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Perspective Article

Dinosaurs to Fossils. What Wiped Out the Heart Surgeons?

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Back in the late seventies, I had gone to medical school with a view to becoming a general practitioner (GP) but it was during my student placement on cardiac surgery that things changed. It must have been an impressive placement because one of the other students on the firm with me went onto become President of the Society of Cardiothoracic Surgeons.

The landscape in surgery was much different then and British cardiac surgery was still in its infancy. Many of the thoracic consultants (as our specialty was known back then) had done their training at the old TB sanatoria and were adept at lung surgery but the heart was a whole new ball game. Many of these thoracic surgeons had taken to valve surgery during the advent of the bypass machine. Coronary bypass surgery with its requirement that the surgeon should have microsurgical skills was yet another frontier. When Dr. Favaloro developed this technique in the Cleveland Clinic, USA, a new set of skills had to be learned including microsurgery involving vessels no more than two or three millimeters in diameter. The UK was light years behind the revolution in America.

This gap allowed for a new qualification to come into the lexicon: The BTA (Been to America). The young registrars had seen and read about this new American Revolution in cardiac surgery and they set off for the New World with the zest of the Pilgrim Fathers. They invaded centers like The Cleveland Clinic and The Texas Heart and there they absorbed as much as they could. The pilgrims all came back carrying varying levels of proficiency and were taken on quickly into the consultant brotherhood. The resulting explosion in coronary artery surgery made many of them millionaires as London became to the go-to place for the treatment of ischemic heart disease. My then chief had a ten-car garage with wall to wall Ferraris, he shared his mechanic with Nick Mason of Pink Floyd. These men were the rock stars of the medical profession. My dreams of being a country GP were swiftly abandoned.

Fast forward thirty years or so and take a look at the profession of cardiac surgery in the current decade. Stephen Westby recently published a memoir. We have a specialty that is on the defensive, frightened of its own shadow, unable to persuade young British graduates to join cardiothoracic training programs and a specialty that seems to be foundering. How did this happen?

My understanding of a possible answer can be distilled into just a few observations. The first being that the pioneering nature of individualism and personal courage is no longer at ease with the current Zeitgeist of how medicine and surgery are practiced. The second is the culture of introspection that has been taken up by the leaders of our specialty and the third being the failure of many surgeons to grasp the opportunities of limited access and hybrid surgery.

If one looks at the pioneers of cardiac surgery across the world whether it was Barnaard or Debakey there is a pattern of behavior that although not universal was prevalent. They were brave, imaginative, determined, visionary and undeterred by recurring failure. Many of these character traits would currently be labelled as arrogance or reckless. However, would we have achieved the astonishing results in cardiac surgery that we have now without them? The uncomfortable truth is that the millions of lives saved by cardiac surgery whether in valve, coronary, congenital or transplantation over the last forty years was built on the risks that those pioneers and society at the time took.

Modern surgery does not tolerate a learning curve. This brings me to the second observation. Unhelpful professional introspection. The tragic Bristol Children's Heart surgery scandal exposed the

NHS culture of silencing whistle-blowers. However, it further created a generation of leaders in the specialty who forced an unnecessary culture of introspection and fear. Despite multiple and loudly proclaimed mantra from the new specialty politburo that this introspection did not create a risk averse environment we all knew that tricky cases were avoided, and that innovation was suffocated and often frowned upon. Our specialty was told that 'soon every other medical specialty will follow us', but they did not. Most NHS Trusts have little idea how many orthopedic procedures are performed let alone the success rate. As for our principal competitors in the treatment of heart disease, the cardiologists, they have pressed on with largely unregulated interventions. They are the Rock Stars now.

The final possible reason for the fall from grace of the specialty has been also been largely self-inflicted. Every specialty in surgery has embraced minimal access or endoscopic surgery. When did anyone last have an open cholecystectomy or prostatectomy? Cardiac surgeons unlike their close relatives the thoracic surgeons have failed to notice that most patients do not want 'An operation'. When offered a needle stick in the groin or wrist compared to a median sternotomy the former seems far more appealing to the majority of patients. For too long the idea that what we do is too important and difficult to do through a small incision has been the attitude of the overwhelming majority of cardiac surgeons. Did they not notice that we were the only ones left who did open surgery? I started minimal access aortic valve surgery in 1997. These procedures are still only performed by enthusiasts with anxious colleagues watching on worrying that the 'figures' might be adversely affected. The same has happened with mitral surgery. The minimal access approach is certainly technically demanding but with training and practice (and a learning curve) it is safe and effective. We left the door widely open for the cardiologists to offer something more palatable. The general reluctance to nurture innovation has seen the specialty left behind by the aggressive approach by interventional cardiology and its associated financial backing by industry. In this whirlwind, we often forget that the results of cardiac surgery are much better for patients in the short and long-term compared with interventionist techniques.

So, what can we do to regain our pre-eminence in our profession? I suspect that our previous rock star status will never return but we still have something to offer. Young trainees need to learn catheter based techniques, the line between cardiologist and cardiac surgeon needs to be less clear cut. We need to get out there and explain that many of the procedures being offered by interventionists are un-tested and experimental and may not stand the test of time. We need to stop putting a noose around our own necks and giving it an extra tweak every now and again like penitent monks. We need to embrace some of the attributes that made cardiac surgery what it was but bring them up to date with modern attitudes. All is not lost just yet, young surgeons nowadays are just as willing to push the boundaries of what is possible as they ever were, they just need to be encouraged and enabled.