



## PRESIDENT'S REPORT

*Sir Bruce E Keogh, President*

There have been times when I have asked myself whether it's worth being a member of SCTS. I could alternatively have a quiet life, go to the annual meeting occasionally and spend my subscription on something else. On reflection that would be an abrogation of professional and social responsibility. We are a small specialty providing an intellectually and physically demanding service to 70 million people in these isles. We owe it to them and ourselves to develop our knowledge and skills and co-ordinate the introduction of emerging scientific and technological developments into our national practice in a way that is most beneficial to the citizens of the United Kingdom and Ireland. Herein lies the role, strength and moral duty of our Society.

Sadly, over the last five years, since the publication of the Bristol Royal Infirmary Inquiry Report and the Government's response, our specialty has been paralysed by the haunting spectre of public disclosure of individual surgeon's results in July 2001. We have harboured grave reservations about the benefits of this information and the Society has expressed our views clearly through the media. The arguments for and against publication have been rehearsed both privately and publicly to the extent that, no matter how enthusiastically articulated, there are no new ideas, no new compelling concepts, just different beliefs driven by different perspectives and different philosophies. But in March 2004 The Guardian newspaper used the weight of the law in the form of the new English Freedom of Information Act to collect and publish individual surgeons' results for coronary and aortic valve surgery effectively kicking in to touch several years of discussion within the specialty and with ministers and the Department of Health and introducing a new reality which made our historical protestations irrelevant. The Society responded by asking the Healthcare Commission, the independent healthcare regulator, to help us publish unit data in a standardised format and where volunteered



to extend this to surgeon specific data. The data was released in April and has attracted favourable comment from all quarters. I hope that the remaining 50% of units will have the courage and magnanimity to follow and to allow publication of their surgeon's results in the next iteration. I think this issue will soon be history. We have crossed the Rubicon, others will follow and we must move on. We have many other activities to develop and more important challenges to conquer.

Firstly, we are facing the potential of unemployment in our specialty. At about the time of the launch of the National Service Framework for Coronary Heart Disease in 2000 the number of surgical trainees was significantly increased. With a training lag time of about 6 years some of the additional trainees are emerging from the system in to the job market. But the jobs have gone. Coronary surgery is falling, the future of the specialty is uncertain and hospital trusts don't want to make a long term financial investment in new consultants at the moment. Estimates vary but the best guess is that there may be up to 70 fully trained unemployed cardiothoracic

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# Thoracic Surgery & Future Patient Representation

*James Roxburgh, Honorary Secretary*

The "Public Portal" launch went well and the society, and in particular the members, were praised for this initiative. I hope the lack of adverse publicity has reassured surgeons that publication of unit and individual data in this format has not turned into the monster that many people thought it would become. I write this on 06/06/06 and so of course I may be tempting fate! Although the public release of data is here to stay the executive will continue to work with the "Public Portal" board and to the audit leads to refine and improve the basis of the analysis. The two areas we need to explore further are other case groupings, as well as what we include and exclude, and the risk models that are utilised. This issue has affected the Society for many years and the time has come to move on to other areas and develop our Society and fully support the members and the specialty.

At the AGM it was agreed that we would concentrate on three areas over the next year and they are:

## Thoracic Surgery

I have already met with the Thoracic Surgery Working Party led by Jim McGuigan and as Jim said at the meeting Thoracic Surgeons are pushing at an open door when it comes to representation on the Executive. There are many issues facing Thoracic Surgery and those tasked by Thoracic and Cardiothoracic Surgeons with representing them on the Executive will have a considerable workload. I would ask all of you with an interest in thoracic surgery, even if you are currently not a member of the Society, to register your interest in this important initiative with Jim McGuigan. It is hoped that this working party will report in the autumn of this year.

## The Constitution

This was formally launched at the ABM (available on the society web page). We are now in a position to undertake a major review of the way the Society works and this may involve a significant restructuring of the Executive. This will continue to be led by Graham Cooper and I know he has already started canvassing people for their opinions.

We have also formed SCTS GBI Ltd to deal with non-charitable issues such as job planning etc. and it is hoped that this will start work soon. This new arrangement will allow us to undertake a much wider range of activities and still stay within the bounds of the increasingly complex charity law.



## Patient representation

Bruce Keogh announced this at the ABM and it was enthusiastically supported by all present. The executive will explore the best way to take this forward over the next year, but always we would welcome your suggestions. Just as the Nurses Forum has been an excellent addition to the ABM I hope patient representation, in whatever form it takes, will also become a valuable addition to the Society.

Finally the Society website will be undergoing a major revision over the next few months and we would welcome your views on what facilities and information you'd expect your society website to provide. An area we hope to develop is the discussion forum for various groups such as surgical trainees, audit managers, nurses and of course consultant surgeons. Please feel free to contact Sunil Ohri or myself.

The Society is there to represent all surgeons and I encourage you all to support the changes over the next year. However most importantly we need your views, ideas and criticisms.

I am way over the word limit set by Sunil and so it is time to go for a drink! (James.Roxburgh@gstt.nhs.uk) ■

### *Presidents report continued*

surgeons by 2010. Mr Christopher Munsch, Chairman of the Specialist Advisory Committee in Higher Surgical Training in Cardiothoracic Surgery, is working with the Colleges, the Departments of Health and the Deaneries to try and find a resolution to this looming crisis. This is our most important challenge. To put it in perspective don't imagine the 70 anticipated unemployed cardiac surgeons will be overburdened with concern for those who don't want to publish their results.

We will work on this issue, but trainees will have to do their part. The imbalance between supply and demand will dictate a highly competitive environment. This will be accentuated by the fact that at the time of the expansion the admission bar was lowered. Not all trainees will get consultant jobs. The difficult truth is that trainees who do not distinguish themselves in some way will not be competitive and should look for less demanding specialties.

This problem is not entirely confined to the UK. Other international organisations are concerned about the pace of change in the specialty. With advances in pharmacological and technological treatment of heart disease, coronary surgery is down by 30% in some countries. Percutaneous and minimally invasive procedures are altering the therapeutic horizon for a number of other conditions in the cardiovascular, thaco-pulmonary and congenital practice. Although these could be perceived as threats, they also provide unique opportunities for development of the specialty in to new areas. Lowering the interventional threshold will bring new patients, previously treated conservatively, for new treatments. We must offer those treatments. The impact of new technologies will be rapid and forceful and will probably affect cardiac surgery more than thoracic surgery (who went through significant change with the advent of videoscopic surgery). If we are to flourish as a specialty we must embrace the new technologies, learn the associated techniques and be prepared to face the discomfiture of change at an individual and professional level.

Increasingly other healthcare professionals are training to become surgical care practitioners or physicians assistants. Their training is competency based which has enabled them to integrate tightly within the surgical team. Within the West these competencies, even in some prominent university hospitals, are starting to include sternotomy, IMA harvesting, vascular purse-strings, chest closure, IABP and chest drain insertion along with emergency re-opening for bleeding on the ITU. This may be a route some units will need to consider as the number of trainees is drastically reduced but it will require careful co-ordination given the current overproduction of trainees in the UK

It is our public duty to focus on improving the quality of the services we offer. Our Society should be proud of its record.

We have among the best national cardiac surgical data in the world. We are supplementing this with a major national study initiated and sponsored by our Society, funded by the Department of Health, conducted by NCEPOD and led by Mr Steve Livesey, to explore institutional and process influences on mortality in coronary surgery. We have all been asked to fill in dedicated NCEPOD forms for every surgical death in the UK over a three year period. Although this is not an onerous task (1-4 forms per person per year) the rate of return has been disappointing. This is only study of its kind in the world. It is important and will help support our contention that influences other than technical expertise influence surgical outcomes.

We have also led the way in developing informed consent through a collaborative initiative between the Health Service Ombudsman and the Healthcare Commission. This project led by Mr David Richens has drawn on our cardiac surgical data and legal and public opinion to develop guidelines on what outcomes and risks we should convey to patients prior to surgery. A booklet has been produced which also gives clear advice on how to relay surgical risk to patients in a way that is easily understandable. Feedback has been positive and other specialties are showing interest in following.

A focus on quality inevitably leads us to recognise the important contribution made other focussed and professional members of the surgical team. Nurses, perfusionists, surgical care practitioners and technicians all play an intimate and essential role in ensuring good outcomes following surgery. Recognising the importance of other professionals the Executive recommended that the Society change its name from the Society of Cardiothoracic Surgeons to the Society for Cardiothoracic Surgery. At the same time we have introduced a nurses' forum which has grown under the able stewardship of Ms Jacqueline Nicol. At the last meeting in Dublin 70 nurses contributed to the nursing, scientific and social aspect of the programme. Jacqueline's term on the Executive has expired and she will be replaced by Tara Bartley from Coventry

Meanwhile the Government is reviewing the concept of re-accreditation. The CMO will be releasing his proposals for re-accreditation / revalidation / maintenance of certification soon. This is another opportunity for our specialty to lead the way, rather than be shepherded in to a generic process. Donald Irvine, past president of the GMC, has discussed this with the Executive Committee which was unanimous in the opinion that this is professional body territory. I have therefore asked Mr Patrick Magee to establish a working group with Sir Donald Irvine to explore how the Society might engage in this process to ensure that it is relevant to our members.

So we face a number of issues: measurement and publication of outcomes, overproduction of trainees, sensible re-validation of established surgeons and concerns that the

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*Presidents report continued*

specialty is being eroded because patients are not always being offered the full facts to decide between the well documented outcomes of surgery versus alternative percutaneous techniques.

Given that my original premise was that it is our duty to serve our patients, it is clear that patients and the public do not want dodgy information in the form of outcome data or incomplete information when choosing therapeutic options, nor do they want training restricted by European legislation or unemployment among highly trained specialists, nor doubt about the re-validation of established surgeons. Most patients have a good perception of our specialty, of the surgeons, nurses and other dedicated professionals who

have looked after them in hospital. Patients are our allies and can not only help us fight our political battles but also develop our specialty in other areas. At the last Business Meeting in Dublin I asked colleagues to consider introducing a "patient member" category within our Society. The response has been remarkably favourable, so I have asked Mr Graham Cooper to form a working group to take this forward in time for the 2007 ABM. He will be helped by Mr Harry Cayton the Patient Czar

Finally, I would like to pay tribute to Mr Patrick Magee the immediate past president and personal friend and to make it a matter of public record that he is not off the hook. Patrick we will be reeling you back in to help with a number of issues! ■

## Steve Hunter, Cardiothoracic Dean

I enjoyed the meeting in Dublin and was pleased to see a decent turn out of trainees. Although the ideal would be to have every trainee attend the meeting every year. I think that this will be more important in the future. The Postgraduate Medical Education and Training Board (PMETB) has stopped the SAC interviews and has taken control of all of the SAC visits to training programmes, which will reduce the opportunities for the SAC members to meet trainees. As Cardiothoracic Dean, I would like to meet all trainees and I think it is important that trainees have direct contact with members of the SAC. Each rotation now has a SAC liaison member who will attend all Speciality Training Committee meetings and all RITAs. Trainees should feel able to contact their SAC liaison member at anytime. The SAC is there to help the trainee as well as overseeing assessment of competencies. Should trainees not wish to contact their SAC liaison member for what ever reason, I hope that they feel they can contact me directly. This will be easier if we have met and in the future the only realistic way the Cardiothoracic Dean can meet all the trainees will be at the annual SCTS meeting.

There is still no resolution of the manpower problem and we have now begun a two year period where the majority of the current trainees will complete their training. The Postgraduate Deans have clarified their position on the "period of grace", which is the time a trainee can remain in programme after obtaining their CCT. Every trainee will receive a six month "period of grace" which can, at the discretion of the Dean, be extended to a maximum of 12 months. The extension will only be granted if the trainee has applied for all advertised consultant posts. It has been accepted by the Deans that it will be possible to re-badge the money from some vacant NTN posts to provide non-training service posts, although this will be a local arrangement between the Deans and the hospital Trusts. However all the



Deaneries have very tight budgets and I will be surprised if many release their money!

All trainees should continue to evaluate their position and future. Many trainees have opted to concentrate on thoracic surgery where hopefully there will be more job opportunities. The SAC is actively investigating the future job prospects in Thoracic surgery. Some trainees have changed career altogether. There is still a shortage of General Surgical trainees and the chairman of the General Surgical SAC, John Black, has said that any cardiothoracic trainees wishing to change career will be welcomed. Our SAC chairman, Chris Munsch, has been discussing with the chairman of the Cardiology SAC, Peter Mills, the possibility of a few of our trainees changing career to cardiology. If anyone is interested in changing career they should contact either Chris Munsch or me for further information.

As always I can be contacted by email at [steve.hunter2@virgin.net](mailto:steve.hunter2@virgin.net). ■

# PMETB, MMC & The New Cardiothoracic Curriculum

*Christopher Munsch, Chairman SAC in Cardiothoracic Surgery*

## The Jobs Situation

Elsewhere in the Bulletin Steve Hunter reports on the action being taken by the Postgraduate Deans with respect to 'periods of grace' for CCT holders. There is, as he says the possibility of training money being rebased to Trusts for service, but this will have to be negotiated at a local level. I think it is unlikely that many new consultant posts will emerge from this process, but we might foresee instead a number of non-training service posts which CCT holders will be able to apply for. This is by no means ideal and is certainly not what trainees expected when they embarked on their careers, but it does reflect the reality of what is happening in cardiothoracic surgery, and the widely held uncertainties about the future of the speciality.

## Postgraduate Medical Education and Training Board

By now everyone will be aware of PMETB and its role in supervising and regulating medical education. There is no denying that the relationship between PMETB and the JCHST and SACs has not been an easy one. We have been particularly concerned about their 'high level, low impact' format for quality assurance of training programmes. Pre-existing SAC quinquennial visits are being replaced by Deanery-wide, pan speciality visits that are designed to evaluate deanery processes, rather than individual training programmes. The role of the SAC has therefore changed, and we propose now that the SAC liaison member for each programme becomes more engaged with the programme, creating a strong working link between deaneries, programme directors, trainees and the SAC. In this way the SAC will be able to provide quality control of training programmes on an ongoing basis, rather than on the back of a formal 5 yearly visit of inspection. To make this process work effectively will need to recruit additional SAC members and we will be advertising shortly. Please feel free to contact me for a chat if you are interested!

## The Curriculum

The curriculum is a bit like Rotherham; everyone knows it exists but no-one wants to go there! But - resistance is useless. The syllabus has been on the web site for the best part of a year now. I for one think it is pretty good, and a useful adjunct to the training process. It sets out requirements for training in cardiothoracic surgery, with defined waymarks and competencies throughout the programme. Trainees and trainers should now be able to set learning objectives using the syllabus, and use it to as a benchmark for assessments, including the RITA. The interactive training package consisting of assessments, logbook, portfolio and learning agreement is being developed more slowly, but is due to be completed and integrated into surgical training by August 2007. I would encourage all trainees and trainers to become familiar with what already exists at [www.iscp.ac.uk](http://www.iscp.ac.uk), so that they will be prepared for what is to come.



## Modernising Medical Careers

Given the manpower problems in cardiothoracic surgery, the aspiration of 'run-through' training embedded in MMC looks increasingly unrealistic. We are currently exploring methods of selecting into the speciality that will be fair and accurate, whilst reflecting the future manpower requirements of the speciality and the capacity of programmes to deliver training. We envisage a national selection process using selection centres similar to those used in commerce and the services, and work is going on to make this process useable by early next year. ■

## Deputy Meetings Secretary Required

The Society is looking for a Deputy Meetings Secretary, to join the Meeting Organising committee (Graham Cooper, Simon Kendall, Isabelle Ferner and Rachel Woolf).

At the very least the post involves a monthly commitment, to plan all aspects of the annual general meeting; venue, catering, scientific programme, guest speakers, advertising, exhibition, budget etc.

The post is for 2 - 3 years in preparation to takeover as meeting secretary.

Please send expressions of interest explaining the qualities that you would bring to the committee, to Simon Kendall, c/o Isabelle Ferner, Society of Cardiothoracic Surgeons.

Appropriate applicants will be interviewed for the post later in the year.

# The Trainee Cardiac Surgeon and Intensive Care

Charles Gillbe, Chairman, Intercollegiate Board for Training in Intensive Care Medicine  
<mailto:c.gillbe@nhs.net>

**Summary:** Intensive Care is a specialty in its own right and draws its practitioners from many specialties. This article sets out to show that cardiothoracic surgeons who wish to practise intensive care should be properly trained in the specialty and goes on to describe how trainees in cardiothoracic surgery can acquire appropriate training.

About a year ago Peter Goldstraw asked me to speak at a session of the SCTs: the question he asked me to address was the controversial one of whether it is appropriate to rely on trainee surgeons to manage postoperative cases on the intensive care unit. My answer was a resounding 'no' and it was based on some of the following incontrovertible facts. There has been a reduction in time available for surgical training owing to the EWTD and this is being exacerbated by the reduction now being seen in cardiac surgery, particularly of the less complex type. The boom in the numbers of cardiac surgical trainees is over. Significant reductions in the numbers of NTN's are planned and it is unlikely that any remotely acceptable roster will be able to function staffed by SpRs in cardiac surgery. It is in the nature of postoperative intensive care that the doctor managing the patient must be on site and this will erode further the training in the core skill of surgery. During the last twenty five years Intensive Care Medicine has developed into a distinct specialty and there is now good evidence that the results from 'closed units', i.e. those managed by Intensivists are superior to those in 'open units' where the patient is managed by the admitting specialist. This view has been taken up by the Leapfrog Group on the grounds that it saves both lives and reduces both hospital and ICU length of stay.

## Should all cardiac surgeons continue to manage patients in intensive care units?

Given that many cardiac surgeons lack the inclination to practise intensive care outside the thorax and the essence of ICM is holistic rather than system based - indeed, Intensivists have been described as the General Practitioners of acute hospitals - the clear answer to this question is in the negative. This is even more the case for cardiac surgeons training with the shortened hours of work following the implementation of the EWTD. The only solution for those cardiac surgeons in training who enjoy the more complex aspects of postoperative management is to train in both specialties. This provides the great advantage to the trainee of being able to apply for posts in either cardiothoracic surgery or ICM or possibly both after the acquisition of a CCT. Given the current state of the job market in cardiothoracic surgery such post-CCT flexibility looks increasingly desirable.

## A historical note

Ten or so years ago the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) was established by the Royal Colleges of Physicians of Edinburgh and London, The Royal Colleges of Surgeons of England and Edinburgh, The Royal College of Physicians and Surgeons of Glasgow and The Royal College of Anaesthetists. Amongst other things its remit is to 'determine the duration, content and assessment of training in ICM' and to 'recommend minimum standards for intensive care units recognised by the Colleges for training'. The stimulus for the establishment of the IBTICM was the recognition that the general quality of intensive care, and particularly training in ICM had fallen behind that of many other countries and the perception was that a solution would lie in an intercollegiate approach. The next step was to establish a recognised training programme: it was clear that the Colleges were not prepared at that time to see ICM established as a wholly separate entity, so a series of proposals were put to the Specialist Training Authority culminating in the acceptance in April 2002 the status of a CCST that could be acquired jointly with Anaesthesia, A&E Medicine, Surgery or Medicine. Historically, anaesthetists had provided the vast majority of Intensive Care, often working intermittently, and sometimes with concurrent clinical commitments in ICM. This position was soon to change.

## How is it possible to obtain training in both Cardiothoracic Surgery and ICM?

Superficially, the answer to this is simple: meet the criteria of both training programmes. In practice it is a little more complicated. The criteria for a CCST, now CCT in Cardiothoracic Surgery are well known to you. To change this to a Joint CCT with ICM requires the following:

1. 3 months training in ICM at SHO level (basic training)
2. 6 months training in acute general medicine
3. 6 months training in anaesthesia
4. 6 months general ICM training as an SpR (Step 1)
5. 12 further months training in ICM (Step 2)

Appointment to a joint programme is by competitive entry and is made before the end of year three of the SpR programme. To obtain a joint appointment it is necessary for the candidate to have an NTN in the primary specialty. Of the training modules above, the last must be taken whilst in the joint programme, the first is clearly taken before application for an NTN and the middle three may be taken either before or after appointment to the joint programme, although some

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### *The Trainee Cardiac Surgeon and Intensive Care continued*

ICM training programme directors may find it difficult to find suitable anaesthetic and medical placements.

Entry is fairly competitive and of recent appointments in the London Deanery about 60% go to those with anaesthesia as a primary specialty and the remainder to those Medicine or A&E Medicine. No surgeons have been appointed to any joint programme in the UK at the time of writing and I am not aware of any who have applied. Certainly there have been no applicants from any of the surgical specialties in London. This is a great pity since there is no doubt in my mind that ICM would be enriched by practitioners drawn from surgery.

Finally, for those who have left it too late in their primary specialty training, it must be remembered that it is not a requirement to be on the Specialist Register in the specialty of one's consultant appointment. It is therefore possible for a CCT holder in cardiac surgery to apply successfully for a post in ICM. Appointment must be made on the basis of curriculum vitae, interview and references, all mapped against the person specification. For those who wish to follow this path, it would be appropriate to have covered the curriculum for training in ICM in an informal manner and to seek a letter of equivalence of training from the IBTICM. More information about training in Intensive Care Medicine is available from the IBTICM website: [www.rcoa.ac.uk/ibticm](http://www.rcoa.ac.uk/ibticm) ■

## Cardiothoracic Surgical Intensive Care - a new specialty, a new opportunity

*Leslie Hamilton, SCTS President Elect & Chairman of the Intercollegiate Board*

Our trainees are of high calibre and their training is among the best in the world - they should be able to compete for jobs anywhere. Nonetheless most have, until now, had an expectation of a Consultant post in the UK. Everyone is aware of the impending job crisis in our specialty - we therefore need to look at alternatives. This edition of the Bulletin contains an article from Charles Gilbe about the possibilities of a joint CCT in Intensive Care Medicine and Cardiothoracic Surgery. However, under the current regulations, trainees have to declare within the first three years - this is obviously not applicable to the situation our trainees find themselves in.

Traditionally much of the post-operative care of our patients has been delivered by our trainees. As the number of trainees is reduced and the hours of work are reduced this will not be feasible in future. We need Specialists who understand the

nature of surgery and the post-operative physiology to provide this care. Who better than Cardiothoracic Surgeons - if we don't do it the general intensive care specialists will by default, take over.

CTSnet currently has an article by Professor Nevin Katz from George Washington University in the USA saying exactly this ([www.ctsnet.org](http://www.ctsnet.org) - "Cardiothoracic Surgeons have an important role in the emerging specialty of cardiothoracic surgical critical care"). Indeed things have moved on significantly. April 2006 saw the 3rd Annual Conference on cardiothoracic surgical critical care and a new "International Society for Cardiothoracic Critical Care" has been formed.

Could this be a silver lining in the cloud of our current job crisis? - at least an alternative to consider. ■

<sup>1</sup> Physician Staffing Patterns and Clinical Outcomes in Critically Ill Patients,  
Peter J Pronovost et al: JAMA 2002;288:2151-2162

<sup>2</sup> Potential Reduction in Mortality Rates Using an Intensivist Model To Manage Intensive Care Units,

Michael P. Young, John D. Birkmeyer: Effective Clinical Practice 2000 6:284-289

<sup>3</sup> [www.leapfroggroup.org](http://www.leapfroggroup.org)

# Trainees Update

Farah Bhatti, Trainee Representative



## Trainee Database

I have now collated and updated the list of trainees from various sources (Mike Lewis' original, SAC data and information from individual regions). I hope this now captures the majority of trainees, but if you are aware of anyone missing please let me know and I'll add them to the list.

## Trainees Meeting Dublin 2006

For those of you who did not attend the SCTS meeting in Dublin, I would like to give you a flavour of how the Trainees Meeting went. A trainees-only lunch was accompanied by a number of presentations on topics that had been requested by SpRs in the past. These included two talks given by Aman Coonar and Max Codispoti of their experiences of working abroad for a year, including advice of a practical nature. Simon Jordan gave some insights into sitting the FRCS CTh examination and tips on how to pass it. The meeting was then opened out to non-trainees. This part of the afternoon had a session by Steve Hunter, Cardiothoracic Dean, on how to get the best out of your trainer. Chris Munsch, Chairman of the SAC, gave a presentation which touched on the issue of the impending 'crisis' due to lack of consultant posts available for CCST holders to apply for, a topic that was revisited at the Annual Business Meeting. In summary, it was a well-structured afternoon that led to one of the best-attended trainees meetings I have attended.

## Trainees Web Page

We are also in the process of revising the trainees page on the SCTS website. As well as having more regular updates, I envisage having a number of direct links to other websites that are relevant to our training needs such as the CTSNet Residents

Page, The Royal College of Surgeons of England, and PubMed, to name a few. I would also hope to provide a list of courses, workshops and wet labs in cardiothoracic surgery being run across the country. We could also have a section which gave local news and views from each deanery. This is an ongoing project and your ideas are welcome.

## Jobs Crisis

We are all aware that there is a growing group of trainees who have CCST or are approaching CCT, but only a limited number of consultants posts for which they can apply. This was discussed at an extraordinary meeting of the SAC, the Society Executive and the DoH Heart Team on the 16th November 2005, which led to a letter from Pat Magee and Chris Munsch being circulated to trainee members of the SCTS in December 2005. This letter stated that *"It was widely recognised that there is no one 'big answer', and the imbalance between trainee numbers and future consultant posts can only be addressed by a variety of different, yet coordinated, strategies."* This problem was discussed again at the SCTS Meeting in Dublin and trainees were informed that COPMeD (Conference of Postgraduate Medical Deans) was due to meet in April 2006 and would be addressing this issue. At the time of going to press I have not had any official information on the outcome of this meeting. One particularly relevant subject is the length of the 'period of grace' allowed to trainees following their accreditation date - whilst trainees are aware that this cannot be an open ended affair, there is a strong feeling that some degree of flexibility should be exercised. The consensus is that cardiothoracic trainees should be offered more than the standard 6 months grace that is currently allowed to all specialties, at a time when so many fully trained cardiothoracic surgeons facing unemployment! I will be putting forward the consensus view from the trainees at the next SCTS Executive & SAC meetings. I will endeavour to provide you an update on the situation by the time you read this article (farahs\_email@yahoo.co.uk). ■



# The SCTS Thoracic Surgical Audit Project

*Richard Page, Thoracic Surgery, Liverpool*

At the meeting in Dublin I presented a summary of the Society's returns for thoracic surgical activity for the 3-year period 2002-2005. The thoracic surgical register is now simpler in format and contains 40 rather than the previous 240 fields and is now relates largely to procedures rather than disease categories. Nevertheless there is a strong emphasis on activity for lung cancer.

Out of the 40 units carrying out thoracic surgery for the period in question 36 were able to send returns, and I am grateful to all those who helped me compile the data for the report. I estimate that the latter has captured over 95% of thoracic activity carried out in the UK and Ireland. Altogether 70980 procedures were performed, with 28951 of those being major operations of which 9784 operations were to remove primary lung cancers. Although treatment of lung cancer remains the principle focus for thoracic surgeons, these figures emphasis the wide range of non-cancer work encompassed within thoracic surgery.

Even within the restrictions of such a simple register it is possible to report on many areas of interest. Although the mortality outcome for the various operations remains universally low, there are wide variations in the relative numbers of pneumonectomy / lobectomy / lesser resection for lung cancer throughout the country. VATS lobectomy remains very much a minority sport, accounting for only 3% of total lobectomies for

lung cancer. The rate of mediastinoscopy/mediastinotomy compared to resection of primary lung tumours shows a huge variation from 30 to 250%. About half of thoracic surgeons continue to prefer to treat pneumothorax with open as opposed to thoracoscopic surgery.

A detailed breakdown of all data in the report will be published in the next SCTS blue book. Meanwhile many units are in the process of developing data collection for a much more detailed analysis of activity, based on the dataset developed by Tom Treasure. Again the emphasis is on management of primary lung cancer with collection of patient specific demographics, co-morbidity etc and should allow some simple risk modelling. Details are available on the SCTS website. I am hopeful that a report on this dataset will be available from at least 25% of thoracic surgical units for the 2005-6 period of activity. Nevertheless many units still have much work to do in terms of developing the infrastructure for collection of data on thoracic surgical activity, to match the achievements of the cardiac surgical database, and to get to the stage when the thoracic register can be disbanded and replaced completely by the Treasure dataset.

Please do not hesitate to get in touch if you have any questions relating to any aspect of SCTS thoracic surgical audit (richard.page@ctc.nhs.uk). ■

# CCAD Secures Funding For Congenital Data Analysis

*Marcus Haw, Paediatric & GUCH Surgeon, Southampton*

The pilot for CCAD data collection in congenital heart surgery commenced in 1996 and national data has been collected since 2000. This is a major advance in the audit of congenital cardiac surgery and has been lead by John Gibbs the current president of the BCCA.

Lack of funds has prevented the CCAD from performing any sophisticated data analysis to compare with the adult CCAD data set.

Until January this year a set of benchmark paediatric procedures were analysed for comparison purposes. Data is displayed by centre, but surgeon specific data is likely to happen soon. At a meeting in the RCS it was agreed that the data would no longer be analysed this way. In the future it is intended to analyze diagnostic categories and compare the results with national averages.

Over the years the DOH has been reluctant to fund central data analysis, which is perhaps ironic in the light of the Bristol inquiry. Recently however funding via the NHS Information Authority has been identified. This will be used to employ a data analyst who will join Bruce Keogh's unit. This will make a major impact on the capacity of CCAD to produce meaningful

congenital data over time. Currently the analysis for 2002-2005 remains unpublished.

The problem of risk adjustment remains. The Aristotle complexity score address the complexity of the surgery, but fails to address the physiological status of the patient, and this may need some adjustment itself before gaining widespread acceptance. Victor Tsang and others continue to work on models of risk profiling in their own patients. The results of these pilots are awaited with interest.

The CCAD still struggles to collect data on adult congenital cases. Some cases continue to be performed in non-congenital units, and data from established centres is complete. Adult congenital heart surgery has become a focus for the CCAD as the number and complexity of these procedures is increasing and will continue to increase for the next 10 years at least.

In summary the national CCAD for congenital heart surgery has made significant progress in the completeness of data collection. Data analysis is now being funded and this will make publication more meaningful. We still need a risk adjustment tool and the collection of complete data for GUCH surgery remains a challenge. ■

## Extent of Commitment is Disappointing

*Steven Livesey, Executive Member*



An interim report on the first year of the study was published shortly in March 2006 by NCEPOD. Copies were sent to all consultant surgeons performing cardiac surgery. There is little doubt NCEPOD were surprised and disappointed by the rate of return of questionnaires. Of the 399 cases eligible for entry to the study, 293/399 (73%) surgical questionnaires and 314/399 (79%) anaesthetic questionnaires were received, but in only 250/399 (63%) was it possible to match the questionnaires from both the anaesthetist and surgeon.

Furthermore, in only 276/399 (69%) were casenotes received, and this meant that the full information of surgical and anaesthetic questionnaires and casenote extracts was only available in 222/399 (56%).

The summary points and recommendations were not complimentary:

- Return of completed surgical, anaesthetic and organisational questionnaires has been disappointing.
- Return of relevant casenotes has been disappointing.
- The main clinical risk stratification tool, EuroSCORE, is not universally available, and where the data is available the calculated global score is frequently incorrect. This undermines the value of this score as a clinical risk stratification tool.

And NCEPOD's recommendations were:

- Failure to record basic clinical data in some units must raise questions about overall organisation and

performance, and effectively prevents meaningful comparison of mortality outcome with those peer units who are able to provide data.

- All Cardiac units in the UK should record standard data fields, and should be able to accurately calculate a EuroSCORE for every patient, in order to aid in the process of risk stratification, and to allow comparative audit to be undertaken.
- Trusts must ensure that clinicians have timely access to medical records, and sufficient time allocated within job plans, in order that they may meet their professional obligations to participate in the work of the confidential enquiries.
- It is important that Medical Directors, as part of their Clinical Governance commitment, take overall responsibility in ensuring that the participation of their Trust/Group remains high.

Thankfully, the returns from the first year of the study improved as more questionnaires and case notes were returned for these cases in the second year. Sadly, the return of year two cases has been disappointingly slow though with commitment there is still time to remedy this as the study enters its third year. NCEPOD fully understand that retrieving casenotes of deceased patients can be difficult - but the return of control data has been equally disappointing. We still have ten months in which to catch up and show that our commitment to the audit of results remains robust. ■

## A study by the Heart Improvement Programme

*Steven Livesey, Executive Member*

Not the most intuitive of monikers I realise - the Heart Improvement Programme is the new name for the CHD Collaborative. The majority of the budget of the CHD Collaborative was devolved to Cardiac Networks last year along with the responsibility for service improvement

The Inter-Hospital Transfer Audit was conducted under the auspices of the Heart Improvement Programme in October 2005 - this was a follow-up to a similar study done in 2004. The study looked at all patients requiring urgent transfer for diagnosis or treatment of an acute cardiac condition (ischaemia, valvular heart disease or arrhythmias) during the month.

Data were collected on the movements of 5098 patients through 227 hospitals in 32 networks. Looking just at acute

coronary syndrome, the median wait from admission to first hospital to definitive treatment was 6 days where the definitive treatment was PCI compared to 14 days for patients who required CABG, - this is an improvement from 9 days and 16 days respectively in 2004. Although this is a welcome trend, these delays in treatment represent an enormous waste of resource (the improvement reflects a saving of over 350,000 bed days) and describe a standard of treatment that would shock our colleagues in most developed countries.

The Heart Improvement Programme would like to set a **target time** within which patients with ACS should be treated - for patients who require CABG the suggestion is that this should be 7 days. I would appreciate feedback on this concept from members (email: [steve.livesey@suht.swest.nhs.uk](mailto:steve.livesey@suht.swest.nhs.uk)).

*continued...*

*A study by the Heart Improvement Programme continued*

This study has reinforced the magnitude of the problem. In some units, patients requiring CABG for ACS are waiting nearly as long as elective patients - this exposes them to the dangers of further ischaemia and hospital acquired infection as well as being extremely demoralising for patients and staff. It is not certain whether or not a third study will be carried out this year, but the Heart Improvement Programme is looking at the

feasibility of developing a real-time web based audit of in-hospital waits - watch this space for further information.

More details of the October 2005 study can be found at:

[http://www.heart.nhs.uk/CHD/5453/28116/IHT\\_presentation\\_s\\_BCS\\_april\\_web.pdf](http://www.heart.nhs.uk/CHD/5453/28116/IHT_presentation_s_BCS_april_web.pdf). ■

## Marjan Jahangiri, Ionescu Scholar 2006



I am very honoured to have received The Marion and Christina Ionescu Travelling Scholarship. I will be using this opportunity to increase my knowledge in the fields of minimally invasive and percutaneous techniques, treatment of atrial fibrillation, and management of research programs.

### Minimally invasive and percutaneous techniques

I will be spending ten days at Cleveland Clinic Foundation in US. In the past year we have developed and expanded minimally invasive surgery for aortic valve replacement at St. George's Hospital. I wish to learn about patient selection and refine some aspects of the surgical technique. I will be joining the cardiac surgical team.

We have also developed and expanded surgery for the aortic arch and descending thoracic aorta, including endovascular stenting and extra anatomical bypass, in collaboration with the vascular team at St. George's. I will be joining the cardiovascular/endovascular team to increase my knowledge of patient selection, staged therapy and technique. I would also like to learn about the introduction of percutaneous training programs for cardiac surgeons.

### Surgery for atrial fibrillation

I will be spending one week at the departments of Cardiac Surgery, Washington University School of Medicine, St. Louis, Missouri, and two weeks at Northwestern Reserve in Chicago. I am keen to expand some aspects of our existing program for treatment of atrial fibrillation, by learning about the patterns of surgical referral, modes of surgery, minimally access techniques and hybrid cases with cardiologists, especially identifying macroentry circuits and treating them with the aid of MRI.

### Management of a research group

I will spend my last week shadowing the Dean of the Medical School at Northwestern Reserve University in Chicago. The main purpose will be to learn about managing a research group, translational research, modern ethical issues, budgeting for research, fund raising and learning about the up to date curriculum for cardiovascular medicine and cardiac surgery.

### SCTS Scholarships 2006

The Marian & Christina Ionescu Travelling Scholarship	Marjan Jahangiri
The Society Scholarship for Thoracic Surgery	J Edwards
The St Jude Scholarship	J Chikwe
Ronald Edwards Medal	A Ranasinghe
John Parker Medal	E Hickey
Society Medal	A Alzetani



*Sir Bruce Keogh with Marjan Ionescu and Domenico Pagano (2005 Ionescu Scholar)*

## Society Scholarship for Thoracic Surgery

*John Edwards, SpR, Trent Regional Training Programme*



I am delighted to accept the award of the Society Scholarship for Thoracic Surgery. This will allow me to broaden my horizons in the fields of malignant mesothelioma (MM) surgery and novel therapies, of which I have an interest in both. I intend to visit centres in the United States and Australia with expertise in the management of malignant mesothelioma. Whilst a research

fellow in Thoracic Surgical Oncology in Leicester, I set up a comprehensive database including all mesothelioma patients in referred to and/or treated in Leicester, which now comprises almost 500 patients. 120 patients have undergone extrapleural pneumonectomy (EPP), forming one of the largest series published, but many have also undergone palliative debulking surgery by way of pleurectomy and/or decortication, by open surgery or VATS. It is not yet known whether either radical or palliative surgery has definite effects on survival or symptoms although it is well known that the relapse will always occur, even after complete microscopic resection. The combination of maximal surgical debulking with an immunotherapy is an attractive approach which deserves evaluation. Professor Bruce Robinson, a respiratory physician from Perth, Western Australia, is running a Phase II trial of autologous tumour lysate vaccination and has presented interesting early results. However, having no surgeon with a specific interest in EPP or palliative debulking surgery, the patients he has treated have had residual bulky disease. It is proposed that this immunological therapy may be more efficacious in the setting of microscopic or undetectable disease. The scholarship will enable me to travel to Australia to visit the laboratories of Professor Robinson to learn the

tissue processing techniques and immunisation protocol. I hope that this will facilitate the transfer of the technique to the UK with the prospect of setting up trials investigating autologous tumour lysate vaccination following EPP, radical decortication or palliative debulking surgery.

The second aspect of the Scholarship will involve travel to the United States, to the Thoracic Surgical units at the New York School of Medicine and MD Anderson Cancer Center, Houston. Dr Harvey Pass, Professor and Chief, Division of Thoracic Surgery and Thoracic Oncology at the New York School of Medicine runs an active laboratory research programme in addition to his clinical interest in mesothelioma surgery. He is instrumental in the current review of the TNM staging of mesothelioma. I have recently presented and published data from Leicester regarding the pattern of nodal metastasis in MM. In addition to observing the clinical and laboratory work of his unit, I hope that my work there with analysis of pathological data will contribute to revision of the TNM system.

Preliminary EPP series data has been exchanged between Leicester and the MD Anderson Cancer Center, Houston, Texas. There were striking similarities in aspects of pathology, stage, and outcome, despite a different approach to adjuvant chemotherapy and radical radiotherapy. It will be an interesting exercise to combine our databases to explore further the effects of treatment. The SCTS Thoracic Scholarship will also enable this promising interaction by funding my visit to Houston.

I would therefore like to thank the Society for the Scholarship and look forward to reporting back to you my experiences on completion of my fellowship. ■

## St Jude Scholar wins Award at the American Association for Thoracic Surgery Annual Meeting 2006



*Amir Sheikh (centre) with Dr Richard Jonas, President of the AATS (right)*

Amir Sheikh, the St Jude Scholar of the Society of Cardiothoracic Surgeons of Great Britain 2003, won the prestigious C. Walton Lillehei award at the 2006 annual meeting of the American Association for Thoracic Surgery. With the Society scholarship award, he undertook research at Duke University, North Carolina, USA in 2004-2005. His research included application of the novel technique of proteomics to paediatric cardiac surgical models. At the AATS, he presented proteomics of brain injury in deep hypothermic circulatory arrest. Eight abstracts were shortlisted and competed in the Walton Lillehei forum. Amir is the first British trainee to receive the Lillehei award. ■

# SCTS St Jude Scholarship 2006

*Jo Chikwe, SpR Harefield Hospital*



I am very grateful to the SCTS and St Jude for this generous scholarship. It enables me to spend three months of my sixth year of training at the Cleveland Clinic on an established endovascular fellowship. I will spend the rest of the year in advanced adult cardiac surgery fellowships at Mount Sinai Hospital in New York, and the Harvard University teaching hospital Massachusetts General in Boston.

I am a fifth year trainee, currently at Harefield Hospital in London. I gained an interest in minimally invasive operating as a result of routine exposure to successful techniques such as Endo-ACAB, MIDCAB and TECAB at the Royal Brompton Hospital; and minimally invasive mitral and aortic valve surgery, pulmonary resection, and off-pump surgery at St Mary's Hospital, which also has a highly successful programme of endovascular aortic surgery.

Endovascular techniques have been embraced by neurosurgeons, vascular surgeons, radiologists and cardiologists in the UK; and in the US many cardiac surgeons are successful adopters. Hybrid endovascular repair of arch, descending aortic and carotid pathology is already the procedure of choice at several institutions, and endovascular valve surgery is an alternative to conventional operations in selected cases.

The Cleveland Clinic fellowship offers dedicated training in advanced catheter and guidewire skills, diagnostic angiography, advanced angioplasty and stenting of the

aortic, carotid and brachiocephalic vessels. They aim to develop fellows' proficiency in repair of abdominal and thoracic aortic aneurysms. The fellowship programme is heavily oversubscribed, predominantly by senior US cardiac surgeons. The Cleveland Clinic fellowship is not salaried: the St Jude Scholarship covers living costs, and some of the expense already incurred in obtaining American medical certification and state licenses, a condition of practice in US centres.

I start an advanced clinical fellowship at Mount Sinai Hospital in New York this October. I applied after speaking to London trainee Ani Anyanwu, who in just over a year there repaired over 30 mitral valves (Alain Carpentier is a visiting professor) in addition to developing proficiency in heart failure and complex aortic surgery. I have been offered a second fellowship at Massachusetts General Hospital that I plan to take up after completing the Mount Sinai fellowship. Both units have a major programme of complex aortic repairs including hybrid procedures, and were keen for me to secure the Cleveland Clinic fellowship.

I hope that 18 months spent at three centres that offer intensive exposure to heart failure surgery, complex aortic and mitral work, and minimally invasive cardiac surgery, as well as having established track record in training surgeons in these techniques, will enable me to return to the UK in early 2008 with a strong portfolio of skills. The opportunities to produce publications from established clinical databases such as that held at Massachusetts General are an added bonus. My husband's work means he's an old hand at the transatlantic commute, so hopefully we'll get to enjoy the many great aspects of New York (which is one of our favourite cities) Boston and Cleveland together. ■

## Intercollegiate Specialty Board - Examiners needed.

We will have an increased number of trainees coming for the exam in the next 3 years and we have a significant number of Examiners leaving the Panel in 2007, having served their 5 years. The Exam is particularly important at present as applicants for the Specialists Register under Article 14 may wish to take it. Being an Examiner involves hard work, both in preparing for the exam and the exam itself but it is an important role and is very rewarding.

Examiners have to have been a Consultant for at least 5 years and for those interested, the other criteria can be found on the Intercollegiate website ([www.intercollegiate.org.uk](http://www.intercollegiate.org.uk) <<http://www.intercollegiate.org.uk>> - panel of Examiners)".

**Leslie Hamilton**  
Chairman, Intercollegiate Specialty Board

# SCTS FORUM

*Tara Bartley, Nursing Representative*



Next year's forum will be the most expansive yet.

Building upon the collaboration seen at the Dublin conference, Manchester 2007 will host the first joint surgeon, surgical assistant and nurse's session. We are aiming to explore new ways of working within a team to deliver patient care, and the forum hopes to discuss new

approaches that will embrace changes in the workforce resulting from modernising medical careers.

With the advent of patient choice establishing 'book and choose', it is hoped the forum can highlight what is important to individuals undergoing cardiothoracic surgery as well as their families. As health professionals we like to think our service reflects the interests of patients, but what are the key influences that constitute a positive patient experience?

Linking with the growing group of surgical assistants we aim to explore the impact that their role has upon the patient pathway. Moreover, how has their role evolved since its advent in the early 90's?

We are currently expanding contacts for the exhibition, which will increase its relevance for nurses. This will enable delegates to review ideas, equipment and products that they may take back to their centres and use to underpin and enhance the delivery of care.

Having established a nationwide network of regional representatives it is hoped that attendance at the forum will increase so that participants will be inspired to return to their respective units with innovative developments and topical issues that they may disseminate among their colleagues.

We will call for presentation papers in September, which will then be reviewed by a panel, and those selected to contribute will hear in November. This is an excellent opportunity for nurses and surgical assistants to present findings from research that has been undertaken, to share new ways of working that have been established, or discuss any projects that may be underway. We welcome a variety of applications that will allow us to create an interesting forum reflecting the keys issues in the Cardiothoracic speciality within the current climate. If you are interested then please email me ([tara.bartley@ntlworld.com](mailto:tara.bartley@ntlworld.com)) or Isabelle Ferner, Society Administrator ([sctsadmin@scts.org](mailto:sctsadmin@scts.org)) so we can ensure you receive the flyer that we will send out in September. Details can also be found on the web site [www.scts.org](http://www.scts.org)

Manchester will be an attractive venue with diverse accommodation in a cosmopolitan environment and there should be plenty to interest all.

We look forward to seeing you...

I would also like to take this opportunity to introduce myself. I was appointed as the nursing representative following the resignation of Jacqueline Nicol as she moves to pastures new. The SCTS would like to thank her for all her hard work over the past three years.



*Nurses attending SCTS Forum*

I currently work at Walsgrave Hospital, Coventry as a Cardiothoracic Practitioner.

I joined the NHS 24years ago having completed my RGN training at The London Hospital. After qualifying I worked in medicine, surgery and accident and emergency before specialising in Critical Care in 1989. I have worked in general and cardiothoracic critical care, heart/ lung transplantation and liver transplantation. During this time I have been fortunate to work at Addenbrookes Hospital and Papworth Hospital in Cambridgeshire, Warwick District General, The John Radcliffe Oxford, and the Walsgrave Hospital, Coventry. I have also spent three years setting up and running a nurse lead clinic in the community, prior to taking up my current position. Along the way I have completed a BAHons in Health & Social policy at the University of Warwick, an MSc in Health Science and Specialist and Advanced practice awards at the University of Birmingham. I am an ALS instructor and my specialist interest, the subject of my thesis, is in collaborative working to improve patient care.

I am delighted to have been offered the position as nurse representative. If you have any comments, enquiries or issues you would like to discuss or that I may take to the SCTS on your behalf then please contact me. ■

# Annual Scientific Meeting Report, Dublin March 2006

*Susan Briffa, Medical Journalist*

Dublin was the unforgettable venue for this year's Annual Meeting in March. It was never expected to be short-sleeved weather, but nobody had planned for the snowstorms that tore through the United Kingdom and Ireland that week.

Delegates from Scotland had their flights cancelled for the day on Sunday, and most other airports suffered delays due to the inclement weather. People stared with incredulity at the snow-covered runways, wondering if they'd ever touch down on the Emerald Isle.

Worse still, on the Saturday night, Scott Clarke and his team of audio-visual technicians from The Hire Company were having real difficulties handling the freak storms on the way to Holyhead Port. They were travelling in a large truck, which was carrying all the essential equipment necessary to make the meeting work. At one stage they feared they wouldn't make it in time to board the ferry. But this fear nowhere near matched the horror of having to tell Graham Cooper of their plight. Fortunately Graham was at home in Sheffield, and in blissful ignorance of the unfolding drama on the other side of the Pennines. Eventually, the guys successfully negotiated the treacherous journey, and arrived at the ferry port; shaken but not stirred!

Slowly but surely, all members, delegates and staff arrived safely in Dublin. Somewhat bedraggled, they soon cheered up when they saw the location of the Conference Centre, set in beautiful gardens and overlooking a challenging - if waterlogged - 18-hole golf course. Once everyone had settled into either one of the two hotels, they wandered into the bar for a well-deserved glass of the black stuff.



It was going to be an early start for those involved in the running of the conference, and they were the first to move

away from the bar and off to bed. The events of the day had been quite fraught, and slumber beckoned. Bright and early the next day, the conference hall was a hive of activity. Audio-visual technicians were erecting the impressive stage, and sound checks could be heard throughout the building. It made one believe the guys were preparing for a pop concert, not a meeting of some of the most important people in the world of cardiothoracic surgery.

Exhibitors had also started to arrive, and there were some striking commercial stands taking shape. It was the largest ever participation from cardiothoracic medical exhibitors. Their latest innovations were being proudly demonstrated, and the sight was really quite impressive.



This year has seen a change in the Societies name, to Society for Cardiothoracic Surgery in Great Britain and Ireland. The reason for this is not to exclude, but rather include the involvement and valuable contribution of all professionals, who are imperative for the success of cardiac surgery. So, a further seminar room was being prepared for the Healthcare Practitioners Forum, taking place on the Wednesday and Thursday. Currently the contributions are chiefly from nurses, perfusionists, operating theatre technicians, and surgeons assistants. However, it is hoped there will be future submissions from other cardiothoracic surgical health care professionals such as physiotherapists, database specialists, etc.

The Society would like to thank Jacqueline Nicol, Nurse Representative, for her hard work and contributions over the past three years, and welcome her successor Tara Bartley. Tara completed her RGN training at The London Hospital, and currently works at the Walsgrave Hospital in Coventry. She believes that healthcare professionals should provide a service that reflects the interests of the patients.

*continued...*

“With the advent of patient choice and establishing 'Choose and Book', it is hoped the forum can highlight what is important to individuals undergoing cardiothoracic surgery, as well as their families,” she says. Tara is delighted to have been offered the position of Nurse Representative, and plans to develop a nationwide network of regional representatives to disseminate information.

Monday's activities saw the President, Mr Pat Magee's, address. High on his list of topics for discussion was the launch of the Public Portal. The Portal has caused much interest in the eyes of the public and press alike, and may well influence decisions by future patients when selecting a centre or surgeon for their surgery.

During the afternoon business meeting, the results of the ballot for President Elect were announced. Mr Leslie Hamilton



from Freeman Hospital in Newcastle, and past Dean of Cardiothoracic Surgery, was declared the overall winner. He was visibly thrilled with the announcement, and spoke of increased unity between thoracic and cardiac surgeons, as well as emphasising the importance of all Society members being involved in the future of the Society.

Retired surgeon and designer of the world's first pericardial biological heart valve, Mr Marian Ionescu, gave an enlightening talk about his remarkable career. This was followed by an enthralling account of his passion for mountaineering.

There was a welcome reception, which was hosted by the Irish Department of Health and Children. Honoured guest, Minister Tim O'Malley told how significant it was to be holding the meeting in Dublin, particularly at a time of such change in the Irish Healthcare Service.



The quality and value of the various contributors from all over the United Kingdom, Europe and the world was phenomenal. All of the work was very well received by the delegates, and prompted some very interesting debates. The continuing and increasing number of submissions is encouraging, and is at the heart of what makes the meeting successful.

Throughout the day the delegates were reminded of start times by the invaluable ringing of bells performed by fifth year medical students from the University of Dublin. Their help and guidance was invaluable - and they looked far too young to be future doctors...!!

This year's meeting saw the appearance of the first 'live' meeting Bulletin. Its publication involved lots of running around the conference hall, collecting information and photographs from the day's events. As you can imagine, the cut/copy/pasting buttons took more than a hammering, and the tension in the



*Annual Scientific Meeting Report, Dublin March 2006 continued*

office was enough to match any Fleet Street house.

Honoured guest speaker Dr Timothy Gardner, from the American Association of Thoracic Surgeons said the meeting in Dublin was a “model for a really good surgical meeting”.

He spoke of the invaluable contributions from senior surgeons, right through to medical students, as well as other allied professionals. “The program itself had lots of new science and clinically relevant presentations”, he said. Dr Gardner also spoke of the “degree of interactivity between presenters, discussants, moderators and a very alert audience.”

The week saw the election of two members onto the Executive Committee of the Society. These were Mr Ben Bridgewater for Wythenshawe Hospital in Manchester, and Mr Tim Graham from the Queen Elizabeth Medical Centre in Birmingham. Ben Bridgewater spoke of his work with IT and the Healthcare



Resource Group, whilst Tim Graham said he would like to see increased alignment of the Specialist Advisory Committee and the Society.

Meanwhile, an outgoing member of the Executive Committee, Mr Richard Page from the Cardiothoracic Centre in Liverpool, will continue to manage the National Thoracic Database. This work is particularly valuable, especially in view of thoracic data being included in the Blue Book this year.

Thursday evening was the Annual Dinner, this year being held at the Guinness Storehouse and Museum in Dublin. Members and guests were excitedly transported through Dublin, before arriving at the historic factory. Medieval entertainers welcomed the diners, with actors on stilts and flamethrowers escorting them into the building.



A tour of the museum and factory followed, where guests read and learned of the complexities involved in the production of the black, creamy nectar.

Afterwards, they were ushered to the top floor. Here was a 360-degree bar, with floor to ceiling windows. Guests were dazzled as they took in the stunning sights of Dublin at night. Guinness was on offer in plentiful amounts, and it would have been very rude to decline.

Eventually, everyone was seated in the regal dining room. The meal itself was nothing but delicious, and as it turned out was not the cause of the gastric viral bug suffered by so many over the following weekend. Then came the announcement of this year's prizewinners. The St Jude's Scholarship was won by J Chikwe, who amazingly diverted her journey between Chicago and London when she learned she'd won the scholarship. The John Parker Medal was won by E Hickey, and the Marian and Christina Ionescu Travelling Scholarship went



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to M Jahangiri. Meanwhile the Ronald Edwards Medal was won by A Ranasinghe, and the Society Scholarship for Thoracic Surgery by J Edwards. Finally the Society Medal went to A Alzetani.



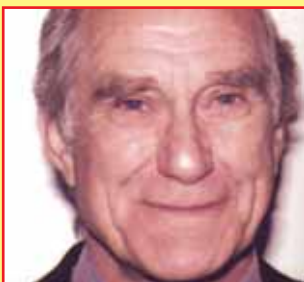
With hands almost numb from applauding, diners settled down to hear the speech from outgoing President Mr Pat Magee. It was a most stirring address, ending with him handing over his Presidential Chain to the new President, Sir Bruce Keogh, in quite a moving ceremony. Sir Bruce then spoke of his vision of the Society achieving greater influence in decision making in healthcare. He sees this being realized by involving large numbers of patients who have been operated on by Society members.



The night continued, the wine flowed and people were clearly enjoying themselves. Everyone was chatting, networking and socialising. It was the perfect end to a fabulous evening, and wonderful conference. The incredible hard work by the Society staff, and the dedication and attention to detail by Meeting Secretaries Simon Kendal and Graham Cooper made the whole event a most successful one.

Next morning, on St Patrick's Day, with a few sore heads in tow, people left the wonderful city of Dublin. It will be a hard act to follow, and Manchester will have to come up trumps to top the charms of Eire. Will the home of the 'Theatre of Dreams' and Coronation Street offer such a happy memory..? You bet it will.....! ■

## Heart Research UK



*David Watson,  
HRUK Founder*

Formerly the National Heart Research Fund, was started nearly 40 years ago by senior member, David Watson, to promote research by cardiac surgeons. The aims have widened to embrace basic science as well as investigation and prevention of cardiovascular disease but HRUK remains committed to progress in heart surgery and

is keen to encourage applications from members for the next clinical round in November.

The charity is currently funding £2.5m of research in 32 centres across the country into the prevention, treatment and cure of cardiovascular disease. The maximum grant awarded is £85,000 and forms and guidelines can be downloaded from



*Barbara Harpham,  
HRUK National Director*

[www.heartresearch.org.uk](http://www.heartresearch.org.uk) or requested on [research@heartresearch.org.uk](mailto:research@heartresearch.org.uk) Applications close 12noon, 30 September.

HRUK will be working with the Society to give a special award in recognition of major contributions to heart research. Mr Watson, HRUK President, and the Trustees are very anxious to promote surgical research and this will be an ideal way to celebrate the charity's pioneering achievements during its anniversary year in 2007. ■

Barbara Harpham, HRUK National Director

# ABSTRACT ASSESSMENT AND PRESENTATION AT THE ANNUAL MEETING

*Graham Cooper, Meeting Secretary*

Over the last six years we have refined the process by which abstracts are assessed and accepted for the annual meeting. We aim to make the selection as transparent and objective as possible, and to present a balanced and varied programme. This article describes the process and new developments for the 2007 meeting.

Abstract submission is electronic, and is accessed on the SCTS homepage ([www.scts.org](http://www.scts.org)). Submission opens at the beginning of September 2006, and closes at midnight GMT on 5th November 2006. Submitting authors are required to choose the appropriate category in which to submit their work, guidelines for this are shown in table 1. The rules regarding style and length are published on the abstract submission page. Every abstract in each category is scored by 3 consultant members of The Society, a lead and 2 co-reviewers. The lead reviewers for the meetings in 2006 to 2008 are shown in table 2. Each lead reviewer chooses two co-reviewers; these may be different each year. At the end of their three-year term they nominate their successor who will have been one of their co-reviewers.

For 2006 we introduced clinical practice as well as scientific sessions. These were well received and will be continued in 2007. Submitting authors are required to designate their abstract as scientific or clinical practice, guidelines for this are shown in table 3.

Abstracts are scored using an assessment matrix (table 4). Reviewers have found this helpful and easy to use. An experience shared by The European Association for Cardiothoracic Surgery and European Society of Thoracic Surgery who have adopted it. Reviewers see only the title and text of the abstract, not the authors or institution. The number of abstracts submitted for each of the past six years is shown in table 5. Following assessment, individual scores are collated and abstracts ranked. The Programme Committee meet towards the end of November. The members of The Programme Committee are The President, Vice-President and Honorary Secretary of The Society, the Lead Reviewers and The Meeting Secretary who chairs the meeting. The abstracts for presentation are chosen with regard to the following criteria, given in order of importance;

- conformation with submission rules, e.g. institution not identified in text
- the abstract score
- the overall balance of the meeting.

The programme committee allocates abstracts to sessions, and designates them as oral or interactive presentations. Oral presentations use slides and are presented for 7 minutes with 3 minutes discussion. Interactive presentations are displayed

as a poster throughout the meeting, and for the presentation an electronic version of the poster is displayed which the presenter can zoom in and out from. The presentation is 3 minutes and discussion 7 minutes. Abstracts are selected for interactive presentation on the basis they will generate an interesting discussion, regardless of their score. In early December authors are notified, and the final programme is published on the SCTS homepage.

For 2007 we will:

- Increase the number of co-reviewers for each category from two to four
- Add a sixth category, Forum for Cardiothoracic Practice, to allow electronic submission of the papers presented in these sessions.
- Introduce a third presentation medium - digital presentations. These will be displayed as a continuous loop on plasma screens in the exhibition hall. Authors will be asked to stand by the screen at certain items to discuss their work. With this third presentation medium we will be able to increase the number of abstracts accepted and increase the focus of the meeting for the various specialty groups within SCTS.

**Table 1: Category selection guidelines**

There are five categories:

- Adult cardiac
- Thoracic
- Transplantation
- Congenital
- Experimental and miscellaneous

Select the category that is most appropriate for your work. If the principle outcome measure is clinical then put it in the appropriate clinical category. If the work is laboratory based or has an outcome measure not in routine clinical practice, submit it in the experimental and miscellaneous category.

**Table 2: Lead Reviewers for 2003 - 2005**

Adult Cardiac*	Malcolm Dalrymple-Hay (Plymouth) Brian Fabri (Liverpool)
Thoracic	John Duffy (Nottingham)
Experimental	Adrian Marchbank (Plymouth)
Congenital	Andrew Parry (Bristol)
Transplantation	Steve Clark (Newcastle)

\*Because of the number of abstracts submitted in this category there are two teams of reviewers each marking half of the abstracts.

*continued...*

**Table 3: Session selection guidelines**

<p>Scientific sessions will contain abstracts that tend to:</p> <ul style="list-style-type: none"> <li>• Be laboratory based or clinical</li> <li>• Have a null hypothesis</li> <li>• Compare two or more forms of intervention</li> <li>• Use comparative statistics, give p values</li> </ul>	<p>Clinical practice sessions will contain abstracts that tend to:</p> <ul style="list-style-type: none"> <li>• Be clinical</li> <li>• Report a case series</li> <li>• Report a new procedure or technique</li> <li>• Use descriptive statistics, not have p values</li> </ul>
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**Table 4: Abstract Assessment Matrix**

*Abstract Assessment Matrix*

Criteria	0	1	2	3	4	
Impact						
Originality						
Design / Data analysis						
Conclusions						
					TOTAL	

*Scientific Abstract Marking Criteria*

- **Impact.** Score 1,2, 3 or 4. This reflects the relevance of the abstract to a clinical cardiothoracic surgical meeting. Work should have direct clinical relevance to score 3 or 4.
- **Originality.** Score 0,1 or 2. Score 0 if the study repeats previous work, 1 if it extends previous work and 2 if it is completely original.
- **Design / Data Analysis.** Score 1,2 or 3. In general a case control series would score 1 and a randomised trial 2. For laboratory work controlled experiments score 1 or 2. If the data analysis is clear, uses appropriate statistics and allows for confounding variables add 1.
- **Conclusion.** Score 1 if the conclusions are clearly stated and supported by the results. Score 0 if this is not the case.

*Clinical Practice Abstract Marking Criteria*

- **Impact.** Score 1,2,3 or 4. In general a series simply reporting an established operation or condition for which the natural history is well known would score 1. A rare condition or operation would score 2. A new procedure would score 3. Add 1 if the work is important.
- **Originality.** Score 0,1 or 2. Score 0 if the study repeats previous work, 1 if it extends previous work and 2 if it is completely original.
- **Analysis.** Score 1,2 or 3. Score 1 if there is important data missing and 3 if there is enough data to put it in context. This would normally include details about the population from which the series was drawn, closing interval and completeness of follow-up.
- **Conclusion.** Score 1 if the conclusions are clearly stated and supported by the results. Score 0 if this is not the case.

**Table 5: Number of abstracts submitted for the past 6 years**

Year	No abstracts submitted	% accepted
2001	184	26
2002	248	19
2003	273	17
2004	290	17
2005	263	18
2006	256	19

# New Consultant Appointments

	Hospital	Starting Date
Rafael Guerrero	Yorkshire Heart Centre, Leeds	January 2006
J Mark Jones	Royal Victorial Hospital, Belfast	February 2006
Pushpinder Sidhu	Royal Victorial Hospital, Belfast	February 2006
Pankaj Kumar	Morrison Hospital, Swansea	March 2006
Mike Lewis	Sussex Cardiac Centre, Brighton	April 2006
Kumud Dhital	Papworth Hospital, Cambridge	
John Hinchion	Cardiothoracic Centre, Cork	May 2006
Edward Black	Nottingham City Hospital, Nottingham	June 2006
Mike Poullis	Cardiothoracic Centre, Liverpool	July 2006

## Other appointments

Name	Hospital	Starting Date	Appointment
Thanos Athanasiou	St Mary's Hospital, London	January 2006	Senior lecturer in cardiothoracic & general surgery
Clifford Choong	Papworth Hospital, Cambridge		Lecturer in cardiothoracic surgery

# Diary of Forthcoming Events

**Meeting:** Aortic Root II  
**Date:** 1<sup>st</sup> July 2006  
**Venue:** The Cardiothoracic Centre, Liverpool, United Kingdom  
**Contact:** Sarah Bradley  
**Phone:** +44 (0)151 293 2463  
**E-mail:** [sarah.bradley@ctc.nhs.uk](mailto:sarah.bradley@ctc.nhs.uk)

**Meeting:** Mitral Valve Repair III  
**Date:** 2<sup>nd</sup> September 2006  
**Venue:** The Cardiothoracic Centre, Liverpool, United Kingdom  
**Contact:** Sarah Bradley  
**Phone:** +44 (0)151 293 2463  
**E-mail:** [sarah.bradley@ctc.nhs.uk](mailto:sarah.bradley@ctc.nhs.uk)

**Meeting:** 5<sup>th</sup> EACTS/ESTS Joing Meeting  
**Date:** 9<sup>th</sup> – 13<sup>th</sup> September 2006  
**Venue:** Stockholm International Fairs  
**Contact:** EACTS Executive Secretariat  
**Phone:** +44 1753 832166  
**E-mail:** [info@eacts.co.uk](mailto:info@eacts.co.uk)

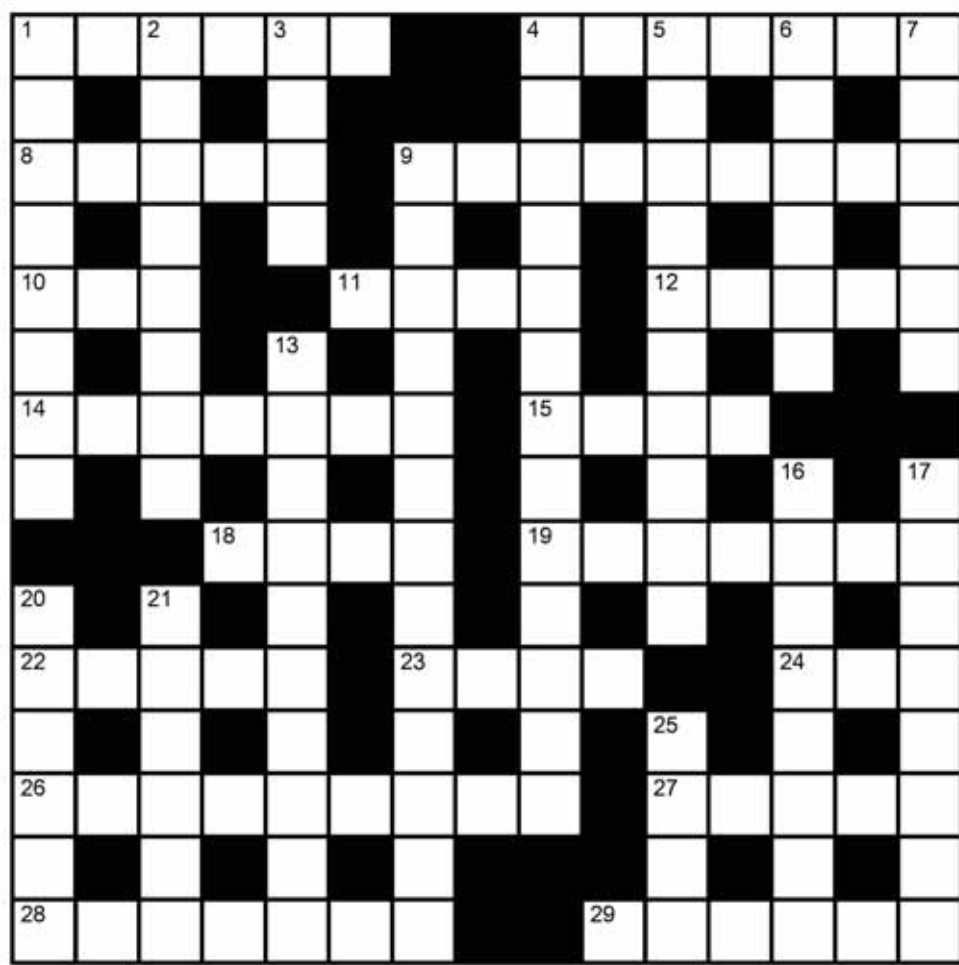
**Meeting:** Birmingham Review Course in Cardiothoracic Surgery  
**Date:** 28<sup>th</sup> September – 1<sup>st</sup> October 2006  
**Venue:** Education Centre, Birmingham Heartlands Hospital  
**Contact:** Ms L Richardson  
**Phone:** +44 (0)1296 733 823  
**E-mail:** [lassociates@lycos.co.uk](mailto:lassociates@lycos.co.uk)

**Meeting:** European School for Cardio-Thoracic Surgery, Thoracic Course level C  
**Date:** 16<sup>th</sup> – 21<sup>st</sup> October 2006  
**Venue:** Villa Elios  
**Contact:** EACTS Executive Secretariat  
**Phone:** +44 1753 832166  
**E-mail:** [info@eacts.co.uk](mailto:info@eacts.co.uk)

**Meeting:** 6<sup>th</sup> Haematology in Cardiac Surgery Meeting  
**Date:** 2<sup>nd</sup> November 2006  
**Venue:** The Association of Anaesthetists of GB & Ireland  
**Contact:** Dr Kanchan Rege  
**E-mail:** [janet.wildber@hinchbrooke.nhs.uk](mailto:janet.wildber@hinchbrooke.nhs.uk)

**Meeting:** Aortic and Mitral Valve Surgery II  
**Date:** 4<sup>th</sup> November 2006  
**Venue:** The Cardiothoracic Centre, Liverpool, United Kingdom  
**Contact:** Sherry Layton  
**Phone:** +44 (0)151 293 2463  
**E-mail:** [sarah.bradley@ctc.nhs.uk](mailto:sarah.bradley@ctc.nhs.uk)

**Meeting:** European School for Cardio-Thoracic Surgery, Thoracic Course level C  
**Date:** 13<sup>th</sup> – 18<sup>th</sup> November 2006  
**Venue:** Villa Elios  
**Contact:** EACTS Executive Secretariat  
**Phone:** +44 1753 832166  
**E-mail:** [info@eacts.co.uk](mailto:info@eacts.co.uk)

**Across**

- 1 Was gloomy on soft-top vehicles (6)  
 4 Ink test result in litter (7)  
 8 She is just short of average (5)  
 9 I am back before cleric is full of sound tea (and what he must do afterwards!) (9)  
 10/11/12 3 fixtures need changing (3,4,5)  
 14 Experience foreign articles on leave (7)  
 15 Ogles bits of dopey Essex girls (4)  
 18 Where pig lives noisily, an affliction of 15 (4)  
 19 Not 27 type of bomb with head slipping (7)  
 22 Ground house (5)  
 23 Brand force (4)  
 24 Pass the cube (3)  
 26 We accept old currency in cyberspace races here (9)  
 27 Poor 25 without end I would find transparent (5)  
 28 He opts out of returning carrot, celery etc (7)  
 29 Just depend on compiler (6)

**Down**

- 1 Nice sums worked out in joint (8)  
 2/20 Reopened box, lid broken: not fair, naturally (8,6)  
 3 Very late (4)  
 4 24 excitement on the vessel (4,3,6)  
 5 Aggressiveness of uncle - truce organised (10)  
 6 No good leaving England's deer (6)  
 7 Coy about boob: it's the drink (6)  
 9 24 like Pinnochio to come across Geppetto (4,4,5)  
 13 Christian worker at demo (10)  
 16 The man, a rising rascal, the man is a pain (8)  
 17 Cosy, like fire from your own side? (8)  
 20 See 2  
 21 Study mad cow disease, including argument (6)  
 25 This begins "come let us evangelise" (4)

# CROSSWORD



*Crossword solution December 2005*

**Edwards Lifesciences champagne winners for December 2005 crossword were Tim Graham & David Luke**



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Publishing Secretary  
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