

Presidential Address March 2004

Members of the Society, honoured guests, Ladies and Gentlemen

When I was elected to the Vice-presidency in 2000 it was obvious that there were many problems looming on the horizon. As a result of the Bristol affair we, as cardiac surgeons, were coming under increasing scrutiny. Several surgeons found themselves the subject of media enquiries and had to undergo close examination of their results and indeed their professionalism. The Kennedy Enquiry into the events at Bristol Royal Infirmary was still under way and due to report that year. The European Working Time Directive was beginning to make its presence felt over and above the reductions in trainees' hours. The Government was pushing many changes in their efforts to cut waiting times and improve services. They promised to correct the gross shortage of consultants by increasing the numbers of trainees and shortening training. One of the changes they proposed was to set up the Post-graduate Medical Education and Training Board which would take over many of the responsibilities of the Royal Colleges and the Specialist Training Authority in the education and training of surgeons. Negotiations leading to the new consultant contract were beginning but when these were likely to conclude was uncertain.

Bristol

The findings of the Kennedy Enquiry were likely to have a major influence on the way cardiac surgeons practiced. There were also many wider issues that would

change the attitudes and practices throughout surgery and indeed medicine. Many of our comfortable assumptions that we were providing a good service to our patients were to be challenged. While the majority was doing an excellent job, there were pockets of resistance to change, a reluctance to accept responsibility for the deficiencies of the service, which needed to be attended to. I do not think that we have yet fully addressed all of these problems.

European Working Time Directive

The second challenge apparent at that time was the changes being pushed by Europe and the Government in working practices – the European Working Time Directive and trainees working hours being the most radical. Again, as I am sure you will agree, these matters are still causing a considerable amount of head scratching and sleepless nights – although not perhaps for those trainees who are on drastically reduced hours! Many surgeons and surgical trainees are very concerned that the reduced hours combined with the pressure to reduce the length of training will make it very difficult to produce surgeons who can cope with the full range of the specialty, as has previously been the case. Everyone, I think, recognizes that to do so will require drastic alterations in both the structure of and the attitude towards training and, while there is a degree of fatalism creeping in, there are also many enthusiastic and innovative people working to develop training systems to cope with these pressures. The main challenge I foresee for the near future is to change the attitudes of some trainers and the Trusts to give training – investment for the future if you like – the priority it

deserves. This again highlights the conflict – also unresolved – between training and service.

The working time issue had – and still has - major and increasing implications for training. The Calman reforms had been designed to reduce the training period and prevent “wasted” training time. These changes had been greeted with skepticism by many surgeons. “ We cannot train a surgeon in 6 years”. The working time directive compounded this skepticism and, while I felt that with dedicated and enthusiastic trainers getting the appropriate support it should be possible to achieve high quality training in that time, the shortening of the working week has made me less confident. There is one initiative, however, that I hope will ensure that future consultants will be “fit for purpose” in the jargon. This is competency-based training. If a trainee is not ready to do the job they should be given more time and training. How this fits with a shortened training I do not know but it should be made to work for us and our patients. As someone who is nearing retirement and my free bus pass, I have a vested interest in ensuring that when I need complex redo surgery young consultants will be confident in their ability to treat me. We must, therefore, use competency assessment properly. I may need to keep a close eye on John Dark’s retirement date as well as my own!

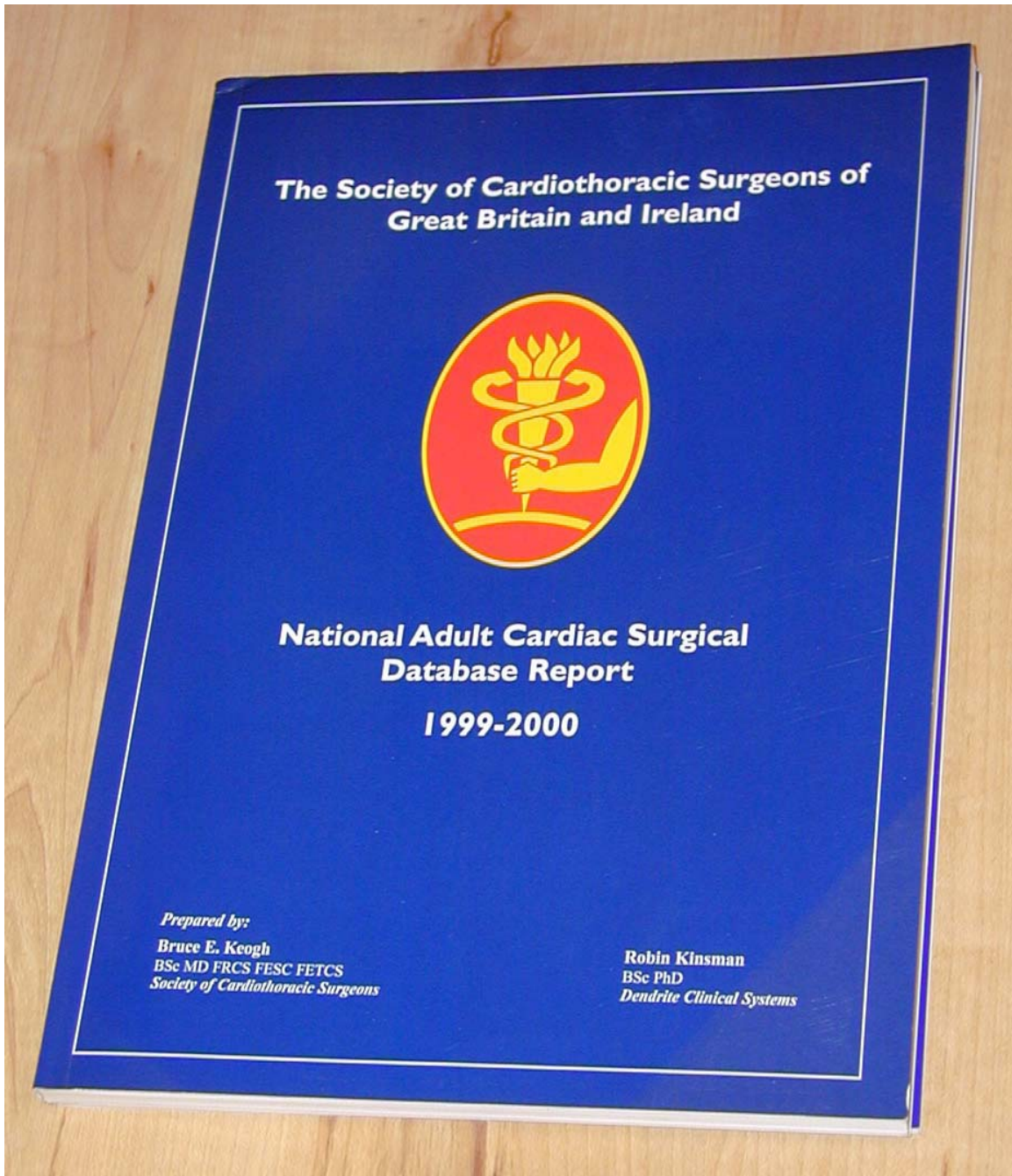
The proposals for seamless training add another aspect. I have always had concerns that seamless training could not and should not guarantee that every trainee would achieve consultant status unless our selection processes were

infallible. Currently, not only can we not select with 100% confidence, but also the RITA process, while improving, has not proved robust enough to guarantee that trainees reaching the end of their training are sufficiently accomplished and experienced to take up a consultant post as we know it. In my view there cannot be a completely “parallel” progress through training but there must be a pyramidal structure to allow the best to the top and divert those who do not make satisfactory progress into other channels.

Data Release

Also on the books in 2000 was the issue of data. Partly as a result of the Kennedy report it became obvious that surgeons outcome data needed to be the subject of closer scrutiny, both locally, as part of audit and clinical governance, and nationally. The government interpreted one clause in the report as recommending the public release of surgeon specific mortality data, not, I believe, exactly what Professor Sir Ian Kennedy had intended. They pointed to the apparent improvement in results following such data release in the United States as evidence that this open scrutiny could lead to an improvement in outcomes. They did not, however, take into account the transfer of high-risk patients to other centres and the reported increase of co-morbidities in the New York patients, which contributed in no small measure to the improvement in the figures. They were also reluctant to adopt another feature of the American release that we regarded as vital. A comprehensive validation process, which in New York took three years, to ensure no erroneous data reached the public

arena, was, in our opinion, essential. I am sure you do not want to hear again the efforts we have made to soften the impact of this dictat on our practice and our careers but I do think we have reached a very acceptable balance. The Database report for this year will include information on individual surgeons' mortality taken from the Cardiac Surgical Register.



There are well-rehearsed arguments for and against this, which I will not go into again, but the Executive of the Society has taken the view that it is better to preempt other organizations that might publish the information. We have the agreement and co-operation of the CMO in this. From a personal point of view I

still, like many of you I am sure, have reservations about the whole concept until we can guarantee the validity and quality of the data and, perhaps more importantly, have the chance to educate the media and the public in the interpretation of the figures. Again, like many of you, I believe that unit data would be much more representative of the way patients are managed but the Government has been adamant. The Society has, therefore, been walking a tightrope. If we were to appear too reactionary the Government would have gone ahead with releasing HES data, probably in a form that would have appeared in the press as league tables. They still could do this as these data are in the public domain and have been used by Dr Foster in some of its publications. You can imagine the press reaction to that! Our data are better, we believe, but are still not robust enough to release as percentages. Even in the database we do not have sufficient data to fully stratify the risk in nearly 60% of patients. This brings me to one of the things for which we, as individuals, must accept some responsibility. If we want to be able to use the database for justifying the quality of our practice and even service developments, we must take the responsibility for ensuring that the figures are accurate and meaningful. True, we do need support in this but it is in our interest to take the lead both locally and, as the Society has already done, nationally. No-one wants to appear on the front page of the Sun and the remedy is in our own hands. We also need to work with our colleagues in Intensive Care and Anaesthesia to ensure that we learn from deaths and near misses, both our own and others'. Anaesthesia has for a long time had critical incident reporting and I am sure we as surgeons will have

figured in some of those incidents but personally I have not seen analyses of the data in cardiothoracic surgery. If there is such data it should not be limited to anaesthetic review. We were delighted that the College of Anaesthetists supported us so publicly when we were under pressure.

Modernizing Medical Careers

The working time directive has spawned further changes in our working lives and Modernizing Medical Careers is about to create even more revolution. This and “Improving Working Lives” – a seriously misnamed document as far as my working life is concerned – will make our jobs almost unrecognizable from those we trained for. The Society, and you as working surgeons, cannot afford not to be in the middle of these discussions. I personally feel, as I suspect many of you do, that there are far too many changes happening too fast. It is a bit like my skiing - out of control heading for the forest! We have to be able to learn to turn and weave in and out of the trees! We need time to stand back and review the changes and their effect before instituting more.

As I intimated at the beginning of my address the Society has been working extremely hard to ensure that such changes as do come to fruition are acceptable to the specialty. The workload placed on the members of the Executive has increased substantially but despite our best efforts there are many outstanding issues which will, I have no doubt, exercise our next President and future members of the team. Several of these are closely related to the issues I have already mentioned but there are new problems looming.

Where are we now with the release of data? This will occur with the publication of the Database report. Bruce Keogh has shown you the proposed format. I am sure you will all agree that that should give useful information to patients while protecting surgeons from uneducated and unfair comments. Hopefully the press will not be able to crucify any one of us although as I intimated in the debate in the business meeting there may be allegations of a cover-up. The consultations we have had with the Government and CHI and the influence of the Royal Society of Statistics and the Nuffield Rand group have had a very positive outcome. I have a suspicion that the DOH do not want us to demonstrate poor surgeons as they then have to come up with some explanations .I am sure that they would prefer to be able to say all is well and pass on to their next initiative. I believe that this release will be a one-hit wonder and that once it has been done the public and press will lose interest for the next time just as we saw with the Unit data tables from Dr Foster.

The future of cardiac data collection will not rest entirely with the Society. The Combined Cardiac Audit Database project will take over much of the responsibility of collecting the data centrally but we have negotiated with CHAI and the Department of Health that we will be have a major role in the management of this data along with them. This project is a major step forward in the audit process, as CCAD will be linked with the Myocardial Infarction National Audit Project, British Cardiac Intervention Society and OPCS to provide

longitudinal follow-up and information on medium and long-term outcomes that has previously been very scanty. I believe that this model is the future of audit and likely to form the basis for further projects in other specialties. We must make sure it succeeds.

The Future

I do not want Pat Magee to think I am trying to influence the way the Society handles issue in the future but it seems to be de rigueur that retiring Presidents attempt to use their crystal ball to look into the future and I am no exception. Some things I can be sure of. My short-term future consists of skiing next week and golf the week after! After that things become much more blurred.

Some four years ago at the STS meeting in New Orleans the cardiac surgical community was indulging in a lot of soul-searching about the future of cardiac surgery and revascularisation in particular. Workloads and, therefore, in the US, incomes, were falling. Surgeons were desperately searching for other avenues - even to the extent of proposing to learn angioplasty! At that time all this seemed irrelevant to British practice with its huge unfulfilled need. However, during the last two years there have been amazing changes in the UK and we are beginning to see a similar picture here. With the emphasis that has been placed on waiting times by the Government and Waiting List Initiatives, the number of people on waiting lists and the time they wait has fallen drastically. This industry on the part of the surgeons has, however, has one slightly unexpected and serious consequence.

As part of the drive to increase the number of consultants there has been a marked increase in the number of Type 1 trainees. Unfortunately, because of the reduction in waiting lists, the anticipated consultant expansion, so confidently expected five years ago, has not happened. Over the past two years cardiologists have done more revascularisation than surgeons. Our trainees are, perhaps justifiably, concerned for their future and will need and expect the Society to support them. The Society must push for new posts. The European Working Time Directive and the new consultant contract may be the catalysts for this to happen. While we may not agree with the working time restrictions placed on us we do have, through our input into the Advisory Appointments Committees, the power to ensure that consultant posts meet working time rules and, where possible, extra consultant posts are created for our trainee members. This will be especially true if a new case currently going through the European courts succeeds. Currently, following the SIMAP ruling, trainees resident in hospital are working even if they sleep the night through. The new case, if successful, will mean that even on call from home will count as work. As the European Parliament has already voted to abolish the opt-out clause, this will mean that we all, consultants as well, will be restricted to a working week of only forty-eight hours. There is already – surprise, surprise – evidence of a reluctance on the part of Trusts to agree to job plans above 12 programmed activities. As most of us work far beyond that there will have to be some expansion of numbers to keep us within the law. Small highly specialized units such as Paediatric Cardiac surgery will have to expand their numbers or merge to provide sufficient work for enough

surgeons to provide cover. Since there is no more work, concentration of the expertise in fewer centres seems to be the only way forward. The Paediatric Congenital Cardiac Services review has already highlighted this problem but the Government, perhaps because of the “Kidderminster effect” have put their heads in the sand and decided to keep things as they are. They do not seem to appreciate that such highly specialized and labour intensive services cannot be sustained on 2 surgeons working 48 hours a week. While at my time of life the prospect of working half the week for the same pay has considerable attractions, I am sure that young enthusiastic surgeons would find such restrictions frustrating and may reduce the attraction of surgery as a career.

The problem is not confined to paediatrics. Thoracic surgery could also perhaps benefit from a degree of aggregation. Tom Treasure, in his analyses of the thoracic registry data has been unable to show any volume/mortality relationship but this is becoming apparent in other parts of the specialty. The paper from the Veterans Administration in the US last year demonstrated such a relationship in cardiac surgery and it would be foolhardy to deny the possibility of future research in the database picking up the same in thoracic surgery.

Combined with the current decline in application for medical schools – medicine is now the seventh most popular subject instead of top three as it used to be - this could have serious implications for both the profession and the NHS. Tuition fees may also have a negative effect if the scare stories in the press are anywhere near the mark. In the US and on the continent surgical training programmes are already struggling to attract trainees. Applications to

cardiothoracic training posts in the UK have held up well so far but the proportion of UK graduates seems to me to be dropping. We cannot continue to rely on overseas doctors as we have done in the past.

As I said previously the Calman reforms were intended to shorten the time taken for trainees to become consultants. They failed because they did not take into account the difficulty in obtaining an SpR post. The intense competition meant that several years might pass while the trainee obtained experience and perhaps a higher degree in order to be competitive. This resulted in training times remaining much the same as before. The new proposed seamless training will, it is suggested, do away with that hiatus and allow trainees to proceed without delay to consultancy. I am not so sure that this will be true as there will still be competition to get into surgical specialties including ours and the candidates will have to do something while they prepare themselves for the competition. Also the new proposals suggest that adding a second year to the foundation programme will add exposure and aid the doctors' choice of career. Unfortunately, the proposals will also remove much of the current basic surgical training structure that, for many surgeons, allowed them to sample different specialties and choose their career.

The government is pushing this new training structure as they see it as the best way of achieving their stated aims of having 8000 new consultants in post by 2008. As you may know part of this programme involves shortening the length of training in some specialties to produce consultant generalists who will do most of

the routine service work for the NHS. Some surgeons will be able to go on to become specialists with post-CCT training. They will be more like the current consultant with special interests. It is proposed that the generalist consultants' training will make them "Emergency safe". Since emergencies in cardiothoracic surgery are often those requiring complex decisions and assessments followed by high-risk surgery, I do not think this pattern fits well in our specialty, although it might in others. The Colleges, who have been working hard in this area, also realize this. I believe the big danger is that we will have a large number of surgeons with a limited training who will, after a few years of practice, become disillusioned with their professional life – rather like many of the Associate Specialists today. While the intention is that generalists will have the opportunity to undertake further training in certain specialist areas such as aortic surgery, paediatric cardiac surgery etc, it is far from clear how this would work. I have even heard that some believe that it could be done as day release!! At present there is no agreement as to the financing, assessment or accreditation of sub-specialty training. The Post-graduate Deans will not have the funds as they are only responsible for the trainee to CCST – or CCT as it will become. The DOH want only qualified surgeons and CCT will do. Trusts may have to finance training but this probably means that they will only pay for an existing consultant to go away to train to provide the service needs of the Trust. How many Trusts do you think will invest in the training of a surgeon not employed by them? Or let a service consultant go away to train in a sub-specialty when they do not need that skill for their own service contracts? I do not think that is a sensible way of

developing and providing a high quality and safe service. It will be up to the Society and the Colleges to ensure that such sub-specialty training is properly supervised, accredited and funded.

So what can we do about this?

Collaboration.

We are a small specialty. We have a high profile, albeit originally for unfortunate reasons. We have been at the forefront of several initiatives by the Government that have not as yet hit other specialties – even surgical ones. They know that unless the Government has a major change of heart they also will be faced with similar demand on outcomes. We must co-operate with them not only for their benefit but also for ours. We need muscle and by linking with other Specialty Associations – and the Colleges - we may be able to improve our chances of reversing some of these initiatives. If other surgeons, with our help, can avoid surgeon specific data release then it would seem only fair that we also could go back to unit data, as we would prefer. The Royal College of Surgeons of England, when we announced that we were going to use non-risk stratified data for our release, was highly critical. They understood the pressures we were subject to and I believe they would be entirely behind us in any effort to reverse this trend. We need not stop at surgery. I suspect physicians would not like to be subject to this scrutiny either, particularly as so much of their work is so difficult to

measure. One area we will not and should not try to reverse is the role the Society now has in policing the data. This is, of course, very different from the arrangement we had with the registers from their inception when anonymity was complete. The political tide has turned and we cannot go back to such a comfortable and obscure arrangement. We have a responsibility to ensure that any variation from acceptable practice is subject to clinical governance procedures. This, of course, does not mean the Society getting involved in the details of the investigations. That is the responsibility of Trusts and, ultimately perhaps, the National Clinical Assessment Authority. We do need to assure ourselves that the processes are working correctly. A failure to do this led us to be severely criticised in the Kennedy Report.

I believe there are other good reasons for forging closer links with other Specialty Associations. PMETB is a national body with which we, and the Colleges, will have to work. The Colleges have the great disadvantage that they are three and, while the Senate has allowed greater co-operation between them, they still do not see eye to eye on many matters. The DOH tends to talk to the English College as they only cover England. Wales has to go through the Welsh Assembly and Scotland through the Scottish Parliament. Northern Ireland is also separate. The Associations are UK wide – in our case international – just like PMETB. This could give us a much stronger voice in training issues and the setting of standards but only if we are united with other associations.

A third reason for such closer links would be the major changes being proposed for training. As I have said the new proposals for training will do away with the period between SHO and SpR and indeed the SHO grade itself. We must, therefore, be prepared for trainees coming into cardiothoracic surgery to have fewer generic surgical skills than before. If the pessimists' view of the future turns out to be correct we must also be prepared to change the way we train to allow trainees to change course. I am sure many of us have met surgeons who have found it difficult to progress in the specialty but who cannot change career as they have been in cardiothoracic surgery for too long. The changes being proposed are supposed to allow trainees the luxury of switching between surgical specialties for the first year or two. This can only be achieved if specialties get together to design training programmes that have sufficient in common to obviate the need for the trainee to start again from scratch. Modular training is part of the answer but the modules need to be defined if trainees are to transfer between specialties. Perhaps for instance vascular and cardiac surgery could have enough in common to do this, Thoracic and upper GI, even - perish the thought - cardiac surgery and cardiology! Interventional radiology might also be linked into the "surgical training". We already have a forum for such co-operation in the Federation of Surgical Specialty Associations. Bob Johnson of the ASGBI has recently taken over as President of the FSSA and it is beginning to make its presence felt with the Colleges - he has been co-opted on to the Edinburgh Council recently and it was the formation of the FSSA that led to the Presidents of the Associations being invited on to the English College Council. I believe, as

he does, that PMETB may find the FSSA a very useful source of specialty advice in the future.

Our co-operation should not be limited to Britain. Many of the threats to our way of life come from Europe so closer links with EACTS make sense. I hope that Bruce's appointment as General Secretary of EACTS and Jim Monro's presidency make be the stimulus for this. The changes in demand that affected the US and are now coming to the UK will also be relevant in most of Western Europe. They will be finding that cardiologists are dealing with increasing numbers of patients. Paradoxically the United States is now following Europe with significant reductions in working hours so we may have something to offer them also.

We have recently seen a major shift in the methods of treating coronary vascular disease. Peripheral vascular surgeons are experiencing a similar revolution. Perhaps their trainees and recently appointed consultants have the same concerns about their careers. While it is important that we train both types of surgeon it is also important that we can change the emphasis in training so the young surgeons can be trained in new hybrid specialties that may arise in the future. We need to be able to anticipate developments that could radically alter the way we work. Recently changes have been so rapid that we have found ourselves reacting to events. We, and other Specialties, must think ahead and be

pro-active, anticipating developments. Our training must be flexible and adaptable. Again co-operation with our colleagues will be key to success.

Much of what I have said is at present more relevant to Cardiac than Thoracic surgery but I can envisage a time in the not too distant future when perhaps surgery in the treatment of malignancy does not have the pre-eminent position it enjoys at the present. Oncology, and radiotherapy are improving all the time. Some of the response rates for malignant mesothelioma using Alimta are a revelation compared with previous combinations. Brachytherapy, photodynamic therapy and gene therapy are relatively early in their development but we must assume that they will get better – and rapidly. They could have a greater effect on the thoracic surgeons' practice than angioplasty has had on cardiac surgery. We must be prepared to embrace these areas so, for instance, the thoracic surgeon may become an oncologist who operates.

As I mentioned earlier and alluded to throughout this address the future will be very different. The Government want service consultants. I have even heard a suggestion that medical training be transferred to the NHS University, making it even clearer that doctors are being trained for service. There is no room in their plans for, for instance, research during training. This presents an obvious threat to academic medicine and a further, more distant, threat to progress in the specialty. Shortened training and shortened working hours will make it extremely difficult for future surgeons to acquire the experience which, along with our

training, make us the surgeons we are. We have to maintain standards and in order to do this we may need to change the way we work together. There are already examples of this in paediatric cardiac practice with two consultants operating together. It may help in keeping up skills when our working time, or operating time, is so limited. I suppose there will also be shared responsibility, making surgeon specific data even more inappropriate.

I have one further plea to you all. While the Government may appear to hold the medical profession, especially consultants, in little regard, we must remember that we are well respected around the world for the work we do, for the training we offer and the service we provide to our patients. Our outcomes match those of health services spending vastly more money with more doctors and facilities. We can do as good work as anybody, if not so expeditiously. Many of you, I know, are somewhat disillusioned with the changes being pressed upon us but whatever we think of them we must learn to cope and continue to behave in a professional manner and do our very best for our patients. We must not allow ourselves to become just another group of service workers despite what the government seem to want. Unfortunately, the new contract, in my view is likely to lead to more of a clock-watching mentality and a reduction in what you might call professionalism. We must be on our guard against such insidious slippage in standards.

As ever on these occasions, I have several people who I must thank for their support and help during these eventful years. The Executive of the Society, including Isabelle Ferner, has been a tower of strength. Bruce Keogh – I will not embarrass him by calling him Sir Bruce – or perhaps I will – Sir Bruce has worked tirelessly in the corridors of power to get us into the position of dictating how the data we hold is to be released. His efforts have ensured that The Society is respected for its forward thinking and openness. Rob Lamb has transformed the finances of the Society – I am sure he will be delighted not to receive my all too frequent and large expenses claims. B Sethia, who is taking over as Rob sails off into the sunset, will also find that Pat Magee is a much cheaper President! GNER has a lot to answer for! Graham Cooper has revolutionized the meeting and one delegate has told me that the Society meeting has, in his opinion, the best papers of any he attends – and it was not Graham! I have also been told that this meeting is the most relaxed and friendly – another important factor in delegate satisfaction. This was however, after a very impressive President's dinner so must be treated with caution!

The second group to whom I must pay tribute is my colleagues at Freeman. Without them relieving me of many of my clinical and local duties, dealing with the demands of the Presidency would have been very difficult indeed. I just hope that they have left a small corner for me to work in and that they do not feel I am superfluous! Finally I should also mention the two women in my life, Helen, my wife and Isobel, my secretary. Without them to support and organize me I would

not have made it through the last two years. Helen has not only had to manage without me on my many trips to London, but has also had to cope with my amateur attempts to run my life on my laptop! I think the frustration I have experienced with computers is only matched by the stress my bad language has caused her!

Finally, I have been honoured to be your President and I wish the SCTS well for the future. I am sure that the new regime of James Roxburgh, B Sethia and Pat Magee will ensure it goes from strength to strength.

Colin Hilton

President

2002-2004