The Society for Cardiothoracic Surgery
in Great Britain and Ireland

DECEMBER 2007

THE bulletin

PRESIDENT'S REPORT

Sir Bruce Keogh

As my time as president draws to a close and I embark on my new role as Medical Director of the NHS I am prompted to reflect on some of the progress that we, as a specialty, have made over the last few years.

We have emerged from the shadow of Bristol as a model specialty – innovative, determined and self governed. Supported by some visionary leadership from the Executive coupled with a national service framework geared towards increasing cardiac surgical capacity, we substantially reduced the prevailing inhumane cardiac surgical waiting lists, we set the gold standard for local and national clinical audit and patient consent. Following extensive consultation we modernised our Society to make it more inclusive and embracing for all those who play a major role in helping our patients through the physically and psychologically challenging journey imposed by surgery.
This is reflected in the change of the name of the Society to "The Society for Cardiothoracic Surgery", rather than "of Cardiothoracic Surgeons". This organisational re-engineering included an attempt to improve both communication and decision making within the Society by reducing the size of the Executive and introducing a Representative Board constituted of representatives from each unit in the country with the aim of including more members in the decision making process. None of these major changes would have been possible without the considerable work undertaken by James Roxburgh & Graham Cooper. I'm confident that the Society will continue to flourish with Graham now appointed as the future Secretary. Following on the highly successful post of Meeting Secretary we have this year introduced and formalised two new portfolios of Communication Secretary and Education Secretary both ably filled by Sunil Ohri and John Pepper respectively. In addition we have focussed our thoracic surgical endeavour under the enthusiastic leadership of Jim McGuigan.

As a result of our endeavours we have been well positioned to respond constructively to the gauntlet thrown down by the CMO for specialty associations to set the standards for recertification, which will then be administered by the Royal Colleges.

We cannot control for all eventualities, but through the reorganisation we have tried to position our Society to respond effectively to both internal and external influences and events.

Both the NHS and our specialty are changing. There is a simple truth that improvement is always associated with change, change is not always associated with improvement. But change is both

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inevitable and unstoppable. We can at best hope to stimulate change, influence change or respond to change – we cannot prevent it.

In the CMO's recent report "Waste Not Want Not" he highlights that "both under use and over use of treatments are rife in this and most other countries and are enemies of effective healthcare".

Within this context our next big challenge is to adopt a balanced, proactive approach to changes in the clinical practice of cardiology with particular respect to identifying the relative merits of surgical and percutaneous interventions. Our approach to this must be scientific with the interests of the patient at the heart. It is our job to engage in debate to find a balance without stifling innovation. Commercial and special professional interest groups are conspiring to pervert the course of this honest debate. But we must not engage in the politics of protectionism where principles of honesty, integrity are sacrificed on the alter of professional and commercial self-interests. But we can, and must, legitimately review emerging evidence, not only in the interests of the future of the specialty but also as professionals, as doctors, as informed guardians of the public interest. We must not, under any circumstances, be seen as Luddites, as a specialty paralysed by the glare of innovation and progress, as a Society running scared.

As a specialty our future lies in appreciating that our patients do not want a major operation with the associated pain and slow recovery. We must seek effective alternatives in the form of effective minimally invasive surgery. This will lower the referral threshold and secure the proven benefits of surgery for our patients in the longer term.

Thoracic surgery has had to face clinical change head on. In the 1980s and early 90s thoracic surgeons tackled the threats and opportunities offered by emerging minimally invasive philosophy in the form of VATS. With support from the NHS Cancer Plan published in 2000 they have developed effective MDTs across the nation, which provides a unique international model. Cardiac surgery should follow this lead.

Finally, I would like to congratulate David Taggart on being elected to succeed Leslie Hamilton as President and also to congratulate and welcome John Duffy and Neil Moat as our two new trustees on the Executive.

The Appointment of Bruce Keogh as NHS Medical Director

I'm sure all Society members would like to congratulate Bruce Keogh, on his appointment as the new NHS Medical Director & Deputy Chief Medical Officer. This appointment offers our Society a unique perspective into central policy making & the future impact on our specialty. Well done Bruce on this outstanding achievement & good luck in your new role.

Society Election Results

In the recent elections David Taggart has been appointed President- Elect from March 2008 & the new Trustees are Neil Moat and John Duffy. Congratulations!

Secretary's Report.....

James Roxburgh

This will be my last report for the Bulletin as I stand down as Honorary Secretary during the Annual Meeting in Edinburgh.

I have served on the Executive for eight years and there have been many changes in both our profession and the way our Society functions; however now is not the time to bask in the warm glow of nostalgia but to look forward to the not inconsiderable challenges that face us.

We must as a Society, and a profession, act to advance all aspects of the specialty and realise that we represent Cardiac and Thoracic surgery in the broadest sense. We must not allow single issues to be advanced to the detriment of our broader remit particularly when we face the challenges of re-certification and revalidation. It has been said by some that we have allowed the publication of results to overshadow many other aspects of our specialty. This may have been true in the early days but I believe that our failure to engage the membership and communicate the considerable amount of work that the Executive does was more of a problem. We have restructured the Executive, made the minutes of the Executive available to the membership and have set up the Representative body. I firmly believe that these changes will ensure that the Society is able to work with its members to advance all aspects of Cardiac and Thoracic surgery within the UK.

Now is the time to look forward to the not inconsiderable challenges that face us

Over a quarter of a century ago our specialty started collecting simple mortality data and I suspect they felt their actions were as inconsequential as a butterfly flapping its wings in Tokyo. However as disciples of the "chaos theory" are well aware such actions can have significant and unimagined consequences. Bristol was not the cause but simply the catalyst for an unstoppable process. It would be foolish to think that we can turn back the clock and revert to the paternalistic approach that the doctor knows best. I believe we have as a specialty gained considerable kudos for the way we handled the problem and it will allow us, to a considerable extent, to be architects of our own revalidation and recertification processes. Pat Magee and Steve Livesey will be leading the Society's submission to the College, which requires us to demonstrate mechanisms for the assessment of knowledge, measurement of outcomes as well as an ongoing educational process.

By the time you read this the first detailed Thoracic Report, compiled by Richard Page, will have been circulated. This is an impressive document of over 90 pages, which will also form part of the new Blue Book that we hope to publish in early 2008. Richard has worked tirelessly to collect and analyse this data on behalf of his Thoracic colleagues but he would be the first to acknowledge that thanks must go to all the Thoracic surgeons across the United Kingdom who have collected this data. Ben Bridgwater has agreed to set up an adult cardiac surgical database group that will comprise both Executive members and those within the specialty who have a particular interest in the subject. This area has simply become too onerous and important a role for a single individual. Ben's group will work closely with Richard Page to ensure that the Society develops a unified approach to the outcome measures that will be required by the re-licensing procedure.

The role of the consultant is rapidly changing and it is important for both patients and surgeons that high-quality surgery, education, training and an appropriate working environment are not sacrificed on the altar of volume. It has been agreed that Graham Venn and Graham Cooper will chair a group that will review all new Consultant job descriptions submitted to the Society for approval. We believe this will allow a pool of expertise to develop and ensure that the Society ensures consistency of the Consultant job descriptions for cardiothoracic surgery within the UK.

A brief review of the national dailies and the medical press highlights the political and public concern over Consultants contracts, performance and outcome measures, and the complexities of the revalidation process. We face significant challenges; we must not lose sight of the big picture. I believe I leave the Society better able to deal with both the "known knowns" and the "known unknowns" as well as the "unknown unknowns" than it was 5 years ago!

Finally I would like to wish my successor, Graham Cooper, all best for the next five years. I leave the Honorary Secretary's post in extremely capable hands.

SAC News update

Tim Graham, Chairman SAC

First of all I would like to congratulate the previous chairman Chris Munsch on his appointment to chairman of JCST which is now the Joint Committee for Surgical Training encompassing the previous JCHST and now core/basic surgical training. Chris has done a great job as chair of the SAC during a difficult and turbulent period. He was primarily responsible for the cardiothoracic curriculum which is held in high esteem by the surgical community.

I was appointed as chair of the SAC following an interview in October. Other personnel changes on the SAC have occurred. John Pepper has been appointed the Educational Secretary and he will now attend the SAC instead of the Secretary. The trainee representative Farrah Bhatti has successfully been appointed to a consultant post and a new trainee representative will be attending the meeting on 14th December. There will be 2 SAC vacancies from February 2008 to replace Chris Munsch and Jim McGuigan (who I would also like to thank for all his hard work over the past 3 years). The SAC welcomes applications from consultants with appropriate educational and training backgrounds to fill these vacancies. Steve Hunter continues in the important role of Cardiothoracic Dean for the next 2 years and has taken the lead with recruitment and selection into the specialty. Steve Livesey has taken on the role as deputy chair of the SAC.

Selection into the specialty 2008

For the MMC 2008 round of recruitment there will be 5 NTN vacancies in England, at the ST3 level (this is a total of 7 for 2008 as 2 ST2's are already in place). Scotland, Wales and Northern Ireland will probably also recruit 1 NTN each. The SAC will undertake national recruitment and selection and person specifications, details and criteria for short and long listing have been submitted to MMC. The SAC and Programme Directors will be involved in selection and one of the national deaneries has agreed to undertake administration of the process in 2008.

Whilst we are on MMC - the recent Tooke Report has been put out to consultation and the SAC has reported back to JCST and a joint response from them and the colleges is being submitted. In brief the findings and recommendations of the Tooke Report were welcomed but we are unsure if there is the political will needed to implement the recommendations fully. For the time being MMC is still with us and the ST1-8 system remains in place.

The recent ruling regarding the status of highly skilled migrants means that issues related to medical immigration will continue and make medical manpower planning difficult for the foreseeable future.

Manpower

There appears to have been some improvement in manpower problems with currently fewer CCT holders unemployed than previously predicted. This is due to a combination of CCT holders going into non consultant posts and other unforeseen factors. It may be that the problem has simply been postponed due to relatively large numbers of trainees having RITA E's to either overcome deficiencies in training or to delay their CCT date. The SAC is currently in the process of undertaking a UK survey to identify the exact numbers of HST trainees by type, year and region and the number of CCT holders who are currently not in consultant posts or other employment.

The recent ruling regarding the status of HSMPs (Highly Skilled Migrant Programme) means that issues related to medical immigration will continue and make medical manpower planning difficult for the foreseeable future.

Other News

The PMETB survey of trainees is due to be re-run in 2008; some specialty specific questions have been added for cardiothoracic trainees. In the previous survey there was some potentially serious issues raised but the methodology and distribution of the survey was flawed and we hope the 2008 survey will be a more accurate reflection of the current state of cardiothoracic training.

There has been some tightening up of the administrative procedures for trainees undertaking out of programme experiences (OOPE). There must now be prospective PMETB and SAC approval and we would recommend that contact with the SAC is made as soon as possible if this is being considered by any of the trainees (scipriano@rcseng.ac.uk).

Steve Livesey is the lead for the continuing development of the intercollegiate surgical curriculum. The SAC firmly believe that cardiothoracic surgical training in MMC must be linked in with the curriculum and its assessment tools. However all surgical trainees should be encouraged to register with ISCP and encourage their trainers to do so as well!

The SAC continues to consider article 14 applications and reassuringly PMETB has agreed with all the cardiothoracic SAC recommendations. There are several outstanding applications and the administrative process remains painfully slow, prompting JCST to suggest a more streamlined simpler process for dealing with these applications.

Professor John Wallwork has taken on the role of academic lead for the SAC and he is developing an academic curriculum as research remains a core element of the cardiothoracic syllabus. Two Walport lecturers have been appointed to the West Midlands programme (these were both existing NTN holders) and 1 has been appointed to the Northern programme. Professor John Pepper is currently reviewing the situation regarding academic clinical fellows being appointed to the specialty.

I can be contacted by email tim.graham@uhb.nhs.uk

Can I encourage as many of the trainees as possible to attend the trainees meeting on the Sunday afternoon of the SCTS meeting in Edinburgh (9th March 2008)- this is a real opportunity for you to air your opinions and be updated on the current training situation.

Update on The Intercollegiate FRCS(CTh)

Robert Jeffrey
Chairman, Intercollegiate Specialty Board in Cardiothoracic Surgery

The examination continues to evolve and I am grateful for the enormous contribution of my predecessor in this position, Mr Leslie Hamilton. The standard at which the examination is set is now considered to be at the level one would expect from a first day consultant.

Under Leslie's guidance, the exam now comprises of two sections. Section 1 is a multiple choice paper with 110 single best answer questions and 135 extended matching questions. It is sat some three to four months ahead of section 2 and following the examination, a rigorous standard setting exercise takes place and the pass mark is set. Those who are successful are then eligible to sit section 2 which comprises a clinical and oral part. Both cardiac and thoracic surgery have long and short cases. Short cases are supplemented with stations where candidates may be questioned on investigations, instruments, angiography and echocardiography. In the oral exam basic science has been dropped as this can be more consistently examined in section 1, and we now only have cardiac and thoracic orals. Each segment of section 2 lasts 30 minutes and candidates are examined by two examiners who should not be the candidate's current trainer. No candidate should see the same pair of examiners again but an examiner may be partnered with a different examiner.

Section 2 of the examination therefore has six parts, and candidates are marked over six domains in each part. The standard close marking scheme continues, i.e. 4 for a poor fail, 5 for a just fail, 6 for a just pass, 7 for a good pass, and 8 for an outstanding performance. In addition, the examiners now mark independently and are encouraged to use the full range of marks since a 5 in one part needs a 7 elsewhere to compensate and allow the candidate to pass. To pass the exam candidates need a total of 432 (6 x 36 x 2) and an overall pass in the clinical part. Once a year, the McCormack Medal is awarded to the highest scoring candidate over both diets of the exam. The medal is only available to those sitting the examination for the first time.

To further enhance the fairness, robustness, and professionalism of the exam, there is now a clear quality assurance programme in place. Each examiner is observed by one of the quality assurance panel, and his performance is fed back to him following the examination. The candidates should perhaps feel more comfortable in the knowledge that not only are they sitting an examination, but the examiners themselves are being observed to ensure objectivity, courteously, equality and impartiality.

For further information about the examination go to www.intercollegiate.org.uk. The closing dates for entry to the examination, the dates and sites of the exams are available by following the calendar link.

Once again, I should like to acknowledge the considerable input by Leslie in making this examination fit for purpose, and I wish all prospective candidates the very best when they come to sit this exam.

Cardiothoracic Forums & Modernising Nursing Careers

Tara Bartley
Nursing Representative

Forum plans for Edinburgh are well under way. We are delighted to welcome Maura Buchanan back to give this year's 'Welcome Remarks'. The plenary sessions will include Gillian Matthews, Implementation Consultant for NICE will discuss the 18 week patient pathway initiative; Julie Sanders, Nurse Specialist in Cardiovascular Research from The Heart Hospital, London, will take us through the process of conducting research and getting published, and Wendy Gray from The Heart Improvement Programme will feed back on the findings from the National Consent Project.

In addition we will be joining the surgeons meeting for their plenary sessions, and following the success of the joint presentation session that opened last years meeting, there will be seven papers representing the cardiothoracic speciality to open on the Monday morning.

Papers have doubled

Abstract submission has now closed and I am pleased to say that the numbers of papers put forward for the forum has increased by 100%. The programme is coming together and it is hoped that ten of these papers will be chosen for the forum, along with contributions for the joint session. The final programme will be put on the website during December. The EICC is an excellent venue for the annual meeting and Edinburgh is a cosmopolitan city to visit. With the ACSA also joining us, it is hoped that this will be the most dynamic forum to date. Furthermore, with the SCTS's decision to support a substantial reduction in the registration fee, it creates a great opportunity for nurses and allied health professionals to attend. Hopefully this will boost attendance and generate wider discussion and debate by delegates during the various planned sessions.

November saw the Midlands Cardiothoracic Forum hold their annual study day for nurses and allied health professionals from around the region. This meeting was a great success and featured many interesting presentations including percutaneous value insertion, current trends in mesothelioma and treatment and care of the adolescent with congenital heart. The opportunity to network and the discussion forum examining the challenges ahead were welcomed by all. Plans are now underway to replicate this forum in the South of England with an executive body in the early stages of drawing the terms of reference and deciding on the way forward. This development will underpin the networking, development and dissemination of information for cardiothoracic nursing and allied health professionals in the speciality, and it is hoped that we will continue to expand the framework around the regions.

Results from the National Workforce Survey have now been collated and are currently under review by the SCTS Executive. This study bench marked current service provision and collected data examining the planned provision for service delivery with the impact of both Modernising Medical Careers and the European Working Time Directive. The findings should be available for comment on the web after consideration by the SCTS Executive. The responses have provoked interesting comments and questions for the cardiothoracic speciality both at national and local level.

Clearly these issues are topical and have wider implications for service delivery in the NHS. Initiatives around Modernising Nursing Careers are reflected in the current Chief Nursing Officer Bulletin which is seeking nursing views on the document *'Towards a framework for post registration nursing careers: a national consultation'.* The suggestion is to build a framework for training around the patient pathway that will address some of the existing weaknesses in nursing careers with training choices between children, family and public health; mental and psychological care; first contact and urgent care; long term care and acute and critical care. The interim report *'Our NHS, our future'* by Lord Darzi sets out a ten year vision for better services for patients that are effective, safe, personalised and fair. The CNO states that nurses will play a key role in reshaping health services to provide a universally world class NHS focused on improving the quality of care. Peter Carter, general secretary of the RCN, concluded that 'the interim report is an important step in the right direction with it's focus in front line staff, partnership working, patient centred care and innovation' but highlighted that high quality care for all will only be achievable with sustained investment in the NHS and it's staff' It is interesting then that many trusts are consolidating staffing levels and reducing support for all but mandatory training. It would seem that national aspirations are continuing to be hindered at local level by the economic constraints on human and financial resources. The outcome of these consultations will no doubt be eagerly awaited nationally and in the field of cardiothoracic surgery.

The suggestion is to build a framework for training around the patient pathway that will address some of the existing weaknesses in nursing careers with training choices between children, family and public health.

Observational Research

Learning the value of observational research with John Kirklin's "auxiliary brain": Experiences from Congenital Heart Surgeons' Society fellow.

Edward Hickey,
John Kirklin Fellow,
The Hospital for Sick Children,
Toronto, Canada

"Research! A mere excuse for idleness; it has never achieved, and will never achieve any results of the slightest value."

- Benjamin Jowett, Theologian 1817- 1893

I recently heard similar opinions ringing in my ears when a retiring London Gynaecologist with a bulging Harley Street private practice expressed to me with derision that my research efforts with the Congenital Heart Surgeons' Society (CHSS) really amounted to little more than audit!

The Congenital Heart Surgeons' Society is a group of approximately 100 North American congenital surgeons. Today, it has become an important, modern organization representing congenital heart surgery. In contrast to some brag-and-boast forums, it was originally formed in the late 1970s as an opportunity for members to discuss their difficulties or poor results – behind closed doors and away from the eyes and ears of others. A "secret society" as some have chided: no minutes were ever recorded, and membership resembled acceptance into a prep school "gang". However, aside from the benefits of establishing a cohesive clinical community in such a sub-specialized field, the CHSS offered an ideal platform for undertaking research into the management and outcomes following congenital heart surgery. The CHSS data centre (CHSSdc) was subsequently spawned by Dr John Kirklin and his "auxiliary brain", Dr Eugene Blackstone in 1985. At the time, the high-risk arterial switch was being proposed as a conceptually more ideal alternative to the established low-risk atrial switch for transposition of the great arteries (TGA). The first diagnostic inception cohort of the CHSSdc therefore involved the recruitment of almost 1000 infants with TGA over 3 years (more than 30 years experience of any single centre) from over 20 institutions. This seminal CHSSdc cohort has subsequently been used to clearly delineate outcomes following both atrial and arterial switch procedures.

A total of 4700 children have since been recruited to nine CHSSdc diagnostic cohorts. All data are received centrally at the CHSSdc, currently based at the Hospital for Sick Children in Toronto under the directorship of Dr William Williams. Cross-sectional follow-up (including reports of all echocardiograms, cardiac catheters and interventions) is undertaken annually, for the life of every patient. The resulting product is a research database of unparalleled quality and depth of information.

In 2000 the CHSS created the "John Kirklin fellowship", offering a congenital trainee a two-year pupilage in the art and science of clinical biostatistical research under the mentorship of Drs Blackstone, Williams and McCrindle. The previous fellows – David Ashburn and Tara Karamlou – have both completed University of Toronto Masters theses in biostatistics, published 45 manuscripts between them and presented at every major international cardiothoracic meeting. I was fortunate to be offered the third John Kirklin fellowship. I couldn't possibly ignore this opportunity – even though some openly thought I should. After all, cardiothoracic training in the UK is reeling at the moment; surely I should keep my eye on clinical opportunities at home, rather than embark on an additional hiatus from the UK training scene? The best advice was offered by one of the recent EACTS presidents: "Ed, when times are tough, you can either be a limpet or a flying fish…" Of course, a flying fish might easily fly into a brick wall !

Cardiothoracic training in the UK is reeling at the moment; surely I should keep my eye on clinical opportunities at home, rather than embark on an additional hiatus from the UK training scene?

But I haven't looked back. A little over a year ago, I boarded a flight towards my new home at Sick Kids in Toronto, and resumed my earlier North American ex-pat lifestyle (I undertook my MD thesis research in Oregon). Elaborately-named posh coffees that come in pint-sizes with whipped cream, the risk of being arrested for "unlawfully not obeying your pedestrian signals" and incessantly being updated on the progress of Paris Hilton's dramas via CNN!

Observational Research *Continued*

I spend my days gazing at complex computer code that resembles Chinese. At the cost of accelerating Dr Gene Blackstone's ageing process, I have been transformed from an amateur who was never quite sure what type of t test to apply to someone very much at home modeling complex parametric multiphase hazard domains, performing bootstrapped risk-hazard analyses, propensity-adjusted comparisons, analyzing competing risks and undertaking longitudinal regressions of repeated measures.

Is it really worth pursuing these research interests? In the UK, a major obstacle is that research and clinical commitments are frequently considered dichotomous pursuits. There are few incentives to undertake clinical research: it is under-valued and poorly rewarded. In contrast, to quote Dr Richard Weisel – Chief of Cardiac Surgery training in Toronto – "We hire, fire, pay salaries and allocate resources solely according to academic productivity." Their aim – and that of every large North American institution – is to become established as an ivy-league centre. They recognize that the same drive to pursue academic excellence is invariably mirrored by a similar drive to achieve clinical excellence. These are the same principles that John Kirklin and other pioneers held in high regard.

Left to right: Dr William G Williams, Dr Eugene H Blackstone and Edward Hickey during a work-weekend at the Congenital Heart Surgeons' Society Data Center.

But what about the value of observational research? It is worth noting that the vast majority of our knowledge regarding cardiac surgery – adult, but especially congenital – has been derived from well-executed observational research studies. Despite the present era in which randomized, hypothesis-driven research and large national registries are highly fashionable, it is increasingly clear that the future of observational database research is absolutely secure. Research databases are orders of magnitude more cost-effective (the CHSSdc costs $250,000 per year, compared with the Pediatric Heart Network which enjoys $6million per year), and are demonstrating the flexibility to address widely disparate clinical questions from the same cohort of subjects. For example, multi-institutional propensity-adjusted comparisons are ideal methods for studying therapeutic strategies in scenarios where randomized controlled trials might otherwise be unlikely or exuberantly expensive. Additionally, the indefinite longitudinal follow-up of CHSSdc children offers an ideal substrate for delineating long-term functional outcomes.

The value of observational research depends heavily upon the analytic strategies employed. We use parametric multi-phase methodology (as opposed to semi-parametric Cox's proportional hazards), which was devised by Dr Blackstone in the 1980s. It enables us to model different phases of "risk" ("hazard") and is far more versatile for prediction and stratification. The term "parametric" simply relates to the fact that the time-related outcome (risk of death, for example) is expressed as an algebraic mathematical equation, with the significant risk factors (covariates) expressed as components of this equation. It has been a source of great amusement to Dr Blackstone over the years that observers have frequently pitted (the ubiquitous) Cox's techniques against parametric methodology. Why amusement? Well, it was Dr D R Cox himself who pointed out the limitations of his own regression technique and challenged Dr Blackstone to go the extra steps during a meeting in London in the early 1980s. "You boys ought to be smart enough to work this out…", a young Gene Blackstone was goaded!

Bagging

We also always undertake final variable selection using by bootstrap aggregating. Bootstrap aggregating ("bagging") involves testing the reliability of risk factors. More than half of all risk factors typically identified during a regression analysis actually do not translate as strong risks when applied to the population at large. Bagging involves randomly re-sampling our study population ("sample") to create thousands of "training sets" against which the variables are then tested. Those risk factors that are consistently significant across the training sets are considered more reliable as risks in the wider patient population.

Competing risks methodology is another technique we frequently employ. Outcomes other than death (for example rates of re-intervention) are typically underestimated using Kaplan-Meier techniques. Commonly, investigators will simply exclude early mortalities from their analyses, which is a

heavy-handed approach. Instead, using parametric models, we can examine continuous competing transitions to mutually exclusive endstates (re-intervention or otherwise death without re-intervention). These models can then be stratified or used to make predictions in the same way that other parametric models can.

Working Groups

An inspiring feature of the CHSS environment is the enthusiasm and involvement of the members. For every analysis, members are invited to form a "working group" of 10-12. The analytic strategy and preliminary results are discussed with the working group via conference calls, and the analysis is steered accordingly. In the final stages, a "work-weekend" is held (usually 2-3 per year). Working group participants congregate at the CHSSdc of their own free-will and expense in order to thoroughly review the raw data and analysis (figure). Frequently, senior officers and past-presidents of the AATS, STS and CHSS are typically found elbow-deep in raw data while I benefit from the one-on-one tutelage of Dr Blackstone's assessment of my analysis.

Attempting to pre-empt Dr Blackstone's thought process is an impossible task. However, several messages strike home when working with him. First, the simplicity with which the specific questions (research aims) are laid out. Second, his attention to the most fundamental basics of a dataset. He will precisely delineate all features of the study population before exploring any subsequent outcome analysis. Third, analyzing a dataset with him is a journey of exploration. New questions are continuously raised during the analysis, each of which is individually explored to reveal even more questions. Lastly, every aspect of a project – from data collection to manuscript preparation – has a regimental organization and structure. "Work smarter, not harder, Ed…" Although, with two consecutive personal secretaries each day to span the 6 am to 8 pm office day, it's clear that he does both!

Irrespective of its merits as "audit" or "research", I suspect in many years to come I will be able to reflect that pursuing the John Kirklin fellowship has been the single most valuable period of my training experience. For this opportunity, I am indebted to David Ashburn – a bright young American trainee who had the insight to approach Drs Williams and Blackstone in 2002 to be the first such fellow. In his recognition, the fellowship will soon be acquiring his name because, tragically, David died this June when his flight crashed during organ retrieval.

For further information regarding the Kirklin-Ashburn fellowship, Edward Hickey can be contacted at: edward.hickey@sickkids.ca

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Trainees Representative

Farah Bhatti

I would like to encourage you all to attend the Trainees Meeting on March 9th 2008 in Edinburgh and as always it is free to attend. Following the success of the Manchester meeting, we will be retaining the format of an open forum. This means that all trainees have the opportunity to ask questions of the panel or voice there opinions – be it on national selection, Article 14 or the lack of consultant posts. Next year's panel will include Tim Graham (SAC Chairman), Steve Hunter (Cardiothoracic Dean) and Bob Jefferies (ISB Chairman). I am also pleased to announce that we have secured two keynote speakers for the open part of the meeting: Professor John Pepper will be speaking in his new role as Education Secretary, and Professor Sir Bruce Keogh will be speaking with his Medical Director's hat on. So make sure you mark your diaries!

Many of you will already know that I have been appointed as Consultant Cardiothoracic Surgeon at Swansea. I will therefore be relinquishing the role of Trainee Representative. I have found the role both challenging and rewarding. My main focus has been to keep training issues (and particularly the 'jobs crisis') at the top of the agenda at the SCTS Executive and the SAC and to communicate frequently with fellow trainees. We now have a good system of regional representatives and direct email contact with most trainees. The Trainees Page has been updated, although we are looking into improving this with the possibility of a discussion board. However, there is still more work to be done. I am delighted to announce that, following an election in November, Sunil Bhudia has been duly elected as the next Trainee Representative to the SCTS. I would like to thank everyone who has supported me in this post, and would urge you all to give Sunil your full support.

Best wishes - Farah

Revalidation, Relicensure & Recertification.

This will affect YOU

Although many may feel that the current system of appraisal is useful for personal development and local regulation, it is not an appropriate tool for assuring the public that a doctor is competent to practise as a specialist.

Liam Donaldson's report "Good Doctors, Safer Patients" and the subsequent white paper "Trust, Assurance and Safety" confirmed that there would be a system of revalidation which would include an element of specialist recertification for those doctors on the specialist register. It is envisaged that doctors will be revalidated every five years – **revalidation** will be the result of successful **recertification** and **relicensure** processes. Whilst relicensure will be the result of cumulative appraisal performed in employing Trusts and will be largely generic, recertification will be affirmation of a doctor's fitness to practice in his/her chosen specialty. The GMC has overall responsibility for revalidation and has specific responsibility for relicensure, whereas the Medical Royal Colleges have responsibility for carrying out the recertification process and issuing a positive statement of assurance to the GMC. The processes of recertification and relicensure will run concurrently and draw on the same sources of evidence.

In order to develop the recertification process, the four surgical colleges have established a Recertification Project Board. It is co-chaired by the Vice President of the RCS England (Anne Moore) and the President of the Federation of Surgical Specialty Associations (James Steers). Its membership comprises representatives from the nine Surgical Specialty Associations, the Patient Liaison Group and the GMC. Its recommendations will be agreed by the four College Councils and passed the GMC for final sign-off. I represent the Society for Cardiothoracic Surgery on this board.

What will be the Criteria for Recertification?

Surgeons will be recertified by the College with which they are registered, but the process will be common to all four colleges. Although the exact shape of the recertification progress is very much "work in progress", it is likely that assurance of achievement in the following areas will be necessary in order for the Royal College to recertify you as being competent in your chosen specialty.

1 **Life-long learning and self-assessment.** Every surgeon must fulfil the CPD requirements agreed by the Colleges and relevant Specialty Association and establish and maintain an up-to-date portfolio.

2 **Test of Knowledge.** Surgeons should demonstrate that they continue to meet the required standard of cognitive expertise relating to their practice. The College and Associations should develop an interactive educational activity, embodying a test of knowledge, tailored to specialist interest.

3 **Evaluation of performance in practice.** Each surgeon must maintain a record of their operative caseload, clinical activities and outcomes for review by the relevant College and Specialty Association. (In addition to outcome data, evidence of a surgeon's performance could be drawn from such tools as simulator tests, patient feedback and observation of practice.) Evidence from Multi-source (360º) Feedback will also need to be presented.

However, the way in which these areas will contribute is very much open to debate – the Society has already established a Recertification Working Group under the chairmanship of Pat Magee, to develop our thoughts and engage in the debate and I would encourage individual members to contribute – I would be very happy to receive emails at steve.livesey@suht.swest.nhs.uk as I am sure would Pat or any member of the executive team.

Current Issues and Tasks for SCTS

The four colleges will restate clearly that all surgeons should keep a logbook.

- What should be in it?
- What is the role of employing Trusts in enabling data collection?
- Is the collection of data by unit data managers acceptable or does it have to be done by each individual?

What will the test of knowledge be like?

The Specialty Association will have to determine their own proposals for their test of knowledge for submission to the Recertification Board for approval. There are several issues to consider: I believe our proposal to explore the use of the American Board of Thoracic Surgery's SESATS (Self Education, Self Assessment in Thoracic Surgery) has many advantages in that it has already been developed and validated and contributes both educational and assessment elements; however it has been designed to be used to assess all elements of cardiothoracic surgery and not just individual elements such as adult cardiac surgery. I do not detect any desire (either amongst our specialty or in the members of the pan-specialty board) for surgeons to prove knowledge across the whole of their SAC-defined specialty but this has to be debated.

The view was expressed fairly strongly by the Patient Liaison Group representative at the last meeting of the Recertification Board that the public will expect an exam to look like an exam – this view was not supported by other members of the board but again has to be debated and evidence provided to support our position.

My own view is that the test of knowledge should be in our areas of practice but we should not allow these to be defined to narrowly – I would suggest that the areas of practice in Cardiothoracic Surgery are:

- Adult Cardiac Surgery
- Congenital Cardiac Surgery
- Mixed practice – adult and congenital
- Thoracic Surgery
- Mixed practice – cardiac and thoracic.

However, as in many areas, where America leads we follow with varying degrees of enthusiasm. The American Board of Thoracic Surgery has agreed that from 2008, "…once during each ten year MOC (Maintenance of Certification) cycle, the diplomate must take, and pass, a secure, comprehensive **written** examination that will test fundamental and practice-related knowledge. The content of these exams will be derived from recent editions of SESATS and **will include all areas of thoracic surgery**."

What will our outcome measures be?

Although we are further down the line than any other surgical specialty on this issue we have only developed a method for measuring outcomes in adult cardiac surgery, though congenital surgery has now made great progress. We need to develop as system of assessment of surgical performance for thoracic surgery – potential measures would be mortality in index operations, return to theatre, wound infection and re-admission to hospital to suggest just a few. Do we also need to define acceptable outcomes for each of the five sub-groups? We also need to consider the role of peer review of cases (such as the ABTS system of structured review of a surgeon's last 100 cases) and also of how local audits could feed into the process.

Should we contribute specialty specific questions to any multi-source feedback questionnaires or would generic surgical questions suffice?

Multi-source feedback will almost certainly be part of the process. At present it is planned that this will be administered by the relevant Royal College. This does not seem logical to me and I feel it would fit in much more appropriately with local processes of appraisal but questionnaires should contain some specialty specific questions. Again this is open to debate.

What is the Timescale?

It is currently envisaged that pilots will be undertaken and evaluated during 2009 and that recertification will commence in mid-2010. This gives us time to make our views known so please don't hold back.

Happy Christmas.
Steve Livesey

While relicensure will be the result of cumulative appraisal performed in employing Trusts and will be largely generic…

…recertification will be affirmation of a doctor's fitness to practice in his/her chosen specialty.

Medico-legal Corner

The Bolam Test & Its Relevance to Cardiothoracic Practice

Leslie Hamilton, President- Elect

Only about 1% of clinical negligence cases ever reach Court – reforms to the civil legal system in the late 1990s strongly encouraged negotiated settlements. Nonetheless, two cardiac surgical cases have recently been heard in court and both may have an impact on practice. For those who want more detail, court judgements are published on legal websites and sometimes provoke articles in the legal journals (as did case 1 below).

It should be remembered that the standard by which you are judged is the classic "Bolam" test. In this case in 1957, the Judge said: "it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art". Note – you are not assessed by reference to the "best", rather by what would be expected from a "reasonable" surgeon. The Judge stated that the standard was a "practice accepted as proper by a responsible body of medical men skilled in that particular area". The Bolam test has come in for much criticism from lawyers as it seemed to allow doctors to set their own standards – "experts" are needed to assist the Court by giving an opinion on what the standard of care should have been. Cynics have suggested that doctors could be found who would (for a fee) back up any practice. The more recent case of "Bolitho" has re-dressed the balance – the expert's opinion can be challenged by the Court if it is "not capable of withstanding logical analysis."

Case 1

A 65-year-old man was admitted with acute coronary syndrome. Angiography showed a severe left main stem lesion and a proximal RCA lesion. He was kept in hospital for surgery. He had an eventful operation with four grafts using the LIMA and 3 veins – the vein was harvested by an experienced SHO and liga-clips were used on the side branches. The operating surgeon checked the vein carefully. The patient was extubated in the early hours of the morning – soon afterwards a cough was associated with sudden significant bleeding and hypotension. The anaesthetist responded to the crash call and re-intubated the patient. The surgical registrar was not resident – however he attended promptly. The chest was opened within 30 minutes - the bleeding was from a side branch from which a liga-clip had been dislodged. It was controlled and the patient stabilised. Sadly the patient suffered significant neurological injury.

There were two issues before the Court:

1. If the liga-clip came off, had it been applied incorrectly?
2. was the action taken to deal with the bleeding appropriate?

On the first point, the surgical experts adopted opposing views – in the end the Judge ruled in favour of the surgeons. On the second point the experts agreed that even if he had been resident, the surgical registrar might have been involved with another patient in another part of the hospital and could not always be immediately available. Thirty minutes was a "reasonable" time in which to open the chest. The Claimant's Counsel argued otherwise but the Judge held in favour of the Trust.

Case 2

A 36-year-old man was undergoing a mitral valve repair for symptomatic mitral regurgitation. At completion of the sternotomy (by an experienced Registrar, sawn from below upwards) significant bleeding was noted, originating from the innominate vein – it was repaired by the Consultant and the operation proceeded uneventfully. Following extubation in the early hours of the morning, a cough was followed by massive bleeding into the drains associated with marked hypotension. The patient was re-intubated and the (resident) surgical registrar opened the chest – achieved approximately 30 minutes after the initial bleed. The bleeding was from the

"it is sufficient if the surgeon exercises the ordinary skill of an ordinary competent man exercising that particular art"

innominate vein – it was controlled with a side-biting clamp. The Consultant was called – the patient was put on bypass in the ICU. After a protracted ICU course (which included heparin induced thrombocytopeania) he survived, albeit with a degree of neurological injury and bilateral foot amputations.

A large number of issues were raised initially. After a prolonged period with repeated exchange of views between the sides, the Claimant's case focussed on the initial injury to the innominate vein. The sole question before the Court was whether injury to the innominate vein during sternotomy fell below the expected standard of care – was it negligent? Could it occur if the surgeon acted with a "practice accepted as proper"? This case was different from the usual situation when the innominate vein is injured – usually it is repaired and no harm follows. In the end the Judge said that injury to the vein constituted a "breach of duty of care" – he accepted the view of the Claimant's expert that it would not occur if the sternotomy was done carefully. As harm followed directly from the breach of duty, negligence was proven. I will leave you to draw your own conclusions.

Interesting that both of these cases involved re-opening of the chest in ICU. Two recent publications suggested that, to avoid neurological injury, the chest should be opened within 10 minutes. Should we consider training the staff at the bedside to do this rather than depending on a surgical registrar who may not be immediately available?

Study of Deaths Following a First Time Isolated CABG: An Update

Heather Cooper, Research Nurse, NCEPOD

In 2003 the Society for of Cardiothoracic Surgeryons, approached NCEPOD to carry out an independent study to look at the impact of organisational factors on outcome following first time isolated coronary artery bypass graft (CABG), to go alongside the increasing pressure to publish surgeon specific data.

Data collection, which has recently closed, was carried out over a three year period, from 1st April 2004 – 31st March 2007. Each unit was asked to report every death following first time isolated CABG to NCEPOD, and following this, the consultant surgeon and anaesthetist were sent a questionnaire for completion and asked to return this alongside copied extracts of the casenotes. Each unit was also requested asked to complete two organisational questionnaires during the study period, one for the first year of data collection (2004 – 2005) and one for the final year (2006 – 2007), to allow NCEPOD to look at the organisational facilities available in units over the study period.

Data returns at the beginning of the study proved to be slow, however, now the final returns counts have been completed; it is apparent data returns have improved over the three year period. We now have a return rate for questionnaires comparable with previous NCEPOD studies, for both the case and the control data, which will allow NCEPOD to make robust recommendations.

In 2006 the first interim report* was published, and highlighted discrepancies in the use and recording of EuroSCORE. Although this data was available in 81% of the questionnaires returned to NCEPOD, where both the additive EuroSCORE, and the EuroSCORE matrix were complete, the value given was the same in only 156/223 (65%) of cases. Furthermore in the second CABG interim report*, published in June 2007, further discrepancies were found in the recording of left ventricular function, a component of the EuroSCORE, between the surgeon and the anaesthetist. Following these findings it was recommended ''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. There should be clarity around how and when these data are calculated, to ensure risk stratification is valid'.

Work is now well under way on the final report. The deadline for the receipt of all data to NCEPOD was the end of August 2007, and we are currently busy analysing the data, and writing the report. This report will look in detail at the 13 research questions defined at the beginning of the study, and outlined in the study protocol, as well as picking up on the measurement and recording of EuroSCORE and its components. The study is due to be launched on Wednesday 4th June 2008**, at Regents College, and we hope to see you there.

* *Copies of the two interim reports and the study protocol can be found on the NCEPOD website; http://www.ncepod.org.uk*

***Further details regarding the launch will be available on the website in due course.*

Annual Meeting 2008 - Edinburgh ICC

Simon Kendall, Meeting Secretary

The 2008 Annual Meeting will be held at the Edinburgh International Conference Centre between Sunday 9th March and Wednesday 12th March. This is the same venue as 2003 providing excellent facilities and a wide range of hotel accommodation within walking distance. Registration will be online only and opens from December 3rd 2007 at www.scts.org

In response to feedback last year, and the ongoing restrictions on study leave and funding, we have reduced the length of the meeting - the Annual Dinner (amazing prohibition theme!) will be on Tuesday 11th March - leaving Wednesday morning for the business meeting with the unit leads.

Our international guests are:

- Dr Randolph Chitwood, North Carolina USA, who will be delivering the Pulse Lecture on New Technology in Cardiac Surgery, and also giving the Hunterian Lecture in association with Heart Research UK
- Dr Doug Mathisen, Boston USA, who will be giving the Thoracic Surgical Address and chairing thoracic surgery sessions
- Dr Paul Sergeant, Leuven Belgium, will be debating with Professor Taggart the optimal strategy for coronary revascularisation

Our guests from the United Kingdom are:

- Ms Maura Buchanan, President of the Royal College of Nursing
- Dr Roger Boyle – Heart Tsar
- Professor Derek Yellon – Head of Medicine UCL

Furthermore we have invited Dr Andrew Cook, morphologist, to hold a workshop for the congenital surgeons, and Dr Niall O'Keefe, cardiac anaesthetist, for a session on Trans Oesophageal Echocardiography.

There will be a full scientific programme for cardiac surgery – and thoracic surgery will have three scientific sessions as well as a repeat of the popular 'What Would You Do' case discussion. The SCTS is providing the Trainees with an excellent programme on the Sunday afternoon organised with the Trainee Representative Farah Bhatti – including a lecture from Professor Yellon on how to be productive in research.

The Database Managers are being sponsored by CCAD to hold their third annual meeting and the Forum for Cardiothoracic Practice has a full two day programme including an opening address by Maura Buchanan, a symposium on consent, Gill Matthews from NICE and Julie Sanders from UCL talking about Clinical Research for nurses. This year the SCTS has reduced

This will be Sir Bruce Keogh's last meeting in office before taking up his post as Medical Director for the entire NHS – he will be giving his Tudor Edwards Lecture and President's Address.

registration for the Forum to £40 for one day and £65 for two days to attract more practitioners involved in our specialty such as our highly valued staff nurses – and I would encourage surgeons to highlight this outstanding opportunity to their nursing staff.

ACSA

On top of this, we are also delighted to welcome ACSA – the Association of Cardiothoracic Surgical Assistants – they have decided to hold their annual meeting in association with our AGM – they have asked Samer Nashef to update them on the exam, and with Malcolm Dalrymple-Hay there will also be a workshop on Endoscopic Vein Harvest.

This will be Sir Bruce Keogh's last meeting in office before taking up his post as Medical Director for the entire NHS – he will be giving his Tudor Edwards Lecture and President's Address. This is an opportunity to lobby him for the future of the NHS as well as reflect on the journey we have traveled to public disclosure of surgeon specific outcomes.

Annual Dinner

The Annual Dinner will be held at the magnificent Caledonian Hotel – there will be a Prohibition theme – the true venue will of course be secret, known only to ticket holders with entry by password only – and this will allow access to the Jazz band, illicit gambling and hooch - to be followed by dinner, speeches and awards– ALL participants in the meeting are welcome to the Annual Dinner and tickets can be purchased when you register.

Registration will be open from 3rd December 2007 and will be online only. Log on to www.scts.org and follow the links.

If you have any questions regarding registration or about the meeting itself, please contact Isabelle Ferner in the Society Office at sctsadmin@scts.org or by telephone at 020 7869 6893.

We look forward to welcoming you in Edinburgh.

Annual Meeting Edinburgh - Rates

Entire Meeting attendance

Memb Category	Early Before 12/1/08	Late By 02/03/08	Onsite
Member	£245	£295	£370
Non-member	£320	£420	£520
Non-medically qualified practitioner	£40 (one day)	£65 (two days)	

Day attendance

Memb category	1 Day	2 Day	CT Forum
Member	£150	£300	n/a
Non-member	£220	£440	n/a
Non-medically qualified practitioner	£40	£65	£40 one day £65 two days

Annual Meeting 2008 - Edinburgh ICC

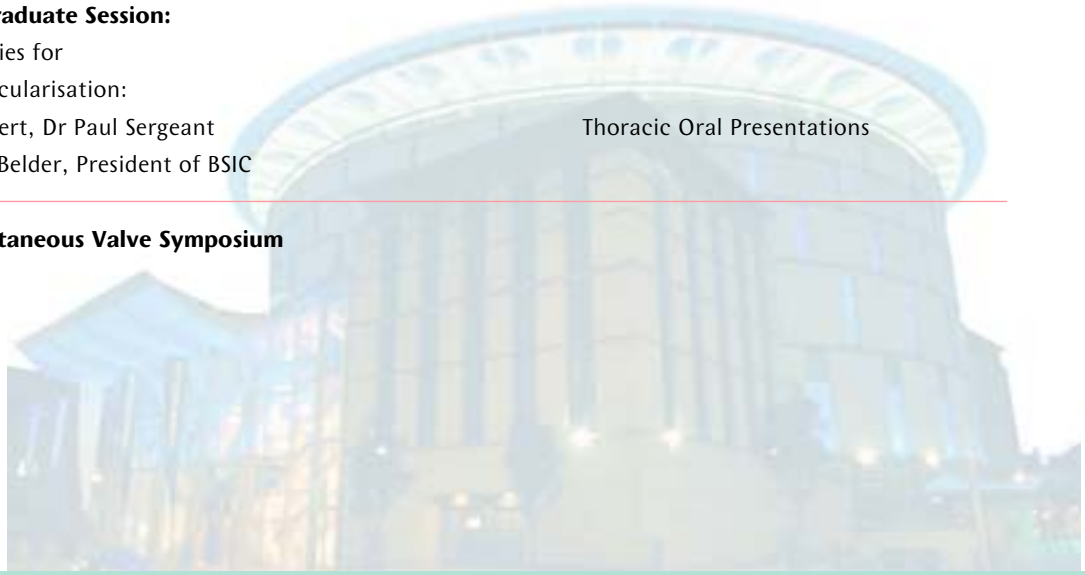
Programme

SUNDAY 9th March

12.30 - 13.30	**Trainees and Assistants Lunch**	
13.30 - 16.00	**Trainees meeting** - presentations and debate on Article 14,Specialty exam, bullying and harrassment and update on ISCP	**Association of Cardiothoracic Surgeons' Assistants**
1600 - 16.45	Professor Derek Yellon, University College London. **How to succeed in Research**	**ACSA Annual General Meeting** (Sponsored by Covidien)
16.45 - 17.00	Tea	
17.00 - 18.00	Pulse Lecture: Dr Ranny Chitwood - **New Technology in Cardiothoracic Surgery**	
18.00 - 19.30	**Annual Business Meeting**	**ACSA workshop** in Endoscopic Vein Harvesting
19.30 - 20.30	**Welcome Reception**	

MONDAY 10th March

8.00 - 9.00	Scientific Oral Presentations			
8.45 - 10.00	**Cardiac and Forum Presentations**			
10.00 - 10.45	Coffee			
10.45 - 11.45	**Cardiac Presentations:** Percutaneous Valve Replacement	**Ethicon Nurses Forum:** Ms Maura Buchanan President RCN	**3rd Annual Database**	**Cardiac Presentations**
11.45 - 12.30	**Heart Research UK Lecture:** Dr Ranny Chitwood		**Managers Meeting** (with CCAD)	
12.30 - 13.30	Lunch			
13.30 - 15.00	**"UK Cardiac and Thoracic Activity: Roger Boyle, Heart Tsar"**			
15.00 - 15.45	Tea			
15.45 - 16.55	**Cardiac Presentations:** Revascularisation	**Nurses Forum:** Papers and How to conduct research	**Thoracic Symposium:** UK Resection Rates	
17.00 - 18.30	**St Jude Post Graduate Session:** Optimal Strategies for Coronary Revascularisation: Prof David Taggert, Dr Paul Sergeant and Dr Mark deBelder, President of BSIC		Thoracic Oral Presentations	
18.30 - 20.00	**Edwards Percutaneous Valve Symposium**			



Annual Meeting 2008 - Edinburgh ICC

TUESDAY 11th March

8.00 - 9.00	**Cardiac Presentations:** Aorta and aortic valve			
8.45 - 10.00	**Thoracic Presentations**	**Ethicon Nurses Forum:** Papers and How to conduct research	**Congenital Presentations**	**Cardiac Presentations:** Mitral valve
10.00 - 10.45	Coffee			
10.45 - 11.45	**Thoracic Presentations**	**Ethicon Nurses Forum:** NICE guidelines	Congenital Anatomy Workshop	First collaborative meeting with ACTA
11.45 - 12.30	**Thoracic Lecture:** Dr Doug Mathisen 'Complex Thoracic Surgery'	**Paper presentations** and results from survey of workforce planning	**Congenital Meeting**	**Workshop on Peri-operative TOE**
12.30 - 13.30	Lunch			
13.30 - 15.00	**Update on Post Operative Atrial Fibrillation -** Mr Sam Nashef and Dr Andrew Grace		**Thoracic Cases: 'How to do It'**	
10.00 - 10.45	Tea			
15.45 - 17.00	**Transplant Presentations**	**Ethicon Nurses Forum:** Consent	**Thoracic Oral Presentations**	
17.00 - 18.00	**President's Address**			
19.30 -	**Annual Dinner** - Caledonian Hotel Prohibition Theme. Presentations of Lifetime Achievements, Scholarships and Prizes			

WEDNESDAY 12th March

9.00 - 12.30	**Executive and Unit Representatives Meeting**

Diary of Forthcoming Events

Date: 17 – 18 December 2007
Location: London United Kingdom
Title: **Specialty Skills in Cardiothoracic Surgery**
Venue: The Royal College of Surgeons, 35-43 Lincolns Inn Fields, London WC2A 3PE
Contact: Ruth Warne, Specialty Courses Administrator
Phone: +44 (0) 20 7869 6353
Email: cardiothoracics@rcseng.ac.uk
Info: http://www.rcseng.ac.uk/education/courses/specialty/cardiosurgery.html

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Date: 16 January 2008
Location: London United Kingdom
Title: **Measuring and Monitoring Clinical Outcomes**
Venue: 76 Portland Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: http://www.healthcare-events.co.uk

Date: 17 - 19 January 2008
Location: Strasbourg France
Title: **2nd EACTS Course on Thoracic Robotic Surgery**
Contact: EACTS Executive Secretariat
3 Park Street, Windsor, Berkshire SL4 1LU, UK
Phone: +44 (0)1753 832166
Fax: +44 (0)1753 620407
Email: info@eacts.co.uk
Info: www.eacts.org

Date: 23 January 2008
Location: Manchester United Kingdom
Title: **A Practical Guide to Improving Clinical Practice through developing and using Care Pathways**
Venue: Manchester Conference Centre
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk

Date: 23 January 2008
Location: London United Kingdom
Title: **Consultant Appraisal and Revalidation in Surgery**
Venue: The Royal College of Surgeons, 35-43 Lincolns Inn Fields, London WC2A 3PE
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk

Date: 24 January 2008
Location: Manchester United Kingdom
Title: **Patient Involvement and Empowerment**
Venue: Manchester Conference Centre
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk

Date: 28 – 29 January 2008
Location: London United Kingdom
Title: **Intermediary Cardiac Surgery Course**
Venue: The Royal College of Surgeons, 35-43 Lincolns Inn Fields, London WC2A 3PE
Contact: Ruth Warne, Specialty Courses Administrator
Phone: +44 (0) 20 7869 6353
Email: cardiothoracics@rcseng.ac.uk
Info: www.rcseng.ac.uk/education/courses/specialty/cardiosurgery.html

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Date: 29 January 2008
Title: **A Practical Guide to Developing and Implementing Good Practice in Consent**
Venue: 4 Hamilton Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk

Date: 31 January 2008
Location: London United Kingdom
Title: **A Practical Guide to Improving Clinical Process, Outcomes and Safety through Developing and Implementing Care Bundles**
Venue: 76 Portland Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk/conf/booking.php?action=home&id=82

Date: 31 January 2008
Title: **Payment by Results: The Clinical Impact**
Venue: 76 Portland Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk

Diary of Forthcoming Events continued

Date: 5-6 February 2008
Title: **Clinical Audit and Improvement 2008**
Venue: Savoy Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcareevents.co.uk/conf/booking.php?action=home&id=53

Date: 13 February 2008
Location: London United Kingdom
Title: **A Practical Guide to Successful Consultant Job Planning**
Venue: 4 Hamilton Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk/conf/booking.php?action=home&id=83

Date: 13 February 2008
Location: London United Kingdom
Title: **Tackling Concerns: Managing Poor Performance and Supporting Clinicians in Difficulty**
Venue: 76 Portland Place
Contact: Hannah
Phone: +44 (0)20 8541 1399
Email: hannah@healthcare-events.co.uk
Info: www.healthcare-events.co.uk/conf/booking.php?action=home&id=77

Date: 14 Februarh 2008
Location: London, England
Title: **Surgical Approaches To Atrial Fibrillation**
Contact: Raven Department of Education Courses, The Royal College of Surgeons, 35-43 Lincoln's Inn Fields, London WC2A 3PE
Phone: +44 (0)20 7869 6300
Email: education@rcseng.ac.uk

Date: 9 - 12 March 2008
Location: Edinburgh United Kingdom
Title: **SCTS Annual Meeting 2008**
Venue: Edinburgh International Conference Centre
Contact: Isabelle Ferner
35-43 LIncoln's Inn Fields, London, WC2A 3PE
Phone: +44 (0) 20 7869 6893
Fax: +44 (0) 20 7869 6890
Email: sctsadmin@scts.org
Info: http://meetings.scts.org/

Date: 10 - 15 March 2008
Location: Bergamo Italy
Title: **European School for Cardio-Thoracic Surgery, Cardiac Course level A**
Venue: Villa Elios, Bergamo
Contact: EACTS Executive Secretariat
3 Park Street, Windsor, Berkshire SL4 1LU, UK
Phone: +44 1753 832166
Fax: +44 1753 620407
Email: info@eacts.co.uk
Info: http://school.eacts.org

Date: 7 – 8 April 2008
Location: London United Kingdom
Title: **Applied Science for Cardiothoracic Surgical Trainees**
Venue: The Royal College of Surgeons, 35-43 Lincolns Inn Fields, London WC2A 3PE
Contact: Ruth Warne, Specialty Courses Administrator
Phone: +44 (0) 20 7869 6353
Email: cardiothoracics@rcseng.ac.uk
Info: www.rcseng.ac.uk/education/courses/specialty/cardiosurgery.html

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Date: 12 – 15 April 2008
Title: **Charing Cross 39th International Symposium Vascular and Endovascular Consensus Update incorporating the Global Endovascular Forum**
Venue: Imperial College
Contact: BIBA Conferences
44 Burlington Road, Fulham,
London SW6 4NX
Phone: +44 (0) 20 7736 8788
Fax: +44 (0) 20 7736 8283
Email: nfor@cxsymposium.com
Info: www.cxsymposium.com/

Date: 14-15 April 2008
Title: **Ebstein's Anomaly - A Comprehensive Approach**
Venue: The Congential Cardiac Unit, Southampton University Hospital Trust
Contact: Cathy Phillips
CFS Events Ltd, 103 High Street,
Stevenage, SC1 3HR
Phone: +44 01438 751519
Fax: +44 01438 751520
Email: cathy@cfsevents.co.uk
Info: www.cfsevents.co.uk

Date: 14 - 19 April 2008
Location: Bergamo, Italy
Title: **European School for Cardio-Thoracic Surgery, Thoracic Course level A**
Venue: Villa Elios
Contact: EACTS Executive Secretariat
3 Park Street, Windsor, Berkshire SL4 1LU, UK
Phone: +44 1753 832166
Fax: +44 1753 620407
Email: info@eacts.co.uk
Info: http://school.eacts.org

Date: 24 - 27 April 2008
Location: Barcelona, Spain
Title: **The 57th International Congress of The European Society for CardioVascular Surgery**
Contact: Prof Claudio Muneretto, ESCVS Secretary General
Venue: UDA Cardiochirurgia, Spedali Civili P.le Spedali Civili, 25123 Brescia (Italy)
Phone: + 39 030 3996401
Fax: + 39 030 3996096
Email: munerett@med.unibs.it
Info: www.escvs.org

Date: 25 April 2008
Location: London United Kingdom
Title: **Cardiothoracics for Surgical Assistants**
Venue: The Royal College of Surgeons, 35-43 Lincolns Inn Fields, London WC2A 3PE
Contact: Ruth Warne, Specialty Courses Administrator
Phone: +44 (0) 20 7869 6353
Email: cardiothoracics@rcseng.ac.uk
Info: www.rcseng.ac.uk/education/courses/specialty/cardiosurgery.html

Date: 18 - 21 May 2008
Location: Buenos Aires Argentina
Title: **World Congress of Cardiology 2008**
Phone: +54 11 4812-3444
Email: wcc2008@congresosint.com.ar
Info: www.worldheart.org

Date: 8 - 11 June 2008
Location: Bologna Italy
Title: **ESTS Meeting "Women in Thoracic Surgery"**
Contact: Organizer: Adelheid End, MD
Medical University of Vienna, Waehringer Guertel 18-20, A-1090 Vienna, Austria
Phone: +43 1 40400 6490
Fax: +43 1 40400 6490
Email: adelheid.end@meduniwien.ac.at
Info: www.ests.org

Date: 9 June 2008
Location: London United Kingdom
Title: **Bypass, Balloons & Circulatory Support**
Venue: The Royal College of Surgeons, 35-43 Lincolns Inn Fields, London WC2A 3PE
Contact: Ruth Warne, Specialty Courses Administrator
Phone: +44 (0) 20 7869 6353
Email: cardiothoracics@rcseng.ac.uk
Info: www.rcseng.ac.uk/education/courses/specialty/cardiosurgery.html

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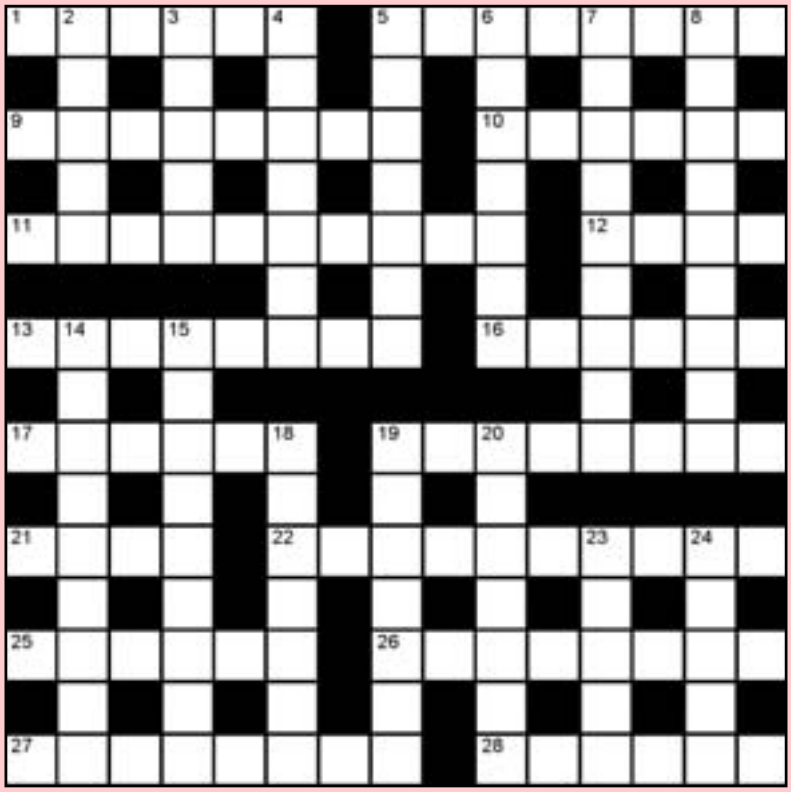

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Across

1 Make void outside a plant (6)
5 Sacred back entrance for 14 22 (8)
9 Live fast and loose, time to celebrate (8)
10 In spring, the edge of a skirt causes riot (6)
11 The boot that crushed Napoleon (10)
12 Tall pine (4)
13 Natural in drink to lose (8)
16 Mean to pain your leader (6)
17 Extraordinary gesture (6)
19 Sections of FBI in places (8)
21 Super potato head not there (4)
22 Ear implant tuned for talking shop (10)
25 Hair part of 14 9 (6)
26 Every law broken in 14 station (8)
27 Protected side held out (8)
28 Split after chairman leaves being a glutton for punishment (6)

Down

2 Kind about eastern relative (5)
3 Up to participating in fox-hunt illegally (5)
4 Perked up, as it happens, by upcoming study (7)
5 Model lost her gun here (7)
6 20 officers have the last word (7)
7 Pretentious, moi? Really in 14 (5,4)
8 Open and close inside till tomorrow (9)
14 Next meeting here, behind rug display (9)
15 Nice groan can be bliss (9)
18 Visually interpret what's said in the mail I pre-addressed (3-4)
19 Bonked's coarse, by the sound of it (7)
20 Mourns sovereign - no loss! (7)
23 Vladimir the impaler has fun (5)
24 Dense, stupid demands (5)

Last issue's solution

Winners of the July 2007 Crossword were Joel Dunning and Jonathan Hyde (again!)

Consultant Appointments

Name	Hospital	Specialty	Starting Date
Simon Jordan	Royal Brompton Hospital	Thoracic	June 2007
Jonathan Ferguson	James Cook Univ Hospital, Middlesbrough	Cardiothoracic	June 2007
Tom Routledge	Guy's & St Thomas' Hospital	Thoracic	July 2007
Juliet King	Guy's & St Thomas' Hospital	Thoracic	September 2007
Vinayak Bapat	Guy's & St Thomas' Hospital	Cardiac	October 2007
E Bishay	Birmingham Heartlands Hospital	Thoracic	October 2007
John Lu	Nottingham University Hospitals	Cardiac	October 2007
Nidal Bittar	Blackpool Victoria Hospital	Cardiothoracic (locum)	November 2007
Farah Bhatti	Morriston Hospital, Swansea	Cardiothoracic	November 2007
Gianluca Casali	Southampton General Hospital	Thoracic	December 2007
George Asimakopoulis	Bristol Royal Infirmary	Cardiac	January 2008
Mobi Chaudhry	Castle Hill Hospital	TBC	No date given
George Kanellopoulos	Blackpool Victoria Hospital	Cardiothoracic (locum)	No date given

Other Appointments

Name	Hospital	Specialty	Starting Date
Gavin Murphy	Bristol Royal Infirmary	Walport Consultant Senior Lecturer	July 2007

Edited by Sunil Ohri, Communications Secretary **Contact:** sunil@ohri.co.uk

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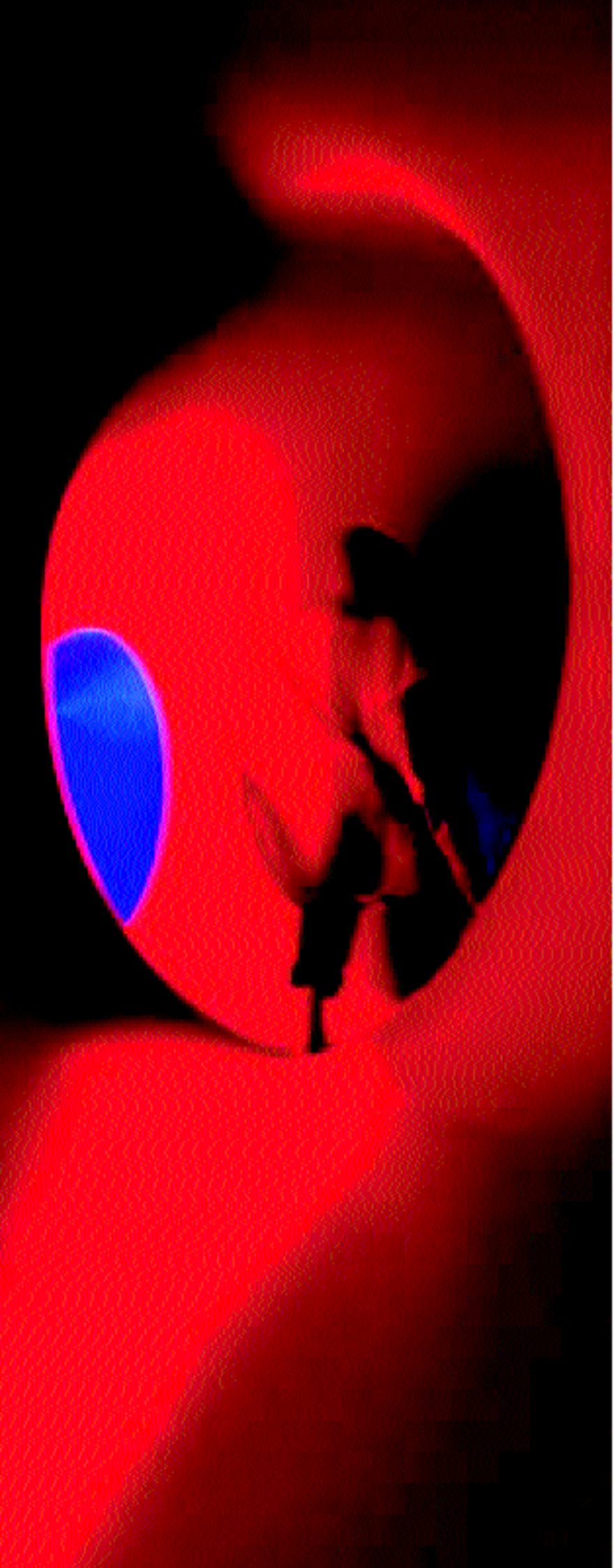

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