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By the time you read this the “Blue Book” will have been published. This is another landmark achievement for the Society. A tribute not only to the skills of Ben Bridgewater as lead Editor and Robin Kinsman (of Dendrite) as chief analyst but also to the professionalism of all the surgeons who contributed their data with a view to improving the quality of patient care. A big thank you to all who contributed and to Dendrite for underwriting the costs of publication. We have always been ahead of the game – not always comfortable but the right place to be. I was interested to note that the first 3 articles in the May volume of the EJCTS were about quality issues in both cardiac and thoracic surgery.

Our focus on improving the quality of care we give to our patients has meant changing the emphasis away from mortality (which ignores the 98.4% of patient who survive) to other outcome measures – this edition of the Blue book is the first attempt to look at these in detail. One way we can identify areas for improvement is to look for variations in care. This analysis has shown two such areas: referral for aortic valve replacement (an issue for Commissioners) and rates of mitral valve repair. We would all agree that, where possible, repair is better than replacement. I doubt that anyone would achieve the 98% reported by David Adams (our guest at our meeting in Bournemouth). There will be valid explanations for some of the variation. However we do need to ask questions of ourselves. It is not easy to be self critical and change is difficult but it is part of our professional responsibility. It is especially important now with percutaneous methods of repair being introduced – the one year data from the Everest (using the Mitraclip) registry has just been released (the randomised trial data is awaited) and the ACCESS – Europe registry is recruiting.

It is my dream that we (SCTS) could produce a similar “book” for Thoracic surgery. Information gives power and influence – power to look at quality of care, to raise the standing of the specialty and to influence the development of the service. The issue of data collection has been more difficult for Thoracic surgeons. No risk stratification existed and there was not the same pressure on Trusts to provide the resources. Things have changed – Thoracascore has been accepted and Alessandro Brunelli (another of our guests in Bournemouth) has published a "performance score" measuring quality of care after lung resection (EJCTS 2009; 35:769) using the European database. I was therefore delighted when this year’s Thoracic Forum affirmed the decision of the previous year to commit to detailed data collection. At the request of the Forum members I have written to all Chief Executives asking for support and resources. In my letter I set out some of the reasons for detailed data collection: if we don’t measure quality of care we can’t improve it; benchmarking against other units, explanation of variations in mortality based on HES data; information for surgeon’s re-certification …the list goes on. The dataset to be collected has now been agreed so I hope we can take this forward. The recent UK Lung cancer audit showed not only low but also variable rates of resection around the UK and we need to be able to address this – we need data! We are currently working on a position statement on this audit with the UK Lung Cancer Coalition.

Annual Meeting

This is the first Bulletin since the annual meeting in Bournemouth – see the report inside. An excellent programme covering thoracic, congenital and adult surgery and the Forum going from strength to strength. I have heard nothing but positive reports so in recognition of the huge amount of work involved, I want to record publicly my thanks on your behalf to the organising team of Simon Kendall, Ian Wilson, Tara Bartley, Isabelle Ferner and Tilly Mitchell (a special welcome to Tilly, our new member of staff in the office) and of course Rachel Woolf, now enjoying her new life in Israel.

I have put off mentioning the European Working Time Regulations until now! John Black, President of the RCSEng is currently leading a response supported by the 4 Colleges – his concern is that lack of forward planning by Trusts and specialties will mean that implementation will have a negative impact on both training and service. All the Specialty Associations have supported him in this concern. However, Our SAC has looked at this at detail and both we (SCTS) and the British...
President’s Report continued

Orthopaedic Association believe that, with changes in how we provide the service and a focus on those in training posts, we can train in 48 hours under the EWTR. As a Society we began to address this in 2003 when a working group put forward suggestions for “new ways of working”. My own Trust has recently appointed a team of Nurse Practitioners to replace the previous tier of SHOs. We had a vigorous debate on the EWTR at the Board of Representatives in March and I recognise that the issue of resident ICU cover is not resolved.

On the question of the Board of Representatives: this was established to act as the forum for discussion / communication between the membership and the Executive. It meets in March and November - please use it. Put forward issues for discussion; ask your unit representative for a report afterwards. Communication is important – if there are any pressing issues you can contact me anytime (0191 2137309 or home: 0191 2850052).

In his report, Pat Magee gives you an insight as to how the Society provides support for ACCEA applications. A new feature last year (introduced I think by the NHS Medical Director) was that the summary statements of successful applicants are available to view on-line. A positive step to transparency – you can now see why awards are made.

Surgery or PCI?

Whether patients have surgery or PCI continues to provoke debate. NCEPOD (see article inside) strongly supported MDT meetings. I have explored this with the President of BCIS and they have set up a working group to suggest which patients should be discussed – Graham Cooper is representing SCTS. Another joint effort (David Taggart, Ben Bridgewater and I) with BCIS has been an editorial highlighting the Syntax trial which we have sent to the BMJ. David has also been asked to work on the revascularisation guidelines for the European Society for Cardiology. The Courage study was controversial (it questioned the benefits of PCI) but highlighted the need to have objective evidence of myocardial ischaemia before PCI. You may have seen the recent “Fame” study which used pressure wires to calculate FFR (fractional flow reserve) in multi-vessel PCI using DES (NEJM 2009; 360:213). Another recent publication which you might find useful in discussion is one from the AHA/STS/AATS: “Appropriateness Criteria for Coronary Revascularisation” (JACC 2009; 53).

An example of new technology being introduced rapidly is percutaneous AVR (TAVI). Neil Moat, elected representative on the Executive, is leading for us in these discussions. Currently there is debate about a UK randomised trial (with pressure to extend to lower risk patients) and a European trial based on the Syntax model. We will keep you posted.

You will be aware of the Department of Health’s intention to introduce the WHO “Safe Surgery” checklist. Having discussed it with number of you, thoracic surgeons seem happy with it but it doesn’t seem to lend itself to cardiac surgery. I have therefore asked Steve Clark (who recently obtained his pilot’s licence) to adapt it. We will have discussed it at the Executive committee in June and if it is accepted I will circulate it via the unit reps for comment. If we can have a nationally accepted / SCTS approved checklist, I hope that the DoH and Trusts will allow us to use it instead of the WHO one.

I recognise that it doesn’t affect many of you but the future configuration of paediatric cardiac surgery is an important political question for our specialty. We have recognised for many years that the service with the current number of units was unsustainable – the one recommendation from both the Kennedy and Monro reports which was not accepted by the politicians was for bigger units. The paediatric cardiac community agreed (at a meeting at the DoH in July 2006) that we would provide the highest quality sustainable service with 5 surgeons in each unit. The DoH has now accepted the need for change – they have asked the NSCG (National Specialised Commissioning Group) to take this forward urgently. Again, I will keep you informed.

Sabbaticals

I will finish on a positive note: sabbaticals. I wish I could tell you that the DoH was going to introduce these into the NHS (like in Australia and Scandinavia). But, we have the next best thing – the SCTS Ionescu scholarship for Consultants. Originally we restricted applications to Consultants within 5 years of appointment but there is now a feeling that “older” Consultants would benefit from a short sabbatical. Let’s have some applications - see www.scts.org.
Secretary's Report

Graham Cooper

The publication of the sixth National Adult Cardiac Surgical Database Report ‘Demonstrating Quality’ represents another milestone for SCTS. This latest edition of The Blue Book significantly advances the agenda for adult cardiac surgery, showing that our vision extends beyond operative survival into a broad range of long term outcomes and equality of access to treatment. As members of SCTS we should all be rightly proud of the achievement. I thank you all for making this possible and we should all join with Leslie in thanking those involved in the Blue Book’s production.

The power of the National Adult Cardiac Surgical Database to contribute to the quality agenda is evident. Less obvious is its power to protect members of SCTS. Since the events at Mid-Staffs concerns about patient safety and service quality have a heightened sensitivity. On several occasions, data from other sources have led the Care Quality Commission to express concern about cardiothoracic services. Thanks to our unique relationship with the Care Quality Commission, developed through the public release of cardiac surgical outcomes, and the unique resource of the database we have been able to effectively and positively provide support.

Over the past few months we have been developing our thinking about how we manage the possibility that a surgeon's outcomes may cross an alert or an alarm line. There are three key principles; the process must not lead to patients who are at high risk being denied surgery, the response must be reasonable and proportionate and that the crossing of a line is a stimulus to interrogate the data and not the surgeon. This has been debated at The Board of Representatives in November 2008, Annual Business meeting in March 2009 and the policy was approved by The Executive on 5th June 2009. Full details are on the website. In outline; there are two alert lines at 95% (equivalent to 2SD) and 99% CL and an alarm line at 99.9% CL, this is about 3.5 SD and is the limit used for the public portal of the Care Quality Commission. There are three patterns of crossing the line and this relationship along with the response are shown in the table.

The response is proportionate and reasonable. There is a four stage process to be undertaken to explain any divergence in outcomes:

- Analysis of the data for accuracy
- Analysis of the caseload to ensure that the risk stratification mechanism in use accurately reflects expected outcomes
- Analysis of institutional factors that may contribute to the divergence in clinical outcomes
- Analysis of the surgeon's performance

We anticipate that it will be an extremely rare event for the process to proceed beyond stage 2. Clearly the first stage, if there is a divergence in outcomes, is to check the data for accuracy. The second stage is equally important. The process must not lead to patients who are at high risk being denied surgery. We know that for some groups of patients, especially some of the higher risk patients, EuroSCORE is a poor predictor of risk. Analysis of the caseload of a surgeon with divergent outcomes is therefore vital, if the surgeon is operating on more patients in these groups then any divergence is likely to be simply explained by casemix.

The rapid strides to developing a National Thoracic Surgical Database in the past year are exciting and have the enthusiastic support of SCTS Executive. With the experience we have gained over the past few years we hope to be able to make this a reality quickly. Richard Page has worked hard on this project and with your support the first National Thoracic Surgical Database report should not be too far away.

We will be implementing this with immediate effect for the next upload to the Care Quality Commission website but as always are continually looking to improve and so any comments are welcome; graham.cooper@sth.nhs.uk.

All in all a time of great optimism, by aligning SCTS with the NHS priority for quality and leading the delivery of this agenda we have gained respect and can look forward to continuing influence. An exciting prospect. Enjoy your summer.

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Launch of the 6th National Adult Cardiac Database Report

This July will see the release of the next ‘Blue Book’ SCTS National Database report; ‘Demonstrating quality’. The previous edition was published in 2004 with data up to the end of March 2003. This latest report has been updated to study operations undertaken up to the end of March 2008; the database now contains over 400,000 operation records.

The analyses show a continuing increase in the number of patients having valve operations, and a stabilisation of the number of patients undergoing CABG surgery each year, at around 23,000 operations each year. Over time, the quality of data submitted to the database has also improved. The majority of important data fields now have a low incidence of missing data. This is due to the enormous work of cardiac surgery audit leads and database managers around the country without whom the report would not have been possible. The majority of the analyses and the publication of the book were kindly undertaken by Dendrite Clinical Systems.

The major finding of the analyses is that the patients coming to surgery are becoming older and higher risk each year. Despite this trend, the mortality rates continue to fall. The degree of improvement is marked; between 2001 and 2008 the in-hospital mortality rates decreased from 2.3% to 1.5% for isolated CABG, 2.6% to 1.7% for all CABG, 5.2% to 3.5% for isolated valves and 8.3% to 6.1% for combined valve and graft operations. We have also been able to gain longer-term outcomes on these patients by linking the Central Cardiac Audit Database (CCAD) with data on life status from the Office for National Statistics (ONS). For example, we have overall mid-term survival on over 88,000 patients who have undergone CABG which shows a survival rate of over 90%. Survival is worse for patients who are older, female, urgent, diabetic, have impaired cardiac function or who are in renal failure. We have conducted a detailed analysis on patients undergoing CABG as elective operations, which shows excellent results, with low mortality, morbidity and good long-term survival. The mortality for patients under 70 years of age who are admitted to hospital from home for their surgery is less than 1%. We have also conducted a detailed analysis on cardiac surgery in the elderly.

The database has now evolved to the extent that we can now analyse valve operations, which have in previous reports only been examined from the returns to the cardiac surgical register. Between April 2003 & March 2008 we have collected data on 30,127 aortic valve and 19,545 mitral valve operations. There has been more than two-fold increase in the annual number of patients who have valve surgery replacement between 2001 and 2008. Patients undergoing AVR are becoming more likely to receive biological valves and those undergoing mitral surgery are more likely to undergo a repair rather than a replacement. A detailed study has been undertaken on patients undergoing surgery for degenerative mitral valve disease. We have also analysed outcomes on 4,967 patients who have undergone major surgery of the aorta, with 2,245

The Evolving Role of the Cardiothoracic Dean

This is my last article as Dean. The Dean’s role in the SCTS has changed during my tenure. The Dean no longer sits on the executive but sits on the Education subcommittee. This committee is chaired by Professor John Pepper (the Education Secretary) and is working hard to support all education within our specialty from medical school to retirement.

With every trainee and consultant having to undergo annual appraisal I think that it is essential that the SCTS takes the lead in stating the educational requirements at all levels of a cardiothoracic surgeon’s career. This becomes increasingly more relevant as we enter the era of revalidation. The SCTS annual meeting continues to grow in attendance and the quality has improved beyond recognition especially when I recall such infamous venues as Llandudno and Norwich (both in the 1990s). This year I was delighted to see a good attendance at the trainees’ meeting, although sadly not every NTN attended. The trainees’ meetings have become more interactive over the last five years and I would encourage all trainees to give their opinion on training (or lack of it). The annual SCTS trainees meeting is the ideal forum for open discussion but I would like to remind all trainees that they should contact their regional SAC liaison member if they have specific issues.

The Dean sits on the Intercollegiate Cardiothoracic Surgery Examination Board. The last five years have also seen many changes in the Examination. The written paper has been introduced negating the need for a basic science viva and the scoring system has been reviewed for the clinicals and vivas. The examiners are now assessed more rigidly by reviewing their marking and by direct observation of their examining skills. The Examination is an intense experience for the candidates but it is also quite an exhausting but rewarding 2 days for the examiners and I would like all consultants to consider applying to be an examiner and you can find the details on the website www.intercollegiate.org.uk.

Steven Hunter, Cardiothoracic Dean
having surgery for an aortic aneurysm and 1,288 having surgery for an aortic dissection. The mortality for patients undergoing urgent or emergency surgery for dissection was 23%, which is in line with published international registries.

In addition to analysing the changes in patients and their associated outcomes, we have also tried to use the database report to respond to some of the external influences that act upon our specialty. We have examined how developments in cardiac surgery audit comply with the recommendations from the Bristol Royal Infirmary Inquiry (2001), the Shipman Inquiry (2005), the Chief Medical Officers report Good Doctors, Safer Patients (2006), the White Paper Trust, Assurance and Safety (2007) and Lord Darzi’s review High Quality Care for All (2008). We have also moved away from mortality measurement to look at other post-operative outcomes including new post-operative stroke, renal failure, length of stay, re-explorations for bleeding or infection and 5-year survival rates. We have used the power of the database to look at issues surrounding equity of access to aortic valve surgery by mapping 29,000 AVR operations into their PCT of residence and adjusting access rates for the age and gender structure of the populations.

We have included good practice examples in the collection and use of cardiac surgery audit data from the hospitals around the United Kingdom. This section includes examples on data validation, feedback, quality bundles, performance monitoring, disseminating outcomes to patients, service reconfiguration, clinical leadership development and multi-disciplinary process and outcomes benchmarking. Finally, we have developed a proposed quality account for one hospital, incorporating patient outcomes, patient safety and patient experience, in line with the planned new legislation, which will require all hospitals to publish these accounts from 2010.

The latest Blue Book contains an enormous amount of data, which has been diligently and comprehensively collected in all the units undertaking NHS cardiac surgery across the UK, with further contributions from some Private Hospitals, Hospitals in Ireland, and a guest contribution from Hong Kong. We hope that the database report will provide useful information to hospitals and surgeons providing cardiac surgical care give accurate information to support informed consent for patients, and contribute towards improving quality across the NHS.

Over the last 5 years the SAC has made huge strides for training in our specialty. Changing from Calman to MMC coincided with a reduction (to zero for a couple of years) of trainees admitted to our specialty. This was a difficult time but necessary to restore balance and avoid subsequent unemployment. The curriculum project has been a huge achievement and now all trainees have instant access on line to an array of assessment tools which can be used by the training programme directors during the ARCP. The establishment of the Postgraduate Medical Education and Training Board (PMETB) saw the end of the quinquennial training programme reviews. PMETB introduced Deanery (pan-specialty) assessments which are essentially a paper exercise. The SAC recognised the failings of PMETB and insisted on the training programme liaison members attending all the Regional Training Programme meetings and RITA/ARCPs and producing an annual report on each programme. This report is discussed at the SAC but can also be used by the Deaneries to trigger PMETB (specialty) visits. I have already mentioned the liaison members and their relationship with trainees but I would like to emphasise the importance of the pastoral role of the liaison members. Trainees should not hesitate to contact their liaison member for advice. The SAC has also taken the lead in national selection. We were the first specialty to appoint our ST3s nationally in 2008. We had another round this year appointing 16 trainees (2 were ACFs – Academic Clinical Fellows). The SAC have organised the selection but the assessments are performed by the Training Programme Directors (TPD) and many of the TPDs are now directly involved with the SAC and the Exam Board are all to be strength to strength. Our colleagues who are involved with the SCTS executive, the SAC and the Exam Board are all to be congratulated for their efforts and it has been a pleasure working along side them for the last 5 years. My successor is to be elected over the summer and I wish him/her all the best and I hope they relish the challenges of the next 5 years.

The last 5 years have provided many challenges but all have been met head on and I believe our specialty has gone from strength to strength. Our colleagues who are involved with the SCTS executive, the SAC and the Exam Board are all to be congratulated for their efforts and it has been a pleasure working along side them for the last 5 years. My successor is to be elected over the summer and I wish him/her all the best and I hope they relish the challenges of the next 5 years.

As always I can be contacted by email at Steve.Hunter@stees.nhs.uk but only as Dean until August.
The sun shone in Bournemouth, the sea looked fabulous and this year's Cardiothoracic Forum was a huge success. Delegate numbers have increased year on year with a diverse audience that gave a lively buzz to the meeting.

This year’s theme ‘Quality Care: can we deliver’ was topical within the specialty and the wider NHS agenda. We welcomed Maura Buchanan back to deliver her opening remarks. She captured the mood perfectly linking current health issues with putting patients first. As part of the NHS agenda and SCTS objective for greater patient involvement, a patient representative group joined the meeting and feedback would suggest that they enjoyed Maura’s comments and specifically the presentation from Lisa Ketteridge and the clinical team from the Queen Elizabeth Hospital, Birmingham. Lisa’s story hit the national press after she developed cardiomyopathy while pregnant with her second child in April 2008. Following an emergency caesarean at thirty five weeks gestation she had an LVAD implanted. Her 60 day stay coincided with the 60 year celebrations of the NHS.

Mr Ian Wilson, Cardiothoracic surgeon presented the case accompanied in the background by Bob Dyans ‘The Times There Are A Changing’, while Judith Derby and Linda Williams, Senior Sisters from the Critical Care unit eloquently express the challenges of caring for a patient with an LVAD, multi organ failure but not forgetting that Lisa had just had her second child delivered. The microphone was then taken by Lisa who told us what it was really like! The impact of hearing the patient perspectives serves to remind us all of what the patient sees as important and should inform the delivery of care.

Other plenary sessions included the new BTS guidelines on Cancer staging, and a review the impact this will have on surgical decision making process, presented by Mr Eric Lim from Guy’s and St Thomas’. This session was clear, concise and demonstrated the positive effect upon patients. It also provoked the audience to contemplate the impact upon surgical units.

Wendy Grey from the Heart Improvement Programme shared the work initiated by the Eighteen Week National Project Sustaining Cardiac Pathways outlining the project and giving examples from pilot sites around the UK. Members of the audience can take the ideas back to their units to review the patient pathway and initiate change.

Dr David Foster, Deputy Chief Nursing Officer, DoH, spoke on the impact of Modernising Nursing Careers on postgraduate career pathways and Andrew Rundle from the Standards & Qualification, Skills for Health discussed the strategic impact of changing the workforce. This provoked a lively debate around achieving a workforce fit for practice and the dilemma around whether Agenda for Change can meet the challenge of ensuring nurses can have a clinical career structure. Clearly, the way forward is not without hurdles but the presentations can be used to inform us in our progress.

Dr Ann Keogh, Birmingham Heartlands Hospital presented on behalf of the National Patient Safety Project. She gave us a very practical demonstration how some of the areas of the work can impact upon practice to underpin the theme of quality care.

The Cardiothoracic Forum Abstract panel were able to select thirteen papers for presentation in addition to the plenary sessions. Speakers were of a very high standard with sessions encompassing Cardiac, Thoracic and Surgical Care Practitioner themes. All these presentations can be accessed on the nurses’ page of the SCTS web site; www.scts.org/sections/nurses/index.html

The audience selected this years winner of the Ethicon £200 prize as:

*Postoperative Pulmonary Complications Following Thoracic Surgery: Comparison Of Three Scoring Systems*

P. Agostini

Our congratulations go to Paula who will receive her winners medal during the Annual dinner at next years SCTS meeting to be held in Liverpool 7th March- 9th March 2010. The theme for next year's meeting will be ‘Excellence in Practice’ where we will hope to encompass the message from the Chief Nursing Officer to engage staff and public involvement that will underpin confidence and trust in delivering high quality care for all. So with this in mind I would encourage you and your colleagues to consider sharing your
work and experiences with next year’s Cardiothoracic Forum. The call for abstracts will go out early in September and remain open until November. This year all abstracts will need to be submitted online to enable the abstract committee to carry out the marking procedure efficiently and to ensure that the programme can be put together in good time.

Other News from the Speciality

Congratulations to the West of Scotland Heart and Lung Centre, Golden Jubilee Hospital who celebrated their first anniversary with a one-day conference that looked at Quality and Innovation within the Cardiology and Cardiothoracic Surgical speciality. The day was well attended with an audience that represented the multidisciplinary professions. The programme encompassed a varied of presentations including ‘How to set up an European Centre of Excellence’ from Professor Hetzer from Berlin who also talked about their LVAD programme. Mr Dalrymple-Hay, Consultant at Plymouth Hospital spoke about Minimally Invasive Conduit Harvest; Dr Grube, chair of Cardiology, Seigburg Heart Centre and Mr Moat, Consultant at the Royal Brompton spoke about their hospital’s TAVI programme. I was invited to speak on New Ways of Working and Professor Begg, Associate Dean Primary Health Care, School of Health, University of Wolverhampton presented on the Physicians Assistants. This is just some of the areas covered during what proved to be an interesting, thought provoking day that gave all an opportunity to hear about developments throughout the UK and Europe.

For those of you who are not aware of the one day ‘Thoracic Surgery Practical Course’ that runs twice a year in June and January at the Heartlands Hospital, Birmingham it combines lectures with clinical wet lab sessions enabling delegates to familiarise themselves with chest anatomy, surgical procedures and disease process. The course is open to nurses, doctors, physiotherapists, surgical care practitioners and other members of the multidisciplinary team. For further information contact paula.agostini@heartofengland.nhs.uk

We have updated and tested the database which is working well. There are now contacts for all nurses who wish to be included; a lead contact in each unit in their critical care, ward and theatres; and thoracic contacts. If any of your colleagues would like to add their names so they can receive the emails then please forward their name, address and title to me at tara.bartley@ntlworld.com

I would also encourage you to take advantage of the greatly reduced Associate Membership of the SCTS. From 2009 the annual fee is £22, with an initial administration fee of £25. Membership ensures that you receive the Bulletin issues, reduced rate to the Annual meeting and other benefits which are on the SCTS web site, including the opportunity to apply for a bursary towards professional development.

It is now two years since the SCTS bench marked service provision and it is important to follow this work up with collating information about progress that has been made. In the December 2008 Bulletin I mentioned that we would like to review role development throughout the Cardiothoracic Centres. We have identified an online survey tool so will be contacting you in the near future to seek information about how nursing and surgical care practitioner roles are expanding to meet the European Working Time Directive and accounting for the impact of Modernising Medical and Nursing Careers. If you receive a questionnaire please take the time to complete it and return it so we can gather information to inform all about current service delivery provision.

Maura Buchanan captured the mood of the Annual Conference perfectly, linking current health issues with putting patients first.
The nursing profession is currently responding to the review Modernising Nursing Careers (MNC) and one of the challenges that nursing must overcome is the preverbal question of how sustain a ‘clinical’ career pathway.

It would be fair to say that traditional nursing career progression often results in a move away from clinical practice to assume a greater managerial role. The advent of the ‘Modern Matron’ role was to address the issue of sustaining quality care and standards of excellence. In reality the Modern Matron often assumes leadership for large clinical areas and the demands draw away from direct practice.

There has however, been a plethora of Clinical Nurse Specialists which have developed in clinical roles, which it could be argued have come to fruition in response to the wider NHS agenda and expanding skills. Specifically the impact of the European Working Time Directive (EWTD) and Modernising Medical Careers (MMC) has reduced the service delivery aspects of doctors in training, creating a void in the delivery of care, which is increasingly being carried out by nurses. Titles include Nurse Consultant, Nurse Practitioner, Clinical Nurse Specialist, Advanced Nurse Practitioner, Perioperative Specialist Practitioner (The area of Surgical Care Practitioners is covered in detail by Samer Nashef in his article). To date the profession has failed to formalise these titles and the specialist practitioner qualification has become recognised on the NMC register, the debate about process of registering the Advance Nurse Practitioner qualification remains unresolved. It follows then that linking such roles with the Key Skill Framework is not always simple.

Not withstanding the ongoing issues many of us would like to progress in our nursing careers while remaining in the clinical field delivering direct clinical care. In response to the EWTD & MMC the Modernisation Agency Changing Workforce Programme ran a pilot project between April 2003 and April 2004. The outcome laid the foundations of the career pathway that would enable further training in clinical expertise along with an academic framework. In response there has been a number of pre and postgraduate courses that have been developed within the university setting, the premise of which is to underpin a clinical role that has relevant clinical competency package and clinical supervision.

The National Survey of Cardiothoracic Service Provision (Bartley & Livesey 2007) concluded that the service would become increasingly reliant upon nurses who could undertake care of the patient throughout the patient pathway and perform many of the roles traditionally undertaken by doctors.

Within the speciality there is a move to embrace these roles providing the training and academic pursuit that will produce expert practitioners to meet the needs of a high quality service delivery from a collaborative team approach.

The following is guidance on how to pursue such a career:

Initially the individual will need to access a specialist role, one where they will be performing the day to day care. The position should be linked with an academic course at a recognised institution. Recommendations from the Perioperative Specialist Practitioner programme are:

- Access a Health Care Training programme at a higher education institution with formal lectures and clinical labs training.
- Secure employment in a clinical role which is a recognised training position in an NHS trust.
- Subsequent completion of the academic course and clinical competencies will result in a higher education qualification that underpins a practitioner with advanced skills and the critical analysis to perform in collaboration with the multidisciplinary team.

Alternatively the individual can access a post basic course to undertake the generic
Surgical Care Practitioners in Cardiothoracic Surgery

Surgical care practitioners or SCPs (previously called surgical assistants) play an active role in the delivery of cardiothoracic surgical care in the United Kingdom, and their careers and roles are probably at a more advanced stage of development than similar roles in many other specialties.

Most SCPs are recruited from the ranks of nurses and operating department practitioners and have a background of experience in cardiothoracic surgery. This can be either in the operating theatre or intensive care setting, but some come from other related specialties and a few join the service de novo from totally unrelated backgrounds.

The existing training system is usually by appointment to a training post and on-the-job training under the supervision of a named consultant surgeon. Units with established SCP programmes have a more formal training and mentoring structure often led by trained SCPs themselves, and Papworth Hospital offers a reasonably open-access training programme for trainees from other units who are usually seconded for basic or more advanced training at Papworth. Other units have linked their training to higher educational establishments so that training can contribute to the award of a University degree.

There are plans for national certification and registration for all such roles in all surgical specialties, but until that happens, cardiothoracic SCPs are currently assessed by the joint Royal College of Surgeons of England and Society for Cardiothoracic Surgery examination. This takes place once a year in November at Papworth. The examination can be taken any time after the first year of training, although the diploma is only awarded to successful candidates after evidence of two years of satisfactory training. The format is one of modified essay questions followed by a viva examination.

The syllabus has slowly moved from the original “Cardiac Surgeon’s Assistant Orange Book” to the existing core and specialty curriculum as published by the Department of Health (DoH) and the Royal College of Surgeons and obtainable from the DoH website: www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4113605

SCPs assist in all aspects of surgical care, from the operating room (conduit harvest, first and second assistance) to investigations, ward care, outpatient clinics communications within the surgical firm. The extent of involvement in the various aspects of care varies according to the hospital and local needs, and in some institutions the role also involves audit, research and training of junior doctors in surgical techniques. In general, the more varied the job and the more it involves patient interaction, the greater the sense of job satisfaction that is obtained.

With the restrictions on junior doctor hours and the curtailment of time the junior doctors spend in service as opposed to protected training, it is almost certain that SCPs are here to stay. It is difficult to predict the final form of this young profession, but it is likely that in due course SCPs will have a properly organised register with national certification and a formal higher education connection. When this will happen will depend on national initiatives, but in the meantime the cardiothoracic surgery programme with its existing training and diploma will continue to thrive.

Aspects of advanced practice then negotiate completing the clinical competencies within their role. This is demanding and difficult option which will take a great deal dedication and time management, although it should be recognised that even those amongst us who have excellent time management skills, may struggle in a role where day to day workload is unpredictable. There is a dichotomy with service delivery and time constraints of achieving the clinical objectives. Before undertaking the role there must be the infrastructure to support the practitioner. Moreover, without the support of an experienced mentor, the multidisciplinary team and the organisation this route is unlikely to succeed.

Once qualified the individual must ensure that they practice in accordance with their NMC Code of Conduct and in line with the employing Trust Policy. They have a responsibility to maintain their clinical competencies and to keep up to date with the changes impacting upon their general and specialist practice. The role needs to reflect the service demands and requires timely evaluation to create change in line with the need for progress. It may also be that the original course studied didn’t encompass further skills or the additional non medical prescribing qualification that the role requires to practice. The practitioner and the organisation must ensure that the necessary training, qualifications, supervision and framework are in place to practice within safe boundaries. Moreover, the organisation and the practitioner have a responsibility to ensure that the role is supported by the multidisciplinary team and the duties are manageable.

In essence the roles are evolving and those practising would suggest that one of the challenges is to be all things to all people. It is then for the individual to know their limitations, communicate effectively and secure the support they need to undertake the role effectively.

Samer Nashef, Consultant Cardiac Surgeon, Papworth Hospital
It is only eight months since I took my seat with the Executive Committee, but a lot seems to have happened since then. It cannot be easy for a group of professionals to have a layperson join them, but I have been warmly received and my perceptions are that my presence does not seem to have inhibited discussion or debate. In fact they must trust my discretion, for there have been some distinctly controversial topics under consideration.

This concept of representation not only relates to the internal business of the Society but also to how it relates to the current and prospective patients out in the community, and to what cardiothoracic patients have to say about matters relating to them. Two issues have been questioned by us during the last few months, one being poor advice concerning post-operative cardiac rehabilitation emanating from the RCS (England) which was only rectified following strong intervention from our President, and the other where the Department of Health in an advisory note excused our post-operative ICU’s from the implementation of same sex accommodation. The patients absolutely agreed with this advice, but neither the SCTS nor we can recall being consulted.

Most cardiac surgery patient representatives have come to be involved through their ongoing engagement with local support groups who tend to foster lively rehabilitation programmes. The patients absolutely agreed with this advice, but neither the SCTS nor we can recall being consulted.

Talking about the British Heart Foundation, again this is a charity fondly embraced by patients, it is their leaflets that are prominent in providing broad advice and guidance about our conditions, and it is the BHF who often provide the pump-priming funds to establish rehab programmes. However, BHF is also a major supporter of research and I have been surprised at the small number of surgical professorships sponsored by them. Does this also reflect on the take-up of doctoral sponsorships amongst our trainee surgeon cohorts? It’s the patients and their families who fund the charity and perhaps this is a question that would benefit from a dose of investigation.

By the time these notes appear the Blue Book will have been published. You surgeons and your teams must take great cheer and comfort from this document. In fact you should all throw Unit parties to celebrate your achievements, take photographs, place reports in your Trust journals, invite the Press. In fact have a ball!

It is a significant and comprehensive record of your commitment to patients, many run of the mill procedures to you, but to your patients from their perspective it’s life or death. The record also demonstrates that you are getting braver; you are regularly accepting more difficult cases, older people, more women, patients with other debilitating conditions and still your successes rise. My understanding is that this Blue Book also challenges the other surgical specialties to look to their laurels and to start to push back their own boundaries still further. It is a call to action to the whole profession. Ben Bridgewater has led up the writing team on your behalf, he and they have done a great job, but remember, what they are doing is displaying your wares. Really well done everyone.

As in life, so in medicine, women are a conundrum. In regard to cardiovascular disease women are under-presented, ...
under-diagnosed, under-treated, and under-represented; these are the findings of the National Joint Working Group for Women's Heart Health. It's not just in the Home Waters; it's an international problem. The World Health Organisation statistics show that not only is cardiovascular disease (CVD) the leading cause of mortality, but more women than men die from this cause. The Blue Book mirrors some of these issues, which means that here is supportable evidence and we need to capitalise on this opportunity to make our contribution to Women's Heart Health (WHH). Would anyone be interested in giving WHH a good dose of looking at?

At the Annual Meeting in Bournemouth, which to me was a thrilling experience, we welcomed our first group of patients from the local cardiac network. Next year we are considering involving patients from the cardiac and the cancer networks of Merseyside and North Wales, Greater Manchester and Cheshire, Lancashire and Cumbria, West Yorkshire and possibly Ireland. That would be a huge population base to have represented at our conference. We are thinking of asking the patients to identify their interests and their concerns so that we can tailor their experience at conference to match their queries. Patients will go back to their regions and report what is going on in our world. It's a great opportunity.

It's only in this previous paragraph that we have touched on thoracic surgery. We are mindful of the need to provide balanced representation in every way possible, and, again, if anyone has any specific suggestions please do have a word. It's a two way, open ended process, and please remember we have only been going eight months.

So, my sincere thanks to our hardworking President and his Executive Committee, and Isabelle and Tilly, for making me so warmly welcome. Comments and feedback are welcome. Enjoy your parties, you deserve them!
The Intercollegiate Examination in Cardiothoracic Surgery

This examination currently has two diets per annum with two sections. The first section is a multiple-choice examination, which is held in January and July and consists of two, 2-hour papers. Paper one is of the single best answer type with 110 questions and paper two has 135 extended matching items. Following the section one examination, a standard meeting is held and the pass mark determined. Those who pass section one are then eligible to sit section two, the clinical part of the exam. This takes place in May and October.

Section two of the exam is divided into six portions. There is a long cardiac case, a long thoracic case, short cardiac cases which include an investigation station where candidates may be shown angiograms, echo's, or CT scans. There is a short thoracic case section, which again will include an investigation station, which may include identification of instruments, CT scans etc. There are two orals, one in cardiac surgery and one in thoracic surgery. Section two of the examination employs a close marking system with marks ranging from 4 to 8. Six is the pass mark and there are six marking areas with six portions and two examiners marking independently. Accordingly, the candidate needs to achieve 432 marks in section two to be successful.

There have been no recent changes in the regulations to sit the exam and these are available on the Intercollegiate website, www.intercollegiate.org.uk. On opening this website, one follows the link to the specialties and all regulations are available online. An application form, structured reference form and guidance notes are also available at this site, with the calendar including the examination dates and the closing dates for application.

I would draw candidates' attention for the instructions to the structured referees. For applicants in approved training posts, all three referees must be on the UK/Irish specialist register. One referee must be the current program director and the other two must be consultant trainers/supervising consultants or senior colleagues in the specialty with direct experience of the applicant's current practice. For those not in training, all three referees must again be on the UK/Irish specialist register and one referee must be the applicant's current lead clinician, head of department/medical director, and the other two must be senior colleagues with direct experience of the applicant within the last three years.

The level of the examination is set at that which one would expect of a first day consultant cardiothoracic surgeon. The examination is a test of the knowledge base of such an individual and covers the generality of the specialty. It is important to point out that passing the exam does not guarantee attaining a CCT. The examination is only one aspect in the assessment of cardiothoracic surgical training.

I think it is important to dispel some of the myths and misconceptions that may have arisen in the recent past. I have expressed this view on many occasions and it is important that candidates realise that there is no understanding that only a certain percentage of those who sit the examination will pass. Further, there is no substance to the rumour that candidates who are not NTN's or those resit the examination are treated differently. The examiners are unaware of a candidate's background. Finally, I repeat, passing the exam does not guarantee attaining a CCT. The examiners receive feedback on their performance. During section two of the exam the examiners are observed by one of the assessors of the panel of assessors for cardiothoracic surgery and the examiners receive feedback on their performance at that diet of the exam.

In the table below, I attach the results of the examination since May 2007. As requested, I have split the candidates into three groups. NTN refer to those with national training numbers and FTTA refer to those who do not possess training numbers but are in training programs. OT refers to those candidates who are out of training.

<table>
<thead>
<tr>
<th></th>
<th>NTN (%)</th>
<th>FTTA (%)</th>
<th>OT (%)</th>
<th>Overall (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 07</td>
<td>82</td>
<td>50</td>
<td>14</td>
<td>61</td>
</tr>
<tr>
<td>Oct 07</td>
<td>88</td>
<td>67</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td>May 08</td>
<td>100</td>
<td>40</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td>Oct 08</td>
<td>77</td>
<td>36</td>
<td>50</td>
<td>57</td>
</tr>
<tr>
<td>May 09</td>
<td>90</td>
<td>57</td>
<td>71</td>
<td>75</td>
</tr>
</tbody>
</table>

You will see that the overall pass rate varies from 57 to 75% over the five examinations since May 2007. As a group, those with national training numbers do better than the other two groups. It is interesting to note that the pass rate of those out of training has steadily improved.

The examination continues to develop and section one of the exam is under tense scrutiny by the educationalists and psychometricians who provide reports following each diet of this section of the exam. Changes will take place to the conduct of section two, particularly the clinical portion, and program directors will be advised of these changes before their implementation. Similarly, any changes will be published promptly in the guidance notes issued to candidates prior to sitting the examination.

I hope this brief resume of the current status of the examination has been of some benefit, and should candidates have any questions I am happy to be contacted through the Intercollegiate Board.
I’m sorry to say that this will be my final report as Cardiothoracic Tutor, as I am about to stand down after over 5 years in the post. I have very much enjoyed the role and have stayed on much longer than I originally planned. There have been a number of challenges during my tenure, including the ‘trainee crisis’ and the adoption of the new curriculum and MMC, but these storms have been weathered and, hopefully, things seem to be moving in a positive direction again.

First of all, a little bit of background: The post of Cardiothoracic Tutor was originally set up with a commitment of approximately one day a week (or two sessions), but the time could be used flexibly. For this commitment, the Trust for whom the incumbent worked would be remunerated on a basis of 2PAs, to allow them to cover the absent consultant, if necessary. The Royal College of Surgeons of England were responsible for this payment, but the funds were originally generated by sponsorship. The network of sponsors covered the payments for Tutors of all surgical specialties, and different sponsorship deals were made for each Tutor. Sponsorship in our specialty was originally allowed the creation of any new courses for the trainees. I originally planned. There have been a number of changes with respect to the post, and I shall try to summarise them now. MMC and the new curriculum necessitated deconstruction and reconstitution of the entire portfolio of courses, which was a huge task over a two year period. In addition, following a period of drought a couple of years ago, where the number of trainees massively exceeded the numbers of potential consultant jobs available, entry to the specialty was temporarily closed and morale amongst trainees was at an all-time low. As a consequence, there was a significant fall-off in applications for courses nationally, and several of our courses were either discontinued or rationalised. The situation was not helped by the almost universal reduction in the amount of remuneration allowed for Study Leave. However, since the specialty has ‘re-opened’ and morale has risen, the interest in education seems to be improving and many more applications are being received.

The situation at present is more encouraging and the portfolio is now at an appropriate level. The climate has not allowed the creation of any new courses for the past couple of years, when the priority has been to sustain the existing ones and not allow them to fail. There is now scope to resurrect certain courses that are currently ‘on hold’, and even develop new ones to reflect evolving technologies. Cost is always an issue, but there is a plan to regionalise certain courses, thereby eliminating the overheads having to be paid for basing them all at The College. Another very important development which was finalised at The Education Sub-committee meeting in Bournemouth, is that the post will now become Intercollegiate, representing the educational interests of all four Surgical Royal Colleges equally. The job description has also changed slightly in that it is now a non-Executive position and is funded to a level of approximately half a day a week (or 1PA), and reports directly to the Education Secretary, currently John Pepper, as well as the Director of Education at the College. The reduced level of time reflects the fact that the portfolio is currently complete, but should things get busier and more time be needed in the future, these things can, I am sure, be negotiated.

The courses currently on offer can be found on the Royal College of Surgeons of England website www.rcseng.ac.uk/education/courses/specialty/cardiosurgery.html, and suit a range of training levels. The ‘masterclasses’ previously run for senior trainees and junior consultants have largely been disbanded as many similar opportunities are now being run by Industry, and are also fully funded. A list of courses currently available is shown in the table opposite.

One of my aims has been to abolish lectures in their classical form and to make all the courses either practical or interactive in their format. This has been successful, and any ‘lectures’ are now used only as a link between hands-on sessions or seminar based workgroups, and are only permitted to be 20 minutes long at most.

I firmly believe that the role of Tutor is a very important one, and that it is essential to maintain and continuously adapt educational courses. The Intercollegiate status will, I hope, help to forge educational links between all four Colleges, and will help to maximise efficiency by eliminating competition between similar courses. I hope that my successor will be as enthusiastic and committed to education as I have been, and I am sure that in injection of new blood into the post is a positive move forwards. I should like to thank the Society for all their support, both financially and spiritually, in what has been a very rewarding time for me, and hopefully for the trainees.

Courses Available

<table>
<thead>
<tr>
<th>Title</th>
<th>Target level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Skills in Cardiothoracic Surgery</td>
<td>ST 1-2, ST 3-6, ST 3-6</td>
</tr>
<tr>
<td>Intermediate Cardiac Surgery</td>
<td></td>
</tr>
<tr>
<td>Intermediate Thoracic Surgery</td>
<td></td>
</tr>
<tr>
<td>Applied Basic Science for Cardiothoracic</td>
<td></td>
</tr>
<tr>
<td>surgical trainees</td>
<td></td>
</tr>
<tr>
<td>Advanced Thoracic Surgery</td>
<td></td>
</tr>
<tr>
<td>Bypass, Balloons and Circulatory Support</td>
<td></td>
</tr>
<tr>
<td>Surgical approaches to Atrial Fibrillation</td>
<td></td>
</tr>
</tbody>
</table>

week at The College, as well as attending all the courses within the portfolio generally exceeds the two sessions allocated, and the Trust needs to be aware of the amount of special leave that will be required. This is something that needs to
The Fate of Abstracts presented at SCTS Annual Meetings 2003-2005

Introduction
The Society’s annual meeting fulfils many roles: invited educational lectures, trainee and business meetings, and of course, spirited social gatherings. However, most of the programme is dedicated to the presentation of original research and audit. These oral presentations and posters have an important role in supporting academic productivity, scientific discovery and the career development of young investigators and trainees in Great Britain and Ireland.

Whilst presentation to learned societies is valuable, the target of original research should be publication in a peer-reviewed journal. The strength of a meeting may therefore be assessed by the rate of subsequent publication. We conducted an analysis of abstracts presented at three consecutive SCTS annual meetings to assess the rate of publication, associated factors and reasons for non-publication.

Methods
Abstract books and meeting reports from the Society’s 2003 (Edinburgh), 2004 (Guernsey) and 2005 (London) meetings were reviewed. This period was selected to allow sufficient time for presented work to be published; studies have shown that following academic meetings, more than 95% of resulting papers are published within the next four years. Medline was searched to identify peer-reviewed publication arising from each work. Factors potentially associated with publication were assessed: type (oral v interactive), origin (GB&I or foreign), category (cardiac, thoracic, transplant, congenital, technical/miscellaneous), study design, projection (prospective v retrospective), subjects (human v animal) and whether the abstract won a prize at the meeting. If no publications directly relating to the presented abstract were identified, authors were contacted by email questionnaire to ascertain its status and reasons for non-publication.

Results
826 abstracts were submitted to the three meetings, of which 156 (18.9%) were accepted for oral presentation. Of these, 99 (63.4%) had been published or were in press: 31 of 48 (64.6%) from 2003, 34 of 54 (63.0%) from 2004, and 34 of 54 (63.0%) from 2005. Succeeding papers have appeared in 36 peer-reviewed journals: 58 (58.6%) in cardiothoracic surgery journals, 19 (19.2%) in cardiopulmonary medicine journals, 5 (5.1%) in general medical journals, 5 (5.1%) in basic science journals and 12 (12.1%) in other journals (Figure 1). The median time to publication was 16 months (range -7 to 66 months) with 8 papers mischievously published prior to their meeting (Figure 2). The only factor associated with publication was study design: randomised controlled trials (84.1%) versus observational studies (51.3%).

Of 57 unpublished abstracts, 28 (49.1%) authors replied to an email questionnaire. 3 (10.7%) papers were under consideration, 5 (17.9%) had been submitted and rejected, and 20 (71.4%) were never submitted. The most common reason given was low priority (42.0%), followed by study ongoing, similar results reported by others and low likelihood of acceptance (each 12.9%).

Discussion
So 63% of presented abstracts went on to be published but is this a good return? This can be assessed in two ways: comparison with SCTS meetings from previous years and with meetings of similar societies in other specialties.

Looking back at the ten years leading up to the 2005 meeting (Figure 3), there has been a steady rise in the publication rate from under 30% in 1996 to consistently over 60% in recent years. Potential explanations include better selection of abstracts for presentation, an increased
number of target journals and more high-quality cardiothoracic research being produced in Great Britain & Ireland; it is likely that all three have contributed to this improvement.

The publication rates of other national surgical society meetings are shown in the table but are difficult to interpret. Some meetings have an affiliated journal, follow-up periods were variable and most studies relate to an era when the SCTS rate was considerably lower than at present; then again, our results are the highest reported for such meetings. This may be a time-related phenomenon – it is unknown whether the publication rates for these meetings have also increased in recent years. In addition, direct comparison with other cardiothoracic surgery meetings is not valid as many have an affiliated journal in which most accepted abstracts are subsequently published.

It was disappointing to discover from respondents that over 70% of papers that remain unpublished have never been submitted. These abstracts had withstood peer-review for the meeting but have not been given the opportunity to reach a wider audience. The successful abstracts appeared in 36 different clinical or scientific journals, suggesting a broad range of potential targets for submission; none of these were tested by most of those remaining unpublished. Perhaps this raises ethical considerations, particularly if the studies had utilised prospective patient or animal participation?

In conclusion, in recent years, the SCTS annual meeting has become a forum for the presentation of high-quality research and compares favourably with the national meetings of other surgical societies. Subsequent papers usually withstand peer-review, most commonly in a specialty journal, although those that remain unpublished are generally never submitted.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Meeting(s)</th>
<th>% published</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery (BAPS)</td>
<td>1995-9</td>
<td>31.9</td>
</tr>
<tr>
<td>Orthopaedic surgery (BOA)</td>
<td>1997-8</td>
<td>35.3</td>
</tr>
<tr>
<td>Colorectal surgery (ACPGBI)</td>
<td>2001</td>
<td>24.3</td>
</tr>
<tr>
<td>General surgery (ASGBI)</td>
<td>2001</td>
<td>34.6</td>
</tr>
<tr>
<td>Transplantation (BTS)</td>
<td>2001</td>
<td>35.6</td>
</tr>
<tr>
<td>Emergency Medicine (BAEM/FAEM)</td>
<td>2001-2</td>
<td>30.7</td>
</tr>
<tr>
<td>Urology (BAUS)</td>
<td>2001-2</td>
<td>42.0</td>
</tr>
<tr>
<td>Vascular surgery (VSGBI)</td>
<td>2001-2</td>
<td>59.4</td>
</tr>
</tbody>
</table>

Table: Publication rates of abstracts from other national surgical meetings in Great Britain & Ireland.

Acknowledgements: We thank Antonio Martin-Ucar, Leicester for providing historical data on abstracts presented at the 1996-2002 meetings (Figure 3). We also thank Isabelle Ferner, Domenico Pagano and all abstract authors who responded to our email questionnaire.
The Role of the Society in Clinical Excellence Awards

The Advisory Committee on Clinical Excellence Awards (ACCEA) website states that Clinical Excellence Awards are given to recognise and reward the exceptional contribution of NHS Consultants, over and above that normally expected in the job, to the value and goals of the NHS and patient care. ACCEA operates the arrangements which replaced discretionary points and distinction awards with a single more graduated scheme comprising both local and national elements.

National Awards
The Society for Cardiothoracic Surgery is a recognised nominating body for national awards, and as such can nominate directly through ACCEA and SACDA (the equivalent in Scotland) as well as via the Royal Colleges. The Society’s Committee for Clinical Excellence Awards is made up of: Graham Cooper, Leslie Hamilton, Richard Page, John Pepper, Patrick Magee (Chairman), Lady Irvine (the wife of Sir Donald Irvine and herself much experienced in NHS matters, as a Lay Member).

We plan to recruit an extra member from those consultants who do not hold a national award, and we now are inviting anyone interested in taking on this role to contact either Graham Cooper or myself.

The Society invites those who are eligible and are applying for a national award, and would like SCTS support, to submit an application. All the applications are scored by the Committee using the following system, up to a maximum of 21 points:

- Contribution to SCTS: 0 – 5
- SAC Training/Education: 0 – 5
- Intercollegiate Examination: 0 – 1
- Science/Innovation: 0 – 3
- Service: 0 – 2
- Impact: 0 – 5

A cross-check of the scoring is done using the ACCEA scoring system, whereby each of the five domains in the application form is scored separately with a score of 10, 6, 2 or 0.

Following the scoring process, SCTS nominates directly to ACCEA. The number of nominations allowed is determined by the number of Consultant members of the Society, and currently with the ACCEA we can nominate up to 6 for Bronze awards, 3 for Silver awards, and 2 for Gold awards. The ACCEA does not invite nominations for Platinum awards from specialist societies. The situation with SACDA, although slightly different, is essentially similar. We have no official role in the process in Northern Ireland, but for the highest level of award we can submit citations in support. In addition to submitting rank lists for each level of award, we also provide citations for those being supported. It is most important to stress that the individual submits his or her own application to ACCEA, and SACDA. We, as a Society, only submit rankings and citations.

In addition to direct nomination to ACCEA, SCTS also gathers support for members via the Royal College of Surgeons, especially that of England and Edinburgh. The Glasgow College does not seek nominations from the specialist societies, although we of course provide support for Fellows of the Glasgow College. In the case of the Royal College of Surgeons of England, any surgeon working in England or Wales is eligible to apply to them for support, whilst in the case of RCSEd, any Edinburgh Fellow, regardless of where he or she is working, can apply to them for support. We, as a Society, provide ranked lists to them for Bronze, Silver and Gold awards, and in addition are usually asked to provide citations for those the College decides to support. The Colleges may also of course decide to support Fellows who, for whatever reason, are not on our list, and we of course provide citations for those applicants also. Citation writing involves quite a lot of hard work for the committee, as the timeframe is often short, and several different citations may be necessary for the same applicant. Identical citations signed by several different people on behalf of several different organisations does not score many points with ACCEA! As a Society we do not score Platinum applications, unless asked to by the Colleges. We submit the names, and if the College decides to support them, they may ask us for a citation. The Colleges then nominate those they support for Platinum to the Academy of Royal Colleges, who then decide which to support and put forward to the ACCEA Main Committee.

Timetable for 2010 Round
The proposed timetable for the forthcoming round is as follows, although experience would suggest slippage is common. I believe, however, that this is going to require considerable effort to avoid that this year:

- 2010 Guide available on ACCEA website by end of July 2009
- Letter to be sent to successful candidates in the 2009 round by end of July 2009
- Full results for 2009 posted on ACCEA website by beginning of August 2009
- Submission to SCTS 4th September 2009 (to be finalised)
- Online system for 2010 round available on ACCEA website by end of September 2009
- Closing date for receipt of all applications, ranked lists and citations Friday 11th December 2009
- The deadline for those seeking RCSEng support for Platinum applicants 14th September 2009
- Bronze, Silver and Gold 28th September 2009

For whatever reason, are not on our list, and we of course provide citations for those applicants also. Citation writing involves quite a lot of hard work for the committee, as the timeframe is often short, and several different citations may be necessary for the same applicant. Identical citations signed by several different people on behalf of several different organisations does not score many points with ACCEA! As a Society we do not score Platinum applications, unless asked to by the Colleges. We submit the names, and if the College decides to support them, they may ask us for a citation. The Colleges then nominate those they support for Platinum to the Academy of Royal Colleges, who then decide which to support and put forward to the ACCEA Main Committee.
We, as a Society have to score and then provide the College with rankings by these dates, and therefore the deadline for applications to the Society will probably be 4th September 2009, although Isabelle and Graham will be advising all members of this shortly.

As the online system for 2010 will not be available by that date, we can provide copies in Word of the application forms which members can use for admission to SCTS and Royal Colleges. In addition to the main application, there are three optional supplementary forms, for management, education and training, and research. These are optional and applicants for Bronze and Silver awards may submit one only; applicants for Gold may submit two, and those applying for Platinum can submit up to three!!

Regional Sub-Committees
All national applicants are discussed and scored by regional sub-committee. All ACCEA regional sub-committees are co-terminous of the whole or part of a Governmental Office of the Regions. There are 13 of these in England and 1 in Wales, and each of these is made up of professional (medical), employer and lay members, with a Lay Chairman and a Medical Vice-Chairman. We, as a specialty, are represented on some of these committees, including Simon Kendall on the North East Sub-Committee, B Sethia on the London North West, and me on the London North East Sub-Committee. Bob Jeffrey is currently on the Central SACDA Committee. Each of the sub-committees meets at the end of the process with the Chairman (Professor Jonathan Montgomery) and the Medical Director (Professor Hamid Ghodse) of ACCEA, and agree the rankings for Bronze, Silver and Gold, which is then confirmed at the main committee. Platinum is discussed briefly, but the main ranking is done by the Central Committee.

Filling Out the Form
Members of the Regional Committee have to score a very large number of applicants, often within a very short timeframe. A well laid-out form is more likely to ensure that important points are recognised, and it is important to follow certain guidelines:

1. Keep within the prescribed size limits and the number of characters used
2. Avoid completely filling in the given space, leave some spaces and consider the use of bullet-points
3. Highlight achievements since the last award. No credit will be given for something that has previously been rewarded
4. Use dates frequently to show that entries are current
5. Avoid repeated use of the same achievement in each domain

Local Awards
There is no formal role for specialist societies in the local awards system. However, SCTS will provide citations supporting any member who is applying for a local CEA award. Any member seeking SCTS support should send the Honorary Secretary a brief summary highlighting the reasons why they feel they warrant a new Clinical Excellence Award. These points will be used to help prepare the citation, which will then be signed by the President of SCTS in support of the application.

Finally, remember that applications for national and local awards must be submitted by the applicant. SCTS offers support, nominations and citations, but does not, and cannot, make applications. Further detailed information on the whole process is available at: www.dh.gov.uk/ab/ACCEA/index.htm
At the Annual Meeting in Bournemouth the Society held a symposium to debate some of the most important issues raised by the recent NCEPOD study. NCEPOD published its final report - *CABG – The Heart of the Matter* - in the summer of 2008 so delegates had plenty of opportunity to absorb its recommendations and this resulted in excellent debate. The report made ten principle recommendations and four were chosen for debate – Multi-disciplinary Case Planning, Consent, Morbidity and Mortality meetings and the Management of Urgent Cases. The symposium was chaired jointly by me, on behalf of the Society and Marisa Mason – the Chief Executive of NCEPOD.

After a general introduction and reminder about the major findings of the study, Russell Smith, Consultant Cardiologist at Good Hope Hospital, Sutton Coldfield described the structure of their multidisciplinary meetings – held with surgeon visiting from the Queen Elizabeth Hospital, Birmingham. He described how cases were selected for discussion and some of the advantages he felt came out of the meetings: in addition to fostering good relations with surgical centres, the meeting provides transparency in how cases are selected for CABG or PCI as well as excellent training for junior doctors and other health professionals. His presentation was very well received. The debate focussed on such issues as how cases are selected for discussion, particularly in centres where PCI is readily available. The impact of the changing environment with the advent of primary PCI and the increasing proportion of CABG being for urgent cases was recognised but it was still felt that the MDT had an important role to play in the management of borderline and complex cases. From a show of hands it seems that MDT meetings were held in about two-thirds of surgical centres.

The symposium then moved on to discuss the issue of how consent was obtained for surgery. The topic was introduced by David Richens, Consultant Cardiac Surgeon in Nottingham, who described the findings of the study and outlined the approach recommended by the Health Service Ombudsman, Ann Abraham, in her publication "Consent in Cardiac Surgery. A good practice guide to agreeing and recording consent". Cardiac surgeons had been criticised in the NCEPOD report for both the number of consent forms signed by SHO’s and for the fact that when this was the case it was unusual for SHO’s to quote hard figures for mortality and significant morbidity (such as stroke) on the consent form. However, when consultants signed the consent form with patients, quoting hard figures for such events was the norm. The general tenor of the debate was that this area of practice could and should be improved upon, but many speakers pointed out that the signing of the form was the end-point of a long process of explanation and that there were many examples of good practice to be found. There then followed a discussion about NCEPOD’s recommendation that local data is used when advising patients of the risks they face – most speakers felt that this was appropriate but the opinion was voiced that this was not necessarily realistic or appropriate for more complex and rarely performed procedures.

The third topic discussed was the use of Morbidity and Mortality meetings in the quality assurance process. The debate was led by Domenico Pagano, Consultant Surgeon and Reader in Cardiac Surgery at the University of Birmingham. He described the process used at the Queen Elizabeth Hospital. They grade the care received by patients who died following cardiac surgery according to the NCEPOD classification.

**NCEPOD Grades of Quality of Care**

- **Good practice** – a standard that you would accept for yourself, your trainees and your institution
- **Room for improvement** – aspects of clinical care could have been better
- **Room for improvement** – aspects of organisational care could have been better
- **Room for improvement** – aspects of both clinical and organisational care could have been better
- **Less than satisfactory** – several aspects of clinical and/or organisational care that were well below satisfactory

He showed how using this system can focus the teams caring for patients on areas where changes need to be made. There was praise for the open and transparent way the Birmingham team ran their M&M meetings but concerns were raised about the difficulties some felt about discussing cases in a full and frank
way in front of a mixed audience containing all grades of healthcare staff comprising the wider multi-disciplinary team. Whilst it was recognised that transparency was important the feeling was widespread that the discussion would be more rigorous if the audience was limited to medical senior nursing staff only. At this point Sir Terence English spoke from the floor. Although he has been a regular attender at Society meetings he explained that since his retirement he preferred to listen rather than contribute from the floor. He described the way in which Dr John Kirklin ran M&M meetings at the University of Alabama forty years ago. He described how, as head of department, Dr Kirklin always chaired the meetings and that cases were analysed in detail in a non-confrontational way so that the team could learn from adverse events and improve care for patients in the future.

The final area discussed was the care given to patients requiring urgent coronary surgery. The mortality amongst this group of patients was higher than for patients having elective surgery. They also form an increasing proportion of most units' workload. Many patients have faced long in-hospital waits for surgery as resources have been targeted on waiting times for elective surgery as these are centrally monitored. This results in wasted resources and may be responsible for some of the increased morbidity experienced by these patients. There was general agreement that these patients should be operated on within a week of referral and that unit managers should adopt this as a target to be supported locally.

The NCEPOD study focussed in detail on coronary surgery in the UK for a period of three years. Interestingly the mortality rate fell through this period and the results from coronary artery surgery in the UK are the envy of the world. Our willingness to participate in such studies will help maintain these high standards for our patients.

The report made ten principle recommendations and four were chosen for debate – Multi-disciplinary Case Planning, Consent, Morbidity and Mortality meetings and the Management of Urgent Cases

I would like to take this opportunity to introduce myself. I joined STCS in March 2009, replacing Rachel Woolf as PA to the Meeting Secretary and Treasurer.

Originally studying Fashion at London College of fashion. I then turned my interest to Finance and completed a BA honours in Accounting and Finance at Greenwich University in 2006. For the last few years I have been working in accounts and PA roles until appointment to the role at the Society.

My role is very dynamic and covers many areas. One aspect is to maintain the Society's finances. This involves up keeping of ledgers, accounts payable, credit control, preparing VAT returns and general accounts duties. I have always had a passion for figures so I have quickly got to grips with procedures and initiated my own accounting system. I have also been involved in identifying ways of reducing costs of the Annual Meetings.

The other part of my role is to provide secretarial support to the Meeting Secretary. I am involved with the planning of the next Annual Meeting. This includes site visits, designing the scheme floor plan, securing exhibitors and sponsors, maintaining the annual budget and preparing for registration. I had the pleasure of attending the March Annual Meeting in Bournemouth. This was my first scientific meeting so it was great to see what is expected of me for in the next meeting in Liverpool 2010.

We have also launched a new website www.sctsltd.co.uk for more of our commercial needs. The website will be used for a recruitment job centre and advertisements. I have been helping to sell advertising space on this website as well as space in the Society's Bulletin. Having never worked in sales or marketing I find this a challenge, which I am keen to tackle.

I have so much to learn but also so much to give. I am thankful for being given this opportunity to work for such an established and reputable organization and I hope my career can develop with the Society. I also look forward to working with the new Treasurer Malcolm Dalrymple-Hay, who will be taken over from B Sethia this Autumn.

Tilly Mitchell, SCTS Administrator
tilly@scts.org
TITRe 2 Trial Summary

A multi-centre randomised controlled trial of Transfusion Indication Threshold Reduction on transfusion rates, morbidity and healthcare resource use following cardiac surgery – the TITRe 2 Trial.

Cardiac surgery centres transfuse over 10% of all units of red blood cell (RBC) used in the UK. Although RBC transfusion is essential in some patients for the management of life-threatening haemorrhage, in most cases decisions to transfuse are made because the haemoglobin (Hb) concentration has fallen to a level or threshold at which the physician is uncomfortable. The transfusion threshold varies between units and physicians, contributing to wide variation in the percentage of cardiac surgery patients who are transfused with RBC (25% to 95%). The threshold variation stems from a lack of evidence as to what constitutes a safe level of anaemia following cardiac surgery.

Unnecessary blood transfusions increase healthcare costs both directly, because blood is an increasingly scarce and expensive resource, and indirectly, due to complications associated with transfusion. Transfusion may cause complications by reducing patients' ability to fight off infection and respond to the stress that surgery puts on the body, as well as the better known, but rare complication of infection transmission.

Randomised trials have suggested that, in other patient groups, only transfusing when the Hb level drops below 7.0g/dL reduces transfusion rates as well as complications. However, to date there has been no large high quality randomised trial of different transfusion thresholds in a population of cardiac surgery patients. We propose to test the hypothesis that lowering the RBC transfusion threshold from a haemoglobin (Hb) level of 9.0g/dL (“liberal” control group, similar to current practice at most centres) to 7.5g/dL (“restrictive”) reduces postoperative complications and NHS costs in cardiac surgery patients. The study is a UK multi-centre, randomised controlled trial that aims to assign 2000 patients to a restrictive or liberal post-operative transfusion threshold. The primary outcome will be a composite of infectious and ischaemic events in the first three months after randomisation.

For further information, contact Gavin Murphy at: Gavin.Murphy@bristol.ac.uk

Two new SCTS Posts

Gavin Murphy

Applications are invited for 2 newly created posts. This is a result of the expansion in both the publishing and web-based aspects of the Society's activities.

1. Publishing Secretary

The individual will be responsible for commissioning, designing and editing the Society's Bulletin. The Bulletin has undergone significant changes over the last 5 years. It requires an individual who is committed to progressing this evolution so that the Bulletin continues to meet the demands of the membership. Marketing through the Society's office, to ensure that advertising revenues continue to support the publishing costs, will also be part of this role. In addition, the individual will be responsible for final proof reading of all the Society's published literature and the generation of Society flyers for the Annual Meeting, including the on-site Bulletin and the Annual Meeting Programme. Individuals with a vision as how these elements may be improved and changed in the future are welcome.

2. Web Secretary

This post is for those who are IT literate. This is an exciting time at the SCTS with 2 websites, which are undergoing development/ restructuring. The SCTSLTD.CO.UK website aims to serve the professional needs of the members and but also for generating income for the Society through advertising and the job centre. It will also host discussion fora for various member interests. The SCTS.ORG website will remain as the ‘home’ site with it’s emphasis on education, news and research. Both sites require a dedicated individual to ensure that they remain up to date, relevant and focused on members interests and needs. Again, an individual with vision for the future direction of these sites would be a welcome member of the team. The Web Secretary will also have support from the Society office and a commercially based IT engineer.

It is anticipated that both individuals when appointed will work closely with the existing Communications Secretary of the Society who will have overall responsibility for the delivery of high quality paper and web-based publications. The future strategic direction and goals will be agreed and set within the team and subsequently ratified by the Executive Committee. The tenure is initially for 3 years and renewable thereafter; the posts are open to Consultant members of the Society.

Please send an abbreviated CV with your qualifications for these posts and your development goals. Applications should be sent by mail to the Isabelle Ferner at the Society office or by email: sctsadmin@scts.org. Closing date is 30th August 2009.
I have been the Trainee Representative for almost 18 months. During this time I have seen positive changes pertaining to training and general outlook for cardiothoracic trainees. I am proud to be a cardiothoracic trainee and feel privileged to be representing the trainees during this exciting time.

The Trainee Forum at the Society meeting in Bournemouth was a great success. Over 100 trainees attended the session, almost double the number from previous year. This is an indication of increasing involvement of trainees to forge a brighter future in cardiothoracic surgery. The Forum was supported by a panel consisting of Mr T Graham, Dr Vicky Osgood, Mr C Munsch, Mr S Livesey, Mr P Rajesh, Mr B Jeffrey, Mr S Hunter, and Mr S Barnard. They entertained questions ranging from entry into specialty, to FRCS(CTh) examinations, to quality of training, to the thorny issue of European Working Time Directive (EWTD). Regarding EWTD, it is approaching fast and will be here in August 2009. General consensus is to examine various methods of training within 48 hour per week time constraint. Suggestions put forward include, trainees to become supernumerary to eliminating night-time duties for trainees.

We need to forge ahead with finding solutions to optimize our training within the time constraints imposed by the EWTD. A contribution to this endeavour is the introduction of procedure based assessments. Another aspect to push for is trainee-trainer matching. There are many ideas floating around but the onus is on us, the trainees, to take responsibility of our training. We are the future and we need to take an active role in defining our future.

Recruitment into the specialty at specialist level was done via the national selection process from January to March 2009. This was second year such a process was undertaken and 16 candidates were selected. I was invited as an observer during the 3-day interview process and I felt that it is a robust and fair process. On the first day, each candidate was interviewed by 2 separate panels of 2 interviewers. First interview involved 6 specific questions asked to all. Second interview was review of portfolio. On the second day, each went through 3 practical stations testing surgical skills and hand-eye coordination. On the final day, all did a presentation on a topic given following short listing. Candidates who were shortlisted for the Academic Clinical Fellow (ACF) posts, in addition to above, on the first day had two further rounds of academia related interviews by the academic team. Each candidate was scored at each station and the scores were collated on the final day. Each was ranked and the first 16 were selected of which 2 were ACF posts. One important requirement for the ACF appointment was that they should have been ranked among the top 16 on the general interview section. Successful candidates were then matched to respective deanery as per their choice. Candidate number one got the first pick, second ranked candidate was then matched, and so forth. It is a very well thought out and comprehensive process.

Tremendous amount of thought and effort are being ploughed into raising the awareness of cardiothoracic surgery amongst medical students through to core trainees in surgery. We have embarked on a mission to get medical students involved in cardiothoracic surgery by experiencing the specialty in some form during clinical attachments. We are also exploring avenues to provide bursaries to medical students to undertake electives in the specialty, either in the UK or abroad.

Over 100 trainees attended the Forum at Bournemouth - almost double the number from previous year.

But as always, we can only move forward together...
Throughout our medical training we are exposed to challenging and stressful situations which trial and strengthen our communication and presentation skills. No amount of rehearsals, examinations or interviews can prepare one for a life-changing interview.

The 2009 interviews for the National Recruitment for ST3 in Cardiothoracic Surgery were held over 3 days in Birmingham in March 2009. Fourteen clinical NTNs and two Academic Clinical Fellowships were advertised and a total of 45 candidates were shortlisted. The interview form requested an order of job preference and successful candidates were subsequently ranked and matched to their choice accordingly.

The interview process: The first day was divided into two parts, with structured questions in the morning and portfolio based questions in the afternoon. Both sessions lasted 30 minutes, with two interviewers present at each session. The structured questions were based on factual knowledge of cardiothoracic surgery concentrating on clinical management, case prioritization, probity and good clinical practice. I found the questions fair, relevant, and appropriate to our daily clinical practice. The portfolio session consisted of questions based on our individual portfolios, giving us the opportunity to discuss our career progression and achievements in depth.

On the second day we were assessed on our practical abilities and surgical skills using OSATS (objective structured assessment tools). There were three OSAT stations lasting 20 minutes each, with two examiners at each session. The knot tying station measured each candidate’s efficiency via special gloves linked to a computer program. The VATS station comprised of specific tasks performed with laparoscopic instruments, and the dissection station involved exposing the sapheno-femoral junction in a groin model using commonly used surgical instruments. We were also filmed whilst performing the dissection and knot tying and though this was initially slightly daunting, it was good practice as we are increasingly expected to operate in front of other colleagues, and in particular this is quite common in training courses.

The last day involved a five-minute audit presentation assessed by a group of consultant surgeons who then questioned us for a further five minutes. This was fairly stressful to start with, but again a good test of our skills and practice for future presentations. At the end of the day we were asked to participate in a virtual reality VATs exercise where we were asked to perform certain tasks using laparoscopic tools on a computer program. This was to help evaluate the usefulness of this as a future assessment tool. I enjoyed this session and think this was an efficient way of measuring hand-eye coordination and will be helpful in future interviews. Successful candidates were informed of the outcome by telephone the next morning.

An interview is always a stressful experience and this was no different. Throughout the three days however, we were very well looked after by Mr Steven Hunter, the Cardiothoracic Dean, Mr Tim Graham the chairman of the SAC and of course the West Midlands Deanery staff, who were always at hand to answer questions and direct us as required. Overall although the three days were grueling, intense and not particularly enjoyable at times, the questions and the process as a whole were fair and objective.

There has been considerable interest (and anxiety) from trainees about the National Selection Process for Cardiothoracic Surgery. We thought it might be helpful to have the account of 2 trainees who went through the process this year to inform those who may be considering applying for the next round. As editor, I have not taken my editorial knife to any of the reports, and I make no apology for the duplication in the two accounts, as they remain intact as two unique perspectives on the process. I thank Alia & Melanie for their submissions and congratulate them on their success!

Alia Noorani
ST3 Cardiothoracic Surgery, East of England Rotation

There has been considerable interest (and anxiety) from trainees about the National Selection Process for Cardiothoracic Surgery. We thought it might be helpful to have the account of 2 trainees who went through the process this year to inform those who may be considering applying for the next round. As editor, I have not taken my editorial knife to any of the reports, and I make no apology for the duplication in the two accounts, as they remain intact as two unique perspectives on the process. I thank Alia & Melanie for their submissions and congratulate them on their success!
The 2009 application process for the national training numbers in cardiothoracic surgery opened in January. The process was organised by West Midlands Deanery and gave us 10 days to complete an online application (I:CAMS) form. There were 16 posts: 14 clinical ST3 training posts and 2 academic clinical fellow (ACF) positions.

Initially the I:CAMS application form looked like a nightmare, but after navigating through the different sections, it did actually make sense and was fairly intuitive to use, if a little slow at times. The application required a mixture of details from your CV and portfolio, including logbook and extra-curricular activities, along with sound questions that were appropriate to our field of cardiothoracic surgery.

Short-listing for interviews was released in mid February, with 47 applicants competing for the 16 training posts. Of these, only a handful of candidates were being considered for the ACF posts.

The interviews were held over 3 days in March at Birmingham City Football Club and were structured in a way to test the candidate rigorously, but fairly. The first day consisted of two 30-minute interviews. There was a structured interview in the morning designed to test your clinical acumen; coping skills in certain situations and also your views on your own career progression. In the afternoon, there was a review of your portfolio. A panel of 2 consultants conducted both interviews.

The second day was OSATS (Objective Structured Assessment of Technical Skills) day! This consisted of 3 skills stations used to assess manual dexterity, movement economy, tissue and instrument handling. The skills stations lasted 20 minutes each and included knot tying, dissection and a thoracoscopic skills station.

The final day of interviews was reserved for audit presentations. Each candidate had 5 minutes to present an audit project, which included time for questions from the panel.

The process was very similar to the 2008 interviews, with improvements. This year, we were given excellent information and the days ran very smoothly, which was a huge achievement given the number of candidates and also the number of consultants involved in assessing us. Lady Cynthia was the Lay Chairwoman and was always on hand to check that the process was being conducted appropriately and fairly.

Obviously, given the number of candidates short-listed, the interviews had to run over 3 days. Most of the candidates stayed in the same hotel, which made the evenings more sociable, but also at times, created an air of mass panic, as people went off for the next assessment or interview!

Overall, although this was undoubtedly the most important and nerve-wracking interview of my career so far, I rather enjoyed the 3 days and was able to share a couple of laughs with the panel when discussing things. I believe the process tested us thoroughly and in a non-discriminatory way. Every candidate at the interviews had great potential, and the three-day process was designed to give us the opportunity to shine. The hardest part was waiting 24 hours for the results!
The Society Cardiac Scholarship
at the Royal Melbourne Hospital,
Melbourne Australia

I have always wondered why more UK cardiac surgical trainees do not undertake overseas fellowships – that is until I had to move my family to Melbourne, Australia! The move was challenging for us all but the rewards have been immeasurable.

I had always planned to do a fellowship abroad and I was quite clear about what I wanted to achieve. I wanted to avoid the trap of following the well-trodden path to the large North American centres with ‘the big names’, which, whilst great for the CV, may not guarantee sufficient hands on experience. I certainly wanted to go to a ‘well known unit’, with a history of innovation, a high proportion of high-risk cases and the likelihood of extensive hands on experience. Essentially I wanted a fellowship that would prepare me to perform my day-to-day work as a consultant in the NHS to a very high standard. The Royal Melbourne Hospital seemed to fit the bill.

The philosophy of healthcare delivery in Australia lies somewhere between the UK and the USA approach. About 40% of Australians have private healthcare and the public hospitals in essence compete with the private sector for this population. This arrangement drives standards in the public sector, encouraging innovation and uptake of the latest techniques and technologies. Public hospitals are very well funded. Some standard features in a public cardiac surgical unit include having two consultant anaesthetists for every cardiac case, routine intra-operative tranoesophageal echocardiography and cardiology consultants on hand to give intra operative opinions. These are luxuries that I will miss. The other obvious effect of the private sector is that it encourages intervention and I never ceased to be amazed by the age and/or the list of co-morbidities of patients referred for cardiac surgery. For instance, being over 90 years of age is no barrier to redo surgery or major aortic arch surgery.

The Royal Melbourne Hospital (RMH) is the largest teaching hospital in Victoria, performing over 1200 cardiac cases per year. It is consistently the best performing unit amongst units submitting data to the ASCATS (Australian Society of Cardiac And Thoracic Surgery) database. Last year’s 30-day mortality for all comers was 1.4% and the re-exploration rate for bleeding was 0.6%. The unit is best known for being one of the world’s leading proponents of total arterial revascularisation and they really practice what they preach. Vein graft harvesting is a very rare occurrence at the RMH whilst bilateral radial harvesting in 80+ years olds is the norm. There is a large thoracic aortic practice and endovascular thoracic surgery is well established. The RMH was the first unit in the world to report EVAR for traumatic aortic rupture. The unit has a large GUCH practice and has one of the world’s largest experiences with the Ross procedure. The RMH is one of two trauma centres in Victoria. Trauma cases from the entire state (an area the size of the UK!) are flown in daily. There was therefore an excellent opportunity to deal with a large volume of cardiac and thoracic trauma and this accounted for over 80% of our out of hours activity.

My Experience
A highlight of my time here has been the extensive level of independent operating that I have been able to undertake. As a fellow I was in theatre five days a week with minimal commitment to ward or outpatient care. In the first six months of the fellowship, I was allocated three all-day operating sessions per week, during which I performed a range of operations, with minimal consultant supervision. The patients were selected from the joint cardiac waiting list. They included medium to high-risk patients undergoing CABG, AVR and aortic surgery. I routinely performed CABG with bilateral internal mammary and bilateral radial artery conduits. Sequential, T-graft, and Y-graft techniques were the norm. This was a key benefit of the fellowship. The opportunity to select my own patients, perform surgery and be in charge of the post-operative care was fantastic. I also had the opportunity to train Australian trainees to perform coronary and valve surgery.

During the second half of my fellowship, the emphasis was on performing more complicated procedures, particularly aortic surgery. Most of this attachment was spent with the three senior surgeons in the unit; Mr J Goldblatt (aortic surgeon), Professor Tatoulis (mitral valve surgeon) and Mr P Skillington (GUCH surgeon). I performed complex aortic surgery including the ‘David’ aortic root remodelling procedures, The ‘Florida sleeve’, warm aortic arch surgery, the Ross procedure, aortic valve repair, homograft aortic valve replacement and thoracic aortic endovascular stenting. I have also performed complex mitral valve repair.
surgery, multiple valve replacement surgery; redo surgery, and other GUCH procedures. No case was considered too high risk for teaching. Independently performing an emergency Redo CABG admitted straight from the catheter suite with IABP support and aortic valve replacement surgery in a ventilated patient with decompensated aortic stenosis on multiple ionotropes are two examples, which come readily to mind.

One day a week was spent performing thoracic surgery. I performed several major lung resections and gained experience in VATS lobectomy, which is routinely performed here. The thoracic trauma workload is huge and includes procedures rarely performed in the UK, like rib fixation for trauma which is being investigated in a large randomised trial. Overall, in less than 12 months I performed 152 cardiac procedures and 50 major thoracic surgical/trauma procedures. There is a significant amount of research activity in the unit mostly centred on arterial grafting. I co-authored five separate original articles as well as a variety of case reports and review articles, which will be published in the JTCVS, the ATS and JACC. This work has been presented at the 2009 SCTS meeting in Bournemouth and the Annual meeting of the Australian Society of Cardiac and Thoracic Surgery in Queensland (2008).

Living and working in Melbourne

I was lucky to undertake my fellowship in a city as beautiful as Melbourne. It is consistently regarded as one of the best cities in the world in which to live. It has a vibrant cosmopolitan feel with an interesting mix of new and older architecture: cubic style Millennium buildings juxtapose 18th century Anglican cathedrals. My wife and 2-year-old daughter have really enjoyed Melbourne's laidback friendly approach, café culture and extensive facilities for children. We have been very privileged, as a family, to visit some particularly beautiful parts of the Southern hemisphere including Tasmania and the South Island of New Zealand.

Working in Australia has been a delight. The ‘can do’ attitude for which Aussies are famous makes working in a team very easy. My experience overall has been excellent. The heavy operative commitment provided an excellent opportunity to develop independent practice. I have acquired skills, which will be widely applicable to my day-to-day work as a consultant in the NHS and will enable me to deliver a high quality service. Furthermore, this fellowship has allowed me to practice cardiac surgery in an entirely different environment from the one I am used to. It has been an excellent training experience and my family and I are grateful to the Society for its generous support that made this fellowship possible.

New Appointments

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<th>Name</th>
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<td>Ranjit Deshpande</td>
<td>Kings College Hospital, London</td>
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<td>Maciej Matuszewski</td>
<td>New Cross Hospital</td>
<td>Cardiac</td>
<td>October 2008</td>
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<td>Malgorzata Kornaszewska</td>
<td>University Hospital of Wales</td>
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<td>Mahmoud Loubani</td>
<td>St George's Hospital</td>
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In the last Bulletin I stated that Bournemouth was easy to get to... and as I sat in the coach replacing the train from Southampton airport to the town centre I suspected that some delegates might contest my claim.

Despite the challenges of travel an amazing 480 delegates registered this year making it another record attendance, and in general the feedback has been very positive – hopefully indicating that the meeting is becoming more and more relevant to our professional lives.

Sunday afternoon started with the best attended Trainees Meeting to date. Sunil Bhudia had created a topical and interesting agenda ranging from National Selection to the Specialty Exam with speakers including the SAC chair, Tim Graham, the Postgraduate Dean, Steve Hunter and the Chairman of Intercollegiate Exam Board, Bob Jeffrey.

Also on Sunday afternoon the Association of Cardiothoracic Surgical Practitioners (ACSA) held their AGM. This is the second time they have decided to hold their meeting in conjunction with the SCTS and included a presentation from Papworth on how surgical practitioners are now performing sternotomies and harvesting the IMA.

After an impressive term of office as President, Tony Jessop (Hull) is being succeeded by Toby Rankin (Plymouth).

**Database Managers**

The Database Managers’ Meeting held their fourth annual meeting, and CCAD have generously supported them all. Tracey Smailes (Middlesbrough) had arranged an interesting agenda including presentations by Phillip Kimberley, Royal Brompton /Harefield and Sheila Jamieson from Freeman Road Hospital. After lunch the main auditorium was packed to hear presentations regarding UK cardiothoracic activity in its entirety, chaired by Ben Bridgewater. This included challenging presentations on the past, present and future of UK transplant activity (Professor Dark) and congenital surgery (Mr Leslie Hamilton). This session was concluded by an outstanding talk by Sir Bruce Keogh on quality indicators in the NHS. His presentation captivated the audience, which included 12 patient representatives from the Bournemouth and Southampton area.

This was the first time that patient representatives had been invited to our annual meeting, all of whom were presented the Melbourne arterial experience and Malcolm Dalrymple-Hay presented the evidence for endoscopic vein harvesting.

The Mayor of Bournemouth generously hosted the Welcome Reception, where delegates relaxed and caught up with friends and colleagues.

More blue sky and sunshine greeted us on Monday, which started early with a well attended scientific session. The plenary session combined the surgeons, ACSA and the Cardiothoracic Forum and was concluded by Professor Alain Carpentier presenting his insight into the recent developments of the total artificial heart.

**Symposium**

After the Hunterian lecture by Patrick Tansley, ‘Reversal of Heart Failure’, we gathered in the main auditorium for the symposium ‘Choice of conduit for CABG’. David Taggart reviewed the current evidence, Philip Heyward
leaders in their respective patient groups. Our executive patient representative, David Geldard MBE, hosted them throughout the day and we enjoyed receiving their feedback on their experience. This is a development that we want to continue in our future meetings and there are already plans for the Liverpool meeting.

The Forum
The Cardiothoracic Forum was privileged again to welcome Maura Buchanan, President of the RCN to give the opening remarks and this was followed by a very touching and provocative session where the group shared the experiences of patient Lisa Kitteridge, who had spent many weeks in hospital under cardiothoracic care being treated with an LVAD. There were presentations from the lead professionals involved in her care, reminding everyone of the great service that we provide, but also how we should always remember to put the patient at the forefront of our thoughts.

Dr David Adams, Mount Sinai Hospital, New York gave the Heart Research UK lecture on mitral valve repair and on the following day he was involved in the very popular cardiac workshop with the help of Frank Wells (tricuspid) and Professor Mark Redmond (aortic).

After tea on the Monday the Thoracic Surgical content started in abundance. In the Cardiothoracic Forum, Eric Lim gave an update on lung cancer staging, followed by a symposium that included Richard Berrisford in his current role as Secretary of the European Thoracic Surgical Society and Alessandro Brunelli (Ancona) who presented the European perspective on auditing quality of care in thoracic surgery.

The day concluded with a symposium on TAVI organised and chaired by Neil Moat. The audience could only be impressed how this new technique is being applied so effectively. Dr Martyn Thomas (St Thomas') presented the cardiology views of success and we enjoyed Professor Friedrich Mohr's (Leipzig) presentation on his outstanding programme and his vision for the future.

Perfusion Scientists
We were delighted to welcome back the Society for Clinical Perfusion Scientists, Great Britain and Ireland, who had elected to continue their association with our annual meeting by holding their workshop on unit accreditation as well as their committee meeting. Although, it is not possible for us to fully merge our annual meetings, it is hoped that we can continue this association for years to come.

On Tuesday we welcomed the congenital surgeons, who had requested an additional session compared to their two previous meetings. Dr Andrew Cook, Morphologist brought specimens to demonstrate the anatomy for Atrioventricular septal defects and in the afternoon we also welcomed Dr Nicholas Doll from Stuttgart to discuss atrial fibrillation.

The thoracic surgeons adopted an oesophageal theme, and following presentations on the subject we were
honoured to welcome Dr Tom DeMeester to present the thoracic surgical lecture on the history of en-bloc oesophagectomy.

In total 111 papers were presented throughout the Annual Meeting and also displayed as posters in the exhibition area. I am greatly indebted to Ian Wilson who has been very innovative with the content and guests. The lead reviewers were pivotal in creating the scientific content - they organised their co-reviewers and the selection process, going on to construct themed sessions that appear to be more popular than our previous format.

Each paper is scored by two chairman and two assessors – over 60 individuals who are vital to the smooth running of the sessions, to encourage good discussion and to score the presentations.

The support from Industry continues to be outstanding despite the current economic recession. Rachel Woolf has now emigrated to Israel and this was to be her last meeting since joining in 2004 – she has nurtured excellent relations with established and new companies and has left us in a much more secure setting than when she started. The meeting could not continue in its present format without industry's close involvement, not only in terms of the exhibition area, but also their sponsorship of scientific sessions. We try very hard to give each of them value for their money and hope we can maintain the relationship to our mutual benefit.

The Cardiothoracic Forum continued to be very well attended on the Tuesday with papers sharing best practice, as well as a session discussing the modernisation of nursing careers and the strategic impact of changing our workforce. The Forum contributes immense added value to the Annual Meeting – Tara Bartley has been the nursing representative since 2006 and has developed the forum out of all recognition. The content has expanded but not at the expense of the quality, and she has attracted outstanding speakers to talk to a carefully considered agenda.

After lunch on Tuesday Steve Livesey organised an NCEPOD symposium to share best practice in MDTs for coronary revascularisation chaired by Marisa Mason, who is herself chairman of NCEPOD.

Prizes
For the second year in a row all the tickets for the annual dinner had been sold, which included a seaside theme before and after the meal. We were delighted that Isabelle Ferner’s father was able to entertain us on the piano throughout the meal, during which the prizes and the scholarships were announced –

Ronald Edwards Medal for Best Scientific Paper –
H Fallouh – King’s College Hospital London

John Parker Medal for Best Clinical Paper –
S Attaran – King’s College Hospital London

Society Thoracic Medal for Best Thoracic Paper –
K Sarraf – Royal Brompton Hospital London

Society CT Forum Medal for Best Forum Paper – Author / Unit
P Agostini

The Society Cardiac Scholarship –
Paul Modi

The Society Thoracic Scholarship –
Carol Tan

At the conclusion of the meal Sir Terence English was awarded his lifetime achievement award for his outstanding contribution to cardiothoracic surgery and in particular transplant surgery. His career was beautifully summarised and presented by Frank Wells.

The Annual Meeting continues to evolve and tries to adjust to current trends in our clinical lives as well as the NHS in its entirety. Prior to 2002 the Annual Meeting was organised by Concorde Services and in some respects it was a duty rather than an enjoyment to attend. As a society we benefited from Rob Lamb’s personal circumstances that allowed him to work so hard to restructure the meeting and allow it to develop as it has. In recognition of his achievement he was presented with an honorary lifetime membership of the society.

Finally I must acknowledge the superhuman contribution by Isabelle Ferner – she is fundamental to so many aspects of the meeting and we are very fortunate as a Society to enjoy the excellence that she continually delivers.

We hope we can continue to develop the meeting in Liverpool next year. The new conference centre is magnificent, situated next to the city centre on the banks of the Mersey and I hope you will be putting the dates in your diary: 7th - 9th March 2010.

We hope to see you there!
## Diary of Forthcoming Events

<table>
<thead>
<tr>
<th>Date: 16 January 2009</th>
<th>Meeting: Yorkshire Advanced Chest Imaging Course</th>
<th>Town: LEEDS UNITED KINGDOM</th>
<th>Venue: Radiology Academy, Leeds General Infirmary, Leeds LS1 3EX</th>
<th>Contact: Dr R J H Roberson, Consultant Radiologist</th>
<th>Email: <a href="mailto:radiologycourses@hotmail.co.uk">radiologycourses@hotmail.co.uk</a></th>
</tr>
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<tbody>
<tr>
<td>Date: 31 July - 4 August 2009</td>
<td>Meeting: 13th World Conference on Lung Cancer (WCLC 2009)</td>
<td>Town: SAN FRANCISCO, CA UNITED STATES</td>
<td></td>
<td>Contact: Khara Robertson</td>
<td>Email: <a href="mailto:wclc2009@meet-ics.com">wclc2009@meet-ics.com</a></td>
</tr>
<tr>
<td>Date: 10 - 11 September 2009</td>
<td>Meeting: 3rd David Sharpe Memorial Symposium</td>
<td>Town: BLACKPOOL UNITED KINGDOM</td>
<td>Venue: Lancashire Cardiac Centre, Blackpool Victoria Hospital</td>
<td>Contact: Lorraine Richardson, L R Associates</td>
<td>Email: <a href="mailto:lorrainericharson1@btinternet.com">lorrainericharson1@btinternet.com</a></td>
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<tr>
<td>Date: 14 - 16 September 2009</td>
<td>Meeting: BACCN Conference 2009</td>
<td>Town: BELFAST UNITED KINGDOM</td>
<td>Venue: Waterfront Hall</td>
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<tr>
<td>Date: 24 - 27 September 2009</td>
<td>Meeting: Birmingham Review Course in Cardi thoracic Surgery</td>
<td>Town: BIRMINGHAM UNITED KINGDOM</td>
<td>Education Centre, Birmingham Heartlands Hospital</td>
<td>Contact: Lorraine Richardson L R Associates</td>
<td>Email: <a href="mailto:lorrainericharson1@btinternet.com">lorrainericharson1@btinternet.com</a></td>
</tr>
<tr>
<td>Date: 29 September - 1 October 2009</td>
<td>Meeting: First International Meeting of the Jordanian Association of Thoracic and Cardio Vascular Surgeons</td>
<td>Town: AMMAN, JORDAN</td>
<td></td>
<td>Contact: Dr. AbdullahAl-Qudah Fawz Shocair</td>
<td>Email: <a href="mailto:dima@e-pamj.com">dima@e-pamj.com</a></td>
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<tr>
<td>Date: 23 - 24 October 2009</td>
<td>Meeting: Society of Clinical Perfusion Scientists of GB &amp; Ireland Congress 2009</td>
<td>Town: LEICESTER UNITED KINGDOM</td>
<td>Venue: The Marriott Hotel</td>
<td>Contact: Simon Philips</td>
<td>Email: <a href="mailto:simon.philips@stgeorges.nhs.uk">simon.philips@stgeorges.nhs.uk</a></td>
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<tr>
<td>Date: 5 - 6 November 2009</td>
<td>Meeting: Advances in Thoracic Surgery</td>
<td>Town: LONDON UNITED KINGDOM</td>
<td>Venue: National Heart and Lung Institute</td>
<td>Contact: Maria Leung (PA to Eric Lim)</td>
<td>Email: <a href="mailto:atso9@rbht.nhs.uk">atso9@rbht.nhs.uk</a></td>
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<tr>
<td>Date: 6 November 2009</td>
<td>Meeting: Yorkshire Chest Imaging Course</td>
<td>Town: LEEDS UNITED KINGDOM</td>
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A UK Surgeon’s Perspective on the AF Consensus Statement…
But What Do you Think?

With last year’s publication of the Consensus Statement on catheter and surgical ablation for atrial fibrillation (AF) (Hugh, Josep et al. 2007; www.heartrhythmjournal.com/article/S1547-5271(07)00498-5/fulltext), there now exists some guidance towards treating and managing patients with both paroxysmal and persistent AF. Over the past few years the management of AF in cardiac surgical patients has been expanding but there has been little in the way of advice to those staring out. The Consensus Statement provides a framework that an individual and/or unit can use to embark and develop a programme for the management of AF. The statement consists of thirteen sections, the bulk of them relating to catheter based interventions. The statement also acknowledges the limitations of consensus agreement, i.e. there was not complete agreement by all authors on all the consensus statements. In common with previous reports, representation from the cardiac surgery was limited. In this article the application of the statement to cardiac surgical practice in the UK will be discussed.

The definition of AF has been addressed and it is recommended that the following terms be used: Paroxysmal, Persistent, Longstanding Persistent and Permanent (Table 1). This classification does away with Cox’s (Cox 2003) simpler classification of AF being intermittent or continuous. The current classification appears to be more treatment orientated.

The origin and mechanism of AF is outlined. This should be read in conjunction with excellent articles by Nattel (Nattel 2002) and Wyse (Wyse and Gersh 2004). These papers review the current theories of the development of AF and explain the evolution from focal triggers in paroxysmal AF (PAF) to substrate change (atrial remodelling) in persistent AF. In this way one can view the clinical picture of a patient as a continuous process that starts as episodes of PAF due to predominately focal triggers of arrhythmic activity and over time becomes persistent due to atrial remodelling.

Currently it is rare in the UK for patients to undergo surgical treatment for lone AF. The vast majority of patients presenting to the surgeon are those with concomitant AF. The management of these patients is highly variable in the UK. The Statement should help to develop a more uniform approach to patients with AF and hopefully management of complications and follow-up. Catheter based AF treatment is time consuming and in these situations, the procedure is technically demanding and requires a skilled operator. In contrast, concomitant ablation in the operating theatre requires skill and knowledge that is easily taught and reproducible. The modern ablation devices are relatively user friendly and quick to use and complications are now rare. All major device manufacturers provide training in the UK with either visits to centres or

<table>
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<th>Table 1</th>
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<tr>
<td>Paroxysmal AF</td>
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<td>Persistent AF</td>
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<tr>
<td>Longstanding Persistent AF</td>
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<tr>
<td>Permanent AF</td>
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The environment in which patients undergo ablation for AF is of paramount importance, particularly for the catheter based procedures. The statement provides principles on how training and competence should be achieved. This ranges from patient selection, anatomical knowledge, conceptual knowledge, technical ability, bringing proctors to a surgeon’s own unit. The technical expertise required to perform an ablation in concomitant procedures is well within the ability of cardiothoracic surgeons.

Although the technical aspects of surgery for AF are easy to master, the extent of the lesion set has been variable between individual operators. The Statement does not set out to define a specific lesion set, but does provide two general observations. Firstly, that more extensive left atrial lesion sets provide better long-term freedom from AF and secondly, results are significantly better with biatrial lesions sets when compared to left atrial lesion sets alone (up to one third of patients have triggers outside of the pulmonary veins). This is more relevant to surgical practice as most patients with AF coming to surgery have either persistent or longstanding AF. In these patients the likelihood or return to SR will be poor with...
PV ablation alone. It will be necessary in these patients to perform extra lesions in the LA and for maximal success rates to treat the RA. This should be taken into consideration when the patient is being consented for this procedure. It would not be acceptable to quote success rates obtained from studies using biatrial ablations to be quoted to a patient having PV isolation alone for longstanding AF.

Although not stated in the Consensus Statement, researchers have been aware of the impact of LA size on the success rate of ablation for AF. No specific size is mentioned, but previous studies have suggested that LA sizes greater than 50-55 mm have lower success rates (Grubitzsch, Beholz et al. 2008), (Geidel, Ostermeyer et al. 2005). A large number of patients undergoing cardiac surgery have atria similar or larger than this and this will impact on long-term results of ablation. The Statement is light on how to manage the left atrial appendage and the Ligament of Marshall. Both these are easily dealt with during concomitant procedures, but pose challenges for the catheter and minimally invasive approaches. The lack of any consensus on this matter is probably more a reflection of the preponderance of cardiologists on the panel. Both these structures should be dealt with in patients undergoing an open surgical procedure. The ligament is easily divided and the appendage can be dealt with by a number of recognised ways. The Ligament of Marshall has been implicated by a number of authors as a site for triggers and recurrence.

It is no longer sufficient to perform a lesion without demonstrating conduction block. This has been common practice in the catheter lab, but not in the operating theatre. With the new ablation kits available, pacing and sensing probes are now sufficiently developed to allow intra-operative testing of conduction block. The newer tools also permit the localisation of autonomic ganglionic plexi, the ablation of which has been shown to increase the rate of success.

Surgical treatment for lone AF has been obtained within the UK but it has been limited by logistical and economical factors. The consensus recommends that patients only undergo stand alone AF treatment in symptomatic patients who prefer a surgical approach, have failed catheter ablation or in whom catheter ablation is contraindicated. Such patients will only come through via electro-physiologists, and in such instances there needs to be more of a multi-disciplinary approach. Proper documentation of the type of AF, LA size, planned lesion set, management of the LA appendage, ablation of ganglionic plexi, documentation of conduction block (see below) needs to be done. With such a plan it will then be possible to consent the patients in a more informed manner. In such circumstances the success rates and risks quoted to the patient should be those based on the units owned experience.

The measurement of success following ablation now has a specific meaning. The primary endpoint is ‘Freedom from AF/flutter/tachycardia off anti-arrhythmic therapy’. The aim of such a strict definition appears to be to provide an ideal state form the patient’s perspective. If widely adopted it will also permit easier comparisons between the various ablation technologies. The follow-up of patients following ablation will impact on standard cardiac surgical practice. Units carrying out ablations should ensure that there are adequate follow facilities and that referring physicians are aware of the need for detailed follow up. It is recommended that patients are seen for two years following ablation and that spot ECGs as a means of confirming success are not satisfactory. Using standardised definitions of success and monitoring it will make it easier in the future to compare the results from different studies.

Surgery has a major role in the treatment of AF. The initial work by Cox has set the methodological approach that surgeons should still adhere to. The aim of such procedures is to cure the patient of AF, relief of symptoms and abolition of long-term problems of AF. In the current era it is easy to be lured into a false sense of security that one is doing the right thing. Surgeons should not limit themselves to inappropriate lesion sets just because certain lesions are not done in the catheter lab. Equally they must resist being restricted by the limitations of technology. The consensus statement provides the groundwork upon which we can build a scientific approach to the various treatments being offered in the treatment of AF. For surgeons this entails treating symptomatic patients or patients in whom the procedure will not incur undue risk. Patients with paroxysmal AF will do well with a left sided ablation alone, but for persistent and longstanding AF a biatrial ablation is strongly recommended.

Ablation patients require long-term follow up. It is not practical for all patients to return to the tertiary centre for such follow up. Using the Consensus Statement, cardiac networks should be able to draw up local protocols for selecting, treating and following up patients. There are a number of unresolved issues, but using such a network approach will permit units to find answers and work in the patients’ best interest.

Please submit your views either directly to: Uday.Trivedi@bsuh.nhs.uk, or log on to the website at www.SCTSLTD.co.uk
Send your solution to: Samer Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744 by 31 July 2009. Solutions from areas over 10 miles from Cambridge will be given priority.

Last issue’s winner:
The winner of the last crossword is Mr Mark Miller, Chief ODP, Department of Cardiac Surgery, Royal Sussex County Hospital, Brighton BN2 5BE
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Indications: Supportive treatment where standard surgical techniques are insufficient. For improvement of haemostasis, or as a tissue glue to promote adhesion, sealing or as suture support.

Dosage and Route: A thin layer is applied to the tissue surface where required. The dose depends on the size of the surface to be covered and method of application chosen. Apply topically – tissue surface should be as dry as possible before application. Application can be repeated if necessary.

Side effects: See Summary of Product Characteristics for detail. Hypersensitivity/anaphylactic/anaphylactoid reactions may occur, especially in patients who have previously received aprotinin. Early symptoms of allergic reactions include flushing, urticaria, pruritus, nausea, hypotension, tachycardia or bradycardia, dyspnoea. Do not inject – risk of thromboembolic complications.

Precautions: Apply with care in coronary artery bypass surgery due to increased risk of inadvertent intravascular application. TISSEEL and/or Thrombin Solution should only be applied topically. Use with caution in patients with prior exposure to aprotinin. Avoid solutions containing alcohol, iodine and heavy metals. Infectious diseases due to the transmission of infective agents cannot be totally excluded.

Contraindications: Do not apply intravascularly. Hypersensitivity to active substances or other components. Not for the treatment of active or spurring arterial or venous bleeding.

Interactions: Avoid solutions containing alcohol, iodine and heavy metals.

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Date of preparation: May 2008

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