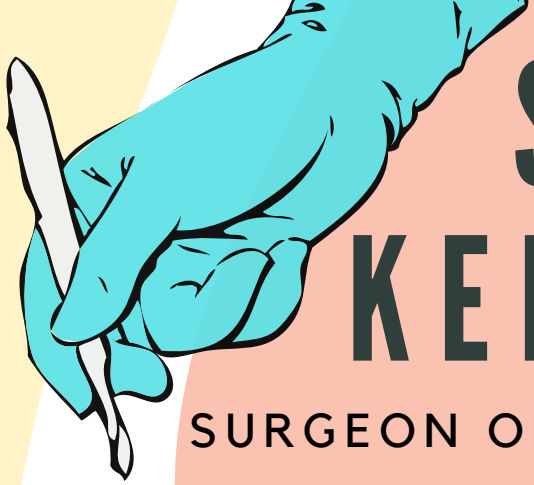

SIMON KENDALL

SURGEON OF THE MONTH

WHICH MEDICAL SCHOOL DID YOU CHOOSE TO ATTEND AND WHY?

I went to the Middlesex Hospital Medical School - right in the centre of London between BT tower and Oxford Street. Applying, I had no idea where it was but knew a friend from school, 2 years ahead, was having the best of times there. Newcastle was also on my shortlist and thankfully I didn't understand the application system and accepted 3 'C's from Middlesex rather than the Newcastle offer of 3 'B's - had I known I would have gone there instead with my 3 'B's. The Middlesex was superb - best 6 years of my life. I learnt how to be a stage manager for the prestigious Christmas Concert that ran for 12 nights each year, I ran (captained is a loose term) the social rugby side and various other organisational roles such as Rag Week, the Guinness Walk etc. I / we didn't learn medicine quite as we should have done, leaving it to the last few weeks to get through the exams - which is probably why I don't trust my medical decisions and continue to reflect on them for some time.

WHEN DID YOU FIRST EXPERIENCE CARDIAC SURGERY?

At the Middlesex, it was talked about in mystical terms - I remember glimpsing one surgery through the glass of at least two doors. Occasionally the team would come across to the pub - but I had no concept that I would ever become a cardiothoracic surgeon. I was on my pre-fellowship surgical rotation in Leeds 1986-89 - General Surgery and Orthopaedics, among others, and... Cardiothoracic Surgery. I started on August 1st 1987, though confined to Killingbeck Hospital for a month, it was easy to fall in love with the specialty. Soon, I was allowed to open and close cases, cannulating (bicaval on every case) and performing the relatively new technique of harvesting the IMA. Looking after patients on ITU was very exciting and the senior nurses were extraordinarily patient in bringing us up to a safe level. In thoracics I was able to perform lung resections unsupervised. The career pathway for the specialty was horrendous with many registrars and senior registrars not progressing - but I had fallen for the specialty and decided to pursue it.

REFLECTING ON YOUR CAREER, WHAT ONE PIECE OF ADVICE WOULD YOU GIVE TO YOURSELF AS A TRAINEE IN CARDIOTHORACIC SURGERY?

'Put the patient first - we serve the patient. We are not doing them a favour' I'm afraid I was brought up in a medical and surgical culture that was paternalistic and although we worked extremely hard for the patients we tended to treat and refer to them almost as a different species. Even nearing the end of my career I am still saddened to see (in my view) too many colleagues across surgery and medicine not really having the compassion to think how they would like to be treated and how options should be presented to them.

SCTS INSINC

YOU LEAD THE SPECIALTY NOW AS THE PRESIDENT OF SCTS, THE GOVERNING BODY OF THE SPECIALTY, HOW DOES THAT COMPARE TO BEING A LEADER AS A MEDICAL CONSULTANT?

Great question! They're very, very different roles! Professional societies are voluntary work subject to their constitution, but as a consultant you are an employee of the NHS, with T&Cs, appraisal and governance. On reflection, the leadership style is very similar - it's about influence and relationships, not hierarchy. As a leader in the NHS you have remarkably little 'power', reaching consensus with the MDT and best patient care at the centre. The role of Clinical Director I find by far the most challenging - looking after colleagues, supporting them, keeping them 'on-side', being receptive and flexible in your own style. You will do a 3-5 year term as CD, after which you work working as usual alongside the team, a follower and no longer the leader - so best to be on good terms with everyone!

YOU ARE RECOGNISED AS ONE OF THE BEST TRAINERS IN CARDIOTHORACIC SURGERY, ARGUABLY ONE OF THE MOST IMPORTANT ASPECTS TO A DOCTOR'S CAREER. WHAT OTHER ACHIEVEMENTS MAKE YOU MOST PROUD AS A CARDIOTHORACIC SURGEON?

Those are kind words but I still don't believe them - I may facilitate surgeons at all levels to operate, but I could do so much better. I tend to assist too enthusiastically which prevents the trainee surgeon in thinking for themselves. I should spend more time talking about the background, theory, science - I am very impressed by my colleagues who are much more diligent at training than I.
Too many teams in cardiothoracic surgery become dysfunctional - as a trainee I observed too much conflict; often seemingly related to private practice, but other factors, including egos, are also involved. In that regard, I am most proud that we were lucky to have a brand new unit in Middlesbrough where we wanted to work as a family - and for nearly 30 years we have been largely successful. It needs continual attention and maintenance, but if colleagues come to work feeling valued, then they can thrive. That rubs off on the care patients receive - collaboration is far better than conflict.

YOU HAVE ACHIEVED SO MUCH IN YOUR TENURE, INCLUDING PUTTING 'EQUALITY AND DIVERSITY' ON THE TABLE FOR DISCUSSION, IN YOUR EYES, WHAT HAS BEEN THE BIGGEST CHALLENGE TO MAKING THIS A PRIORITY?

I would regard the biggest challenge as reaching the 'tipping point' - where there's enough momentum to get the 'oppressors' to acknowledge the problem is real and also wrong. The Sufragettes were phenomenal in the early part of the 20th century before WWI - the effort and sacrifice that it took was remarkable.
I hope now that the 'oppressors' are able to understand the experiences of the oppressed, who are now beginning to feel they can speak out and share what they have endured. In turn we all make the decision to change, be generous and be kind. I am not proud of the culture I grew up in and adopted - I hope, and think, our specialty has just passed the 'tipping point' and the agenda will gather pace.

SIMON KENDALL
SURGEON OF THE MONTH

SCTS INSINC

THE RCS RECENTLY PUBLISHED A REPORT ON DIVERSITY AND INCLUSION WITHIN SURGICAL CAREERS. WHAT CAN WE BE DOING TO ENCOURAGE & NURTURE THIS WITHIN THE WORKPLACE?

This is a massive question - and to do it justice should have an extensive answer, But I suspect if anyone has read this article to this point they will have had enough already!
So - here goes in brief -
1. Reach out to sixth form that our specialty is inclusive and diverse
2. Reach out to students - nursing, medical, physio that our specialty is diverse and inclusive SCTS are expanding their portfolio of engagement sessions for just this reason.
3. That the media portrayal of our specialty is diverse
4. Ensure adverts, shortlisting, interviews and selection are performed by diverse panels and that diversity is recorded and audited.
5. That behaviours are appropriate in the work place - and that poor behaviours are not tolerated and called out - the behaviours that we turn away from are the ones that we are accepting. Easy to say - but that is key that the moderates no longer tolerate poor standards.

WHAT SCHEMES AND SUPPORT MECHANISMS HAVE SCTS PUT IN PLACE FOR MENTORSHIP FOR STUDENTS?

As yet we haven't achieved any formal schemes of mentorship for students. We have introduced schemes for new consultants, consultants in difficulty, national surgical trainees and just recently trust appointed doctors - these are all for members of the SCTS. We are a bit behind the curve with students - I apologise - we now have a committee with high calibre colleagues such as yourself - and I might turn this question around and ask you what you would like us to do to provide such mentorship? This would be so right to put in place - so the sooner the better and I hope we can put a strong and sustainable structure in place - what do you think?

FINALLY, IN YOUR OPINION, WHAT PROPORTION OF BEING A SKILLED SURGEON IS TALENT AND WHAT PROPORTION IS EXPERIENCE?

Another great question!
Experience, talent, knowledge, situational awareness, emotional intelligence, flexibility, lateral thinking, resilience, stamina, compassion.....
But for the first two -
If you have talent with no experience you're dangerous and if you've no talent and a lot of experience (and I guess it would be a lot of bad experience) then you'd be dangerous.
So these two qualities can compensate for each other - probably looks like a bell curve - I would go for 70% talent and 30% experience as optimal.
I'm sure there would be diverse opinions on this!

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