



## PRESIDENT'S REPORT

*Sir Bruce Keogh*

At our annual meeting in Manchester this year the President of the Royal College of Nursing observed that in the face of the current barrage of NHS reform the only constant was change. In my presidential address entitled, "A decade of immunisation through engagement", I gave an account of how, through the Society, the specialty had effectively immunised itself against "external micro management and political interference through deliberate engagement". In this article I will look forward to some of the challenges that that are likely to emerge over the coming year and argue how in an increasingly competitive and regulated environment these can be used to enhance a number of our initiatives.

### **Payment by Results**

In England we have been grappling with Payment by Results in which our institutions receive payment, based on a national tariff, for different procedures. The Department of Health have announced the next step – "Pay for Performance" (P4P), unashamedly copied from the US. This attempts to relate clinical outcomes, quality and incentives by linking reimbursement to clinical outcomes and other measures of clinical quality. The initiative will first be piloted in the North West of England and will likely be rolled out in April 2008. In the US the STS have worked proactively to define a set of outcome and process measures of quality to ensure that the specialty is in the driving seat. The resultant statistical methodology of a balanced scorecard combining weighted process and outcome measures is described in a supplement to the April edition of the *Annals of Thoracic Surgery*. These measures have been adopted unchanged by the piloting North West SHA in England. CCAD provides a facility whereby this could be rolled out with little difficulty. It is, therefore, absolutely clear that we must now reinvigorate our National Cardiac and Thoracic databases. We have the opportunity to move away from blunt



measures of mortality towards measures of best practice and long-term survival. This is an opportunity to inform our patients better and enhance further the reputation of our Society and its members.

### **Professional Regulation**

Similarly, Dame Janet Smith's fifth report on Shipman stimulated a review of professional regulation which was commenced by the CMO at the beginning of 2005. In both the initial report and the recently released parliamentary white paper published in February, our Society has received considerable credit and positive publicity for our professional approach to performance review. We had seen this coming and had gained approval from The GMC in 2001 for our own data to be used for members' revalidation. This has been reinforced in the white paper and our leadership has underpinned the principle which will be enshrined in legislation that specialist associations should be responsible for setting the standards for revalidation and the process will be administered by the Royal Colleges. Mr Patrick Magee is chairing our "Revalidation Working Party" for the Society. The membership includes Sir Donald Irvine, past president of the GMC and Angela Coulter CEO of Picker Europe, who not only provides a lay perspective, but is also on the board of PMETB.

There is a simple truth that improvement is always associated with change but change is not always associated with improvement. However, change is both inevitable and unstoppable. Thoracic surgery has had to face clinical change head on. In the 1980s and early 90s thoracic surgeons tackled the threats and opportunities offered by emerging minimally invasive philosophy in the form of VATS. With help from the NHS Cancer Plan published in 2000 they have developed effective MDTs across the nation which provides a unique international model.

### **The decline of Cardiac Surgery?**

Until recently cardiac surgery had enjoyed unparalleled expansion as the demand for effective cardiac revascularisation exploded. But four issues have conspired to erode the growth of coronary surgery. Firstly, patients do not want operations if there is another alternative; secondly, over-the-wire and stent technology has dramatically improved the safety and efficacy of percutaneous coronary interventions; and thirdly, the cardiologists, who themselves offer an alternative treatment are the gatekeepers of surgical practice. Finally, improved pharmacological treatment in the form of statins and better antiplatelet therapy has resulted in more effective plaque stabilisation and reduced progression of disease before patients are ever considered for surgery. The end result has been a dramatic reduction in coronary surgery around the world. However, evidence is accruing that alternative percutaneous revascularisation strategies have not achieved their promise. As a specialty we are founded on robust clinical evidence and many are feeling disquiet at the unbridled expansion of alternative strategies based at best on an incoherent evidence base.

We must not, under any circumstances, be seen as Luddites, as a specialty paralysed by the glare of innovation and progress, as a Society running scared. But we can, and must, legitimately review emerging evidence, not only in the interests of the future of the specialty but also as professionals, as doctors, as informed guardians of the public interest. In the CMO's recent report "Waste Not Want Not" he highlights that "both under use and over use of treatments are rife in this and most other countries and are enemies of effective healthcare". It is our job to engage in debate to find a balance without stifling innovation.

Some commercial and special professional interest groups are conspiring to pervert the course of this honest debate. But we must not engage in the politics of protectionism where principles of honesty, integrity and are sacrificed on the altar of professional and commercial self interests.

We must retain our sense of scientific enquiry and honest analysis. We must strive to be impartial. We must thank Professor David Taggart with his talents for forensic analysis for bringing this debate to the boil in an increasingly widening arena. Angioplasty is here to stay. It is a good technique but the indications need to clarify, mature and stabilise.

In the 1980s we were complacent. Because there was such a demand for surgery we failed to learn percutaneous techniques. The vascular surgeons watched and learned from our failure. Are we sleep-walking into the same mistake again - this time with valves?

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### **Coming of age**

Percutaneous pulmonary valve implantation has come of age. Now, the aortic valve arena is hotting up. The issues surrounding embolisation and coronary occlusion are rapidly being eliminated. Paraprosthetic regurgitation is being tackled. It is clear that in terms of valve orifice area the percutaneous valves, which do not have a sewing ring offer a significant advantage. Flexible metal valves, biodegradable metal stents and other remarkable technologies coupled with shareholder and other interests will drive this forward. Should we learn to do this before it is too late?

Finally, congratulations to the congenital surgeons and cardiologists for developing a unique website of procedural outcomes and for grasping this very prickly nettle. (see <http://www.ccad.org.uk/002/congenital.nsf/vwContent/home?Opendocument>)

# Secretary's Report

James Roxburgh

"Vote early and vote often". Patrick Magee has often told me that this is the basis of a good democratic process! As always I listen to the wise words of our former President and I'm sure he will be pleased that the new voting system for the elected members of the Executive (Trustees) which is based on proportional representation at least allows you to "vote often"! However as I write this article only 44% of the membership had voted and the closing date has been extended by a week to allow for late returns. Voting early has never been a strong point of our elections but I hope that the new e-mail server that we have installed in the office will improve our communications with the membership and make it easier for us to deliver gentle reminders!

The increasing problem with spam e-mails has had a major knock-on effect in terms of our ability to rapidly e-mail the whole membership. The various filters and blocking systems have meant that we have been forced to send out e-mails to the membership in aliquots of 10. This is obviously an inefficient and very time-consuming process and over the last six months has significantly impaired our ability to communicate rapidly with the membership. The new e-mail server will allow us to send out bulk e-mails to the membership in one go. However since Isabelle and I have to write these e-mails I can assure you that there will not be a deluge of e-mails now that we have got a new toy to play with in the office.

The Annual meeting was very successful and as always there was considerable debate on various aspects of data analysis, presentation and publication. A considerable amount of time was spent, quite correctly, on debating the various mechanisms of performance monitoring for internal

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*At the Annual Meeting a considerable amount of time was spent, quite correctly, on debating the various mechanisms of performance monitoring for internal professional review and external publication.*

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professional review and external publication. If the specialty has in place appropriate mechanisms to allow surgeons to be alerted if their performance, or that of their unit drifts, away from the accepted range then we can act before outliers appear in the Public Portal. This is a complex topic and highlights the fact that nowadays data collection and analysis can no longer be managed by an individual. I have therefore decided to collate all the various talks, presentations and documents relating to all aspects of data collection and analysis into a single reference source that will form the basis of the Society's data policy over the coming years. I hope to have the first version out for consultation in the next few weeks and the definitive publication should be released in the autumn. In addition the new structure of the Society will allow me to set up a system that ensures that no one individual is responsible for the whole process.

The Annual meeting also agreed to the new representational system for the Society and the June Executive meeting will be devoted to developing the rules and regulations for this. These will be confirmed at the September Executive meeting, with the anticipation that the process in place for the first representational meeting in November 2007. This is an enormous change for the Society and it is absolutely certain that we will not get it right first time, we all have to accept that minor and even major modifications to the process may be required.

Finally, I step down as Secretary of the Society at the end of the 2008 Annual Meeting. The process for the selection of my successor is guided by the Constitution but the first step is to elicit expressions of interest from those eligible to stand. This will be done by e-mail in early July, the applications are considered by the Trustees and in the result should be announced in the autumn.

# The MTAS Disaster

*Steven Hunter, Cardiothoracic Dean*

I was pleased to see a good attendance at the meeting in Manchester although I would like all trainees to attend the annual SCTS meeting. It is a great opportunity for the trainees to air their views. Not surprisingly there were concerns about future consultant posts and future training posts.

There continues to be a steady number of consultant posts appointed each month but still less than the number of trainees with CCT. This means that the competition for each post is fierce. This is seen as an advantage to the employer as the choice is wide as it is a “buyers market”. As I have said in previous articles the CCT holding trainees need to pay attention to all areas of their curriculum vitae in order to make themselves the most employable candidate. I am constantly amazed to find many senior trainees have not had their curriculum vitae reviewed prior to applying for consultant posts. It is worthwhile asking consultants and managers their opinion on the curriculum vitae well before an application; not only to find deficiencies that could be addressed but that the format and emphases are clear and easily interpreted. Each post has a person specification and if one wishes to be short listed ones curriculum vitae should contain all the “essential” requirements and a significant number of the “desirable” requirements.

By the time of this publication there should have been appointments to ST3. However I think it unanimous that the MTAS process has been a disaster. The person specification and weighting for the current ST3 appointments did not resemble the weightings suggested by the SAC and since it was heavily biased towards research and academic achievements it was against the original ethos of MMC. We still have the ambition to run national appointments for the 2008 round of ST2 and ST3 posts, which I hope will prevent repeating the fiasco that was created by the 2007 round of appointments. There inevitably will be a large number of junior doctors who have been in our specialty for a number of years and yet cannot and will not acquire a NTN. The only posts available will be either LAT posts or trust grade posts. Progression to the specialist register will be possible but almost certainly take much longer than a NTN. The regulations for sitting the specialist examination are changing and currently require three structured references. The route to the specialist register requires a CESR (Certificate of Eligibility for the Specialist Register) and then application through PMETB (Postgraduate Medical Education and Training Board) and article 14. The competencies outlined in the curriculum will be the standards by which these article 14 applicants will be judged against.

As always I can be contacted by email at [Steve.Hunter@stees.nhs.uk](mailto:Steve.Hunter@stees.nhs.uk).




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# Back to the Future?

Chris Munsch, Chairman SAC

## **Fiã`scõ**

*n. Failure or breakdown; ignominious result*

The editor, in his wisdom asked me to say a few words about the MTAS fiasco, but in a rapidly changing scene, the article would be out of date before hitting the press. Instead I thought it appropriate to revisit our own position on MTAS and MMC. The following is a précis of the paper I submitted to MMC in April 2006 in response to their request for consultation on the selection process. The paper was drawn up following discussion at the SAC, at the Executive, and in open forum and the SCTS ABM in Dublin. I believe it accurately represents the position of the speciality, and has been resubmitted to the Tooke Inquiry.

## **Selection and Recruitment into Cardiothoracic Training**

- Close examination of these proposals, and benchmarking them against current thinking in selection methodology, shows them, in our opinion, to have serious shortcomings in terms of reliability, validity and utility. We feel the proposals as presented are not applicable for selection into a surgical speciality. We recognise that they may be relevant to non-surgical specialities where generic rather than specific attributes are valued, and may, with appropriate modification, form the basis of a selection process into the generality of surgery.
- Cardiothoracic Surgery is in an isolated and vulnerable position. The speciality as a whole recognises the need for radical change. It is now proposed that only a very limited number of trainees (approximately 5 per year nationally) are enrolled into the speciality. In order that they subsequently meet the educational requirements of the curriculum, trainees will be considered supernumerary. A reconfigured workforce, consisting largely of surgical care practitioners and non-consultant career grade doctors, will in future assume the service responsibilities of trainees. Given this situation, selection into cardiothoracic surgery will continue to be speciality led and will remain absolutely specific to the needs of the speciality.
- We have abandoned our proposals for a speciality based programme similar to the neurosciences programme, as we have been unable to secure the involvement of the medical specialities



- Our research and experience leads us to believe that, with the current state of knowledge, selection into cardiothoracic surgery cannot and should not take place directly into ST1. There also is real worry that early and ill-informed selection will produce a large number of failed trainees with no further opportunity to make new career choices and for whom the only remaining option for the rest of their lives will be a non training career post. (We could call this group 'The Lost Tribe'!)
- We are convinced, instead, by the arguments for generic surgical training, and would make the case for a two-year generic surgical programme with selection into speciality at the end of ST2. Posts in cardiothoracic surgery would be available to ST1 and ST2 programmes for all surgical trainees, as the speciality offers an opportunity to gain valuable transferable skills.
- We make no apology if this sounds like reinventing BST. We have yet to hear a convincing argument against the concept of general professional surgical training, and after three years of debate we do not feel that anyone has put forward a better alternative.
- We defined some years ago the requirements for entry into Higher Surgical Training at ST3. We shall begin work to develop these requirements into a viable national selection process for our speciality at ST3

Needless to say our concerns were ignored by the politically driven juggernaut of MMC and what happened next is history. Nonetheless, this remains our position and fits in with the positions now taken by the ASGBI and the English College. It makes sense, it is practical, and despite what 'they' say it has worked in the past. If only things were that simple!



# 'Turf Wars' or Patient Choice and Informed Consent: The Need for Multidisciplinary Teams (MDT) in Coronary Artery Disease

David Taggart



I recently had the privilege of being invited to give a lecture on 'How do surgical techniques affect clinical outcome' at EuroPCR in a session entitled 'The surgeons meet the Cardiologists: Burning Questions in Coronary Revascularization'. EuroPCR is an annual interventional cardiology meeting which attracts in total around 12,000

delegates from around the world and, enticingly, the meeting was being held in the beautiful city of Barcelona. I was, however, apprehensive that our allocated session was not to be held in the main auditorium as part of the plenary session but in a smaller auditorium while several other sessions were also running.

The main meeting opened with a plenary session in an enormous lecture hall with an estimated audience of perhaps four or five thousand delegates. During this session an angiogram was shown demonstrating severe and complex four vessel coronary disease in a fairly typical patient. To my astonishment around three-quarters of the audience voted electronically in favour of stenting as the best treatment with only around 5% voting for CABG. A panel of around 15 well known experts on the podium endorsed PCI as the appropriate first line treatment with varying degrees of enthusiasm with the sole dissenting voice being Dr Jose Pomar who tried to suggest that perhaps surgery was the better option. He was heavily outgunned! In a similar plenary session in the afternoon entitled "The Great Debate" a similar angiogram

demonstrating severe coronary artery disease was discussed by a panel of five experts which included the views of an interventional and non-interventional cardiologist as well as a statistician but, most tellingly, no cardiac surgeon. The interventional cardiologist's lecture was full of erroneous facts but went completely unchallenged.

Even more disappointingly, at our surgical session there was an audience of perhaps around one hundred with only a handful of interventional cardiologists. To add insult to injury our session was opened by the famous interventionist Patrick Serruys, who after giving his twenty minute lecture disappeared to another meeting without hearing a single surgical presentation. So much for the title of the session, 'The surgeons meet the cardiologists'.

I simply re-count these related episodes because they seem to illustrate that there is no real wish from the interventional community to genuinely hear the surgical view point. Having a session for the surgeons at EuroPCR allows the interventional cardiology community to pay lip service to the notion of acknowledging the role of surgery in coronary artery disease while, in reality, holding the session in a side room during eight other simultaneous sessions ensures that few interventionalists will attend and that the surgical position will not be heard.

This reluctance to hear the surgical viewpoint or to offer patients access to a surgical opinion is, regrettably, an increasingly common position and flies in the face of the principles of evidence based medicine and informed consent. In several publications I have evaluated the totality of the evidence for stenting versus surgery in most multi-vessel and left main coronary artery disease. Two things become crystal clear (i) clinical practice has been actively distorted by randomised trials which were heavily stacked against the prognostic benefits of CABG by only including a tiny percentage of all potentially eligible patients and specifically those who were known to have no survival benefit from CABG (one or two vessel disease and normal ventricular function) and (ii) evidence from several large databases which consistently demonstrate the survival benefit of CABG in real-life practice, are ignored. A similar pattern of the distortion of clinical practice has been seen with Drug Eluting Stents (DES) where the results from pivotal trials in low risk coronary lesions have been applied to much larger populations with much more complex disease ('off label' use) leading to a marked increase, estimated to be between 1%-5% per annum, of stent thrombosis.

Compared to PCI, CABG offers a definite and consistent survival advantage, a marked reduction in the need for repeat

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Almost 80% of diagnostic angiograms are done on an elective basis - giving patients a few minutes to make what is possibly one of the most important decisions in their life is clearly not informed consent.

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## 'Turf Wars' *continued*

intervention and is a far more cost-effective treatment. The statement from some cardiologists that "there is no difference in survival between PCI and CABG", widely written in the literature and frequently stated in cardiology lectures (and most worryingly told to patients), is the most widely perpetuated myth in cardiovascular medicine. And the recent demonstration by Health Economists that while optimal medical therapy and CABG are cost effective treatments for the NHS, PCI is not and should have important messages for allocation of resources.

However, the concern, as clearly illustrated at EuroPCR, is that Evidence Based Medicine and economic arguments which favour of CABG in the majority of patients will be ignored as long as the Interventional Cardiologist remains the sole "gatekeeper" of the patient and surgeons are excluded from the decision making process. Already a similar approach has been established by some Electrophysiologists who rarely offer patients the option of surgical ablation of atrial dysrhythmias despite a much higher success rate than with catheter procedures (even after repeat attempts). And how long before interventionists decide that the inferior options of percutaneous repair of the mitral valve or replacement of the aortic valve should become the standard procedures without the need for a surgical opinion?

As suggested in the title of this article this issue must not be seen a 'turf war' but as dealing with the vital issue of patient choice and informed consent. Almost 80% of diagnostic angiograms are done on an elective basis and giving patients a few minutes to make what is possibly one of the most important decisions in their life is clearly not informed consent. My personal view is that real patient choice and informed consent can only be achieved by the use of MDTs. In most other areas of medicine the MDT approach is used to ensure the best and most balanced advice is offered and this should also be the minimum standard of care for patients with ischaemic heart disease. And it is not acceptable that the MDT approach should be used only for those patients whom the Cardiologist has pre-selected for discussion but, rather, for ALL patients. For example, when the strongest evidence shows that the best long term outcome for proximal LAD disease, in both medical and economic terms, is an IMA graft this should be offered as an option to appropriate patients. While many

patients will, understandably, prefer a less invasive approach that is informed consent

It behoves our Surgical Societies, in Asia, Europe and the USA, to take a pro-active and assertive stance to insisting on an MDT approach. The attitudes expressed at EuroPCR demonstrate that there is no real wish for such an approach from many members of the interventional community but no clinician, with the real interests of the patient 'at heart', could defend any other position. On a potentially encouraging note I have been invited to act as Special Adviser to NICE with regards to coronary revascularisation. With an appropriate explanation of the medical and cost effectiveness of CABG in comparison to PCI and the related issues of patient choice and informed consent perhaps NICE can be persuaded to recommend an MDT approach, as the 'minimum standard of care' for UK patients with coronary artery disease.

Another interesting approach used by Domenico Pagnano who organising a debate in Birmingham of PCI versus CABG invited a much wider audience than the usual surgeons and interventionists but most importantly the Health Commissioners who pay for the services. During the debate, data demonstrating that CABG is usually the most clinically and economically cost effective treatment as well as the need for MDTs to ensure patient choice and informed consent was considered to be an 'eye-opener' for the purchasers.



**Now remember what I told you. You have had informed consent involving a MDT.... My Drug eluting Therapy!**

# A Busy but Rewarding Year in Office

*Tara Bartley, Nursing Representative*



Having completed twelve months as the Nursing Representative and am glad to report that it has been an eventful and interesting year.

I would like to thank the regional reps for their support. They play a key role in disseminating information between their areas and myself. They underpin the

work that I do and are instrumental in reviewing papers for the nurses' forum at the Annual SCST meeting.

One of my first duties was to contribute towards writing the Nursing Representative bylaws, thus establishing a formal process of appointment to the position of Nursing Representative on the SCTS Executive. I have been part of a working group reviewing national guideline and standards for National practice and this is work in progress. I have been working with Steve Livesey, Consultant Cardiac Surgeon at Southampton to produce a document for the Heart Improvement Programme that has updated the original 'Exploring New Ways of Working in Cardiothoracic Surgery' (first published by the Workforce Review Team in February 2005). We explored models of practice and in particular those from the National Nurse Practitioner Programme, which has now sadly been disbanded. The Manchester Forum reviewed workforce planning and your comments were attached to the document that has been submitted to Sir Roger Boyle' National Director for Heart Disease.

Communication among the cardiothoracic nurses has expanded, developing links with other cardiac organisations, specifically the British Association for Nursing in Cardiac Care and The Paediatric Cardiac Nursing Association. I have written an article for the PCNA Bulletin and hope that we can share interests and practice. The nurses' web page on the SCTS site

remains open access and it is my intention to develop the information further with a plethora of protocols, presentations etc.

## Successful Nurses' Forum at Manchester

Attendance was good and the programme diverse and stimulating. We were delighted to have Maura Buchannan, President of the RCN deliver the opening remarks with Sir Bruce Keogh as chair. Maura talked about the unique art of nursing and how we should be proud of our profession. These thoughts were underpinned by the emotional comments from former thoracic and cardiac patients. We were privileged to hear their individual perspectives recounting their experiences of surgery and the hospital stay. Both talks served as a pertinent reminder of what the National Health Service is really about. We could be forgiven for believing that we are driven only by Government targets to achieve excellence within increasing economic constraints. Refreshingly both speakers highlighted that to patients service delivery is about just that, the way in which we deliver care. They lamented about the personalised care, the importance of a smile and one reflected on the reality of staff shortages and waiting for a dressing to be done. It speaks volumes that there is no substitute for being a patient to focus the ways in which the NHS should concentrate resources and development.

Manchester also provided the opportunity to share selected papers with colleagues. We had our first ever joint presentation session with the surgeons and within the Forum there was a disparate group of interesting papers. The Best paper was awarded to Helen Munday, Clinical Research Nurse from Papworth Hospital, Cambridge for her paper 'Talc Pleurodesis: doctor versus nurse led procedure. A prospective, randomised, multi-centre, pilot study.' Congratulations to Helen who received £200 from our sponsors Ethicon.

I will put the comments from the 'Membership' session at Manchester to the next Executive Meeting, as it is our intention to explore ways of increasing the Associate Membership at an affordable rate.

With this excellent foundation, I am looking forward to next year's SCTS Annual meeting and the Nurses' Forum, which will take place in Edinburgh. The Forum theme will be 'How Broad Changes in the NHS are impacting of the delivery of cardiothoracic services'. We will call for papers between September and November and presenters will be informed in December. I would encourage you submit an abstract and share your work with a friendly and receptive audience.

During this coming year I intend to conduct a national benchmarking survey examining current workforce patterns in the UK & Ireland and the strategic planning that is under way to

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accommodate the advent of changes that will come about as a result of the European Working Time Directive and Modernising Medical Careers. Hopefully, the data from this survey will answer the many questions that are being asked around the country and provide some direction for development of workforce patterns.

If you would like to submit an abstract for the forum or contact me on any other matter please email me at tara.bartley@ntlworld.com



*'Helen Munday – awarded Ethicon Prize for best paper'*

## Society Scholarships for Cardiac Surgery

*Pedro Catarino*

In July 2007 I will be taking up the post of Advanced Fellow in Cardiothoracic Transplantation at Duke University Medical Centre, North Carolina, under Carmelo Milano. This is supported by the Society scholarship for cardiac surgery.

I am in the sixth year of my training rotation on the East London program, currently at the London Chest Hospital working for Patrick Magee. I have always had a particular interest in heart failure. I was part of the team which performed the first series of Jarvik 2000 implants for destination therapy under Steve Westaby in Oxford. I went on to do laboratory research on the changes in gene expression in the mechanically unloaded ventricles of heart failure patients and was also involved in the preclinical testing of the Terumo implantable left ventricular assist device. I gained further experience in transplantation and in various forms of mechanical circulatory support for the short, mid and long-terms, while at the Royal Brompton and Harefield under Mario Petrou and John Pepper.

This post at Duke will allow me to complete and consolidate my training in the surgical management of heart failure. Duke performs 50 heart and 70 lung transplants per annum and 50 ventricular assist device implants, and is certified as a destination therapy program. This occurs against a background of 1600 cardiac operations and 1500 thoracic operations per year in an academic tertiary referral environment. During my time at Duke I also expect to benefit from exposure to the latest technology and research in the generality of cardiothoracic surgery, as well as an experience of a completely different model of healthcare funding.

My core interest will be mechanical circulatory support and I will have the opportunity to conduct research and publish in this field. On my return to the UK I expect to promote myself as a cardiac surgeon with a special interest in assist devices.

I also plan to seek to acquire the administrative experience and industry contacts in order to be able to establish and run an assist device service.

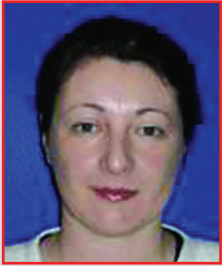
As part of my year in the United States, I will also take the opportunity to visit other centres, particularly the Texas Heart Institute in Houston and Columbia Presbyterian Hospital in New York, to maximise my exposure to different devices and technologies. All this would not be complete without my family (wife and 3-year old son) who will join me for a large part of my stay and with whom I anticipate discovering some of the non-medical aspects of North Carolina.

I am extremely grateful to the Society for awarding this Scholarship.



# Society Scholarships for Thoracic Surgery

*Juliet King, formally SpR West Midlands, Appointed Consultant at Guy's and St Thomas' Hospital NHS Trust*



I am both delighted and honoured to be awarded the Society Fellowship for Thoracic Surgery. This will support a six-month secondment in minimal access thoracic surgery at the Chinese University of Hong Kong (Prince of Wales Hospital) under the tutelage of Professor Anthony Yim.

The Chinese University of Hong Kong (CUHK), under the leadership of Professor Arthur Li, was one of the first institutions to recognise the potential of minimal access techniques in surgery. Having completed his training in the UK and the USA, Professor Yim returned to his native Hong Kong in 1992, and quickly established himself as an early pioneer of minimal access thoracic surgery, particularly VATS lung resection. He remains an international authority in this technique, and his philosophy is perpetuated by his trainees who undertake approximately 90% of all lung resections for cancer via VATS. The CUHK also possesses a Da Vinci Surgical robot which the thoracic surgery department has regular access to, and the International Symposium of Robotic Surgery is being hosted by the CUHK in June 2007.

Although my main objective is to improve my thoracoscopic surgical skills, I hope my time in Hong Kong will also expose

me to other aspects of thoracic surgery less commonly experienced in the UK. Lung cancer is an increasing problem in Asian populations, particularly non-smoking-related adenocarcinoma and bronchiolo-alveolar carcinoma. Professor Yim is also the only surgeon in Asia authorised for the insertion of endobronchial valves for emphysema. At the other end of the spectrum of thoracic disease, an old and currently resurgent enemy, Tuberculosis, is endemic here and I hope to gain new insights and experience in its management.

I would like to thank the Society for its generous support in the awarding of this fellowship. I would like also to acknowledge and thank the following for helping to make this fellowship a reality: Professors Yim, Underwood and van Hasselt at the CUHK, and Messers Rooney, Graham and Rajesh in the West Midlands. I look forward to presenting a summary of my fellowship at the Society Meeting in Edinburgh next year.



## SCTS Awards 2007

### **The Marian & Christina Ionescu Travelling Scholarship**

*Steven Rooney*

### **The Society Scholarship, Cardiac Surgery**

*Pedro Catarino*

### **The Society Scholarship, Thoracic Surgery**

*Juliet King*

### **Ronald Edwards Medal**

*J Finch*

### **John Parker Medal**

*D Healy*

### **New Executive Members**

The Society would like to congratulate **John Pepper** & **Jim McGuigan** for their success in the recent election as new members of the Executive.

# Interested in an Academic Career in Cardiothoracic Surgery?

*Domenico Pagano*

*Consultant and Reader in Cardiothoracic Surgery, Leader of the Walport Clinical Lecturer Programme*



The Academic Career Subcommittee for Modernising Medical Careers and the UK Clinical Research Collaboration have recently introduced academic training in the NHS. Two types of posts have been made available to various specialities: Academic Clinical Fellows (ACF) and Clinical Lecturers (CL). The

ACFs are essentially designed for doctors to receive training towards a higher degree, whilst the CLs are designed to provide further research and academic training to doctors who have obtained a higher degree. In November 2006 Cardiothoracic Surgery was identified as one of the specialty's that could benefit from this initiative and applications were submitted from various Units. In December 2006 the successful bids were announced and these included 2 CLs in Birmingham. All successful bids can be viewed on the internet at <http://www.nccrcd.nhs.uk/intetacatrain/index.html> We describe the Birmingham Programme for CLs.

The aim of our programme is to train two clinical academics in Cardiothoracic Surgery and therefore the training scheme is designed for individuals with a significant academic interest. This is a joint programme between the West Midlands Deanery and the University of Birmingham and will comprise of 2 posts as Clinical Lecturers. These posts have been designed to comprise a 50-50 split between academic and clinical training and are funded for a 4 year period. The 2 Lecturers will effectively job-share a clinical SpR post to provide a 1.0 whole time equivalent clinical training and service commitment.

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The academic components of the scheme have been designed by the Leader of the Programme in collaboration with Professor M. Frennaux (BHF Professor of Cardiovascular Medicine-University of Birmingham) and Mr T.J. Jones (Consultant Paediatric Cardiac Surgeon – Birmingham Children Hospital) and will run along 3 main stems:

1. Research,
2. Training Courses,
3. Medical Education.

Research will focus on myocardial substrate utilisation as part of the Myocardial Metabolic Research Group of the University of Birmingham. The Lecturers will be expected to contribute to the supervision of ongoing research activities, participate in writing grants proposals, manuscripts, lectures, analysis and presentation of data.

Core training in areas such as:

- a) clinical trials legislation
- b) advanced statistics
- c) epidemiology
- d) research ethics
- e) human tissue storage and legislation
- f) molecular biology techniques.

The training will take place in form of courses or attachments to relevant departments within the University of Birmingham.

Lecturers will be involved in teaching medical undergraduates from the University of Birmingham. A number of courses have been identified to develop training and educational skills of the Lecturer(s) from the extensive list of Deanery Professional Courses already available. The Walport Lecturers will be incorporated into the West Midlands CT Surgical Training Scheme for their clinical programme. The Regional Training Programme Director (Mr SJ Rooney) is the leader and coordinator of the clinical component of the scheme.

The academic and the clinical components of the scheme will be assessed jointly as part of the RITA process of the CT surgical training scheme. These appointments are outside the MTAS scheme as they are designed for current NTN/VTN holders.

# Revision of BUPA Lengths of Stay for Cardiothoracic Surgery

Graham Venn



In 2005 BUPA issued a new schedule of procedures incorporating the new CCSD codes and narratives. This incorporated anticipated lengths of stay (LOS) for some of the more common procedures. BUPA had anticipated this LOS data to represent uncomplicated patient stays. It became apparent from feedback from a variety of specialties that the LOS data was inaccurate, resulting in clinicians and their secretaries having to write and 'justify' stays longer than the BUPA anticipated stay. This process was tedious and time consuming.

In 2006 BUPA engaged the profession in consultation over the LOS issue using FIPO as the final portal for response to BUPA. The consultation period ended in September 2006. The Society for Cardiothoracic Surgery in Great Britain and Ireland was asked for input into the more common procedures with published anticipated LOS data in the BUPA schedule. We responded with data taken from the CCAD (cardiac data) and from the higher volume thoracic surgical centres to provide realistic LOS data. The large numbers of patients in our databases added significant weight to our own analysis. Pleasingly this has resulted in revision of many of the previous inaccuracies that are shown in the table below.

There remain errors in the new CCSD and BUPA codes, part of which are transcription errors from the old schedule. Examples of these are:

- L0110 Truncus Arteriosus is mis-banded and should be a CMO5

- L2200 is not abdominal aorta but was aorta 'unspecified.'
- L2382 Aortic Root Replacement is mis-coded / mis-banded and should be CMO 5 on both surgical and anaesthetic counts
- K2580 previously uplifted at £2400 following the re-banding exercise performed in 2003 and has been wrongly transcribed back to a CMO5. The anaesthetic banding also needs checking.

There are others that need revision.

The review process above has formally finished but BUPA have an on-going process for reviewing additional consultant comments about complexity coding and seek feedback at [schedule@bupa.com](mailto:schedule@bupa.com). Any queries regarding length of stay, particularly as practice changes, can be sent to [lengthofstayreview@bupa.com](mailto:lengthofstayreview@bupa.com). Any feedback relating to the codes and narratives of existing procedure codes or requests for new procedure codes are being co-ordinated directly by The Clinical Classification and Schedule Development Group (CCSD), a group consisting of representative from six private health care insurers. CCSD can be contacted via The CCSD Manager, c/o Westhill Consulting Limited, Amadeus House, Floral Street, London WC2 9BT. I suggest that rather than members responding directly to BUPA and CCSD, comments should be sent directly to Isabelle Ferner at the Society office at [sctsadmin@scts.org](mailto:sctsadmin@scts.org) so that we can produce a co-ordinated response.

## Revised BUPA Anticipated Length of Stay Data

Procedure Code	Narrative	Previous anticipated LOS	Revised anticipated LOS
E5180	Diagnostic bronchoscopy and biopsy	Day case	Day case
K2540	Replacement of the mitral valve with sub-valve preservation	7	8
K2542	Replacement of the mitral valve – redo operation	7	9
K2580	Repair of the Mitral Valve	7	8
K2600	Replacement or repair of the aortic valve	7	8
K2612	Replacement of the aortic valve with a homograft or stentless prosthesis	7	8
K2612	Replacement of the aortic valve with a homograft or stentless prosthesis	7	8
K2613	Replacement of the aortic valve – redo operation	7	9
K4100	Bypass for coronary artery(ies) including harvesting of grafts and endarterectomy	6	8
T1240	Insertion of tube drain into the pleural cavity	1	Not specified (heterogeneous group)

# Clinical leadership course – Stratford-Upon-Avon – April 2007

*Malcolm Dalrymple-Hay*

The society recently sponsored twelve delegates to attend a two day clinical leadership course. The programme was jointly developed by Rothwell Douglas and the Society and therefore had the significant additional benefit of focusing on issues pertinent to cardiac and thoracic surgical practice in the modern era. Rothwell Douglas is a team of occupational psychologists, business psychologists and management development specialists who have over 20 years experience in both public and private sectors. Over the last decade they have carried out extensive research into contemporary leadership and best practice management. They have a clear understanding of the importance of people development to bring about organisational change.

The faculty included a partner of Rothwell Douglas, Carol Rothwell and Conell Platts an independent consultant. They both work in today's rapidly changing NHS environment with acute and primary care trusts as well as strategic health authorities. They also specifically act as individual coaches to chief executives and other senior staff in both the NHS and private sector. Three senior Cardiothoracic Consultants supported the faculty, who have extensive management experience at clinical director, divisional director and associate medical director level as well as holding several national positions.

The course was organised into a series of discussions and workshops rather than didactic lectures. The discussions were well structured to guide delegates around different leadership and change issues but the subject matter arose from the discussion and was therefore selected by the delegates and almost entirely cardiothoracic in content. As the discussion developed there was complete flexibility of content and direction. This encouraged all the delegates to get involved, which ensured they had a good handle on the subject matter and they were not short of opinion!

The workshops were used to explore the implementation of the techniques that were introduced in the discussion. The scenarios were based on a mixture of examples that had occurred in clinical practice and other fictitious examples that were intentionally difficult and controversial. The workshop groups were continually changed which ensured we were all challenged with different styles.

The 2 days started with an analysis of the components of good leadership versus those of clinical expert or manager. Specific attention was paid to developing listening skills and we

discussed our thoughts on leadership in the present NHS environment.

The remainder of the first morning was spent exploring the use of analytical tools to aid problem solving. We discussed the application of techniques such as root cause and fishbone analysis to encourage collaborative problem solving.

Much of the first afternoon was used to discuss managing clinical performance, how to get the best from yourself and others, and dealing with your clinical leadership qualities as performance coaches; using skilful questioning and genuine listening to improve your leadership qualities. As part of this we discussed the concepts of situational leadership, which offered valuable insight into the different styles required to be an effective coach or leader. We discussed these different styles and their appropriate application to various situations. A workshop and demonstrations of them within scenarios was particularly challenging and enjoyable.

We finished the first day discussing appraisal and ways that this could be used to improve performance. Within this context we all developed and practised techniques for difficult meetings. This gave us valuable insight into the planning of a difficult meeting and the ways into a conversation that may be uncomfortable for both parties. We explored how different techniques and structures of meetings result in a variety of emotions and outcomes. This prepared us not only for appraisal as an appraisee or appraiser but also for 360-degree appraisal. The workshop consisted of real life past and present cardiothoracic issues, which we used to practically demonstrate these techniques.

The second day was concentrated to a greater extent on change management. Attention was paid not only to the physical consequences of change but also to experiencing the emotions of change. We discussed the multitude of reasons why change in the NHS is sometimes so difficult to initiate. We spent long periods discussing the frequently encountered problem of resistance to change. Several of us were conscious of our inability to direct a meeting or exert change in the direction we intended and therefore we specifically addressed the issues of how to engage, influence and deal with resistance. This included discussing the requirements to bring about a collaborative approach and produce a critical mass



*Continued on next page*



## Clinical leadership course – *continued*

that allows change to occur. Where possible this was linked to the situations we all frequently face today.

We all enjoyed developing skills to deal with conflict management. We discussed the requirement to adopt a balanced view of conflict that allowed us to recognise its value and limit its potential for destruction. This was done by recognising both the positive and negative elements and taking what is appropriate from each. This requires a collaborative approach to negotiations which we subsequently practiced in workshops introduced around issues of conflict.

The two booklets that accompanied the course are full of useful thoughts and techniques as well as reference material.

They contain a certain amount of jargon and management speak but this is kept to a minimum. They describe a number of aids and techniques which will be useful as we individually develop our relationship with medical and managerial colleagues in our own trusts and have already proved useful.

The real test of any course of this nature is to see if the delegates find it useful in the future. We spent two challenging days reflecting a lot on our own personal style as well as that of fellow delegates. Ultimately changing one's approach is the challenge. The course provides a useful insight in a very constructive cardiothoracic environment. The aim was to provide useful aids for turning talk and good intentions into effective action – only time will tell.

## Quality Accreditation and Data Validation

*Mark Jones*

Following the introduction of the Quality Accreditation Programme, by Sam Nashef in 2000, there were 7 units which were accredited and certificated under this scheme. There was subsequently a lull in interest until discussions about public disclosure of unit and surgeon specific outcomes led to regular audit leads meetings and a further 7 units being visited. The purpose of these latter visits was to benchmark systems for data collection and validation, and to emphasise deficiencies in units to help obtaining resources for infrastructure - aspects of governance were left to individual units. Data Quality visit reports are available on the Society home page along with a model for best practice in data validation. It was originally anticipated by the Society that all units would be visited.

With time, however, it seems there is more understanding and familiarity with the process of cardiac surgical data management. Data submission to CCAD and its subsequent presentation on a public portal, emphasise the importance of completeness, accuracy and validation of data. There's no doubt that publication of outcomes on the Health Commission website is a potent driver to improving systems and thereby data quality. On the SCTS home page there is a model for best practice in data validation under quality accreditation.

A mechanism for undertaking Data Validation visits still exists and I would be pleased to hear from any units which feel they would like to pursue this ([mark.jones@smuht.nwest.nhs.uk](mailto:mark.jones@smuht.nwest.nhs.uk)).



## NCEPOD: in the Home Straight for CABG Study

*Steve Livesey*

- The period under study (April 2004 – March 2007) ended on 31 March.
- All first-time CABG death should have been reported to NCEPOD by 16 May 2007 – if you have missed this deadline please file a late report as soon as possible.
- Questionnaires must be returned by 26 June to enable the last round of matching and generation of control cases to occur.
- **Return rates are still too slow** – please help now as this important study is drawing to a close.



# Annual Meeting Report - Manchester 2007



*Susan Briffa, Medical Journalist*

**Manchester was the host city for this year's Society Annual Meeting, and once again saw a record attendance of over 350 delegates. The venue for the conference was the Manchester International Conference Centre, sitting alongside the familiar setting of the Greater Manchester Exhibition Centre. This location had seen the Labour Party conference just a few weeks earlier.**

The journey to the north west of England proved a little less fraught than last year's journey across the Irish Sea in a terrifying snowstorm. Transporting several tons of audiovisual equipment is no mean feat, made somewhat easier by Manchester's accessible network of motorways.

Manchester is an ideal setting for such a conference, with a myriad of cosmopolitan restaurants – many of which were sampled by the delegates.

Most attendees drove into Manchester, nearing a very odd-shaped building at every turn. The building turned out to be the new Hilton Hotel, a landmark on the city's skyline since October 2006. The hotel occupies 23 floors of the 47 storey asymmetric Beetham Towers on Deansgate.

By Sunday afternoon the conference centre's main auditorium was taking shape, with the familiar Society emblem as the dramatic backdrop. The podium would, over the following days, accommodate many renowned speakers who would discuss the past, the present, and the future of cardiothoracic surgery in Great Britain and Ireland.

The welcome reception on Sunday evening was an opportunity for delegates to enjoy a glass of wine and a chat with fellow clinicians. This was held in the conference centre, and brought together people from around the United Kingdom and further afield.

Society Nurse Representative, Tara Bartley, coordinated submissions for Health Care Professionals, which produced some very interesting and thought provoking talks. Tara has wished for the forum to be a meeting to disseminate information, and this was certainly achieved. There was also a distinct move to the integration of roles between the different disciplines. Enthusiastic discussions followed every session, with many of the delegates exchanging details and emails in order to follow-up ideas. This has led to visits from individual professionals to other centres around the country, and Tara must be proud that already her intentions are being realised.

During the Business Meeting on Sunday, proposed changes to the structure of the Society were met with overwhelming enthusiasm. The changes include creating a new executive membership, with a secondary representative board.



## Annual Meeting Manchester 2007



Sunday also saw the very well attended trainees meeting. With junior doctor training very much in the public eye at the moment, they were particularly keen to hear of the Society's vision for the future of cardiothoracic surgery. Despite the media presenting a somewhat bleak outlook for the future of doctor training, applications for cardiothoracic surgical training currently stands at an incredible 50:1.

James Roxburgh talked of the introduction of the new e-Logbook. The software for this groundbreaking tool will soon be available, and will have the ability to break down each clinical procedure into its constituent parts. Trainees will be able to access their individual logbook for any centre.

Honoured Guest Speaker, Dr Fred Grover gave a stimulating presentation which prompted a provocative debate. Dr Grover, immediate past President of the STS, focused his session on training and the problems facing cardiothoracic surgeons all over the world. He highlighted the fact that whilst opportunities for UK trainees are plummeting, in the USA there are reducing numbers of takers. Trainee Representative, Farah Bhatti, enquired if this might lead to an opening for British trainees to fill the places in the USA. Dr Grover felt this was something worth exploring.

Guest speaker Terry Hubball is a mountaineering instructor gave a most incredible talk on his experiences, using them as an analogy to illustrate the teaching of complex skills in a high-risk environment.

Later on during the week, invited speaker Sir Donald Irvine, along with Alan Wood, Head of Manchester Police Firearms Unit, gave possible approaches to revalidation in cardiothoracic surgery. Ways of formulating a robust structure were discussed during this session.

Society President, Professor Sir Bruce Keogh gave his Presidential speech on Wednesday afternoon, where he spoke of the increasing profile of the Society, as well as the challenges ahead. Surgeons have largely embraced the publication of surgeon specific results, and despite the publications, standards continue to increase, and British surgeons remain among the best in the world

Once again the quality of presentations from all the contributors was truly outstanding. Clinicians attended from Great Britain, and all corners of the world to address delegates of the Society. Valuable and interesting discussions followed every session.

This year also saw an amazing record number of exhibitors. Their contribution to the annual meeting is extremely important, and the society would like to thank them for their support. The exhibitions offer clinicians the opportunity to view and see the latest in technology.



## Annual Meeting Manchester 2007



The Labour Party Meeting in Manchester proved to be the final one for Tony Blair. Similarly (oh yes) the 2007 Society Meeting was the final one for Graham Cooper as Meeting Secretary. Graham has dedicated a great deal of time, skill, dedication, and more than a few grey hairs to organising the meetings over the past six years. The Society thanks Graham for his much appreciated efforts, and his contributions to the positive changes to its structure.

The reins have now been handed over to the capable hands of Simon Kendall, along with David Taggart.

The Society Annual Dinner 2007 will no doubt remain in everyone's memory forever – whether a red or blue fan. Coaches left the conference centre, bound for the Theatre of Dreams, home ground to Manchester United Football Club. Dinner was preceded by a tour of the ground, which included players' tunnel where the teams nervously prepare for battle. The tunnel is also the setting for the press to hold their post match interviews with players and managers. Diners had the opportunity to sit in Sir Alex Ferguson's pitch-side seat and, of course, take a peek inside the changing rooms. The home players dressing room was surprisingly plain, and contained no luxuries one would expect some of England's highest earners to demand. The room was not unlike a school sports changing room – apart from the safe in the corner to maintain the security of the players bling. Many people asked the tour guides for truth about the changing room Ferguson v Beckham 'match', where a football boot was used instead of a ball. The guides did not disappoint; every detail that resulted in the famous cut to Beckham's forehead was shared.

Finally, everyone was ushered toward the dining room, and enjoyed an excellent meal. The after dinner speaker was no other than legend Sir Bobby Charlton. Sir Bobby was one of the winning team of the England world cup winners in 1966.

During his speech a pin could be heard dropping in the room. Everyone was enthralled to hear this amazingly modest man regale stories of his wonderful life; from when he travelled down to Manchester as a teenager, to the moment he lifted

the world cup. He is now an ambassador for the sport, as well as being involved with many fundraising events.

How fortunate that he would agree to come and speak to the Society. The reason he did this was because he wished to acknowledge the hard work and dedication of the delegates. His brother had recently undergone cardiac surgery in Sheffield, and he wanted to show his gratitude.

Afterwards he kindly signed many autographs, and posed for several photographs. It provided lasting memories for many people.

The awards were handed out, with the very pleased recipients coming to receive their prizes from Sir Bobby. Amusingly, when Ionescu Prize Winner, Stephen Rooney, made his way to collect his award there were shouts of "Rooneee, Rooneee", similar to the ones chanted from the terraces. Sir Bruce was quick to point out the two Rooney's are highly unlikely ever to be mistaken for one other.....!

Next year's meeting is to be in the wonderful city of Edinburgh. A previous Society meeting in Scotland's capital coincided with the year Edinburgh won the European City of Culture. Since then it has progressed and developed further, and is now the home of the Scottish Parliamentary Offices. It is a proud, interesting and sophisticated city, and a most appropriate setting for the meeting.



## Diary of Forthcoming Events

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**Meeting:** The 13th World Congress on Heart Disease, International Academy of Cardiology Annual Scientific Sessions 2007

**Date:** 28 - 31 July 2007

**Venue:** Vancouver, BC, Canada

**Contact:** Asher Kimchi, M.D

**Phone:** 1 310 657 8777

**E-mail:** klimedco@ucla.edu

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**Meeting:** A Doctor's Guide to Implementing the White Paper on the Regulation of Healthcare Professionals

**Date:** 12 September 2007

**Venue:** Manchester Conference Centre

**Contact:** Clare Gallagher

**Phone:** +44 (0)208 541 1399

**E-mail:** clare@healthcare-events.co.uk

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**Meeting:** 21st Annual Meeting of the European Association for Cardio-Thoracic Surgery

**Date:** 15 - 19 September 2007

**Venue:** Geneva, Switzerland

**Contact:** EACTS Executive Secretariat

**Phone:** +44 (0)1753 832166

**E-mail:** info@eacts.co.uk

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**Meeting:** 2007 Annual Education Conference, Developing Careers in Surgical Education conference

**Date:** 20 - 21 September 2007

**Venue:** The Royal College of Surgeons of England

**Phone:** +44 (0)20 7869 6351

**E-mail:** pdcourses@rcseng.ac.uk

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**Meeting:** Leeds Perioperative Echocardiography two day lecture course

**Date:** 1 - 2 October 2007

**Venue:** Department of Anaesthesia, Leeds General Infirmary, Great George Street, Leeds LS1 3EX

**Contact:** Jennie Smith

**Phone:** +44 (0)113 392 6672

**E-mail:** jennifer.smith@leedsth.nhs.uk

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**Meeting:** Leeds Perioperative Echocardiography three day 'hands-on' course

**Date:** 3 - 5 October 2007

**Venue:** Department of Anaesthesia, Leeds General Infirmary, Great George Street, Leeds LS1 3EX

**Contact:** Jennie Smith

**Phone:** +44 (0)113 392 6672

**E-mail:** jennifer.smith@leedsth.nhs.uk

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**Meeting:** European School for Cardio-Thoracic Surgery, Thoracic Course level C

**Date:** 15 - 20 October 2007

**Venue:** Bergamo Italy

**Contact:** EACTS Executive Secretariat

**Phone:** +44 (0)1753 832166

**E-mail:** info@eacts.co.uk

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**Meeting:** Society of Clinical Perfusion Scientists of GB & Ireland Congress 2007

**Date:** 2 - 3 November 2007

**Contact:** John Campbell

**E-mail:** john.campbell@nuh.nhs.uk

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**Meeting:** The Aortic Root: Infection and Dissection

**Date:** 5 November 2007

**Venue:** The Institute of Child Health

**Contact:** Nicky Britt

**Phone:** +44 (0) 207 829 8692

**E-mail:** info@ichevents.com

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**Meeting:** European School for Cardio-Thoracic Surgery, Cardiac Course level C

**Date:** 12 - 16 November 2007

**Venue:** Bergamo, Italy

**Contact:** EACTS Executive Secretariat

**Phone:** +44 (0)1753 832166

**E-mail:** info@eacts.co.uk

## New Consultants

<i>Name</i>	<i>Hospital</i>	<i>Starting Date</i>
<b>Isaac Kadir</b>	Wythenshawe Hospital	Feb 2007
<b>Rana Sayeed</b>	John Radcliffe Hospital	April 2007
<b>John Edwards</b>	Northern General Hospital	May 2007
<b>Jagan Rao</b>	Northern General Hospital	Aug 2007
<b>Juliet King</b>	Guy's and St Thomas' Hospital	Sept 2007

# CROSSWORD

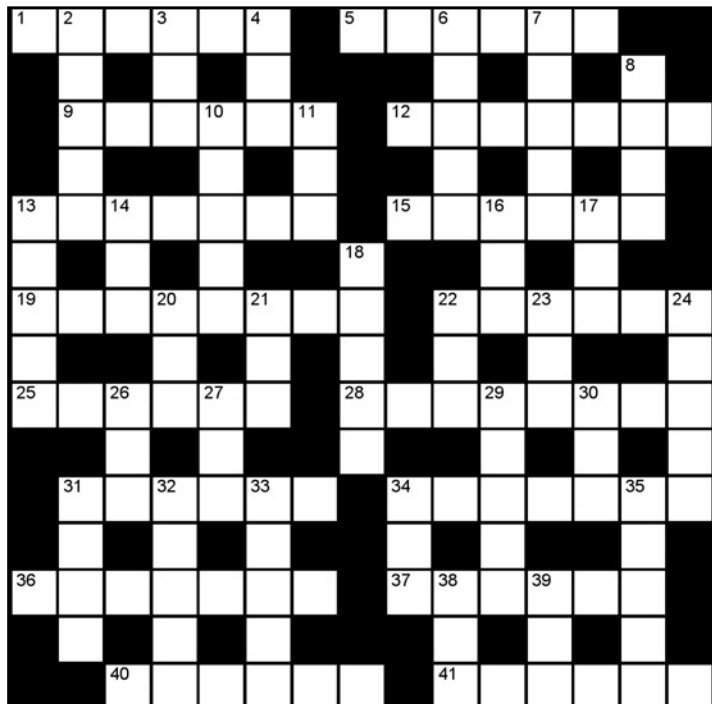
produced by Samer Nashef

## Across

- 1/5/9/15/22/28/31/34 Jacques's universal cast theory (3,3,6,1,5,3,3,3,3,5,6,7)
- 12 I am not that dark a killer (7)
- 13 Any loch can be idyllic (7)
- 15 See 1
- 19 She feeds wee runts! (3-5)
- 22 See 1
- 25 Originally sacred creature to an Egyptian, perhaps (6)
- 28 See 1
- 36 Mars or Venus excited (7)
- 37 See 10 Down
- 40 Elegant and coy girl for love (6)
- 41 Regularly knit boots, why stop? (6)

## Down

- 2 Animal up a street (5)
- 3 Thanks model for cheap stuff (3)
- 4 Urge for breakfast (3)
- 6 Russian aristocrat drops off Italian (5)
- 7 Drink and a bit of excitement (5)
- 8 Secure beast (4)
- 10/37 Your choice of setting for 1 etc (2,3,4,2)
- 11 One lost in time (3)
- 13 Sells no doves (5)
- 14 Landed on French bed (3)
- 16 Homer's note - for carrying bricks upwards (3)
- 17 29 in 2 (3)
- 18 Dean's crashed the car (5)
- 20 And not in ignorance (3)
- 21 Tease revealing part of chest (3)
- 22 Bit of a citadel (3)
- 23 I say, love (3)
- 24 Numbers smart when dressed to this (5)
- 26 Traditional beer of Wales (3)
- 27 Chop 40 from the heart of 26 (3)
- 29 Thrash western journalist (5)
- 30 Starts to move away- East and West (3)



Solution to Samer Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480364744 by **31 August 2007**. Solutions from areas over 10 miles from Cambridge will be given priority.

## CROSSWORD WINNERS

The winners for the December 2006 were Andrew Goodwin and Jonathan Hyde. We are aware that winners have not received their prizes to date. Prizes will be distributed shortly!

July 2006's winners were Jonathan Hyde and David Luke

Last issue's solution



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