EXECUTIVE COMMITTEE

2013-2014

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In this Issues

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Scientific Program
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BRIDGE initiatives
Cardiac Surgery in the Developing World
Hello. I hope everyone has had a terrific summer to relax and recharge. This is just a brief update on some recent happenings affecting your society and a preview of what’s coming up.

The spring meeting of the CSCS was combined this year with the Association of Cardiovascular and Thoracic Surgeons of Quebec (ACCVTQ) Annual Meeting in June in Quebec City. It was a terrific meeting combining great talks with the opportunity to interact with our fellow surgeons from across the country. The talent we have in this country and how free and open the exchanges are at these meetings continues to amaze me. I know there is a lot of competition out there for our time but I do feel this meeting is one of the best places to truly cut through a lot of the hype and find out what the status of our specialty is and where it is going. Our Quebec hosts were wonderful, the food and camaraderie terrific.

We will be polling the membership about the future direction of the Spring Meeting. One option would be to hold it at different sites across the country, perhaps in conjunction with other meetings such as we did this year, in the hopes that more surgeons and trainees will be able to attend. We need your input.

Louis Perrault has organized a great program for CCC. This year we are fortunate to have Dr. Irving Kron join us as and he will be giving us a less formal presentation during Sunday’s CSCS dinner as well as the Bigelow Lecture. I think those of us who attended last year really enjoyed meeting Dr. Schaff and his presentation on some lesser known aspects of the Mayo Clinic. Dr. Kron is a highly regarded surgical educator, and like Dr. Shaff, a past president of the AATS.

Louis is completing his term as our Scientific Program Director and I would like to thank him for his hard work at putting together great meetings. Our format for these meetings keeps evolving and again we need your feedback to ensure we stay relevant.

This October will complete my 2-year term as President of the CSCS and I just want to close by saying what a great honour and experience this has been for me. The biggest surprise to me was the quality of the Spring Meeting and I regret I did not take advantage of attending it prior to the last 2 years. I am very optimistic about the future of our specialty and the CSCS. After many years of talking about it I sense that our younger surgeons, and some not so young, are developing true team approaches with their cardiology and vascular surgeons to the betterment of everyone, most importantly our patients. Our surgeons at most centres are integral members of the TAVI and TEVAR teams and are fully involved with even the transfemoral valves. The progress in VADS has been remarkable.

Louis Perrault will take over as President this October. We have tried to make the process of selecting members of the executive more open and democratic and I am delighted to see that we will have elections for a number of positions on the executive due to great interest, and nominations, from the membership. Most importantly for our future we have 6 nominations for our resident representative! That level of interest is terrific and we look forward to the vigour and enthusiasm that our trainees always bring.

Dave Ross
CSCS President, 2012-2014
This year, for the first time, the Canadian Society of Cardiac Surgeons decided to have their annual Spring Meeting joint with the Association of Cardiovascular and Thoracic Surgeons of Quebec.

The meeting took place June 5 and 6 in Quebec City at Auberge Saint-Antoine. More than 40 Cardiac surgeons from all across Canada attended, as well at 2 international speakers.

The success of the meeting has been ensured by the variety of subjects (TAVI, ICU, Valve replacement, Etc.) that were discussed at the meeting. The feedback from participants was very favourable and we conducted a survey of participants and non-participants following the meeting which indicated that there was support for future meetings of similar format and venue as we had this year.
The incoming Scientific Chair for next year will be Dr André Lamy from Hamilton. The meeting will be front-loaded until the end of Monday. We are pleased to present, this year again, amazing results in terms of submitted abstracts for the CSCS Surgery learning track. Taking a glance at last year’s wrap up, the number of abstract submitted has grown. A total of 118 abstracts have been submitted this year, and 77 of them have been selected to be presented. Throughout the course of the congress, there will be more than 10 sessions, including 6 oral sessions and 4 poster sessions. On Saturday morning, the Postgraduate Course is again a "do not miss" event featuring a mix of both Canadian and US experts such as Dimitry Davydow (Post-traumatic Stress Disorder in the Paradigm Shift in the Surgical Treatment of Type A Dissection) and Michael A. Acker.

(NIH/CIHR Network Projects: Update). There will also be a video session on Saturday night. We are looking forward to the Bigelow Lecture «Resident Mentorship» which will be presented by Dr. Irving Kron. He will also be giving a talk on University of Virginia at Sunday night’s dinner. As the Department of Surgery Program Director at University of Virginia Health System, Dr. Kron is a distinguished surgeon. Additionally, we are delighted to have received a great amount of nominations as of today to the Dr Paul Cartier Cardiac Surgery Resident Award. This award was created in honour of Dr. Paul Cartier, who was highly regarded as an outstanding Canadian Cardiac Surgeon. It is sponsored by the Canadian Society of Cardiac Surgeons (CSCS) and is presented annually at the Canadian Cardiovascular Congress. The award will be given to a Cardiac Surgery Resident who has made an outstanding contribution to the field of cardiac surgery through basic science or clinical research and who has demonstrated promise for a distinguished academic career in cardiac surgery.

Louis Perrault
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<th>Time</th>
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<td>11:00-12:30</td>
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<td>11:00-12:30</td>
<td>Oral: Transplantation / Basic</td>
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<td>CSCS Annual General Meeting and Luncheon</td>
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<td>16:30-18:00</td>
<td>Oral: Other / ICU / Education /Arrythmia</td>
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The CCC 2014 App is now available for iOS and Android

Make the most of your congress experience by viewing the CSCS programme and creating your personalized schedule on your phone.

Dr. Jennifer Higgins
2013 PAUL CARTIER AWARD

Be in the Know on the Go – Get the CCC App.
EXAMINATION BOARD REPORT

For the 2014 Examination in Cardiac Surgery, 15 candidates completed the exam, including 7 Canadian trained medical school and residency candidates (CMDPG). The examination was divided into an SAQ component that was comprised of 2 papers; each allocated 3 hours of exam time, and an oral question component consisting of 2 sessions of 90 minutes each. The total length of the exam is 9 hours. The average pass rate over the past 3 years for all CMDPG students has been 95%. There are 2 processes employed by the Royal College to ensure the exam is reliable and fair.

The first process is that of a Post-Examination Survey (PES), administered anonymously to all candidates at the end of their exam. Candidates rated the exam in several categories. It was then compared to a benchmark average for all candidates in all specialties who wrote a Royal College exam, and also to our past cardiac surgery exams. This year, 100% of candidates (vs. 76% for benchmark) felt the written exam was a fair assessment of their competence. This result was similar for the oral exam, where 90% (vs. 84% for benchmark) felt the exam was a fair assessment of their competence. As in previous years, most written comments were positive and constructive.

The second process is that of a Psychometric Examination Report (PER), in which questions are tested for their structure and outcomes. This report focuses on the final results, broken down by individuals and exam component. An item analysis report revealed that every question met the College’s standard, as measured by discrimination index. In other words, all questions were felt to be appropriate.

In the past 5 years, all cardiac surgery exams have been rated very favorably. Much of this credit must go to Richard Novick, who completed his 5 year mandate this past June. All of the exams led by Dr. Novick’s exam committees received positive reviews from the examination review committee, and also were rated highly by the examinees themselves. Dr. Novick should be congratulated for the devotion and leadership that he provided in developing the cardiac surgery exams. We are equally grateful to Drs. Nancy Poirier, Denis Bouchard and Andre Lamy who also completed their terms on the examination committee. This year, we welcome several new members to the examination committee: Dr. Stacy O’Blenes (Vice-chair), Dr. Michael Chu and Dr. Stephen Korkola.

All members of the exam committee strive to make the exam a fair evaluation of the competencies in cardiac surgery. Members devote many hours of their time to ensure the exam is constructed properly and that questions are relevant to our field. We hope and encourage all candidates to respond to the Post-Examination Survey at the end of their exam. Those comments are extremely valuable and have led to important changes in the exam structure over the past few years.

Marc Pelletier, Head, Cardiac Surgery Examination Committee
As a CTS trainee, the road is long and filled with moments of anxiety. Perhaps what stresses trainees above all else are: how am I going to pass my exam and how am I going to find a job. While these 2 events may at times feel like the final destination, they are merely the beginning of a long career. Over the summer and over the last 2 months as I am transitioning to being a staff surgeon, I had a chance to reflect over my 6 years of residency and 2 years of fellowship and offer some thoughts and advice.

You’re training to be a surgeon not a physician assistant and while, it is acceptable to be an information gatherer in the first months of residency, you want to become an information processor. Treat every patient like your own, formulate your opinion and plan before talking to the staff.

Like most surgical trainees, I loved the OR, while dreaded consults and especially clinics, however it is the latter that gives you judgement and most importantly, the feel for whom is not an operative candidate.

As a CTS resident, you are one of the most experienced and skilled physician in the hospital and are accustomed to taking care of sick unstable patients. Take the time to teach, especially the off service residents, students and nurses. While it may not be fun to take 45 min to teach someone how to put in a chest tube at night when it may only take you 15 min, they will respect you and be indebted to you. You may need their help one day.

I owe much of my knowledge and skills to my seniors Michael Chu, Basel Ramlawi, Robin Varghese, Darrin Payne and Scott McClure and always tried to teach and help my juniors. Your CTS residents are your family. Be the glue to hold everyone together, a rising tide lifts all boats. When the program is strong, everyone looks good.

Be aware of yourself and reflect on your strengths but particularly your weaknesses. Seek out feedback not just from your staff but also from your colleagues and those who report to you. Focus on improving your weaknesses. Be aware of how you conduct yourself in calm times but particularly in times of stress both in and out of the OR. You are the surgeon and a leader thus all eyes are on you. The tone you set will dictate how other will act around you. Give praise when deserved and be constructive when giving feedback on areas of improvement.

Anticipate potential problems at every step of the case: a dissection during cannulation, air embolus, can’t come off pump, fibrillating heart with AI during a redo sternotomy, etc. Rehearse them in your mind and think through how you will deal with them until it becomes second nature. If ever they occur in the OR, you may not have time to think clearly. This way, you are always prepared and can move ahead through a case with confidence.

Find what subspecialty interest you and pursue that interest but not at the neglect of all else. While your interest may be in percutaneous valves or mitral valve repairs, the job
you’re interested in may ALSO want you to do heart failure. Be versatile and be what Nasim Taleb call “antifragile.” Being a good clinician and technical surgeon will merely get you considered for a job. It’s what ELSE you can do that will distinguish you from the crowd whether it’s research, teaching, administrative, etc. Research is hard but your publications are your currency. I wish I had written more. In a period of flux and change such as today’s cardiac surgery environment, it is those with the broadest skill sets that are the most heavily recruited. Don’t train for today, train for the future. Your career will be 30 years long, and the operations done today may not be what you will do in 10 years. A wide skill set will ensure that you can evolve.

Finding the right fellowship takes time. Start looking at least 18 months before graduation. Learn about different programs by talking to previous fellows. Assess where you are on your learning curve: do you need more repetition in doing routine cases or are you ready to focus on a niche subspecialty. Ask about the center’s volumes, the operative experience and the culture. Make sure it fits with what your personality and your objectives. Also, advanced fellowships in cardiac surgery do not have a match, and each program will have different time frames. Remember that most states and provinces require 3-9 months to get a license. If you are at all contemplating fellowship in the US, I encourage you to write your USMLE as early as you can in residency especially STEP 1, 2CS and CK as many states will require you to complete them before you can even apply for state license. You don’t want to be doing it in your final year while you’re preparing for your royal college exam. Talk with your staff about being your referee so they have time to prepare when program directors call them. A ringing endorsement from them will carry more weight than anything else.

On the job front, there are more jobs out there than you think as most are unadvertised and some are even created if they want you. Speak to your staff surgeons particularly ones who are well connected. Use your network and talk to other fellows and industry reps as they may be the first to know if center is interested in a specific technology and are looking for someone with a specific skill set. Be prepared to cast a wide net and write letters, speak to other surgeons at conferences. Get involved in various organizations and get your name out there.

Most importantly, remember that residency is a marathon, not a sprint. Stay healthy both physically and mentally. Your free time is limited so spend it wisely. Maintain your hobbies and your relationships.

Michael Tong
Areas of Focused Competence:
Numerous diploma programs have been presented to the College recognizing very specific areas of specialization. These diplomas are aimed at maintaining a high standard of care. An AFC was introduced on Certification in Advanced Heart Failure and Transplantation. After some discussion the AFC is going to be presented in two parts - a cardiology based AFC and a surgery based AFC. The cardiology component will likely be enacted in 2015. The surgical component will be developed over the next year and will be the first AFC to come from our discipline.

Proposed changes to the Specialty Training Requirements in Critical Care:
A number of our trainees have pursued further training in Critical Care. Some Critical Care programs have permitted concurrent training which allows completion of the program with a single additional year following Cardiac Surgery. The Specialty Committee in Critical Care proposed changes that would eliminate concurrent training and would be fairly rigid in its structure. The Committee on Specialties overturned this proposal and subsequent changes to the Critical Care program will likely reflect the transition into competency based training.

Documentation:
The majority of documents that govern our training program were revised last year. Revision of the Specialty Training Requirements was completed this year and will become active in July 2014, and is now reflective of current surgical practice. The content of the six year program has been annually reevaluated and now provides very comprehensive training in the cardiac sciences. All programs in Canada have full accreditation. While the quality of training remains exceptional, concerns have been expressed with regard to:

- Heart failure, transplantation and mechanical circulatory support
- Pacemakers
- Interventional Cardiology
Competency by Design (CBD):

Following the positive results of the pilot project with Orthopedics at the University of Toronto, training in Canada will be moving towards demonstration of competency as opposed to a defined period of time. Our discipline is well suited to this and will be preparing to make the transition in the next several years.

CBD brings some challenges including methods and frequency of evaluation. The Specialty Committee appreciates that Program Directors are facing increasing administrative burdens and the transition to CBD will add to this. Therefore we have initiated the nationwide standardization of all documentation, including tools for evaluation. The first of these will be a series of “Encounter Cards” designed for the rapid evaluation of several CanMEDS competencies. The encounter cards will be available on an iPad and ideally as a phone app as well.

Canada is home to many recognized physicians, researchers, and educators. The committee is working towards organizing a nationwide lecture series that will be teleconferenced. This has been utilized at numerous institutions with great success. National lectures will decrease local teaching commitments as well as providing cutting edge education to our trainees. Depending on the teleconferencing package selected, lectures may also be made available as podcasts.

"Boot camps" are becoming popular and introduce new trainees to some of the basic technical skills specific to their specialty as well as common scenarios that they will encounter when on call. The TSDA, with Dr. James Fann, have been running a 2 ½ day program for several years with very positive feedback. A survey of residents demonstrates both a need and desire for such a program. A Canadian boot camp is being planned and we hope to see the first one held in the summer of 2016. Simulation will be a significant component of this boot camp and will become more central to all resident teaching in the years to come.

The Royal College, in contrast to previous years, is becoming involved in manpower planning. Drs Chris Feindel and Maral Ouzounian have published a number of papers on both our present and future manpower needs. The committee feels that the employment situation is improving in Canada but do not have data to support this. We will begin collecting manpower data and reporting this on an annual basis.
SEVEN QUALITY INDICATORS SELECTED FOR CARDIAC SURGERY

The Cardiac Surgery Working Group has selected seven preliminary quality indicators (QIs) to establish national standards for excellence in cardiac surgery. These QIs will be entering a web consult with (CCS members and the cardiovascular community.

The 11-member Working Group consists of cardiac surgery experts from across Canada, representatives from major cardiovascular registries and an observer from the Public Health Agency of Canada. It is chaired by Dr. James Abel and vice-chaired by Dr. Ansar Hassan. Over the past year, the working group has selected the following preliminary quality indicators:

1. 30-day risk-adjusted mortality for coronary artery bypass grafting (CABG)
2. 30-day risk-adjusted mortality for aortic valve replacement (AVR)
3. 30-day risk-adjusted mortality for AVR and CABG
4. Risk-adjusted hospital CABG postoperative length of stay
5. 30-day risk-adjusted stroke/cerebrovascular accident after CABG
6. 30-day all-cause readmission rate after CABG
7. 365-day readmission for cardiac diagnosis (myocardial infarction, unstable angina, congestive heart failure)

The seven preliminary cardiac surgery QIs are now being reviewed by three other BRIDGE committees. After this review, the QIs will be subjected to a 30-day web consult with the CCS and cardiovascular community. Anyone with feedback regarding the preliminary QIs is encouraged to share their thoughts with the Working Group.

A new working group, chaired by Dr. Anita Asgar of Montréal, has been created to develop data definitions and quality indicators for transcatheter aortic valve implantation (TAVI).

The 12-member committee of TAVI experts established terms of reference for their contribution to BRIDGE (Benchmarks, Research, Innovation and Data Generate Excellence). They expect to complete the data definitions and select relevant quality indicators by March 2015.

"While TAVI is a relatively new field in cardiovascular care, it is a rapidly expanding one, in which Canadian experts have been world leaders. Our committee's work will help ensure we establish standards of excellence across Canada," explains Dr. Asgar, who is an interventional cardiologist working at the Institut de Cardiologie de Montréal and the Director of its Transcatheter Valve Therapy Clinic.
Membership Update

Membership this year has decreased slightly from 2013. Based on preliminary data the CSCS represents close to 85% of cardiac surgeons in Canada.

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At present, we have 12-15 cardiac surgeons, 20-25 cardiac anesthetists and 5-10 perfusionists across Canada that have expressed interest in helping out. The plan is to have 2 of each category, plus support staff, go out on missions for 10-14 days once a month to help with surgery as well as teaching the locals so that the locals can have their own program in place within the next 5 years. Individual would likely only travel once per year and only when it is safe to do so.

The leadership at the Cardiac Center of Ethiopia (in Addis Abada) is very interested in our help. They have good infrastructure and missions currently going every few months. The organization – Canadian Humanitarian has good support systems and personnel living in Addis that would work with participating surgeons. Expenses for the missions can also be made tax deductible.

In order to get registered with the Ministry of Health in Ethiopia, the following are required:

1. Curriculum vitae for each member
2. (Notarized) Degree/Diploma/Specialty training certificate of the members
3. (Notarized) letter of Minimum of two years’ work experience
4. (Notarized) Updated License to practice
5. Letter which states Proficiency in the English Language
6. Medical Certificate of each individual member of the team (mental and physical health)
7. Two passport sized photographs
8. Letter which states good social standing of the team members.

Thank you to everyone that has already expressed an interest. Individuals can forward me their questions or information via email (rizmanji@shaw.ca)

Rizwan Manji MD PhD FRCSC MBA
Winnipeg, Manitoba

Contact us:
CSCS@CCS.ca
222 Queen Street – Suite 1403 – Ottawa, ON – K1P 5V9
(877/613) 569-3407 ext.417