through, and landed into my next great training position in the Northern deanery.

National selection has the whiff of all or nothing. By this point, we have put all our eggs in the one basket, but have also been witness to those who have struggled to get a training number. For my part, I found it to be an interactive, realistic and fair blueprint of what is expected of you as a registrar, in terms of both technical and non-technical skills. There was opportunity to highlight your strong points, and I do even remember enjoying some of it.

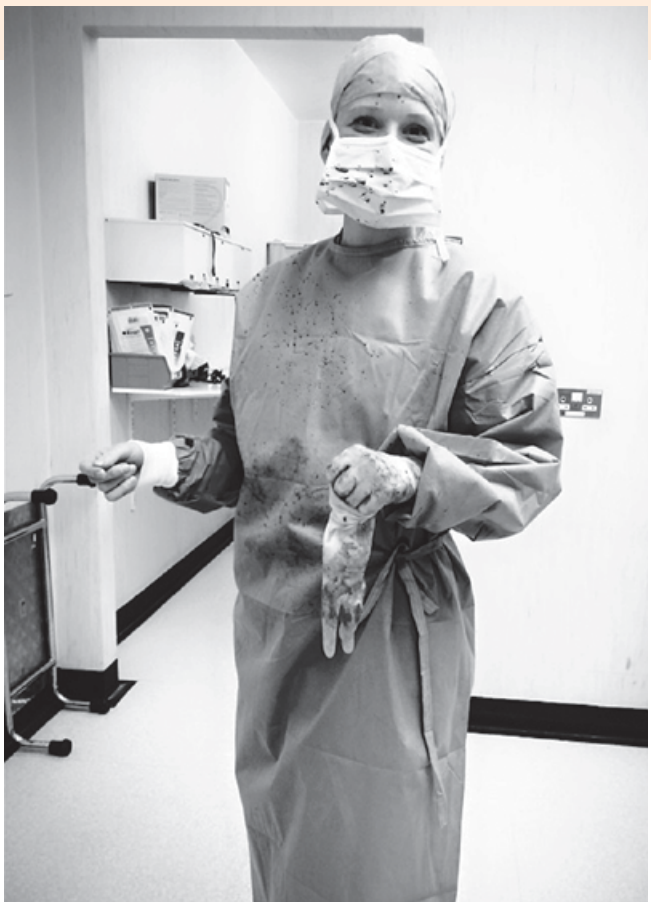
For any candidates planning for national selection, beating the matrix is the first step, a phenomenal portfolio is a must, and then remember the words of Rudyard Kipling from the poem 'if'..

'if you can keep your head, when all about you are losing theirs..'

(Indeed, I would recommend it as a reminder for momentum in any day at work.)

Also, don't go snowboarding and break an arm a week before. Although it gives opportunity to show resilience and left-handed operating, it shows a distinct lack of situational awareness.

ST3 and onward



Since starting ST3, I have found my training to be almost entirely a positive experience. Like all other trainees, I have had to battle with EWTD and the tension with service provision.

There is an undercurrent found in many units, that the trainees are there to train, and service provision gets in the way. In my experience, we often mistake 'training' for operating, and, for my part, it is important to remember we are training to treat human beings, not just coronary arteries or whichever anatomic structure. Part of being a trainee surgeon is inextricably linked with providing a service. I believe our wages are not paid to us today in advance of the experienced surgeons we will be, once we have completed our training in the operating theatre. We are paid today to provide a service to our patients today.

Don't get me wrong, I love to operate, and I would do it everyday, but during those frustrating 'service-provision' shifts, when I'm missing out on a case in theatre, I have to remind myself that it is as much my job to see patients on the wards, and in A+E, to answer phone-calls from their GPs and speak to their families, as it is to operate on them.

EWTD has limited the hours we can spend training, but nonetheless we have to strike the right balance of inside and outside of theatre. I have been known to rock the boat by pushing to get my time in theatre, and upsetting colleagues along the way. While it is true, you have to break a few eggs to make omelettes, I think as assertive, competitive trainees, we should support each other's training as well as driving our own. We will be each other colleagues throughout our careers after all.

Within the units I have trained in, the service provision has always been fairly well balanced with non-numbered trainees. I have rarely missed opportunities to train in theatre or clinic, however I am aware of trainees who have missed out on a year, or even more, of constructive, useful training, due to the set up of the unit or the lack of willingness to train. I have had one experience of working under a trainer with little willingness to train, and it is a challenging situation to navigate. Some train, and others don't, but it is worth bearing in mind, there is something to learn from everybody, even if it is ' I wont do that when I'm grown up'.

continued on next page

A Trainee's Journey into into Cardiothoracic Surgery

There is concern that with limited hours under the EWTD, we wont be competent operators at the end of our training, and maybe we should be looking for alternative structures to training programmes.

I was recently in the university town of Davis, California and fell into conversation with a football coach, and it got me thinking. I'm not the first to make the comparison of course, but what interested me was that in the training of an expert sportsman, enormous efforts go into identifying the appropriate person specification of coach-to-player. The qualities of the coach are considered in terms of three domains – knowledge, skills and attitude. For young learners, where potential is noted, the coaches selected tend to be those better at garnering enthusiasm and directing energy. Whereas with the senior, expert sportsman, the coach is likely to be someone with extensive skill and knowledge and the ability to pick apart the specifics of a success or failure, down to the devil of the detail. We all know that guy, right?

It is possible to identify surgical trainers who are appropriate to each level of training, and, when matched at the right time can be an exceptional game changer. Inversely the trainer who picks apart the 'sportsman', at a time when support and enthusiasm is required, can demotivate and dishearten. But with the senior trainee, who is pushing for expertise and perfection, it is ideal.

With constraints of EWTD, and the push to turn out competent surgeons, a trainee doesn't have the time to lose being poorly matched, demotivated and delayed in progression.

I would ask, should we shake it up? Are we small enough as a speciality to acknowledge the qualities of our 'coaches' and potentially build an exemplary trainee to trainer matching programme, even perhaps allowing travel and exchanges from our defined deanery boundaries to study under a well-aligned partnership? I put it out there as food for thought.

> ***We work so closely as a team, that I believe it is helpful to have trained, even for just short periods, within the discipline of other members of the team.***

Research

I have currently taken a year out of programme, focussing on a masters in surgical education, and a research project regarding global surgical placements in low and middle income countries, specifically looking at the fine balance of educational benefit and patient safety. I admit I struggle to align my career in a high-expense, high-technology speciality with my aspirations of health equality and development, and this year has given me the opportunity to explore both. Global surgery is an evolving field, which remains a vital part of my career. While it provided a positive and formative year of training for me, it has the potential to be damaging if not structured according to the individual and the area. While I would not recommend such a career move to all trainees, I do think the right trainee placed in the right placement abroad can do wonders for both personal and professional development. From my experience, I feel that investing time in certain types of placements, can provide a far more constructive experience of team working skills, management, communication and leadership than many of the compulsory training courses we attend as part of our professional development. I would encourage interested trainees to investigate their own potential, with serious consideration to their motivation, learning outcomes, and both the positives and negatives.

I have kept my hand in, with locum shifts and operating lists, but I am glad to have the opportunity to add the string of education, and research of global surgery to my bow. It's easy to vanish down the rabbit hole of a career as absorbing and demanding as cardiac surgery, but I believe maintaining other channels of interest keeps it fresh and motivating. I look forward to returning back to training with even more energy!

Cardiothoracic Surgical Training at Papworth Hospital

Alia Noorani
StR, Papworth Hospital

The Eastern Deanery cardiothoracic training programme is based almost exclusively at Papworth Hospital, although some of the thoracic training is also provided by Norfolk and Norwich University Hospital (NNUH).

Papworth Hospital is the largest cardiothoracic centre in the UK with over 2200 cardiac surgical cases performed here last year. The training rotation as others in the country spans 6 years, but unlike other programmes, trainees at Papworth spend the majority of their training in one hospital. Some may consider this to be a disadvantage citing lack of experience from other centres and trainers. With 16 consultant cardiac surgeons including 8 transplant surgeons and 4 thoracic consultants, I'd argue the opposite.

I was appointed to this rotation in 2009 and although I had never previously worked at Papworth, I was aware of the excellent training opportunities from previous trainees. Within a week of my appointment, the training programme director had been in touch with me to invite me up to Papworth to formulate a plan for my training. This already gave me a positive insight into how much training was valued at this institution.

As a general rule all trainees are expected to complete one year of thoracic surgery and 6 months of a sub-specialty, which for us is cardiothoracic transplantation, before the end of the ST5 year. There is also an opportunity to undertake out of programme research or training should one like to do so. As regards the latter, some choose to gain some exposure to congenital cardiac surgery.

As a year 1 trainee, my first 6-month attachment was thoracic surgery at the NNUH. This is a unit consisting of 3 full-time thoracic consultants undertaking the full breadth of thoracic surgical workload, including lung cancer, oesophageal resections and benign lung pathology. In addition to two operating lists a week where I was usually the primary operator, I attended 2 MDTs and 2 outpatients clinics - seeing both new and follow up patients. Following on from this I moved to Papworth and the rest of the article focuses on this.

There are 9 surgical registrars and we share a partial shift on call rota. Our on call commitments comprise of being first on call for an 8-bedded Cardiac Recovery Unit for immediate postoperative patients and a 28-bedded Intensive Care Unit. In addition to this we cover all the surgical patients and receive external referrals. The on calls are extremely busy, as one would expect but the overall experience is fantastic and valuable. It is a given that on on-calls days one is not allocated to the operating theatre and you are expected to be on the ICU floor or attending to patients on the wards. However, when not on–call, we are allocated to theatre usually 5 days a week.

There are 5 operating theatres in total, (including 1 thoracic theatre 4 times a week, the rest are cardiac lists) with 2-3 cardiac cases each. Traditionally at Papworth, unless there are unusual circumstances, a trainee allocated to a list usually performs both cases. There is no limit on the type of cases we are trained to do, even at a junior level. Our trainers consider every operation to have a potential training opportunity, be it a coronary case, combined valve and grafts, double valve procedures or even aortic surgery.

There have been some changes of course, with time and service constraints, but even in the light of this, we trainees receive excellent operative and overall clinical experience, which from my own personal experience is not the norm in other centres.

Besides the operative experience, we have an excellent in house teaching programme. This programme is usually formulated by one of the registrars with guidance from the TPD and is set out for each year in advance. Every month there is a teaching day where 2 registrars present a chosen topic with a consultant chairing the session. Topics can vary from basic science that we may be expected to know for the exam or surgical practice related to specific disease conditions. In addition to lecture based teaching we also have two wetlabs a year, one thoracic and one cardiac related held on site. In the past these have included aortic root replacement, root enlargement and mitral valve surgery.

As far as the pastoral side is concerned each trainee has an Assigned Educational Supervisor (AES) who remains their mentor for the entire length of their training. We meet with our AES at the start, mid way and end of each six-month rotation to formulate training objectives and targeted plans and to monitor progress. Additionally we have fortnightly meetings with them where we can discuss any issues with training or education. We are lucky to have quarterly TPD-trainee meetings as well where we can voice any major concerns directly to the TPD or suggest changes to the training or educational programme. These are great opportunities rather than waiting till the end of year ARCP to highlight any concerns that we as trainees have.

To an outsider reading this it may seem that we are a closely regulated group of trainees. I would agree wholeheartedly with that but would argue that perhaps to deliver a safe and effective service in the future, particularly in a specialty such as ours where results make such a great difference an apprenticeship like programme such as Papworth's prepares you extremely well.

State of Training

Aaron Ranasinghe

Consultant Cardiothoracic Surgeon, Queen Elizabeth Hospital, Birmingham

Training *"...the process of learning the skills you need to do a particular job or activity..."*

Good training *"...to be a useful experience that will be helpful when doing a particular thing in the future..."*

Apprentice *"...someone who has agreed to work for a skilled person for a particular period of time and often for low payment, in order to learn that person's skills..."*

Being a Cardiothoracic Trainee is a mixture of being trained and being an apprentice. Training in the present era requires a trainee to acquire a variety of clinical, technical and professional skills. Currently this needs to be completed within a finite time period, on an increasingly elderly and complex patient mix with increasing public scrutiny on unit and surgeon specific results.

Even in the short period of time since I was a Senior Trainee and appointed as a Consultant things have changed immeasurably. I learnt my trade harvesting my "mile of vein" before moving on to the business end of the operations. During this time period I garnered further surgical experience as an SHO on a surgical rotation, honing tissue handling, administrative skills and care of the critically ill surgical patient, giving me an all round education in surgery. Following this, I moved onto a period of dedicated research with Registrar level operating, care of patients on the ITU in a Clinical Trial and further experience of research administration, methodology, manuscript preparation, critical appraisal and working as part of a team. When I was eventually appointed as an NTN, I had been involved in Cardiothoracic Surgery already for a period of five years - just short of the time-period given these days for somebody to be trained!

I moved through the operative steps in both Cardiac and Thoracic surgery and gradually built myself up to becoming an independent operator. I also took on responsibility for scheduling of patients and administrative jobs of rota-co-ordinator and Regional Trainees Representative.

So what is different for Trainees in the current era? Their training time is compressed and focus narrowed. No longer is a prolonged period of research mandatory to gain either a training number or a Consultant job (skills which I have been extremely glad of in my short Consultant career so far). With the constraints of rotas and EWTD, they have moved away from an apprenticeship style of training to more structured training and they face a more complex group of patients to operate on with their Trainers under a great deal of scrutiny. Inevitably this means that there are potentially less suitable cases for Trainees to do, with the obvious impact on the number of cases that Trainees have performed prior to being appointed, however, it is beholden on Trainers to ensure that during even the most complex of operations, there is a learning experience made available and for Trainees to realise that there is a lot that can be learnt about how to conduct (and not conduct) operations by assisting and observing. Personally I have observed that the best assistants are those who understand the operation and its conduct.

However, operative skills (although highly important) are not the only skills that a Cardiothoracic Surgeon must master. Interpretation of multiple investigations, decisions regarding operability, ITU management, waiting list management and data analysis to name but a few are also of paramount importance and these cannot be obtained from books.

So is everything bad for new Trainees? I don't think so. The Education Committee of the Society has done an excellent job in ensuring a structured (and free) series of courses, with an emphasis on simulation and wet-labs throughout the training period. As a Consultant, it should be and is a privilege to have a National Trainee as part of your firm. Trainees are generally the most motivated and hard-working Junior Doctors in the Hospital and if treated correctly and nurtured will provide an excellent level of care for all the patients. They may not necessarily get everything right but nobody does and after all they are still Trainees. There will be personalities that do not work well together but this can to a degree be mitigated against by a structured learning agreement with regular meetings to discuss progress and acceptance of interpersonal difficulties. The constant filling of assessments is time consuming and at times annoying, however, this again can be made more palatable by sending these on a regular basis rather than a deluge being received the night before an ARCP.

In the end, however, it should be remembered as Oscar Wilde once said, ***"Education is an admirable thing, but it is well worth remembering that anything worth knowing cannot be taught".***

State of Training

Yassir Iqbal
ST3 trainee:
West Midlands rotation

Cardiothoracic surgical training has undergone major changes over the course of its history. Factors such as the European Working Hours Directive, publication of surgeon specific mortality, the introduction of competency based training, and changes to the demographics and pathology of the patients we operate on are only a few areas, which have impacted on training.

Firstly since the introduction of the MMC changes to specialty training the pressure has been on trainers and trainees to develop into independent surgeons within a specific time frame.

Trainees' concerns have been to show evidence of progression during their course of training, to acquire an envious logbook of procedures to demonstrate their experience and exposure. However across the country there has been a ongoing debate as "what counts as a case?", "Is that my mammary?" "How many cases must I do before I complete training?" On the other side of the coin the Trainer is now under increased pressures to demonstrate training to show their trainee is being trained. In addition the trainer must meet the needs of the NHS trust such as completing a full list, ensuring operation list do not over run, reducing the waiting list, and most importantly keeping the patient safe.

Cardiothoracic surgery has always been at the frontier of advancement in technology. The specialty although relatively young has been extremely dynamic in adapting to change. Surgeons of the future will be expected to sub-specialise to ensure greater case volume, and better outcomes.

> ***"Whether trainees undertake healthcare MBAs or business masters courses is another area which may impact the future cardiothoracic surgeons' skill set"***

Furthermore with financial constraints in the NHS this may lead to a shake up in how cardiothoracic centres are organized. This month in London we see the opening of Europe's largest cardiovascular centre, which will offer a diverse range of cardiovascular therapies from conventional surgery to possible hybrid procedures.

In addition to gaining the basic training required to perform fundamental aspects of cardiac surgery. Trainees will be planning for their future to decide which sub-specialty interests them, again this has to be balanced with future work force planning.

Furthermore the progression and excellence within this specialty depends on having a strong grounding in basic biomedical, translational science, and clinical research. Due to changes in the structure of training, trainees are now entering the specialty without higher degrees or significant periods in research. Some trainees will decide to perform this during their NTN years others may decide not to embark a period of academia.

Running a cardiac or thoracic surgical unit in the future will need a greater business acumen, whether this is in the hand of the surgeon or hospital manager is another factor trainees can potentially control. Whether trainees undertake healthcare MBAs or business masters courses is another area which may impact the future cardio/thoracic surgeons' skill set.

Currently the state of training remains fluid, with the potential to create a breed of future cardiac and thoracic surgeons who can recognize the needs of the specialty within the healthcare system of the future, equipped with the academic and possible business and leadership skills needed to excel the superior standards set by our Trainers.

This can be achieved with trainees –mentor discussions, continue with competency based assessments and perhaps have a rigorous method to assess competency with numbers of cases needed, support for trainees to pursue certain sub-specialty training to protect the specialty's impact in the of future cardiac and thoracic disease. Trainees also being aware of the changing environment of the healthcare they work in and to secure our roles within this dynamic system.

Learning Mitral Valve Surgery on the Cadaver

Alan Dawson

It was a bitterly cold and snowy January morning in Glasgow for the first cadaveric mitral valve course held in the Clinical Anatomy Skills Centre (CASC). It was an apt location very close to the Hunterian Museum and from where the Hunter Brother's originated.

This course was designed to give an overview of mitral valve disease along with management principles and benefitted greatly from a multi-disciplinary approach. The morning began with a session on mitral valve anatomy through the dissection of a human cadaveric heart allowing the appreciation of the surrounding structures of the mitral valve and the 'at risk' areas during surgery. The pathophysiology of mitral valve disease and the principles of surgical intervention were discussed along with the techniques of repair available. A consultant cardiologist delivered a presentation on the work-up of a patient with mitral valve disease focussing on the salient points of transthoracic echocardiography. Following this, a consultant anaesthetist discussed the use of intra-operative transoesophageal echocardiography (TOE) and its application.

Following lunch, each course participant was given the opportunity to practice TOE with a simulator learning how to obtain views and identify the scallops of the mitral valve under the direct supervision of a Consultant. Candidates then moved into the dissecting room and were divided into four groups allowing participants to expose the mitral valve satisfactorily through opening and suspending the pericardium, right atrium and inter-atrial septum. The technique of assessing the mitral valve leaflets and their scallops was learned along with the method of how to identify the commisures and chordal insertions. The procedure of sizing the valve and placing the sutures for the mitral valve ring were also explored and performed by the participants. The course ended with a feedback session and certificate of course completion before braving the arctic elements to return home.

> *"During this course, participants were able to learn from and practice with human cadaveric specimens and in my view, there is no substitute for this."*

This is the first cardiothoracic cadaveric course to run at the new CASC facility at the University of Glasgow. The venue was fantastic in terms of the facilities that were available to allow the course objectives to be met. During this course, participants were able to learn from and practice with human cadaveric specimens and in my view, there is no substitute for this. The number of faculty to candidates was very high allowing ample opportunity and time for every candidate to participate. The faculty ensured that all participants rotated so that each person had the chance to gain hands-on experience. Fundamental principles were demonstrated and practiced by each participant under the supervision of a faculty member.

The feedback received from the participants was very positive: "very good for the final exam", "cadaveric and TOE sessions excellent", and "good atmosphere".

With the positive feedback received, I am confident that this cadaveric mitral valve course will be run again and modified as a result of the feedback received in order to address any issues identified. Given its success and the excellent facilities at the University of Glasgow, I feel that other courses covering aortic valve surgery, aortic root surgery and tricuspid valve surgery will be on the horizon. For any cardiac surgical trainee, this course will provide full coverage of mitral valve disease. The use of cadaveric dissection will aid with examination revision but more importantly, provide a deeper appreciation of the practicalities and decision-making processes during mitral valve surgery.

Alan G. Dawson*
Adam A. Szafranek**
David Richens**

** ST3 trainee in Cardiothoracic Surgery, East Midlands Deanery*
***Consultant Cardiac Surgeon, Nottingham City Hospital*

My experiences of the New ST1 cardiothoracic run-through programme

Tom Combellack
Trainee (ST2): Wales rotation

In 2012, while working as a Foundation Year 2 doctor I was excited to hear about the new competitive-entry ST1 run-through training programme in cardiothoracic surgery. At the time, I was fortunate to be working within the specialty so did my utmost to maximise my portfolio to bolster my application. Thankfully, I was short-listed and was invited to the selection centre with eight ST1 posts available across the UK. After assessment of my portfolio, communication skills, surgical skills, ethical and clinical management skills I was delighted to be informed that I had been successful and began my ST1 training in August 2013 in Wales.

During ST1, I undertook 4 month rotations in cardiothoracics, general surgery and trauma and orthopaedics. While I was initially concerned about the focus away from my preferred specialty I now feel that this added breadth to my surgical training and, in particular, facilitated my preparation for the MRCS.

Having successfully passed the MRCS I entered ST2 with a renewed focus on cardiothoracic surgery with four month rotations in thoracic surgery, cardiac ITU and cardiac surgery. I quickly felt the benefit of continuous dedicated cardiothoracic training, building relationships within the department and enjoying a firm-based training akin to an apprenticeship. As a result, in these past twelve months I have felt a rapid progression in my clinical and surgical skills. These include everything from managing patients on ITU, on the ward and in outpatients to wedge resection, pleurectomy, thoracotomy/sternotomy, LIMA harvest and proximal anastomosis. I have also had the opportunity to present twice at the national annual SCTS meeting and have been involved in numerous projects including audit, teaching and research within the department.

After speaking to my fellow trainees I am aware that there is currently a spectrum of cardiothoracic ST1-2 programmes across different deaneries varying from purely cardiothoracic surgical training to something akin to core-surgical training with a cardiothoracic theme. While my experience lies somewhere in the centre of this spectrum, I expect that this variety will be attractive for many applicants.

There are clear benefits to the new programme. I feel very fortunate to have the security of run-through training, this allows me to focus on my training and avoid the uncertainty of ST3 selection which many of my colleagues are currently enduring. Furthermore, I believe that if I had opted for core surgical training within the current UK surgical training structure I would have felt compelled to develop my portfolio in more than one specialty – distracting me away from my focus on cardiothoracics. I also strongly believe that the ST1 programme fosters a stronger trainer-trainee relationship as there is a clear return on investment in training time and opportunities.

The development of a new and modern training programme obviously presents challenges. For my part, it was essential to pass the MRCS to progress to ST3. A particularly modern training issue is that junior doctors feel the pressure to choose a specialty early in their careers, sometimes with minimal exposure. It is therefore critical that prospective candidates seek out training opportunities and "taster" experiences to inform their career choice.

Next year, I will become an ST3 and this will be the first opportunity for myself, fellow trainees, trainers and the training committee to directly compare our progress with one another and both entry streams. This is likely to crystallise the benefits and challenges facing both ST1 and ST3 entry programmes and how future selection and training will be shaped. Cardiothoracic surgery remains an exhilarating specialty to work within and I would absolutely recommend the ST1 training programme to future applicants.

> ***"I feel very fortunate to have the security of run-through training, this allows me to focus on my training and avoid the uncertainty of ST3 selection"***

The National Congenital Heart Disease Audit

The history of the national audit of cardiac surgical outcomes goes back to the 'Society Returns' that were voluntary submissions of unit performance to the SCTS that started in 1977. Mandatory submission of data began in 1997 and by 1999 the paediatric (later re-defined as 'congenital' to include all adult congenital cardiac surgery) dataset had become fully defined. This became the Congenital Heart Disease component of the Central Cardiac Audit Database (CCAD), which was administered by the NHS Information Unit from 1999.

The Congenital Audit has developed alongside and in parallel to the Adult Cardiac Audit and together they represent the most detailed and complete analysis of national cardiac surgery outcomes anywhere in the world. The UK and Ireland should be rightly proud of the quality and transparency of this national audit data and our profession has led the field in the analysis and publication of surgical performance, with the Society having had a pivotal role from the outset.

The audit has revealed consistently high quality outcomes for Congenital Heart Disease Surgery in the UK and Ireland, with a recent analysis of over 36,000 cases from 2000-2010 showing a decrease in all-comer mortality from 4.3% to 2.6% ($p<0.01$), occurring despite an increase in the complexity of the workload. The audit has also highlighted that this is an expanding specialty, increasing at 1.0% per year in paediatric caseload, and 4% per year in adult congenital[1].

The three defining characteristics of the congenital audit are:

- **Surgery & Intervention:** It is the only audit that reports a combination of all Surgery (paediatric and adult congenital) and Interventional Cardiology. Thus, there is joint ownership of the dataset by cardiac surgery and cardiology – with joint professional society involvement from the SCTS and the British Congenital Cardiac Association (BCCA). The audit is also unique in including all private patients as well as NHS activity.
- **Validation:** All data is independently peer validated through annual site-visits, which gives the stakeholders a great deal of confidence in the data and allows for annual data-quality reporting.
- **Unit-level Reporting:** Data is reported at Unit Level, not individual level. This reflects the fact that care is delivered through teams and has been strongly supported by the profession and by NICOR as the most meaningful way to present the data to the profession and the public. Unit data allows for valid statistical analysis of the entire dataset, giving the most complete possible view of entire practice including all emergency and salvage cases. This is a small specialty with over 60 major categories of index procedures and statistical analysis down to individual operator level is not practical to this level of detail.

Management and Governance of the audit continues to undergo changes with each reconfiguration of the NHS structure, reflecting the unrelenting public and professional interest and scrutiny in the performance of doctors (and of surgeons in particular). The CCAD was absorbed by the new National Institute of Cardiovascular Outcomes Research (NICOR) in 2011 which adminsters the six national audits of cardiac surgery and interventional cardiology. NICOR now forms part of the Healthcare Quality Improvement Programme (HQIP) of the NHS which commissiones these audits - and so the cardiac surgical audits are all now embedded within the governance framework of the NHS, with the Congenital Audit being re-christened as the National Congenital Heart Disease Audit (NCHDA) in 2014. The structure of the audit is a healthy collaboration between NICOR statisticians and administrators supported by strong clinical leadership from both the SCTS and the BCCA. Governance is through a Steering Committee that is led by clinicians and there is also a Research Committee to oversee and encourage the use of the audit data for research.

Components of the Audit

The audit of surgery for congenital heart disease offers particular challenges due to the great variety of conditions that are treated and the complexity of the surgery, such that each procedure can include multiple components and encompasses a range of underlying risks. Practical statistical analysis is further challenged by the relatively small volumes of cases performed (5500-6000 cases nationally per year, compared to more than six times this number in adult cardiac surgery) and fragmenting the audit into too many subsets can result in such small

David Barron

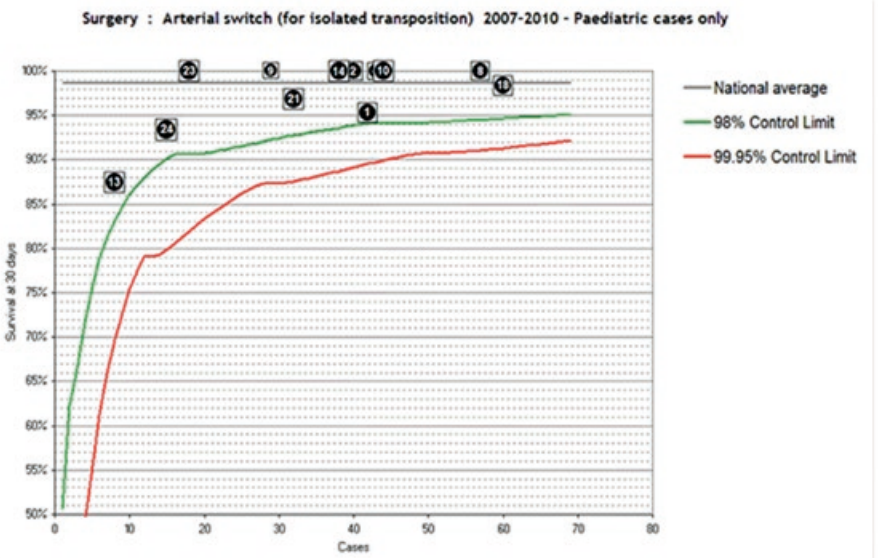


Fig 1. Example of Funnel Plot for a Single Procedure. Each point represents a surgical centre (the names have been omitted)

numbers that useful analysis becomes impossible. However, after years of detailed collaborative working between clinicians, statisticians and analysts the myriad of international codings and definitions from multiple international registries and databases has coalesced to produce a practical and functional set of definitions that have created a robust grouping of 39 major surgical procedures in children and 17 in adults. The audit produces funnel-plots for each of these major categories and presents them with Confidence Intervals that reflect 2- and 3-standard deviations from the mean; an example for the Arterial Switch procedure is shown in Fig. 1.

Risk adjustment is equally complex within congenital surgery, which has never had a system equivalent to the EuroScore in adult cardiac surgery. A breakthrough was made in 2013 with the Partial Risk Adjustment in Surgery (PRAiS) tool that was created by a multi-centre team led by Great Ormond Street and working in collaboration with NICOR2. The system is unique in that it uses the national dataset itself as the raw material to generate the risk model, and so the results of every centre can be risk-adjusted against real-time performance across the UK. This has the advantage that the entire caseload of every centre can be analysed and published in a risk-adjusted format such that nothing is excluded and a true picture of the entire national practice is presented, including all emergency, high risk and salvage procedures – even those that are difficult to categorise into specific operative groups. Unit performance is then presented as observed vs expected outcome score in the form of a bar chart with the confidence intervals for each centre being bespoke for the individual caseload and risk-profile of their patient group. An example of the PRAiS analysis is shown in Figure 2. The software package that performs the analysis is sent by NICOR to all participating centres and is regularly updated since the risk profiles change year-on-year. It also includes software for each centre to generate their own VLAD (Variable Life Adjusted Display) plots in real-time to facilitate internal governance monitoring of outcomes (Fig 3).

Reporting

An annual report is published by NICOR that summarises the annual activity across the UK and Ireland3 giving the annual activity totals and a breakdown of the 57 major index procedures performed within each unit in the country. Total numbers are divided into neonatal, infant, child and adult congenital categories. A data-quality score for each unit is also reported, based on the quality of the records examined in

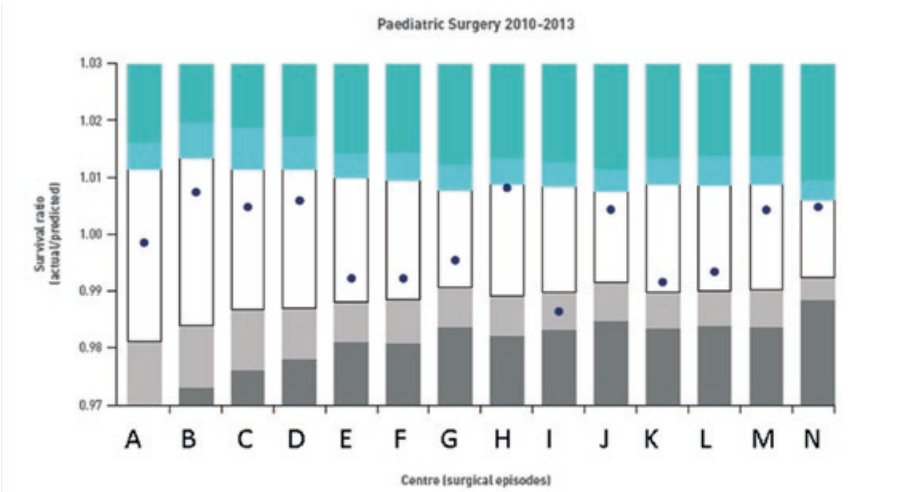


Fig. 2 Example of the Aggregate Risk Adjusted Outcome Data for all UK and Irish Units (Unit identifiers have been removed)

Each dot shows where each units outcomes lie according to their expected performance for the risk stratification of their casemix (PRAiS tool). The paler bars represent the 97.5% Confidence intervals and the darker bars represent the 99,9% Confidence Intervals.

continued on next page

The National Congenital Heart Disease Audit *continued*

each centre from the peer-validation site visit. The validation visit also reviews the staffing and resource committed to audit and will make recommendations to the Trust if it is insufficient.

Outcome data is reported as a three year aggregate data (both to generate adequate numbers of cases for statistical analysis and to reduce the risk of a chance fluctuation in outcome unduly influencing analysis) and presented as (a) a series of funnel plots for the individual procedures (Fig1), and (b) a risk adjusted plot of the entire caseload showing observed vs expected outcomes (using the PRAiS tool, Fig 2). Outcomes are reported as 30-day and 1-year survival with alert (98% CI) and alarm (99.9% CI) levels for each individual plot and for the aggregate analysis.

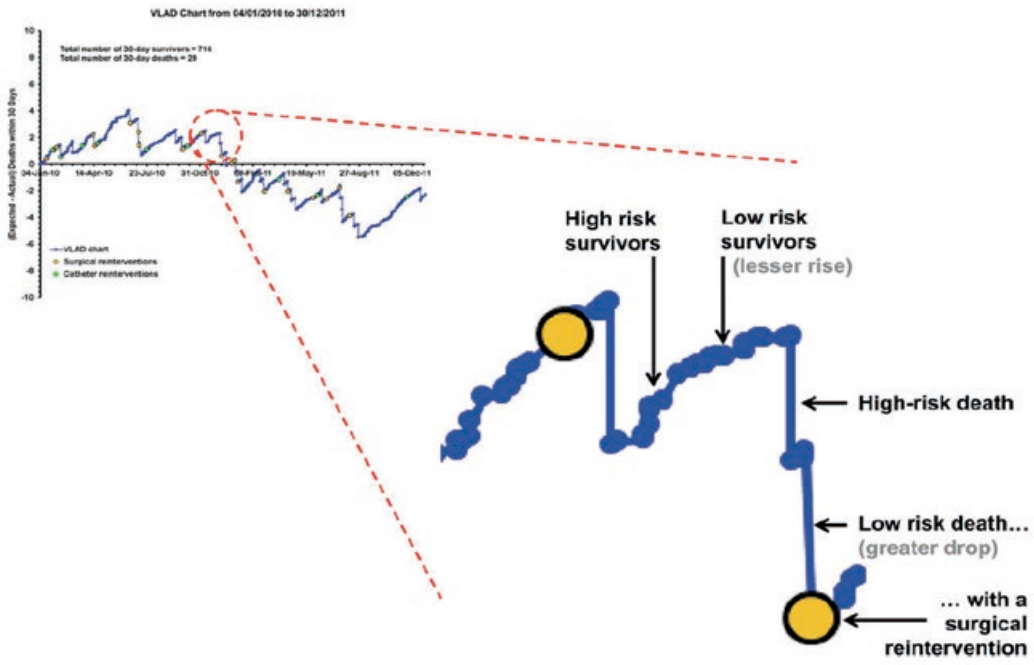


Fig. 3 Example of the VLAD Plots (Variable Life-Adjusted Display) Used to track Unit Outcomes.

In addition, the audit reports the antenatal detection rates of congenital heart disease across the country and also gives an indication of the case-mix complexity seen in each unit based on the risk-adjustment model.

If units should breach the alert or alarm level then the outlier management process follows very much the same process as that with adult cardiac outliers, (covered by the HQIP guidance in outlier management4). The close relationship between NICOR, the SCTS and the BCCA means that the process is very much a shared responsibility and the process of informing an outyling unit has been through a letter co-signed by NICOR and the Presidents of SCTS and BCCA, which has been a great strength of the audit in reassuring the profession that the Society are closely involved in the process from the outset.

The audit is a remarkable achievement and the role of the Society and its representatives in supporting and delivering the audit is essential. It is a unique archive of national outcomes that provides quality assurance for the profession, the public and the Health Service. The risk adjustment systems are amongst the best in the world and the database is an invaluable resource for research and development.

There remain many challenges, not least because the audit is continually expanding and needs to collect more morbidity data as well as survival data. However, the more complex the data-set becomes the more difficult and time-consuming it becomes to ensure accurate validation and achieve timely submission and publication. NICOR is aiming to achieve analysis and publication within 6 months of year-end by 2016, but this will be quite a challenge.

Also, there is currently no accepted risk-adjustment tool for adult congenital heart surgery. Although the EuroScore system can be applied with some success, it was not designed for this patient group and a more inclusive risk-adjustment model is being developed. Finally, accurate longer-term follow-up data is essential for us to understand the prognosis and expectations from surgery. The data relies on accurate ONS population data which is still not sufficiently complete, particularly in Scotland and Northern Ireland.

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Thoracic audit - the LCCOP takes root

Doug West
SCTS thoracic audit lead

Last year thoracic surgery in England saw its most significant changes in many years, as HQIP published the Lung Cancer Consultant Outcomes Publication (LCCOP). This year will see the second year of this project, with data from the 2013 audit year made available in late 2015. It is worth looking again at how LCCOP works.

The Consultant Outcomes Publication is an NHS England initiative that releases data from multiple surgical audits into the public domain. These national audits (including the Adult Cardiac Surgical Audit in NICOR, the National Joint Registry, OG Cancer audit and others) are HQIP commissioned and funded.

In thoracic surgery, LCCOP uses data from the National Lung Cancer Audit (previous known as LUCADA) to report three outcome measures for thoracic surgery units. These are the mortality rates at 30 and 90 days after surgical resection of primary lung cancer, and the resection rate for MDTs served by that unit. It reports data at unit (not individual surgeon) level, with the caveat that surgeons' names appear beside the MDTs they serve, and their annual case volume appears under their name. If you haven't done so already, have at look at the data on "mynhs" or on scts.org. It can be searched for by both unit and named surgeon. SCTS.org now has surgeon profiles, where you can upload details about your training, practice and other information, including a photograph.

The Society has an important role as the relevant specialty association in providing clinical input into LCCOP. We have long supported data collection and analysis to improve standards of care, and we support HQIP and the NLCA in producing the COP. However, it is important to understand that the SCTS itself does not collect or analyse the data.

There were some inconsistencies in the NLCA data last year, so it is important for audit leads to validate their unit data when it arrives this summer. Not validating will not, however prevent publication. This year, to ensure that Trust management are fully involved, we plan to communicate with both the SCTS audit leads and the Clinical Leads for each unit.

The structure and outcomes of the LCCOP for 2015 will mirror those of last year; re-commissioning of the NLCA in 2015 has put any changes on hold this year. However, it is important that we plan for future development of the project. Development an adequate risk adjustment tool takes priority, as LCCOP currently reports unadjusted mortality. After that, we need to consider whether further outcome measures, for example one and three year survival rates, are needed.

It is vital that hospitals and medical directors know how to respond if their unit appears as an outlier in LCCOP, and that surgeons understand the support available to them from SCTS and others. The Society is developing its LCCOP outliers policy, to provide clear advice in this situation.

LCCOP of course ignores two major areas of interest to members. These are audit in the devolved nations and Republic of Ireland, and non-cancer activity. We would like to see robust audit in place for all thoracic surgery in the UK and Ireland, and continue to advocate for expansion of the English audit beyond just primary lung cancer.

For those units that practice oesophageal cancer audit should already be submitting their data to the National Oesophagogastric Cancer Audit.

It is more important than ever that members are engaged with the audit process in thoracic surgery. I am grateful to Joel Dunning, Eric Lim, Carol Tan, Mo Asif and Kieran McManus for joining a new SCTS thoracic audit group, to give input into the development of the audit. This year we also ran our first thoracic audit session at the Manchester meeting. It was well attended, with talks from Ian Woolhouse of the NLCA, Richard Page and Pierre Emmanuel-Falcoz of the European Database Project. Please come along next year and make your voice heard.

I'm always available for questions at doug.west@bristol.ac.uk.

SCTS.org now has surgeon profiles, where you can upload details about your training, practice and other information, including a photograph

The National Adult Cardiac Surgery Audit (NACSA)

As cardiac surgeons we have lived and worked with our patients' risk-adjusted mortality in the public domain for 10 years. This period has been associated with a sustained improvement in outcome for patients with a reduction in risk-adjusted mortality.

We have comprehensive national data to prove that our specialty provides patient care at the very best international standards, and the 'Blue book' on-line will be updated later this year. This period has also seen significant changes within the NHS and no longer is the analysis of our data, or the process of publication, the sole responsibility of SCTS. As most of us are now aware, the data collection and analysis is the responsibility of the National Institute for Cardiovascular Outcomes Research (NICOR), who are commissioned until 2017 by the Healthcare Quality Improvement Partnership (HQIP), and ultimately we are all responsible to NHS England. Over the last 2 years your executive have worked hard with NICOR, HQIP and the NHS choices team to ensure that our data is presented in the most appropriate way for patients and with due fairness to surgeons.

Some aspects of the audit, and its presentation, do remain within our control, but submitting validated data and inclusion in consultant outcome publication are no longer voluntary and are national directives from NHS England. We do retain the most important local responsibility to ensure our data is as complete and accurate as possible at the point of entry to the system. This is a key responsibility that should not be underestimated and is part of being a good doctor as articulated by the GMC and RCS (1). NICOR now ask all units to ensure their data is appropriately validated locally. Although our data will continue to be presented on the SCTS web pages, it is also included in the NHS England initiative to publish consultant outcomes (COP), and appears on the NHS choices pages, with links to the more detailed information on our own website. We have met directly with the NHS choices team to explain our concerns at the way the data was presented last year and we hope to see improvements this year. In addition, we now have the opportunity to add material to our individual page on the SCTS website, and patient feedback suggests that this is as important to patients as the outcome data itself, so I encourage all to do this. It is this description of our training and practice that is reassuring to patients and it allows us to put our activity and results in context.

Changes

In 2014 there were two events that precipitated the need for changes. When NICOR reviewed the prevalence of reported risk factors in the audit, it became obvious that some of the definitions used were not clear enough and there was variation in their interpretation. The unstable angina field was the most problematic and units were asked to revalidate their data using a new definition. There was an external review of the NICOR systems, and NACSA in particular, and Prof Black's report is available on the NICOR website (2). The second event was the increased media interest in surgical outcomes publication with the launch of the COP websites by NHS England, and release of all results together.

> *Some aspects of audit remain within out control, but submitting validated data and inclusion in consultant outcome publication are no longer voluntary and are national directives from NHS England.*

Some are rightly concerned about the potential consequences of outcome reporting at individual surgeon level when we all recognise that cardiac surgery is a team activity. However, one cannot deny that we take overall responsibility for our patients as team leaders. The unit data vs individual data argument is rehearsed in the RCSEng Bulletin in a debate between colleagues Westaby and Bridgewater (3), and I agree with some aspects of both sides of the argument. The SCTS executive has communicated members concerns to NHS Eng and lobbied through the Federation of Surgical Specialty Associations to articulate your arguments with respect to unit vs individual reporting. The clear answer from NHS Eng is that the strategy of consultant outcome publication remains paramount and is compulsory. Following the BORs meeting in Dec 2014, the executive constructed a 13-point plan to deal with concerns – and we recently wrote to update you with the actions completed.

We expect to publish the NACSA at the end of June, with the new data to the end of March 2014. Later in the year we aim to catch up and include the year up to end March 2015. In response to your concerns and to the external statistical review there will be some changes this year that I sincerely hope will be seen as improvements for both patients and

DP Jenkins
Chair, adult cardiac surgery subcommittee and audit committee SCTS

surgeons. Some of the most important are outlined below.

Data will be presented as survival rather than mortality (the funnel plots will be upside down), and we are working with NHS choices to influence a similar change on their websites.

The methodology for identification of statistical outliers will change to be consistent with other audits. There will be simplified categories with 2 levels using two tailed exact binomial confidence intervals at 0.5% (alert) and 0.002% (alarm), identifying both 'negative' and 'positive' outliers for worse and better than expected risk adjusted survival respectively. The previous 3 colour coded system is now abandoned, with the old red category corresponding approximately to a new 'alarm' for a negative outlier at 0.001% and the old yellow and amber to an 'alert' at 0.25%. The same methodology will be used for units and surgeons.

Results for individual surgeons will not be shown until they have accumulated at least 100 cases.

Recalibration

The issue of the need for contemporary recalibration of the data is not completely resolved. Some may argue that with actual mortality for elective CABG at < 1% nationally, recalibration becomes less and less important, but I think it is important that we take the best advice and use the most appropriate methodology. The NICOR analyst has reviewed a number of options, and these will be evaluated in time for the next data update and the audit will also be subjected to external statistical scrutiny. In the meantime, NICOR have provided the unit data managers with a spreadsheet tool to allow conversion of your local data into the recalibrated equivalent to enable better tracking of local performance in real time, as I know this has been an area of concern to some of us.

Only units and surgeons outside the 0.002% CI will be made public, and this approximates to the old red category. We have also been instructed to identify 'positive' outliers this year, hence the 2 tailed tests above. Whilst in the past, it was possible to estimate likely better than average candidates from the funnel plots on our website, NHS England want to celebrate surgical success in the outcome publication process. Some of us were worried about the potential implications of highlighting positive outliers at individual surgeon level, and could not see any benefit to patient choice or indeed team and unit harmony, but we have been reassured by HQIP and NHS England that this will be appropriately communicated.

The next work stream involves redefining the risk factors to make them as objective as possible for practice in 2015. As part of this work we will also provide a guide for interpretation of these factors in clinical practice to reduce the variability between surgeons and units. I am convening a project group to complete this work in early July. We have been asked to include other outcome and process measures in future, and the same group will be asked for advice. I am very much aware that whilst there are lots of likely morbidity markers including bleeding, stroke, infection, length of stay etc, the devil will be in the detail and precise definitions will be necessary to make valid and fair comparisons. If done correctly this could provide patients with a better summary of our whole practice to compliment the current mortality/survival numbers.

SCTS is also updating its outlier guidance process to reflect these recent changes and respond to central guidance from HQIP. We will write to membership in the near future to explain the changes.

NACSA is one of the more mature, complete and successful audits, but in the future it may have to change and adapt to prove its worth to the NHS. The funding for continuous data collection into cardiovascular audits will be in competition with other disease audits, where some may argue there is more to learn and more to gain for patient benefit. Potential changes could involve new uses including longer-term surveillance of valve prostheses, as with the joint registry. SCTS also want to use our data more constructively, and the executive is considering funding an additional SCTS analyst to work with NICOR to focus on research projects of interest to surgeons.

My final plea is that the data we rely on, and publish for patient benefit, is entirely dependent on the accuracy and completeness at source entry and this is where our own role remains so important. If we can make sure our data is accurate, the risk factor definitions are correctly interpreted and our internal governance and monitoring systems are appropriate, my sincere hope is that within another 3 year audit cycle we will not identify any further alarm outliers as action will have occurred at the alert stage. This will be reassuring to all UK patients and a measure of the success of the audit and our own professional responsibility.

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Joint Annual Meeting Secretary's Report

This year's Annual Meeting (The SCTS/ACTA Joint Annual Meeting and Cardiothoracic Forum, Incorporating the SCTS Ionescu University and ACTA Academy) was held from the 25-27 March in Manchester Central, Manchester.

Arrangements and organisation was truly a team effort in all senses of the word. Venue selection, choice of University streams and faculty invitations commence up to two years prior to the Annual Meeting. The team at the time was led by Ian Wilson as Meeting Secretary with Jonathan Hyde as his deputy. As the wider Society is aware, both Jonathan and Ian resigned their posts during 2014. However, much of the success of the Meeting was built on the foundation that they had laid.

A new Meeting team made the final arrangements and oversaw the Meeting in Manchester 2015. In addition to me, Enoch Akowuah (Deputy), Clinton Lloyd (Associate), Sunil Ohri (Meeting Treasurer) and Vipin Zamvar (Publishing Secretary) were central to the Annual Meeting organisation. The Meeting was the second joint conference with the Association of Cardiothoracic Anaesthetists (ACTA) and their representatives, Niall O'Keeffe and Donna Greenhalgh, organised the Anaesthetic programme and played a major part in decision making for the organisation of mutual events such as plenary sessions, the Annual Dinner etc. Christina Bannister, Forum Lead, organised and led a much expanded Forum component.

In all previous years, but this year in particular, it is important to emphasise the part played by Isabelle Ferner in particular, but also Tilly Mitchell, the two SCTS Administrators. Tilly Mitchell, as Exhibition Organiser and Accounts Administrator, effectively approached and arranged attendance of all exhibitors, arranged international faculty travel and hotel bookings and managed registration accounts and other expenses. The role of Meeting Treasurer is in evolution, and will clearly strengthen these interactions. This year, however, it is Tilly who deserves our tremendous thanks and credit. Isabelle Ferner is the lead Conference Organiser – and that is precisely what she does! Feedback from the Meeting has been overwhelmingly positive and criticisms and suggestions, such as there were, related to Scientific and Business aspects. These decisions are taken by the Secretariat and implanted by the Administrators. Feedback on the Administrator's roles – Registration before and on-site, queries and troubleshooting, travel arrangements, Dinner tickets and many more – was overwhelmingly positive. Isabelle has led the increase in registrations to a record level as I will describe later. Moreover, of course, Isabelle and Tilly had to 'adapt' to the new Meeting Team only months before Manchester 2015. They deserve our tremendous thanks and appreciation for their involvement throughout the entire process and the stability they provided.

The SCTS Ionescu University and ACTA Academy on Wednesday contained 10 simultaneous streams. There were four Cardiac, two Thoracic, three Anaesthetic and one Forum stream. More than 60 international invited speakers, as well as over 40 National speakers, addressed the University and subsequently the Meeting and Forum sessions. An enormous contribution was made by other Society members who served as moderators and in other capacities. A total of 338 abstracts were accepted for oral and poster presentations. As in previous years there were combined SCTS/ACTA Plenary as well as separate sessions for Cardiac, Thoracic and Anaesthesia. In all there were over 900 delegates.

In addition to the scientific sessions, the programme included medical student and trainee meetings. There were working Groups of the Cardiac and Thoracic CRGs, Thoracic Data Committee, NDHCA Steering Committee and Congenital CRG Working Groups. A session of the Cardiac Database managers was held to improve data return uniformity throughout the UK. An education subcommittee meeting and the Ionescu Fellowship interviews were also held. The College of Perfusion had an all day session that ran in parallel to the opening day scientific sessions, as did the Association of Cardiothoracic Surgical Assistants (ACSA). There was a trainee research collaborative and a fund raising meeting by Scott Prenn. Important business meetings included the SCTS Annual Business Meeting and the Board of Representatives meeting.

On the social front there was a mostly successful and enjoyable Annual Dinner attended by over 350 guests and the usual football tournament.

Over 60 exhibitors were present in the well laid out exhibition centre and there were a further six organisations who sponsored events. More than 200 exhibitor staff registered, taking the total number of attendees to almost 1200. Tilly Mitchell played an enormous role in the organisation of the exhibition and the total budget was in excess of £450,000 with a small operational surplus being made. While a major part of the surplus is used for administrators' salaries and distributed to ACTA, it does mean that some funds can be returned and used by the Society.

There were a number of innovations and adaptations of existing concepts in Manchester. These included the website, App, the bag with inclusions, the printed programme, newspaper and film interviews that are up and running on CTS Net – our thanks to Joel Dunning. While the configuration of the App and website are liable to be streamlined and changed in the future, these were very well received and Clinton Lloyd deserves a particular mention for his role in both the online programme and creation of the App.

Clifford Barlow

Formal and informal feedback from members and delegates has been constructive, suggestive and helpful in planning for the future. Clearly the current organisational team had little time together and many decisions had been taken by the previous team which the current team was implementing. There are several ways in which we hope to change and improve future Meetings. One major change is that the educational aspect of the Meeting and University will be better co-ordinated with the SCTS Education Secretaries to ensure no overlap with other educational activities provided by SCTS. We are also aware that there were too many simultaneous sessions at the University and this will be addressed. The balance is difficult as delegates are attracted by large and varied programmes and so we will work to improve this at future meetings.

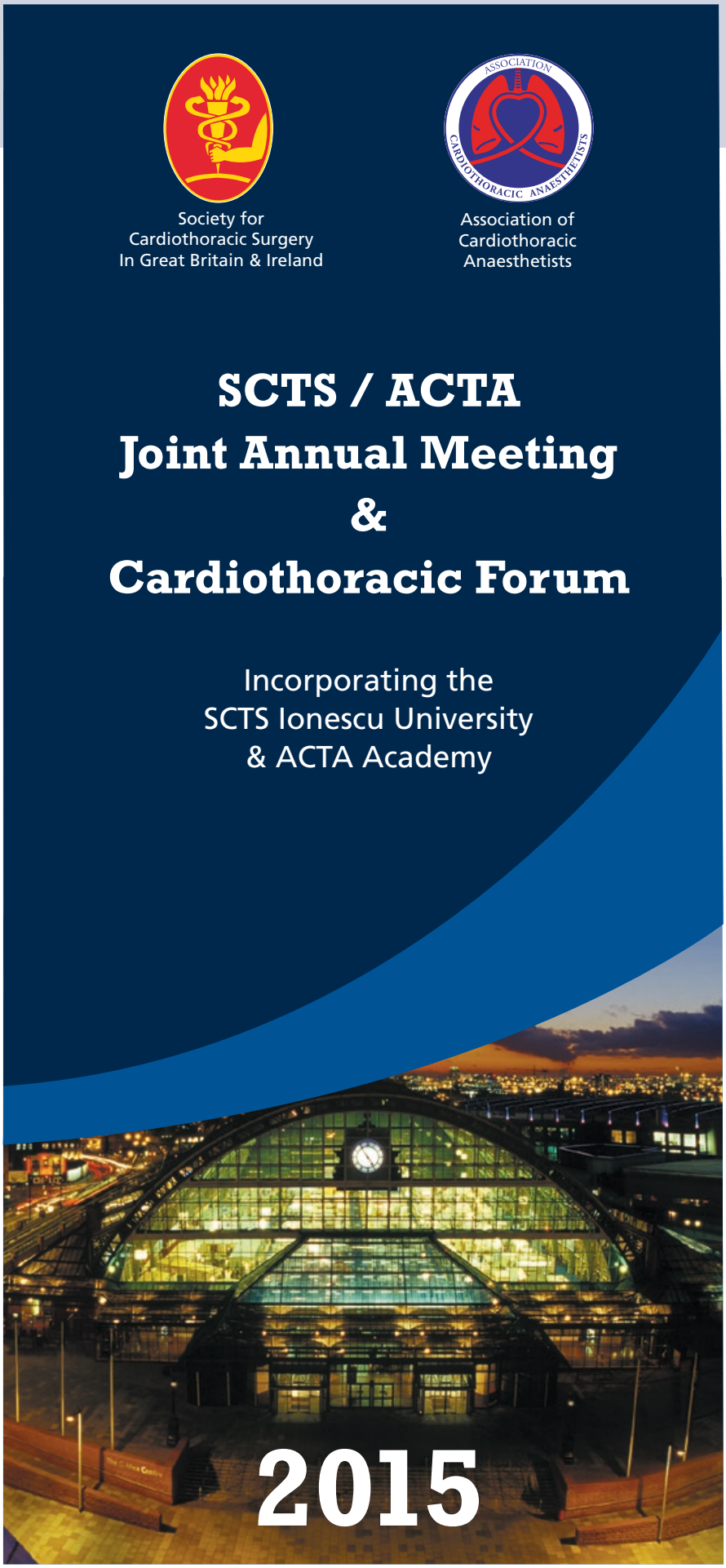
There will also be greater communication with the SCTS Executive for better co-ordination of the various Management and Business meetings. The role of education to trainees, Forum members and medical students requires expansion. Christina Bannister is expanding and developing the Forum and her detailed report is included elsewhere in the Bulletin. We plan to increase links with organisations such as the Perfusion Society, ACSA and others (for example the Heart Valve Society). We are also aware that registration charges for different categories need to be revised.

We have now confirmed the 2016 meeting in Birmingham from 13-15 March. You will note this has reverted to the format of University on Sunday with the Meeting Monday and Tuesday.

We hope to see you there!

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

Consultant Cardiothoracic Surgeon



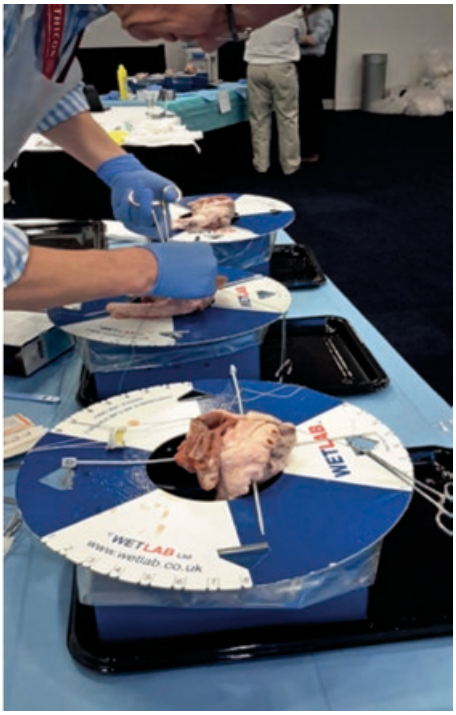
Cardiothoracic Forum @ The SCTS Annual Meeting

The 2015 annual meeting was held at the Manchester Conference Centre. This was the second combined meeting with ACTA (Association of Cardiothoracic Anaesthetists), and once again gave all Cardiothoracic Forum participants the opportunity to network with nurses and allied health practitioners from all aspects of cardiothoracic care, including those working in theatres and on cardiothoracic intensive care and high dependency units. This years' forum looked at aspects of work across the entire spectrum of cardiothoracic care as they related to the patient's journey, and had a special focus on enhanced recovery and critical care. We had an international faculty participating with professionals from Nursing and Allied Health backgrounds attending from the United States, Europe and the UK. As this was a joint meeting we again offered one free registration for every five booked.

This years' meeting ran over the entire three days in March; starting with a Nursing and Allied Health Professional stream at the joint SCTS University and ACTA Academy. This was the first time we have had a stream at the University and we had a full practical day planned. The University day was split into a half cardiac / half thoracic day, which enabled participants to either take part in the entire day, or join for either the morning or afternoon session and then attend another University stream session with other delegates. Kevin and his team from WetLabs provided us with an array of hearts and lungs, and it proved to be an exciting and educational session for all participants. I would like to thank all the company representatives and also the surgical faculty that took time to teach the nurses, allied health practitioners and all other participants.

We worked hard selecting the papers for this years' CT forum presentations during the main meeting. We had a record number of abstracts submitted this year, from a wide group of participants ranging from advanced nurse practitioners and SCP's to theatre nurses and critical care practitioners. This enabled us to examine in-depth all aspects of care related to cardiothoracic patients and gave us an enhanced breadth of knowledge from all nursing and allied health specialities as we linked with the anaesthetists throughout the meeting.

We had a number of fascinating plenary sessions presented at the meeting in March. The new President of the RCN, Cecilia Anim, gave us an up-to-date nursing perspective within her opening remarks and with her was Andrea Spyropoulos, the past RCN President, who once again provided some lively discussion points and food for thought. I would like to thank Andrea for all the contributions to the CT Forum over the past few years, and hope she remains in touch with our network. Jill Ley, Clinical Nurse Specialist from San Francisco



Christina Bannister

SCTS Nursing & Allied Health Professional Representative

gave us a very informative presentation entitled 'Wake up from alarm fatigue, using our monitors wisely'. She also stayed for the entirety of the meeting and participated in the University day; we thank her for her insights, especially from an American perspective.

We also had a session planned which has been requested from a number of delegates at the 2014 conference. The 2015 joint SCTS/ACTA meeting was a prime time to listen to the patient's perspective of undertaking cardiothoracic surgery, and we were lucky enough to have two patients, from both cardiac and thoracic surgery to detail their experiences of surgery and take questions from the floor. I would like to thank both Peter Earp and Stewart Malcolm for their extremely interesting and entertaining insights into their patient journey, and also would like to thank them for answering a myriad of questions from the participating nurses and allied health practitioners.

Each CT Forum we have held has been a big success. We have gained a network of core nurses and allied health professionals across the country that have in interest in progressing training, development and service provision with cardiothoracic surgery, from a wide range of backgrounds; from nurses, medical staff, surgical care practitioners, physiotherapists, physician assistants and other allied health professionals across the country. I would like to take this opportunity to thank all the plenary speakers, chairs, presenters and participants without whom the CT Forum could not exist. Not only do we all learn from others at the Forum but the networking and shared working practice information that we all get is invaluable.

Ionescu Nursing and Allied Health Practitioner Fellowship

This year SCTS Education advertised the opportunity for two Ionescu Nursing and Allied Health Practitioner Fellowships worth £2,500. We had a number of excellent applications from across the UK and Ireland and shortlisted 4 applicants to be interviewed at the annual meeting in Manchester. I am extremely happy to say we offered two nurses the Ionescu fellowships and we look forward to the feedback from both Emma Hope and Daisy Sandeman's experiences.

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

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

Advanced Cardiothoracic Course

This year's Advanced Cardiothoracic Course is planned for Autumn 2015. Once the details have been finalised they will be advertised on the SCTS and ACSA websites. Please see the SCTS website for a link to a film of the course.

Developing an Advanced Allied Health Professional Practitioner Service Course

Due to the changes in cardiothoracic workforce in the UK related to the EWTD and issues in recruitment of the junior doctor workforce, a course was put together to examine the role of nurses

continued on next page

and allied health practitioners in new ways of working. The first course was held last December at the Royal College of Surgeons of Edinburgh in Birmingham, and Advanced Nurse Specialists across the UK presented their experiences of setting up their services. The feedback was very positive, and we plan to run the same course again at the end of 2015, with an additional course to be held at St Thomas' Hospital in London earlier in the year. Once the details of both courses have been confirmed we will advertise them on the SCTS and ACSA websites.

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

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

Surgical Care Practitioner Update

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

Throughout 2015 there are a number of Master Classes planned at the Manchester Surgical Simulation Centre, Manchester in collaboration with SCTS Education and Ethicon. In April 2015 there was a SCP Master Class in Thoracic Surgery. The Master Class in Cardiothoracic Surgery is planned for 23rd June, and the Master Class in Cardiac Surgery is planned for 8th September 2015. Details for both courses are on the SCTS and ACSA Websites. We would like to thank the surgical faculty and all the clinical international trainers from Maquet, Sorin, Terumo, Sonasite and Karl Storz for their participation in these courses, and we also thank Ethicon for sponsoring the courses.

Following consultations with the Royal College of Surgeons of Edinburgh, the SCP exam was held in December at the RCS, Edinburgh in Birmingham. There were seven candidates who sat a Q&A hour exam, followed by a 30 minute viva. Out of the seven, five passed which reflects the high standard of the exam process. Congratulations to all who passed and thank you to all the examiners and participants also. This year's exam will be held once again at the end of 2015. There will be a revision course held prior to the exam on the 1st and 2nd September in the CTCCU seminar room, Wythenshawe Hospital, Manchester; details again on both the SCTS and ACSA websites. Work remains ongoing to update the SCP course for the exam, with a rigorous QA process being developed. Thanks go to the RCS, Edinburgh for all their help, support and backing for this process. A 'silver scalpel' award for the best candidate was obtained from Swann Morton, and was awarded at the annual meeting dinner. Congratulations go to Daniel Burns.

CTSNet Allied Health Portal

Over the past year work has been ongoing to create an Allied Health Portal within CTSNet. Nurses, perfusionists and physicians assistant from the US and UK have been having regular meetings to establish allied health pages with clinical practice protocols, meeting presentations, published papers, educational videos and an online discussion forum for allied health professionals within the CTSNet site. Some allied health content is already on the CTSNet site and we encourage all nurses and allied health practitioners to keep looking for the detail. One excellent video discussion related to 'Human Factors and Cardiothoracic Surgery' is on the CTSNet portal with insights from Joel Dunning, Tara Bartley, Jill Ley and Arie Blitz. For any nurses or allied health practitioners that would like to provide good clinical protocols, journal articles or options for videos please contact me on chrissiebannister71@gmail.com

World Society of Cardiothoracic Surgeons (WSCTS) Annual Meeting, 2015

This year the WSCTS meeting is to be held in Edinburgh from the 19-22 September at the Royal College of Surgeons of Edinburgh, Edinburgh. Tara Bartley and myself are currently planning the Nursing and Allied Health Practitioner stream at the meeting. We are inviting some of the top marking speakers from the SCTS meeting this year and look forward to seeing as many nurses and allied health practitioners participating

in the meeting as possible. We hope that support will be given from each cardiothoracic centre to allow nurses and allied health practitioners from the UK and Ireland to attend the meeting and network with practitioners from across the globe.

EACTS

The postgraduate nurses' day at EACTS is once again planned to be run by nurses and allied health professionals from the UK, the Netherlands, Denmark and Germany. This is planned to be held at the Amsterdam RAI Conference Centre, Amsterdam on Sunday 4th October 2015, and has a focus on patient frailty and creating safe environments for patients. The SCTS CT Forum top marking presentations will be invited to present at this meeting, and plenary talks from Specialist Nurses from across Europe are planned for this meeting also. Again we hope that support from each cardiothoracic centre in the UK and Ireland will enable practitioners to attend, and share their knowledge and experiences with other nurses and health care professionals from across Europe. If any nurses or allied health practitioners have presentations they would like to discuss for the upcoming meeting please contact either Tara or myself on the e-mail addresses below.

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

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

Bupa/SCTS Patient Information Website Portal

Currently there is a nursing project running to create patient information pages for the SCTS and Bupa Websites. The aim is to create a central repository of Quality Assured information which will provide accurate information regarding cardiac surgery for both patients and their relatives; and to provide a resource for nurses and allied health practitioners working with cardiac patients. A group of nurses met during the annual meeting in Manchester with researchers from Bupa for an insight meeting and discussed the patient journey and pathway around Aortic Valve Surgery. A patient survey has been given to a group of patients with regards to the information they receive; and discussions are ongoing for nurses, surgeons and patients to film videos for the websites, detailing their experiences. If any nurse or allied health practitioner would like to get involved in the project or has specific patient information they would like to share please contact me on chrissiebannister71@gmail.com

SCTS CT Forum Contacts

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

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

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

Follow us at Twitter - @SCTS_CTForum

Join the Facebook Group - SCTS CT Forum

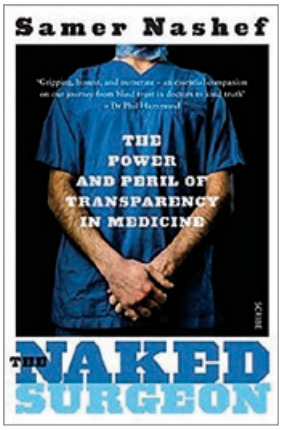
If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward their name, address and title to me at Christina.Bannister@uhs.nhs.uk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

Chris Bannister

Nursing & Allied Health Professional Representative

The Naked Surgeon –
The Power and Peril of Transparency in Medicine

Review by Mark Jones



This book should be on the essential reading list of any aspiring or practicing cardiac surgeon, and probably any surgeon anywhere.

During his career as a Cardiac Surgeon Sam Nashef has made a significant contribution to the study of risk and quality in our specialty. He dedicates the book to his mother and Neil Armstrong and all other patients who died after cardiac surgery, and reminds us of that well-known aphorism "Primum non nocere ". The book seeks to provide the answer to the question that any patient should ask himself or herself - How well do those who treat us actually treat us?

He takes us on a personal journey of governance starting with a 4th year medical student audit of outcomes in surgery for ruptured abdominal aortic aneurysm when he first encounters the "secrecy, complacency, and arrogance " which characterises the medical establishment response to hearing unpalatable truths.

Throughout the book, medical lexicon and bio-statistics are well explained. The reader is guided through the understanding of risk, the variables that feed into quality improvement, and the presentation of outcomes. There is frequent reference to the Hawthorn effect and mention of Sir Bruce Keogh's maxim "Do we make what's important measurable or what's measurable important ?"

Nashef is endlessly curious, questioning and thought provoking in his challenge of medical dogma. Extensive use is made of the Papworth adult cardiac surgical database to seek answers to his enquiring mind – take note trainee surgeons of these rich pickings!

He examines the parallels between the safety of the airline industry and that of the invasive specialty of cardiac surgery. Through another surgical aphorism "choose well, cut well, get well ", he dissects out the varying behaviours of different surgeons in their appetite for risk, their conduct of surgery (do all surgeons lock knots when they tie prolene? Answer No!) and how they cope with the unexpected calamity of a postoperative death – the self-flagellators and the castigators.

The book is written in a highly engaging, deprecating, and at times folksy and zany style. It includes many illustrative anecdotes, and an offering of surgical "bons mots".

There is a foreword by Sir Terence English. There are two appendices, one written by Dr Steven Bolsin vividly and very emotionally describes the inordinate difficulty that he experienced in bringing the tragedy of the Bristol Babies to the attention of those responsible – this makes for truly harrowing reading. The second, written by Mr Steven Large, describes his emotions in the wake of an early post –operative death in a 17 yr. old patient undergoing an aortic root replacement.

Cardiac surgeons have pioneered the agenda of Consultant outcome publication in the UK and this has been associated with a demonstrable improvement in surgical results. That this has succeeded, is in no small part due to the relentless energy, and ingenuity of Nashef towards a culture of openness and transparency. This was, however, a team effort by the SCTS and the contributions of others could, perhaps, have been reasonably acknowledged.

As Nashef concludes – "medicine has never been as good as it is now, and nowhere is that truer than in the specialty of heart surgery". For patients this should be a source of great reassurance.

This book will be of interest to health care professionals and patients alike. Along with recent contributions of Atul Gawande and Henry Marsh it adds to the growing body of literature giving an insiders view of medicine.

Tutors' Report

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

SCTS Education delivered education programme has gone from strength to strength in the last 6 months. It's impressive to think what we have achieved in partnership with Ethicon in the last 12 months. It was in May 2014 we organised the Cardiothoracic Access and intensive Care Course in Hamburg for the ST3s.

Our proposed course calendar has progressed steadily with structured courses targeting the national trainees as appropriate to their training years. The Portfolio courses running in 2015 have the programme and learning objectives finalised. The Courses will have the heavy simulation and small group delivery as we stated in our previous report.

The ST5 and ST7 Viva courses were greatly received by the trainees. They had intense small group discussion teaching followed by viva sessions in the afternoon. The highlight of the programme was the ST6 Subspecialty course in Hamburg, with simulated operating, wet-labs and taking cardiothoracic education to the next level.

The SCTS Education Course on Essentials Skills in Cardiothoracic Surgery was developed and was held in the Royal College of Surgeons of Edinburgh last year. This year that course has moved under the auspices of SCTS and will be offered free to ST2 NTNs on run through programme. There will be 10 places offered free to core trainees with an interested in cardiothoracic surgery who are nominated by the Core TPD and Cardiothoracic TPDS.

We feel the trainees should have an ownership in their training. So we have launched the SCTS Video prize which invites trainees to make short videos appropriate to their level of training. The videos will be judged and best videos will get awards as well as archived in the SCTS Educational Archive. The feedback has been excellent and reassuring us that we are doing what the SCTS and SAC want us to deliver as tutors. As tutors we have introduced trainee self-assessment to bench mark the improvement in the knowledge or skills as a self-assessment tool.

The portfolio of courses is evaluated according to the SCTS Education standards with a standing invitation to the SAC chair to visit our courses for quality control. The Education secretaries have discussed wider external validation with the SAC and are working with the Education department of Royal College of Surgeons of Edinburgh.

The SCTS Education has also developed a Taster in Cardiothoracic surgery Course to be held in the Royal College of Surgeons of Edinburgh to offer insight to aspiring core trainees and foundation doctors.

We as always would like to take this opportunity to thank all the course directors and faculty members, who have provided their time, wisdom and enthusiasm. It has been much appreciated by the trainees and without which it would have been impossible to deliver these courses. If anyone else is interested in teaching on the portfolio of courses in the future, we would be grateful if you could contact us (narainmoorjani@hotmail.com or sridhar_rathinam@yahoo.co.uk), as we would value your support.

We are also greatly indebted to our industry partners, especially Ethicon and Sorin, for their organisational and financial support.

Course Calendar

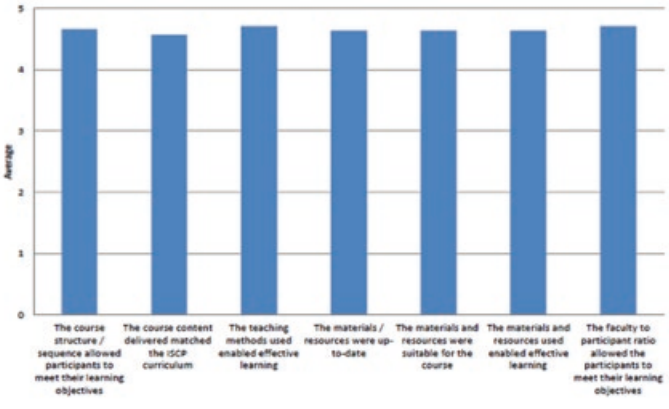
Cardiothoracic Intensive Therapy & Surgical Access Course
(ST3B)20-22 May 2015 Ethicon Centre Hamburg
Course Directors: Mr J Dunning, Mr N Roberts, and Dr C Moore

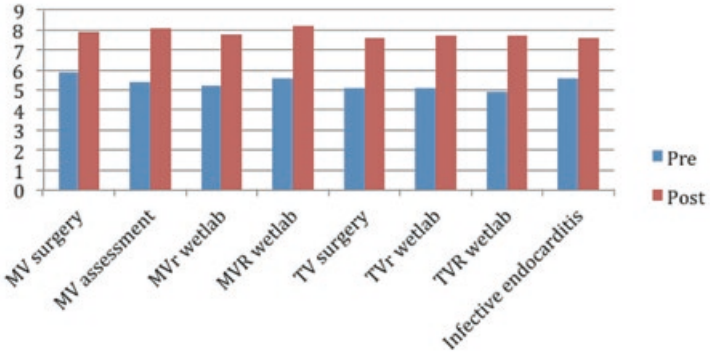
Core Thoracic Surgery (ST4B)
22-24 June 2015 MATTUS Centre Surrey
Course Directors: Mr T Routledge and Mr S Rathinam

Non Technical Skills in Cardiothoracic Surgery (ST5B)
July 2015 St George's Hospital
CourseDirectors: Tim Jones, Mike Lewis, Ian Hunt

Introduction to Specialty Training in CT Surgery ST3A
Sorin National Wet-lab Centre Gloucester
Course Directors: Mr N Moorjani & Mr S Rathinam

Professional Development Course (ST8B)
4-5 November 2015 Ethicon Centre Pinewood
Course Directors Tim Graham & Mike Lewis





A Year in the Gulf

I have survived my first eighteen months in the Gulf and I thought that my colleagues in the SCTS might be interested in my new life as an expat surgeon.

I had fallen out of love with the NHS in its current form, for me I see it as a wonderful institution run by people with sometimes questionable motives. Phrases like 'Governance Issue' and 'Patient safety' were being used far too often to justify an ever heightening hostility to the professionalism of us physicians. I felt increasingly like a square peg in a round hole. The environment where I worked at the Trust in Hull was becoming ever more hostile to medical staff. It was no surprise to me that the then Chief Executive moved on to new challenges soon after the well publicized Superman affair, (what possessed him?). I still loved the clinical work, the technical challenges of new procedures, the camaraderie of the operating theatre and of course the grateful patients. But after thirty two years of giving my best efforts to the NHS I was jaded and restless. It was time for a change. I have to admit that there was more than a lump in my throat as I closed my office door and walked away from the NHS last year. Apart for a trip to see Hull City in the FA Cup Final I have not been back since.

So now I am a lone practitioner in a foreign land.

The hospital where I work is superficially very glitzy. Chrome and polished, dark wood abound. Italian marble is the preferred construction material. Scratch the surface though and it is a hospital like any other, we have clinics and operating theatres, X Ray suites and waiting rooms. Our business is treating patients and it is a business. We are a for-profit organization and we are entirely privately funded, nothing can be done to anyone without sourcing the finance. All procedures and tests have to be run past the insurance companies before we go ahead. For self-funding patients money must change hands up front. Credit card machines are prominent in all clinical areas. Medical care is expensive in the UAE but then so is everything else apart from petrol. The system here invoices on every item used for a patient and puts on a handling tariff in addition. Unlike the private system in UK there is no NHS safety net. When things go wrong we have to deal with the issues and fund the care, it certainly concentrates the mind when you order a test or use a bag of blood.

Dubai is one of the melting pots of world. UAE Nationals make up only fifteen percent of the population. The largest racial groups are the huge armies of low skilled workers from the Indian Subcontinent and more educated clerical staff from the Philippines and North Africa. The better educated Indians, Europeans and North Americans appear to occupy the best paid jobs and comprise the majority of the patients that come to our hospital. Good occupations have good healthcare insurance, poorer paid jobs have none. English is the language of general purpose, this sounds as if it might be easy for an Englishman but it is not. Most people speak English as a second language and have learned it from a person for whom English is also a second language. Communication in my mother tongue is often more difficult that one would expect.

There is a form of racism here that is subtle and initially impenetrable, it actually has nothing to do with race or colour of skin. It is based on passports and training status. As much as the Arab world likes to hate the United States it admires that nation above all others. People with American qualifications and passports command higher salaries than others who do not, this applies in the medical word as much as in the oil and gas industry. As a mere holder of the FRCS C/Th I am slightly less financially valued than someone who is American Boarded. One learns to live with these slights.

The work load in the UAE is very different from that which I was used to in the UK. It is like running my old private practice without having to attend my NHS duties. I am a single handed surgeon so I am on call all the time which is no different from my old life where I usually had a patient in a private clinic and had to be available for them at all times. I have three cardiological colleagues, they are all American trained and of course love to do angioplasty and stenting. As in my old practice I hope we have come to an understanding of what constitutes a high Syntax score and may be better treated with surgery. I think we understand each other and there have been few disagreements. I generate my own referral base from marketing and word of mouth as time goes on my practice has grown.

Steve Griffin

There are differences in the work that have surprised me. One is the Middle Eastern attitude to time keeping, appointment times are difficult. The patients often arrive hours late then complain if you don't see them immediately. There is a huge general mistrust of doctors. This stems from the large number of doctors who frankly over treat and over investigate and as such are nothing short of malpractice Gurus. I have grown to understand that what passes as normal behaviour in some parts of the world we may consider unacceptable in Europe. Gaining trust here is a slow and difficult process but once it has been achieved then that trust becomes absolute.

My first operative case was a baptism of fire. I had barely got off the plane to be confronted with a type A dissection. I just took a deep breath and did it. Circulatory arrest and all. Much to my relief he did well and showed his gratitude with a generous gift. Generally the work is similar to the UK with the biggest difference being the age of the patients. There are fewer old folk here. The pathology is of a more florid type and every bit as extreme as we are all used to, just in a younger group.

I had been wanting to develop my career away from operating, which is probably a bit questionable as it is the only thing I'm actually any good at, (our Society may not agree with that statement), but it cannot go on indefinitely. I have been given the role of assistant medical director. Funnily enough I enjoy it rather more than I thought I would. I have been surprised at the type of things that seem to land on my desk. What petty people doctors can be, I am not too proud of our profession sometimes. I have also found myself as Head of Medical Imaging as there was a leadership vacuum there. This has necessitated a crash course in what goes on in a radiology department. It is a new world for me, I thought X rays just happened, apparently they don't.

Domestic life is very agreeable in Dubai. We have a 3,600 sq ft lovely house in the best part of town. It is 6 kilometres from the hospital and an easy drive or a cheap taxi ride if I have consumed any alcohol (zero tolerance here for alcohol and driving). The house is near the beach and close to all the amenities like off licence and supermarket. Our local shops even sell pork, to non Muslims of course. Our home is large, cool and very Arabic in design and we love it. We have never lived in such a nice place. The rent is astronomical, one could buy a house in Hull for my yearly rent. Fortunately that rent is included in my contract. We have a pool and gym plus maids quarters. We do not have a maid though.

Those of you who know me know I have a weakness for cars and the price of petrol (27p per litre) means that my Corvette is rather more affordable than it would be in UK. The second car is an enormous 4x4 which comes in handy with the ever present sand.

Dubai is a garden in the desert, although there may be a great deal of sand culturally it is not a desert. Opera, theatre and ballet are serviced by a stream of visiting companies. The music scene is vibrant and just about all the top acts seem to play here. Sting, Santana, The Who, Michael Buble, Kylie, John Legend, James Blunt, Jennifer Lopez just to name a few.

For sport lovers we have the tennis championships, cycling tour, football (Manchester City are owned by the Abu Dhabi royal family and play here often), sailing and Formula 1. There are endless pursuits for sport participation but these tend to be limited in the summer months when the temperature climbs into the low fifties centigrade. I manage to run in the winter, sea swim in the summer and the Autodrome is a very nice place to waste some hydrocarbons.

So, what do I miss? My lovely patients from Hull and Scunthorpe, I do miss them very much. Being in a team with other surgeons, however much we annoyed each other. Being able to get away and hand the call to someone else. The endless and bottomless financial resources of the NHS (yes…really). Being called mister, I'm just doctor here and after thirty years that took a little adjustment.

What do I not miss? Rain, grey skies, income tax, aggressive NHS managers, expensive petrol, litter and graffiti.

I think I was not alone in my move to the Middle East, I see other members of our society have moved to Jeddah and Bahrain. The UAE can be overwhelming and the certainties of life in UK are non existent but for now it is home and I am very content. In fact the longer I am here the more I like it. I don't think I will ever work in UK again, which is probably just as well as nobody would have me anyway!

Consent –
"all changed, changed utterly"[1]

In the beginning there was Bolam … then Sidaway … then Chester … now Montgomery. The recent Supreme Court judgement in the Montgomery case[2] sets a new paradigm for the consent process which will have a major impact on how we as surgeons discuss operations with our patients.

Our standards for practice are set by the GMC in their publication "Good Medical Practice", last updated in 2013. The Royal College of Surgeons of England produces specific guidance for surgeons in "Good Surgical Practice" (2014). Legal boundaries are set by case law – not so much what the individual case was about but what the Judges said in their judgements.

The standard of care by which we are judged in legal terms is the "Bolam" standard (Hunter and Hanley in Scotland). Although this case was about consent, the standard of care set by Mr Justice McNair in 1957 has stood the test of time and applies to all aspects of clinical practice: *"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest skill … . a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. … a standard of practice recognised as proper by a reasonable body of opinion … not negligent … merely because there is a body of opinion that takes a contrary view".*

In 1985, Mrs Sidaway's case went to the House of Lords. Again it was about consent. She claimed that had she been told about the risks she would not have had the operation. Four of the five Law Lords agreed that the Bolam standard applied – other doctors would not have told her about the risk as it was small and so she lost her case. Lord Scarman dissented – he suggested that the test should be what a "prudent patient" would want to know. This was the first hint that things were to change.

"Lord Scarman dissented – he suggested that the test should be what a "prudent patient" would want to know. This was the first hint that things were to change."

In 2004, another consent case came to the House of Lords. Miss Chester argued that Mr Afshar did not tell her about the risks of "cauda equina syndrome". However she admitted under cross examination that her back was so bad that she would have had the operation. So, on the basis of Bolam and Sidaway, she should have lost. However, she said that she would have had it at another time … and possibly by another surgeon. She won. The Law Lords said that as the risk had occurred then and it was small, it would not have occurred at a different time! Don't question the statistics. Lord Steyn said: "As a result of the failure to warn, she cannot be said to have given informed consent to surgery in the full legal sense. In modern law, medical paternalism no longer rules and a patient has a prima facie right to be informed of a small, but well established risk of serious injury as a result of surgery."

That should have changed our approach. Some felt that this superseded Bolam. The Department of Health "cascaded" letters to everyone. However little changed.

Now comes Montgomery. It dates back to 1999 and has been working its way through the Scottish Courts. It came to the Supreme Court this year. Consent again. An obstetrician did not tell Mrs Montgomery that as a diabetic (and so carrying a big baby) there would be a 10% risk of should dystocia during delivery – and if that happened, there would be a small risk of injury to the baby (it happened). The concern was that she might then choose an elective C section. This was in keeping with practice in 1999. The first two Courts said this met the Bolam standard.

The Supreme Court disagreed – unanimously. The leading judgement said: *"The doctor is therefore under a duty to take reasonable care ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments".*

"The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely to attach significance to it."

Leslie Hamilton

LLM FRCS Eng
FRCS Ed (C-Th)

"Whether a risk is "material" cannot be reduced to percentages. Its significance … likely to reflect a variety of factors: the nature of the risk, the effect on the life of the patient of its occurrence, the importance to the patient of the benefits of the treatment, the alternatives available and the risks of those alternatives".

They went on to say: "The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form" (is this a paraphrase of current practice?).

Lady Hale added a specific comment: *"It is not possible to consider a particular medical procedure in isolation from its alternatives". I would suggest that this means that cardiac surgeons will need to discuss PCI with patients referred for CABG and TAVI with patients for AVR.*

Just in case you thought that you would not have the time or the inclination to get to know your patients and assess their values, the Judges pointed out that this is already what the GMC expects of us. They went on to say that they were imposing this new legal obligation: "so that even those doctors who have less skill or inclination for communication, or are more hurried, are obliged to pause and engage in the discussion which the law requires."

The legal minds are still digesting this judgement as it sets new standard for consent (Bolam still applies to other areas of practice) but it seems to me that a new world has arrived.

References

1. Easter 1916; William Butler Yeats
2. Montgomery (Appellant) v Lanarkshire Health Board (respondent) [2015] UKSC 11

New Consultants

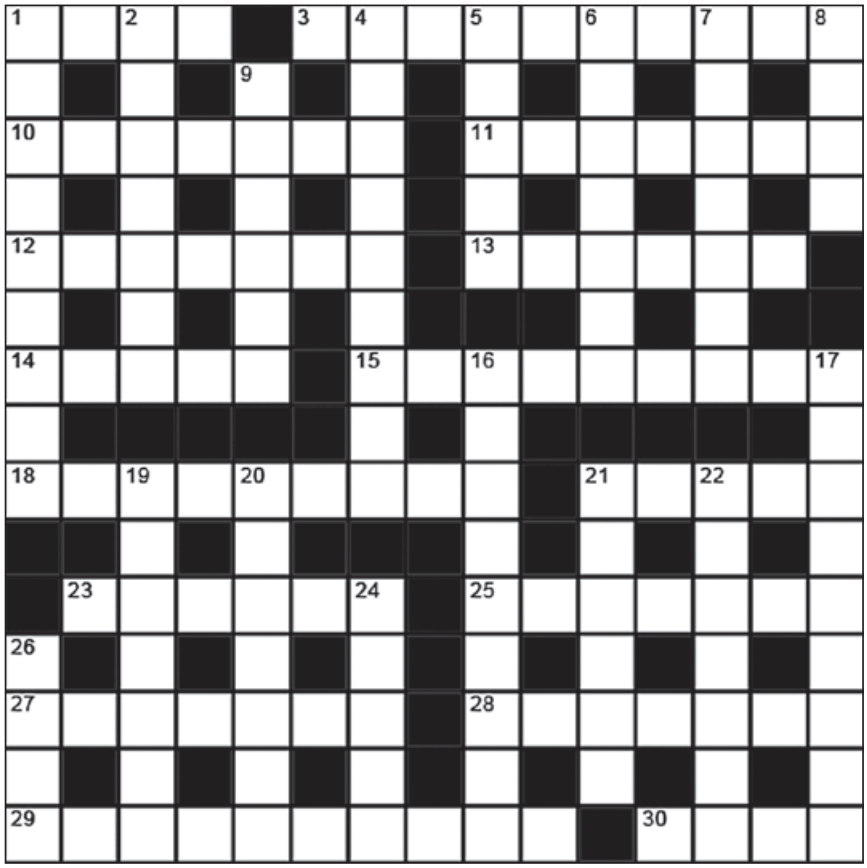
Name	*Hospital*	*Specialty*	*Starting Date*
Ed Peng	RHSC Glasgow and GJNH Clydebank	Congenital	February 2015
Andrea Bille	Guy's Hospital, London	Thoracic	July 2015
Lukacs Veres	Guy's Hospital, London	Thoracic	August 2015

Other appointments

Name	*Hospital*	*Specialty*	*Starting Date*
Sara Tenconi	University Hospitals Leicester	December 2014	Locum Thoracic

The Crossword

Samer Nashef



December's winner:
Andrew Goodwin (Middlesborough)

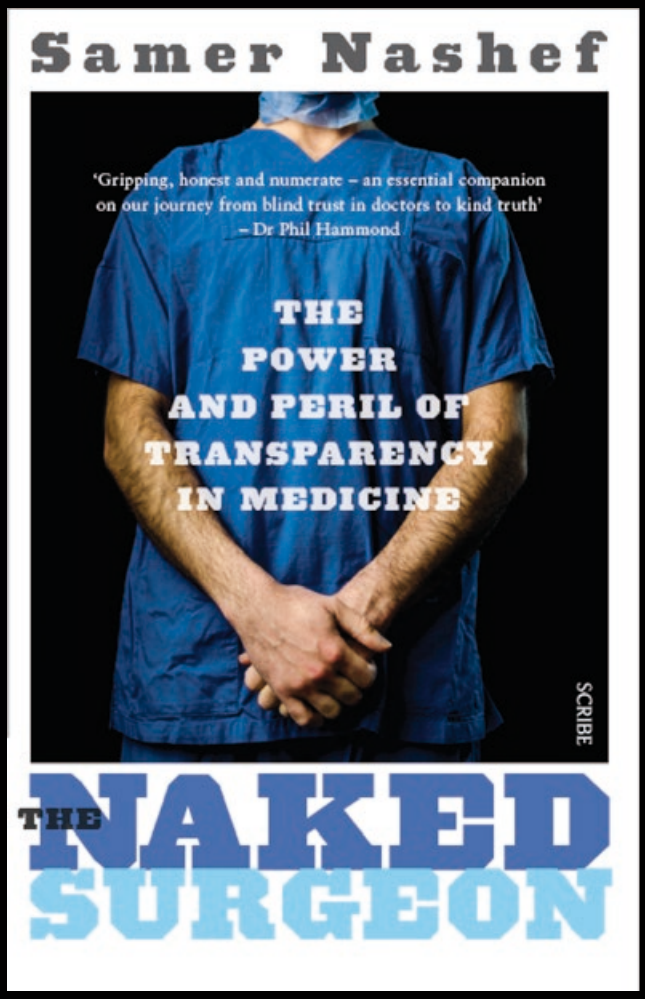
Send your solution by 31 Dec 2015 to:
Sam Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744
Solutions from areas over 10 miles from Cambridge will be given priority.

Across

1 Run a little (4)
3 Fix confusion in the ratings (10)
10 Rise of comedian (5-2)
11 Fruit and most of another for CABG surgeon? (7)
12 Our deal is off with this dish (7)
13 Food to make you smile (6)
14 Soundly fed up with those in charge of a hospital trust (5)
15 From the 13 14 for torque converter (9)
18 Food junction (9)
21 Miss Muffet tasted piece from the 13 14 (5)
23 Boost marionettes - flipping heartless (4,2)
25 Keen to have a look into god (7)
27 Funny lot isn't from the 13 14 (7)
28 Gorge from the 13 14 (7)
29 Gently store pet and see (10)
30 Game break (4)

Down

1 Depicts seeds scattered around bed (9)
2 Casual pink top worn off the shoulder (7)
4 Highly confidential with respect to organisation (3 6)
5 Jelly in Christmas picnic (5)
6 Bloke eats right here in London from the 13 14 (7)
7 Bill, a Caledonian, doesn't finish sauce (7)
8 Standard unit of force or mass (4)
9 I should join club, perhaps - it might be needed to buy a drink (2 4)
16 Perplexed by the French who snore in concert (awfully loud to begin with) (9)
17 Footballers' kit - they remove it on their travel (4,5)
19 Social worker's mound provides an exciting experience right away (3-4)
20 Pertaining to organ which, with sores, can develop spirochaetes (7)
21 Yellow and soft in marsh (6)
22 To reform our daily diet, eat nuts initially processed as grapes (7)
24 Love to be found in a beer and a wine (5)
26 Second-hand American edition (4)



" a very stimulating read"
Sir Terence English

"a must-read for all surgeons"
Dr Phil Hammond

"an outstanding masterpiece"
Maria Von Hildebrand

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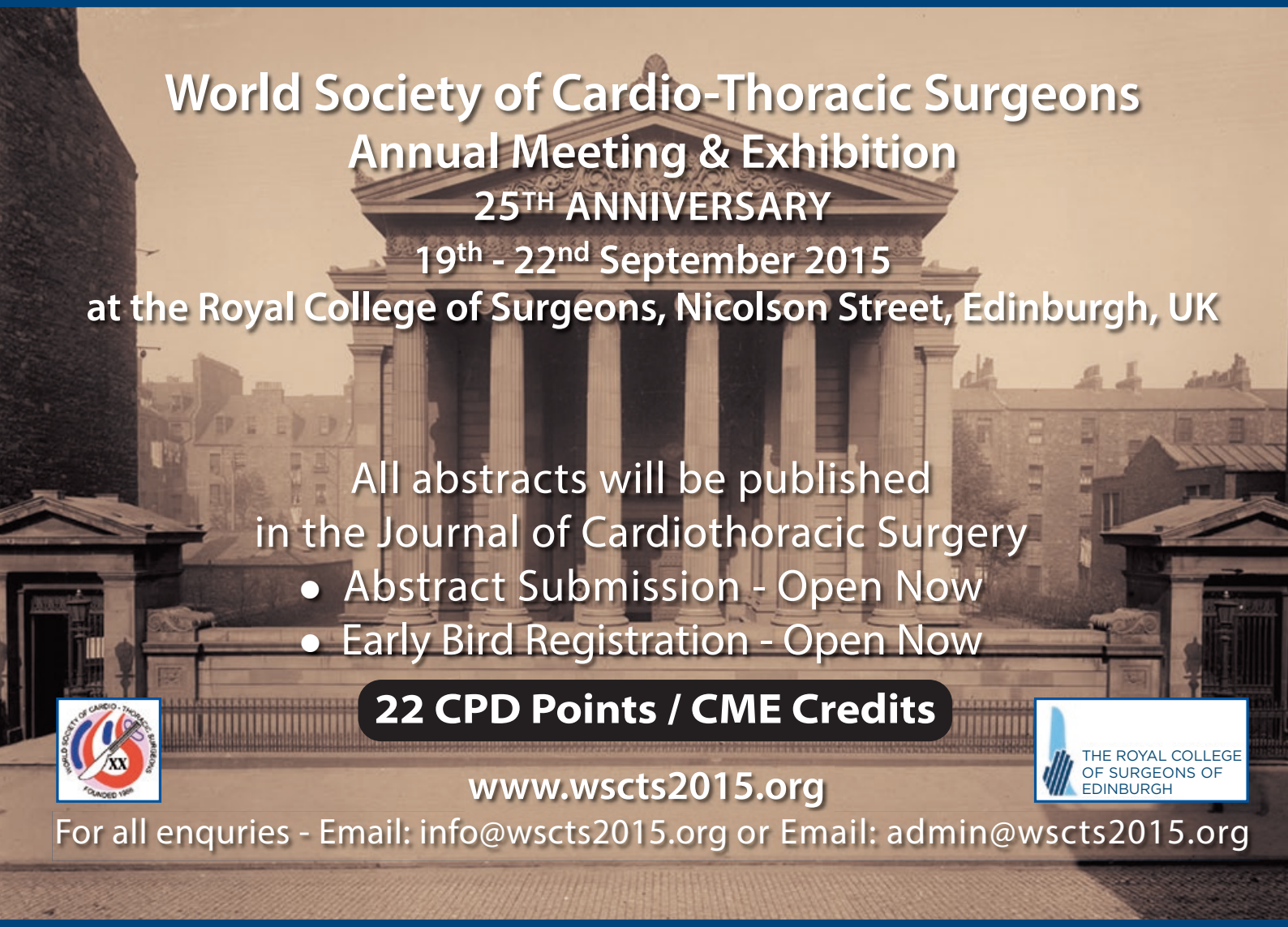
Melbourne • London


World Society of Cardio-Thoracic Surgeons
Annual Meeting & Exhibition
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