

the
bulletin



Society for Cardiothoracic Surgery
in Great Britain and Ireland

December 2008

New Patient Representative

Article 14 Applications

Mesothelioma & Lung Cancer Initiative

The Changing Cardiothoracic Workforce

Here to the North Pole!

Travelling Fellowship report

Annual Meeting 2009

Cardiac Surgeons
A Pain in the Neck!

Contents

President's Report	3
Secretary's Report	5
Revalidation	6
New Patient Representative	9
Mesothelioma and Lung Cancer Initiative	10
Article 14 Applications	11
Annual Meeting Bournemouth 2009	12
Cardiothoracic Surgeons: A pain in the neck!	14
Trainees Report	17
Treasurer's Report	18
National Selection for Trainees	19
The Marian and Christina Ionescu Travelling Fellowship	20
SCTS Cardiac Scholarship	21
Here to the North Pole	22
Nursing Report	23
Society Cardiac and Thoracic Scholarship	25
Ionescu Travelling Fellowship	25
New Appointments	25
Forthcoming Events	27
Obituary	29
Applications for SCTS Treasurer	29
Crossword	30



Society for Cardiothoracic Surgery in Great Britain and Ireland

The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields, London WC2A 3PE

Tel: +44 (0) 20 7869 6893

Fax: +44 (0) 20 7869 6890

Email: sctsadmin@scts.org

www.scts.org



Edited by Sunil Ohri, Communications Secretary

Contact: sunil@ohri.co.uk

Designed & produced by CPL Associates, London

President's Report

Leslie Hamilton

They say that a week is a long time in politics (and hasn't that been reinforced by recent events). Change may happen a little more slowly in medicine but for us, as cardiothoracic surgeons, what a difference a year makes. We were being told that pills for lung cancer were just around the corner; stents were going to conquer myocardial ischaemia and drugs would deal with heart failure.

Now the Chair of the UK Lung Cancer Coalition and the President of the RCSEng have asked to meet us to see how we can increase the rate of surgery for lung cancer. I have also been in discussion with the President elect of the British Thoracic Society about closer cooperation.

In October, the Syntax trial (PCI vs CABG) reported its one year results. This has prompted a new mood of realism and cooperation. We already have a good relationship with BCIS and they have set up a group to update the guidelines on PCI, particularly in the light of the NCEPOD recommendation that appropriate patients should be discussed at MDT meetings – we are represented on that group.

Technology

The technology for ventricular assist devices is developing rapidly and these look set to become a routine part of our armamentarium in the not too distant future. I was asked recently to give a talk on the artificial heart – my initial reaction was that it would be a very short talk! I had assumed that it had moved only from the world of science fiction (my research uncovered the fact that one of the Starship Enterprise Captains in Star Trek had one) to an experimental phase. I was amazed to discover that almost 800 Cardiwest (Jarvik 7) hearts had been implanted as bridge to transplant. The AbioCor heart (trans-cutaneous power source) has just been approved for Medicare / Medicaid funding in the USA as destination therapy for patients not suitable for transplant. You may have seen, on the news, the recent press conference in Paris to launch the



Carmat heart by a group lead by Alain Carpentier – due for clinical implants within 2 years.

So exciting times. Yet there are pressures. The potentially unfair consequences of focussing on individual surgeon's results continue to cause angst among cardiac surgeons. On the positive side, this puts cardiac surgeons in a strong position with regard to re-certification. It re-enforces my desire to move towards looking at measures of morbidity at unit level as a means to improving quality of care – I accept that there are issues of definition and data quality but these should be

The potentially unfair consequences of focussing on individual surgeon's results continue to cause angst among cardiac surgeons.

challenges not problems. The need to have outcome measures for Thoracic surgeons to inform recertification has provoked considerable debate and will have been discussed in detail at the Board of Representatives meeting at the end of November. I am hopeful that the Thoracic surgeons will confirm their agreement (at the Thoracic Forum) to collect the full dataset (currently collected by 6 units), which will allow adoption of the Thoracoscore.

On the subject of outcome measures: all patients undergoing surgery for congenital heart disease should be reported to the congenital section of CCAD. Centres which do not do paediatrics are not used to reporting to congenital CCAD. The Board of CCAD have asked that these patients are reported so as to give an accurate picture of overall workload and outcomes – they can be registered directly on-line to CCAD (enquiries@ic.nhs.uk).

Directive

I have to mention the European Working Time Directive. I think we should stop thinking about it! – the focus on 48 hours is misleading. However we do need to think urgently how we are going to provide the service in the future and on patient safety. Changes to immigration rules and the fact that the Deaneries are no longer going to fund the large numbers of FTTN posts we had in the past, mean that we must find alternative ways of providing the service. At the request of the Executive I wrote to all Chief Executives (letter on SCTS.org) to highlight the impending crisis – the response was deafening silence! The Aussies and Kiwis have been looking at the question of patient safety (the EWTG is Health and Safety legislation) - "Safe Working Hours" is a very sensible document. They point out that working continuously for 24 hours is the equivalent of a blood alcohol level of 100mg (our driving level is 80). If your trainee came to work with that level they would be in front off the GMC. They conclude that trainees

continued on page 4

President's Report *continued*

should ideally have day working of no more than 10 hours (maximum 14) and should have a minimum of 8 hours sleep in every 24. Could anyone reasonably disagree with these? So should our trainees spend 16 hours providing night cover for ICU (taking 16 hours away from surgical training time)? The College advice is that trainees should not be on resident night shifts. We have to develop new ways of providing the service.

Objectives

The Executive sets objectives at the beginning of each Presidential term. The current ones are:

- **Improving quality of care:** aim to develop the thoracic surgery database with appropriate outcome measures – Jim McGuigan and John Duffy as elected Trustees and Eric Lim have been putting a lot of work into this. On the cardiac side, look at outcome measures other than mortality – with a mean mortality rate of less than 2%, focussing on mortality means ignoring the care of the other 98%.
- **Revalidation / recertification:** Steve Livesey is our lead on the Intercollegiate Board – see his article later in this Bulletin. We (SCTS) have been given the opportunity to set the standards and measures – we should take it.
- **Board of Representatives:** the focus groups who helped with the review of the Society gave a strong message that we needed a way of hearing the views of members. The Board is that conduit and the Executive feels very strongly about its importance – it should hold the Executive to account. It is up to members to use it – each unit is represented. We had feedback that the meeting after the Annual Meeting in Edinburgh did not allow discussion – we have therefore extended the meeting at the end of November to a full day.
- **Raise the profile of the Society:** we have set up a database committee, not only to oversee the handling of data, but also to use the data to publish

articles on behalf of the Society. We also hope to develop the website of the SCTS Company commercially.

- **Patient involvement:** we have started by appointing a patient representative to the Executive. David Geldard (see later article) has already shown that he will be a valuable asset on the committee.

Measures of clinician's performance and outcome measures for patient care are very high on the political agenda in the UK – all specialties will be assessed. An interesting development in the USA is that of commercial websites for patient reporting: DrScore, Healthgrades and RateMDs give a flavour. The professional bodies have responded by launching their own: "Patient Charter for Physician Performance Measurement" (BMJ 2008; 337:a1408). Will these cross the Atlantic? Interesting times.

*Leslie Hamilton
President*



NHS Improvement

NHS Improvement is a national improvement programme working with clinical networks and NHS organisations to transform, deliver and sustain improvements across the entire pathway of care in cardiac, stroke, cancer and diagnostic services. Working closely with the Department of Health, NHS Improvement helps bridge the gap between policy and practical implementation, providing value for money by ensuring quality improvement remains patient-focussed and by ensuring measurable benefits for the whole system

We pilot, test, share and support practical implementation of service redesign methods, at both national and local levels. Through the continuous development and support of clinical networks and individual project demonstration sites, NHS Improvement demonstrates a "how to" approach to achieve sustainable and effective clinical pathways and systems to improve the efficiency and quality of NHS services.

The Heart Improvement Programme, now part of NHS Improvement, is delivering on a range of national priority projects and bespoke pieces of work for 2008/09 including a focus on cardiac surgery and primary angioplasty. The cardiac surgery project is working with a number of district general hospitals and tertiary centres across England to explore sustainability of cardiac pathways, incorporating a broad focus on both elective and non-elective work aimed at improving local cardiac surgery services, for example:

- utilisation of outpatients and visiting consultant satellite services
- management of surgical referrals
- pre-assessment of patients
- scheduling of patients for surgery
- reducing length of stay
- workforce redesign

If you would like to find out more about these projects or are interested in taking part please contact Wendy Gray on 07884 003659. For information on your local cardiac network, please go to www.improvement.nhs.uk/heart

Secretary's Report

Graham Cooper



And for a change, more change. We have received a record number of applications for membership so far this year but are also losing two people. B. Sethia steps down as Honorary Treasurer at the Annual Meeting in 2010 and Rachel Woolf will be leaving after the Annual Meeting in Bournemouth next year.

Rachel joined SCTS in 2004 with responsibility, along with B Sethia for managing the financial side of the Society, and running the Exhibition at the Annual Meeting. The financial side of her role is little seen but is demanding and of vital importance. With B she has vastly improved the accounting and tax return systems for SCTS. Most members, however, will know Rachel from her work at the Annual Meeting. In this role she has shone; her engagement with and responsiveness to the needs of our customers have led to a massive increase in revenue from the Exhibition; in 2003 we sold 28 stands in the Exhibition and in 2007 we sold 60. As well as increasing the size of the Exhibition, Rachel has been a vital part of the team that has developed all other aspects of the meeting. And she has been a great colleague. Rachel will be moving to Israel and we wish her all the best for her future.

Stepping down

B Sethia steps down as Honorary Treasurer a year later. He has made a significant contribution to SCTS with his wise financial management and played a vital role in changing the Constitution and developing the commercial arm of SCTS, SCTSGB Ltd. We will appoint B's successor at the Annual Meeting in Bournemouth to enable a year's overlap. The post of Honorary Treasurer offers a significant opportunity. The establishment of SCTSGB Ltd provides exciting potential to develop new revenue streams for SCTS. We hope that B's replacement will seize these and generate innovative ways of financing SCTS. The advert appears in this Bulletin. Anyone interested should free to contact Leslie, B or me to discuss the post.

As well as two significant departures we welcome a significant number of new arrivals. Applications for membership for the period April to October 2008 stand at 22, of which 10 are for Associate Membership. This is a significant increase from the 5 to 6 applications that we have received for this similar period in the past five years. Please encourage those you work with to join. Associate Membership costs only £25 a year and brings a reduction in registration fee for the Annual Meeting. Full and Trainee Members enjoy all the benefits membership provides.

One benefit for Consultant Members is support in applications for National Clinical Excellence Awards. The number of members SCTS is able to support is proportionate to the size of its membership. This year, in addition, we have increased the weight of our support by appointing a lay member of the SCTS CEA Committee, Lady Cynthia Irvine. The CEA Committee

is chaired by Pat Magee and this year members of SCTS have had a record haul.


This is a significant improvement on previous years, see table. Obviously recognition is down to the efforts of those individuals but effective support from SCTS helps.

Finally, this year, as a trial we are extending this support to Members applying for Local CEA awards. If requested SCTS will provide a citation to your Trust in support of your application for a local award. Details have been communicated by e-mail and are on the members pages of the website. And for another change at this time of year, I would like to wish you all the best for Christmas and the New Year and I look forward to meeting you in Bournemouth in March.

	2008	2007	2006	2005	2004
Bronze	6	6	6	4	3
Silver	2	2	-	2	1
Gold	2	-	1	-	-
Platinum	3	1	-	1	-
TOTAL	13	9	7	7	4

National CEA Awards to Members of SCTS

THE ROYAL COLLEGE OF SURGEONS
EDINBURGH



Introduction to Cardiothoracic Surgery

Friday 6th February 2009

Venue:	Royal College of Surgeons of Edinburgh
Convenor:	Mr Graham Cooper & Mr Robert Jeffrey
Fees:	Early Bird Fee: £215 (book before 31 December 2008) Fee: £240 (from 1 January 2009)

This one day course provides a theoretical basis and practical application for those interested in an Introduction to Cardiothoracic Surgery. This course is aimed at CT1, CT2, ST1 and Specialist Cardiac Assistants. The course will cover Intra-aortic Balloon Pumping, Angiography & PCI, Staging of Lung Cancer, Principles of smaller Vascular Anastomosis and Staplers in Thoracic Surgery.

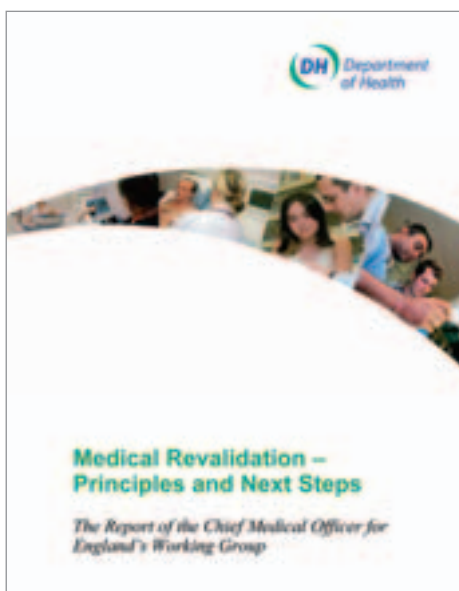
To register interest please email: lmcquade@rcsed.ac.uk or Telephone 0131 668 9238

Book online at:
www.rcsed.ac.uk

Revalidation and the SCTS

To Recap.....

Liam Donaldson's report "Good Doctors, Safer Patients" (2006) and the subsequent white paper "Trust, Assurance and Safety" (2007) confirmed a system of revalidation for doctors which would include an element of specialist recertification for those doctors on the specialist register. The recent pamphlet, "Medical Revalidation - Principles & Next Steps" (July 2008) has set out the principles of revalidation. This will happen on a five-yearly cycle.



A doctor will be revalidated when he has been relicensed – this will be the end result of successful appraisal, and recertified – this will signify he/she has met the standards set by his/her specialty association.

For recertification, a doctor will need to present evidence about their practice from several sources. This will include:

- evidence of continuing professional development
- meeting standards laid down by the relevant Specialty Association and agreed by the Royal Colleges and GMC
- evidence that surgical outcomes are above a minimum standard agreed by the Specialty Association

The Approach of the SCTS

The Society has formed a working group to develop our approach to recertification. This group has representation from across the spectrum of membership as well as lay representation and has made the proposals outlined in this article.

The GMC's principle is that a doctor should be revalidated in his/her area of practice; these should not be defined too narrowly. It was agreed that the areas of practice for Cardiothoracic Surgery should be:

- Adult Cardiac Surgery
- Thoracic Surgery
- Congenital Surgery

As part of the revalidation process each surgeon should give a more detailed description of his/her practice but align themselves broadly with one or more of the above, i.e., a cardiothoracic surgeon with a mixed cardiac and thoracic practice would need to meet the standards described for each of those subspecialties. It is recognised that some surgeons may not fit comfortably into the standard descriptors of an area of practice, e.g., a thoracic surgeon with a large oesophageal practice - standards for this type of practice will be developed in time.

Many of the building blocks for the recertification process have been developed by the Pan-Specialty

Recertification Board under the aegis of the four surgical colleges. Their work has focussed on three main areas.

Standards & Assessment

The GMC's new categories of Good Medical Practice are likely to form the basis for the setting of standards. The categories are:

- Knowledge, skills and performance
- Safety and quality
- Communication and teamwork
- Maintaining trust

However, it is not yet clear to me exactly how the standards set will map to these domains.

The group considered how standards could be set in the following areas:

- Development of a "Test of Knowledge". My feeling is that this is unlikely to be compulsory but successful completion of a test of knowledge would be a strong piece of evidence of being both knowledgeable and up-to-date. It was felt that as SESATS already existed adapting this for use in the UK should be explored – this is currently underway.
- Multi-source Feedback: The Academy of Medical Royal Colleges is working on the development of MSF. It is indicated that information from MSF's will be required at least twice during a five-year revalidation cycle and would be administered locally.
- Simulator tests: there is no evidence for their use in assessing Specialists and are unlikely to play a part in routine revalidation
- Observation of practice: Again there is no evidence for this tool for the "routine" assessment of specialists though NCAS do use this tool to as part of the assessment of doctors who have "caused concern". Other sources of evidence: For example, the use of minutes of Morbidity & Mortality meetings to assess performance was discussed. It was felt that the NCEPOD system of assessment of care in patients who had died was useful and it was recommended that Trusts adopt it.

Steve Livesey
Revalidation Lead for SCTS

CPD

- Surgeons will be required to record, in a portfolio, their CPD according to the following areas; Clinical, Professional and Academic and should include internal, external and personal study.
- Surgeons should participate in a balanced range of activities that meet the needs of their practice and personal development.
- Fifty credits per year over a five-year period would be required. Credits will normally be earned at the rate of one per hour of activity – guidance will be issued for those activities that are difficult to measure on an hourly basis
- Surgeons should participate in reflective learning.

Outcomes & Peer Review

The Darzi review – “High Quality Care for All” had recognised the need for all surgeons to move towards making their surgical outcomes available. It was the intention that outcome measures developed for recertification should also lead to the improvement of quality overall rather than just be used for assessing individual doctors. It was recognised that different sub-specialties would require different methodologies for assessment of their surgical outcomes and there is a hierarchy of quality of outcomes data which could be presented.

1. **National Clinical Audit.** Data sets utilising outcomes data down to individual surgeon level (e.g. CCAD). It was felt that where national clinical audits are available, contribution of data to them would be mandatory.
2. **Administrative data sets** (HES, ID, PEDW, HIS, ONS mortality data). The sub-group had undertaken an in-depth examination of the potential usefulness and limitations of administrative data sets.

It is possible to use these data to show individual surgeon's outcomes for length of stay, re-admission rates, mortality within a defined period and revision rates for a given procedure could be compared to their peers. These data are available and routinely collected and can generate strong

evidence about the quality of outcomes to feed the recertification agenda

3. **Process-based audit data sets** (e.g. National Joint Registry)
4. **Local audit data**
5. **Peer review.** This may be useful for recertification where clinical outcomes are not amenable to rigorous interpretation – e.g., some aspects of congenital surgery where volumes are low. This could take the form of both peer review of the individual or the unit. Peer review would also form part of the mechanism for looking in more detail at surgeons whose outcomes may be outside accepted limits. However, the mechanism needs to be robust, rapid and non-stigmatising.



The need for **administrative support** for data collection was recognised. Surgeons must be able to provide a “logbook” of their operative data whether this be an individually maintained log or part of a departmental contribution to a national audit.

The group agreed that both short term and longer term plans were needed for outcome analysis. The proposals for the subspecialty areas were as follows:

- Adult Cardiac Surgery should continue to work on refining risk adjustment, outcome measures and mechanisms of peer review of outliers. It was also felt

that, in addition to national audit data, HES data could provide a useful basket of measures which could be presented as evidence for recertification.

- Thoracic Surgery could consider using administrative (HES) data analysis in the short term with a view to developing a comprehensive national clinical audit in mid-term.
- Congenital Cardiac Surgery could consider a combination of CCAD analysis and unit based peer review mechanisms of structures, process and outcomes.

Plans for Sub-Specialties

Generic Issues

- Outcomes for M&M meetings should feed into the recertification process. The Society strongly recommends that the NCEPOD Classification of care is used. All cardiothoracic surgeons will be encouraged to produce evidence of this grading of care at their annual appraisals and Trusts should be asked to facilitate this.
- Further work is needed on the final structure of CPD before firm recommendations can be made.
- If a Test of Knowledge is adopted it is likely to be based on SESATS and further discussions need to take place with The American Board of Thoracic Surgery about the possibility of adapting this for UK practise.
- Some assessment of the patient's experience of care will be essential for revalidation. Although this should be assessed as part of routine appraisal, it would form a valuable piece of evidence of aspects of the care provided by both individuals and teams. This was felt to be particularly useful in areas where routine outcomes measurement is not straightforward, e.g., congenital surgery.

Adult Cardiac Surgery

Surgical performance would be assessed using the data publicly available from our submissions to CCAD. Submission of data to CCAD will be a mandatory standard for recertification. Should appropriate outcomes data become available from analysis of administrative data (e.g., HES),

Revalidation *continued*

cardiac surgeons would be encouraged to present these as part of their portfolio of evidence.

Thoracic Surgery

As yet there is no national database for thoracic surgery with sufficient national coverage to be used for recertification. It was agreed that Thoracic Surgeons would work, through the Society and the Thoracic Forum, to develop a risk-stratified national clinical database, based on the "Thoracoscore". Contributing data to this would be mandatory. It was felt that this would take three years to report meaningful outcomes data from this national clinical audit and thus, in parallel, work should begin on developing useful outcomes using administrative data.

Congenital Cardiac Surgery

The difficulties of meaningful outcomes analysis in this area was discussed – the

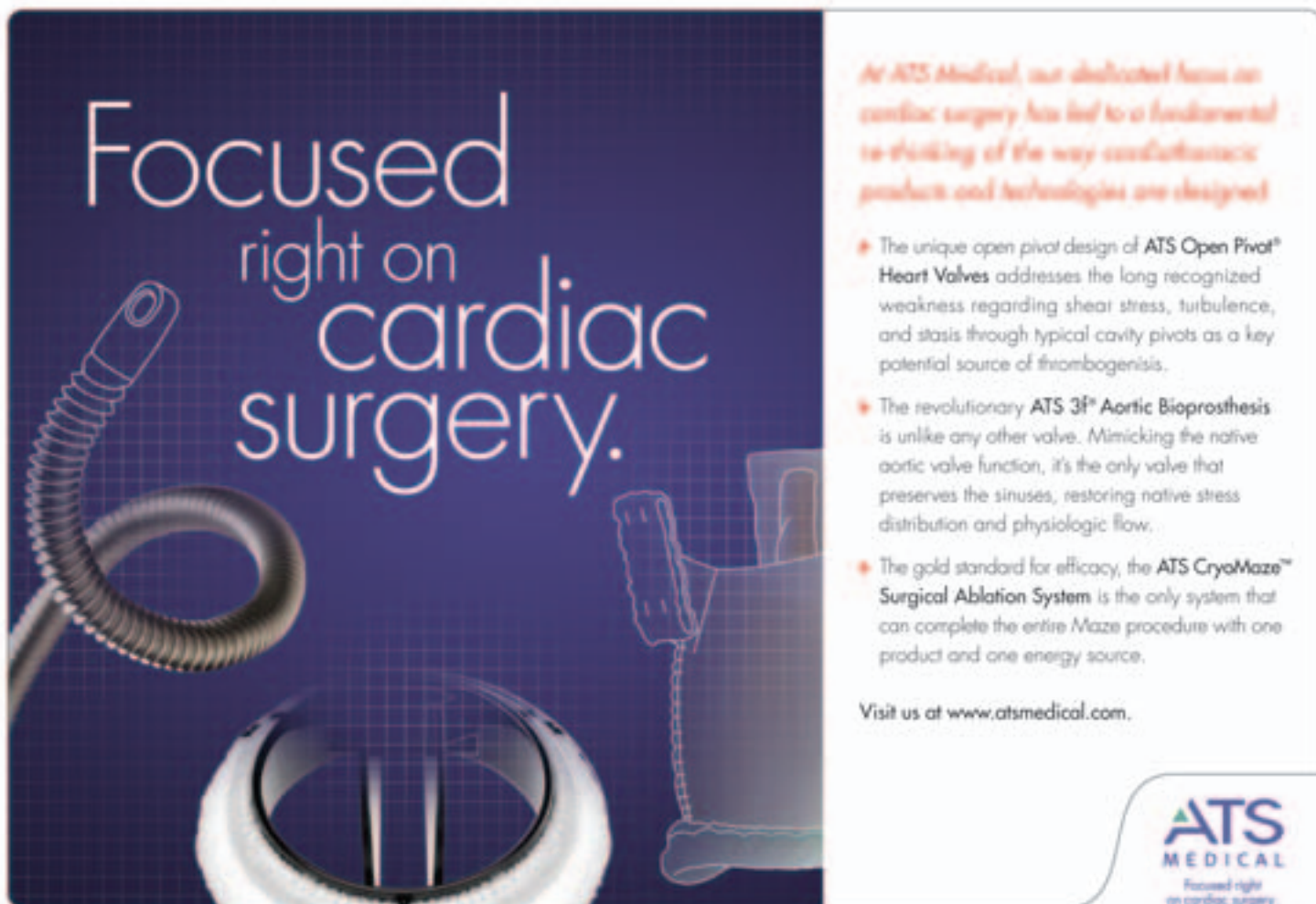
combination of small units with small numbers of any one procedure combined with the increasing practise of consultants operating together make this difficult. The possible reorganisation of paediatric cardiac units would help to make any assessment process more robust. However, analysis of CCAD data and peer review is likely to remain the cornerstone of assessment of practice in congenital cardiac surgery.

Implementation

I think there is a realisation by the GMC that there are varying degrees of preparedness for revalidation (and recertification) across the country and between the various specialties. Their initial thoughts – that this could be rolled out according to a random process based on GMC number – is not likely to be practicable. Clearly the GMC would like the process to get off to a good start – this

would mean asking for volunteers from those groups who thought they were closest to being ready. Because of our history, cardiothoracic surgeons are now accustomed to using outcome data to look at individual performance, and if asked, I would propose that we volunteered to be amongst those early implementers as a way of testing out our proposals for recertification.

The above proposals are the recommendations of the Revalidation Group established by the SCTS. In line with the new constitution they will have been presented for ratification to the Unit Representatives meeting on November 28th 2008. There is clearly more work to be done before our plans are finalised and I would be very pleased to receive feedback on any of these issues. I can be contacted at steve.livesey@suht.swest.nhs.uk



**Focused
right on
cardiac
surgery.**

At ATS Medical, our dedicated focus on cardiac surgery has led to a fundamental re-thinking of the way cardiovascular products and technologies are designed

- The unique open pivot design of **ATS Open Pivot® Heart Valves** addresses the long recognized weakness regarding shear stress, turbulence, and stasis through typical cavity pivots as a key potential source of thrombogenesis.
- The revolutionary **ATS 3F® Aortic Bioprosthesis** is unlike any other valve. Mimicking the native aortic valve function, it's the only valve that preserves the sinuses, restoring native stress distribution and physiologic flow.
- The gold standard for efficacy, the **ATS CryoMaze™ Surgical Ablation System** is the only system that can complete the entire Maze procedure with one product and one energy source.

Visit us at www.atsmedical.com.

**ATS
MEDICAL**
Focused right
on cardiac surgery.

New Patient Representative

The SCTS welcomes David Geldard

After thirty years as a Prison Service education officer and a few more as a college Faculty Director, it was in July 2004 that I turned myself in and declared a problem with chest pain. Despite being assured that I would be dead by Christmas if I didn't agree to a CABG, it was the following February when Geir Grotte performed a six grafter at the Manchester Royal Infirmary.

On graduating from my rehab programme I joined my local heart support group, Rochdale Heartbeat, and it was there that I came across a flyer from the BHF advertising a sponsored cycle ride from Jerusalem through the Negev Desert to Eilat in April 1996. The very first overseas risky fundraiser organised by any charity. I managed to raise £12,000. My training for this event meant that I was taking my rehabilitation seriously, and another BHF ride in Jordan in 1997 was closely followed by the Lands End to John O'Groats 1,069 miles, staying in hostels and averaging 76 miles a day. Joining the Cyclists' Touring Club I have since ridden in South Africa, India, and the Santa Fe Trail in USA, which was another 1,200 mile cycle/camping epic. A ride in Indo China was more serious when on our return a Foreign Office notice warned Brits that a minibus load of passengers had been murdered on our route to Luan Prabang. Rides with my own cycle club in Europe and with Sustrans in UK have been an ongoing source of adventure, except for the last twelve months when I have had two crashes that have restricted my training. Since 1996, when I joined Trans Pennine Cycling Club, we have organised ten sponsored rides into the Pennines near Rochdale and "Over The Edge" has so far raised £125,000 for the British Heart Foundation.

In late 1995 my GP nominated me as the patient representative on the local Area Health Authority's Cardiac Taskforce, later an invitation to join a pilot Cardiac Network across Greater Manchester and Cheshire must have been successful enough to herald the 32 networks which now embrace England and Wales.

It was in 2001 that a national pilot scheme in extending choice for patients was



proposed with a focus on cardiac surgery cases. I was invited to join the Trustee Board as the patient representative. Members were allocated oversight of specific centres and mine were, Central Manchester, Nottingham, Birmingham, and South Manchester. In particular we were expected to note the strength and weaknesses of the scheme and advise on lessons learned from the pilot for the wider rollout of patient choice. Colleagues will recall that this scheme was so successful that the project was curtailed at the end of 2003, and choice was to be introduced as a benefit for all surgery patients.

By invitation I joined the National Service Framework CHD Task Force, the Department of Health's CVD Programme Board and in 2003 I was asked to help establish a patient arm of the British Cardiac, now Cardiovascular, Society that we called Heart Care Partnership (UK). I was vice-chair when we formed HCP, but they soon made me chairman-cum-

president, and in October 2008 I handed on that position to Ken Timmis, but I still continue to serve as a trustee. There are other groups and initiatives that I am keen to support, particularly cardiac rehabilitation, Women's Heart Health and supporting the British Heart Foundation. It was Danny Keenan with his HCC hat on, and Ben Bridgewater with his media campaign, who involved us patients from their Cardiac Board in consultations and advice around the rollout and development of your public portal on surgical results – and hasn't that been a huge success and a real benefit to patients and surgeons?

Nowadays there is no escape from patient involvement in medicine and I really was honoured when I was asked to consider becoming a patient representative for the Society for Cardiothoracic Surgery. The invitation coincided with the retirement of my own surgeon, Geir Grotte, who kindly invited my wife and I to his retirement

continued on page 10

New Patient Representative *continued*

party. I always used to send him postcards from my adventures abroad, and I understand he used to keep them on his notice board for ages. Now I don't expect at all that cardiothoracic surgeons should remember the names of their patients, but I'm telling you that your patients remember you and yours. Like it or not, you have become a close member of their extended family. I will try to bring the patient perspective to your deliberations and, if necessary, cast wider to obtain an objective view. We have contact with all the cardiovascular networks in England and Wales, links with Scotland and Northern Ireland, and I've been on rugby tours and cycling tours in Ireland so there's a start.

The involvement of patients does seem to have an effect on deliberations and their outcomes, and discussions and decision

making becomes more objective and less self focussed. It is important that representatives are not subservient, but they do need to be comfortable with their role and their status. As this participation evolves I would see surgeons practically and subconsciously accepting the involvement of patients in all aspects of clinical care and planning. We need to consider how the needs of thoracic patients can be met, and we need to seek ways of funding the expenses for your patients and their carers to attend and participate in events like the annual conference. We already have sound working relations with the Patient and Public Involvement lead officer with the Department of Health's Heart and Stroke Team. We need to forge stronger links with the DoH Health Improvement Programme and with other national charities who

support cardiothoracic patients. I am also the Provincial Grand Charity Steward for the Masonic Province of East Lancashire, and our Grand Charity has for many years been supporting initiatives with your Royal College of Surgeons, there may be some more useful links?

We seem to have made a good start. Patients are always expressing to me their appreciation for the skills of their surgeons. Your President, your administration officers and members of your Executive have been most welcoming and courteous and being a patient representative with your Society is an exciting prospect. Remember, the watchword of patient representatives is, "Nothing about us, without us!"

Thank you again, and Tally Ho!

Mesothelioma & Lung Cancer Initiative

John Edwards
Consultant Thoracic Surgeon, Sheffield

The International Study for Lung Cancer / International Mesothelioma Interest Group / Mesothelioma Staging Project

I would like to inform you of this initiative, which is being driven by core members of the team which has reported the IASLC Lung Cancer Staging Project (Journal of Thoracic Oncology, 2007). Surgeons performing thoracic surgery will be aware of the revisions to Lung Cancer staging which were proposed and are likely to be ratified in early 2009.

The current staging system for malignant pleural mesothelioma dates from a series of round-table meetings in Colorado in 1994, when a group of experts from the International Mesothelioma Interest Group decided the system by consensus. Thus it was based on opinion of the preceding systems, rather than data analysis. The best validation of the staging has been carried out in numerous surgical series of moderate size, with no effort to pull together data from multiple settings and institutions until now.

The IASLC/IMIG/MSP is co-chaired by Dr. Valerie Rusch (New York) and myself, with valuable input from Prof. Goldstraw, Dr. John Crowley (Cancer Research And Biostatistics, Seattle) and significant others from all disciplines. The team is being expanded and data acquisition ongoing. Funding has been received from the Mesothelioma Applied Research Foundation for retrospective analysis of data combined from existing institutional surgical series and chemotherapy trials. Retrospective data will provide a valuable insight into the accuracy and applicability of pathological and clinical staging, doubtless giving rise to many questions to answer in the prospective phase.

Prospective data collection will start in 2009 and continue until 2014; the dataset is being finalised. Submission is most likely to

be electronic, with systems being developed to allow easy transfer from existing datasets. In the UK, we are in an excellent position to collect data prospectively via the MDT systems. I appreciate that not all cancer networks have a functioning specialist mesothelioma MDT, as proposed by the Mesothelioma Framework. However, the SM-MDT is the ideal opportunity to record clinical (radiological) stage and I hope that the SM-MDTs will feed their data into the IASLC/IMIG MSP. It is important to include data from all sources in the study, not just from centres of experience. I would ask that UK surgeons, lung cancer MDTs and specialist mesothelioma MDTs contribute generously to the project, both with clinical and pathological data. Dori Giroux (CRAB) or I would be delighted to receive expressions of interest or any other enquiries.

The IASLC/IMIG MSP will be holding a conference at the National Heart and Lung Institute, London, on February 26th and 27th 2009. The faculty will include experts from around the world. The programme will be both educational about mesothelioma and informative about the Project. Further information will be e-mailed. I hope that we will see you there.

Contact: john.edwards@sth.nhs.uk



Article 14 applications in Cardiothoracic Surgery

Megan Wilson
Policy and Non-CCT Specialist
Registration Manager
& Tim Graham
Chair SAC Cardiothoracic
Surgery

Article 14 enables doctors who wish to join the Specialist Register who have not followed a full PMETB approved Certificate of completion of Training (CCT) programme to apply under Article 14 of THE GENERAL AND SPECIALIST MEDICAL PRACTICE ORDER for a Certificate confirming Eligibility for Specialist Registration (CESR) ie enables them to join the specialist register.

This route to specialist registration differs from routes under previous legislation in that knowledge, skills and experience however gained can be taken into account provided that the applicant satisfies the 'entry' criteria. It is not just an assessment of training.

You can apply under 14 (4) if you are applying in a CCT specialty and 14(5) if you are applying in a non CCT specialty.

The 'entry' criteria for 14 (4) are that you have undertaken:

- specialist training in a CCT specialty and/or
- a specialist qualification in a CCT specialty.

Specialist training for this purpose should be for at least 6 months.

If you satisfy this then all your knowledge, skills and experience will be taken into account. The standard that you need to demonstrate is equivalence to a CCT in the specialty in question.

The 'entry' criteria for 14(5) are that you have undertaken:

- specialist training in a non-CCT specialty and/or
- a specialist qualification in a non-CCT specialty.

For 14(5) the qualification or training **has** to have been undertaken outside the UK in a non-CCT specialty that is recognised as a specialty outside the UK. In the case of specialist training it must have been at least 6 months in length. If you satisfy this then your knowledge, skills and experience will be taken into account. The standard you need to demonstrate is that of a day one consultant in the NHS.

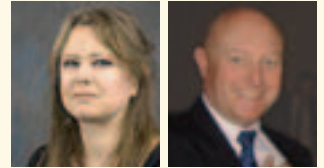
The implication for this for cardiothoracic surgery is that an applicant may be eligible to apply under 14(5) in thoracic surgery or cardiac surgery provided that they meet the 'overseas entry' requirements.

There is a further route to CESR under 14(5) which is the 'academic route'. This is unusual and is best explored at the PMETB website www.pmetb.org.uk.

How to apply

PMETB are the statutory body responsible for the Article 14 legislation and process. They may ask the colleges (devolved to the SAC in cardiothoracic surgery) and faculties to perform an evaluation but any decision is theirs.

Applications **must** be made directly to PMETB. Full details and application forms can be found on their website. www.pmetb.org.uk.



The standard that you must demonstrate is discussed above.

The onus is on an applicant to provide primary evidence to demonstrate this standard. For help, an applicant should refer to the curriculum current at the time of application and the Specialty Specific Guidance available on PMETB's website. It is worth stressing that structured reports and testimonials do not count as primary evidence, but can be used to triangulate other evidence.

An applicant should consider how to best demonstrate what they have done and at what level, so evidence of logbooks and any assessment and appraisal which comments directly on clinical skills is very helpful.

As PMETB are responsible for the process you should contact them for guidance and application forms. If you want to discuss your application you may contact Megan Wilson from the JCST on 020 7869 6256 or mawilson@jcst.org.



GRANTS PROGRAMME ANNOUNCEMENT

From 2009 HRUK will be offering the following awards:

Clinical Research Training Fellowships, up to £150,000 each
Deadline 12 noon, 2 March 2009

Translational Research Project Grants, up to £150,000 each
Deadline 12 noon, 1 July 2009

Novel and Emerging Technologies Grant, up to £200,000
Deadline 12 noon, 3 August 2009

Clinical Travel Scholarship, up to £50,000
Deadline 12 noon, 16 March 2009

Young Researchers Travel Scholarships, up to £7,000
Deadlines: March, June, September, December

See www.heartresearch.org.uk for full details
or call Helen Wilson on 0113 234 7474

Annual Meeting Bournemouth 2009

Simon Kendall
Meeting Secretary

Registration is now open for the 2009 Annual Meeting, to be held at the Bournemouth International Centre on Sunday 22nd March to Tuesday 24th March 2009. For all of you who are medically qualified there is a considerable saving for early registrants before 11th January 2009.

will give the Heart Research UK Lecture and Professor Friedrich Mohr from Leipzig, Germany who will present the St Jude Lecture on his experience in percutaneous valve replacement. Furthermore, Professor Alain Carpentier is also attending the meeting to present recent advances in mechanical heart devices.

In thoracic surgery we welcome Dr Tom DeMeester from Southern California who is delivering the thoracic lecture and Dr Alessandro Brunelli from Ancona, Italy is joining the thoracic symposium on risk stratification in thoracic surgery. We will also be joined by Richard Berrisford in his role as secretary general for the European Society of Thoracic Surgeons.

Furthermore, Sir Bruce Keogh is joining us for the UK activity session and Sir Terence English will receive his lifetime achievement award at the Annual Dinner on 24th March.

We are delighted with the number and quality of the abstracts that have been submitted for this year's meeting which have been assessed by the 37 reviewers involved in the process.



The Programme Committee met on 27th November 2008 to allocate the successful abstracts to the appropriate sessions - all scientific and clinical presentations will be five minutes long, leaving five minutes for questions and we are asking ALL presenters to bring a poster that can be displayed in the exhibition area during the meeting.

Besides the thoracic symposium there are three other symposia arranged. On Sunday afternoon the Pulse Lecture will be delivered by Professor Taggart, updating us on the current evidence for conduits using coronary bypass surgery and Malcolm Dalrymple-Hay will update us on the current techniques used to harvest conduit. On Monday afternoon there will be a symposium about the experience and implementation of percutaneous valve replacement and on Tuesday afternoon

continued on page 14



There is a myth that Bournemouth is difficult to get to! Bournemouth and Southampton airports (20 minutes on the train) connect to the major UK / Irish airports and there are excellent train links to the midlands, north west and north east.

We hope that each and every one of you will find a very significant amount of interest, education and enjoyment from the programme, which is now finalised and can be accessed through the SCTS homepage.

In cardiac surgery we welcome Dr David Adams from Mount Sinai, New York, who

We hope that each and every one of you will find a very significant amount of interest, education and enjoyment from the programme, which is now finalised and can be accessed through the SCTS homepage.



Programme



SUNDAY 22nd March

12.30 - 13.30	Trainees and Assistants Lunch	
13.30 - 15.00	Trainees Meeting - presentations and debate	Syneture Surgical Practitioners ACSA
16.00 - 16.45	Hunterian Lecture	
16.45 - 17.00	Tea	
17.00 - 18.00	Pulse Lecture: Professor David Taggart: The latest evidence in conduits for CABG	
18.00 - 19.30	Annual Business Meeting	ACSA
19.30 - 20.30	Welcome Civic Reception	

MONDAY 23rd March

8.00 - 9.00	Papers	Covidien Symposium			Society of Clinical Perfusion Scientists, Great Britain and Ireland Workshops
8.45 - 10.00	Papers Presentations				
10.00 - 10.45	Coffee				
10.45 - 11.45	Moderated Papers	Papers	Ethicon Nurses Forum	Database Managers CCAD	
11.45 - 12.30	UK Heart Research Lecture: Dr David Adams				
12.30 - 13.30	Lunch				
13.30 - 15.00	Cardiothoracic UK Activity	Guest: Sir Bruce Keogh			
15.00 - 15.45	Tea				
15.45 - 16.55	Thoracic Symposium Dr Alessandro Brunelli	Forum	Papers		
17.00 - 18.30	St Jude Lecture: Professor Friedrich Mohr				
18.30 - 20.00	Nycomed Symposium				

TUESDAY 24rd March

7.30 - 9.00	Papers	ATS Medical Symposium			Society of Clinical Perfusion Scientists, Great Britain and Ireland Workshops
8.45 - 10.00	Papers	Forum	Congenital Papers	Thoracic Papers	
10.00 - 10.45	Coffee				
10.45 - 11.45	Moderated Paper Session	Ethicon Nurses Forum	Congenital Papers	Thoracic Papers DeMeester Thoracic Lecture	
11.45 - 12.30					
12.30 - 13.30	Lunch				
13.30 - 15.00	Thoracic Cases	NCEPOD: Heart of the Matter		Symposium	
15.00 - 15.45	Tea				
15.45 - 17.00	Thoracic Posters	Forum	Congenital Papers	Papers	
17.00 - 18.00	President's Address				
19.30 - 23.30	Annual Dinner - Royal Bath Hotel - Sir Terence English				

WEDNESDAY 25th March

9.00 - 12.30	Unit Leads Executive
10.00 - 10.45	Coffee
10.45 - 11.45	Unit Leads Executive

Annual Meeting

Bournemouth 2009

there is a symposium about the implementation of the NCEPOD report (Heart of the Matter).

Like last year we will run parallel sessions and the congenital surgeons are inviting Dr Andrew Cook, Morphologist to run a workshop on atrial ventricular septal defects.

Tara Bartley has put together another very impressive agenda for the Cardiothoracic Forum with the theme 'The Delivery of Quality Care'. For the third year we will welcome back the President of the Royal College of Nursing Ms Maura Buchanan to make the opening remarks.

The Database Managers are holding their fourth Annual Meeting with us in conjunction with CCAD and we are delighted to welcome back the Association of Cardiothoracic Surgical Practitioners (ACSA) who have elected to hold their Annual General Meeting in conjunction with ours.

The Society of Clinical Perfusion Scientists, Great Britain and Ireland (SOPGBI) are holding their own workshops on Monday and Tuesday on quality assurance as well as their own committee meeting.

Prior to the Annual Dinner (when there will be some unusual entertainment) the meeting will be concluded by Leslie Hamilton's President's Address – which will include our final guest - Major-General Garry Robison, Commandant-General of the Royal British



Marines who will talk to us about leadership and team-working.

For non-medically qualified staff the registration has been kept at a very reasonable level at either: £50 per day or £75 for two days, if they register early.

I would encourage you to look at the programme online as it will demonstrate what excellent value for money our Annual Meeting provides.

We look forward to seeing you there.

Cardiothoracic Surgeons: A pain in the neck!

Cervical pain is fairly common among the wider population. Fortunately, it is often transient and not associated with long term side effects. However, on occasions it can be disabling with extreme symptoms, disturbing with uncertainty about recovery, and disruptive to ones career. We all know or heard of colleagues who underwent surgery for cervical symptoms. However, the prevalence of cervical pain / radiculopathy and its subsequent impact on surgical practice among cardiothoracic surgeons in the United Kingdom is largely unknown. Therefore, a questionnaire was sent out under the auspices of the Society of Cardiothoracic Surgeons (SCTS) to the consultant members registered on its database via e-mail on 2 occasions.

A total of 105 replies (response rate 44.1%) were received from the 238 questionnaires sent. 35.2% (37/105) reported experiencing either neck pain or cervical root symptoms at some stage in their

career. The type of surgical practice did not appear to influence (22 cardiac, 4 thoracic, 11 mixed) the development of symptoms. Overall, a fifth (21/105) had radiological imaging (X-ray, CT or MRI) and approximately a tenth (10/105) were so severely affected that they required a period of sick leave to recover from their pathology.

It would appear from this survey that cervical pain / radiculopathy affects a significant proportion of cardiothoracic surgeons. At least 1 in 3 develop cervical symptoms and the majority appear to adopt the philosophy of 'physicians heal thy self' and work through the pain barrier. We could adjust the way we work (perhaps getting someone else to harvest the mammary artery or go on annual leave!). Nevertheless, some surgeons are so profoundly affected that their ability to operate is impaired with implications for patient care and service delivery.



Bournemouth 2009 Rates

Membership category

	Early (Before 12/1/09)	Late (By 13/03/09)	On Site
Entire meeting attendance			
Member	£250	£295	£370
Non-member	£320	£425	£450
Non-medically qualified practitioner (member)	£50 (one day)	£75 (two days)	
Non-medically qualified practitioner (non-member)	£80 (one day)	£110 (two days)	

Day attendance

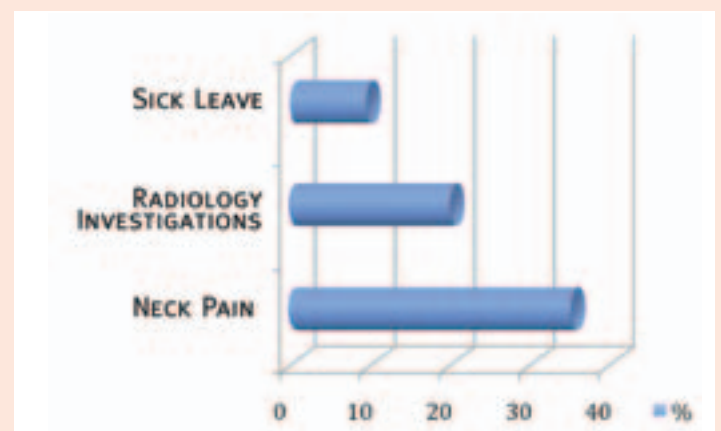
Membership category	1 day	2 days
Member	£150	£300
Non-member	£220	£440
Non-medically qualified practitioner (member)	£50	£75
Non-medically qualified practitioner (non-member)	£80	£110



Mark Jones

*Sing Yang Soon, Peter Charleston
& Mark Jones, Wythenshawe Hospital, Manchester*

Faced with such a prevalent condition, it is prudent to not only to highlight the issue but also to address various remedies available. Preventive measures are usually the simplest and most successful. Measures such as avoidance of extremes of neck movements and prolonged fixation in one particular position with regular counter position neck stretching throughout the length of operation are advised. If symptoms develop, one should to seek help early from the local occupational health department. Early interventions are also more likely to be successful with shorter duration of treatment required.



Data for 105 Survey Respondents (44.1%)



Solutions for Advanced Cardiovascular Surgery

Products for Cardiac and Vascular Procedures

PRESCRIBING INFORMATION - TISSEEL Lyo ▼ Two-Component Fibrin Sealant (Please consult the Summary of Product Characteristics before prescribing)

Name and composition: Powders and solvents for fibrin sealant. 1) Sealer protein concentrate; after reconstitution 1 ml contains 96-125 mg total protein of which 72-110 mg is fibrinogen; 2) Aprotinin Solution, 3000 KIU per ml; 3) Thrombin Powder, 1 ml contains 500 IU of Thrombin in 45-55 mg total protein; 4) Calcium chloride solution, 40µmol per ml.

Indications: Supportive treatment where standard surgical techniques are insufficient. For improvement of haemostasis, or as a tissue glue to promote adhesion, sealing or as suture support.

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

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

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

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

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

Overdose: Not reported.

Legal category: POM

Basic NHS price: 2 ml kit - £78; 4 ml kit - £156; 10 ml kit - £355.

Marketing Authorisation Number and Holder: PL 00116/0321 - Baxter Healthcare Limited, Caxton Way, Thetford, Norfolk IP24 3SE

Date of preparation: May 2008

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Any adverse events relating to Baxter products should also be reported to Surecall – Baxter Medical Information on 01635 206345.

Baxter, FLOSEAL, TISSUDURA, TISSEEL and ADVANCING SURGERY, ENHANCING LIFE are trademarks of Baxter International Inc. COSEAL is a trademark of AngioDevice International GmbH.

ADV 08/23008 November 2008

Trainees Report

Sunil Bhudia
Trainee Representative
& Tim Graham
SAC Chairman

Cardiothoracic Surgery as a subspecialty has been through a difficult period not only in United Kingdom but also in many Western Countries. There has been uncertainty amongst trainees regarding their future in the field and budding cardiothoracic surgeons have been somewhat deterred from entering the specialty. Various measures were taken and also due to changes in the cardiology field and lung cancer treatment the future of cardiothoracic training is again looking brighter.

Considerable effort has been expended in getting the right balance between the number of trainees and the future requirement for fully trained consultants. There are new challenges on the horizon including the European Working Time Directive. We need to start at the grassroots and improve the somewhat tarnished image of cardiothoracic surgery amongst medical students. We need to encourage more medical students to rotate through the subspecialty to appreciate the nature of the work. This can be achieved by having representation at the universities and influencing undergraduate curriculum.

ST3 level entry

At the moment entry into specialty is at ST3 level. We therefore have to influence education and training at ST1, ST2, CT1 and CT2 levels and develop cardiothoracic opportunities at this level. In addition thought should be given to Foundation Year doctors having exposure to the specialty and having a positive experience!

The number of trainees entering at ST3, previously as SpR1, was reduced in the years 2004 to 2007. In 2008, 5 trainees were appointed at ST3 level via a national selection process in England. Scotland and Wales appointed 1 each outside this process. In 2009 there will be UK wide selection and the number of posts will be increased to 14 - 16 with numbers rising to 20 in 2010 and in 2011. There will be academic training opportunities also advertised and appointed within this process in 2009 and 2010.

All trainees with CCT since 2005 are in employment. Of the 17 CCT holders in 2005, 15 are in a substantive consultant post and 2 are in a locum consultant post. In 2006, 16 CCT holders, 14 are substantive consultants, 1 is a locum consultant and 1 is a clinical fellow. In 2007, 28 CCT holders, 22 are substantive consultants, 4 are locum consultants and 2 are clinical fellows. So far in 2008, 12 CCT holders, 5 are substantive consultants, 2 are locum consultants and 5 are clinical fellows. As more consultant posts are advertised the above ratios will change. On the whole most CCT holders have attained a substantive consultant post.

Assessment

There is an ongoing review of Cardiothoracic Transplantation services in the UK. This will assess current and future consultant manpower and opportunities for training at the peri-CCT level in this area of the specialty. Generally, there is a need for an



increased number of consultants in this area over the next few years.

The SCTS Annual Meeting is in Bournemouth from 22 to 24 March 2009. All trainees are invited and expected(!) to attend the meeting. The Trainee Forum will be on Sunday 22 March 2009 and an informative session has been organised with various speakers. This dedicated session for Trainees' and those interested in becoming trainees' provides the opportunity to find out answers to all your questions.....this is your one chance in the year to come and put the SAC and the Exam Board on the spot; so come and join in!

Merry Christmas and a Happy New Year to all the trainees from the SAC!

There has been uncertainty amongst trainees regarding their future in the field and budding cardiothoracic surgeons have been somewhat deterred from entering the specialty.

Treasurer's Report

B Sethia
Treasurer

I have had the privilege of being the Honorary Treasurer of our Society for nearly 5 years now so it seems appropriate, at a time when we will be looking for my successor very shortly, to expand upon the events of the past five years and clarify the current remit of the job.

Trustee of the Society

The Hon. Treasurer of the Society is one of the Office holders of the Society and is a Trustee. All Trustees have obligations under UK Charity Law to act with integrity in the interests of the Society and to ensure that the activities of the Society are maintained in line with the stated aims within our constitution. Failure to comply with their obligations, for instance acting dishonestly or in their own interests contrary to the aims of the Charity, is a criminal offence. Any person holding the position of Honorary Treasurer could easily contravene some of the Charity Commission regulations, particularly with respect to the management of the Society's financial resources. Therefore, there needs to be a regular external audit of all the Society's financial activities. I will not expand upon the considerable legislation in this area but any person interested in this position should read the Good Trustee Guide, NCVO publications as well as the Charities Act 2006 – 'what trustees need to know' (published by the Charity Commission).

What does the Hon Treasurer do?

The Hon Treasurer is the custodian of the Society's funds. He/she has to anticipate the likely cash flow requirements of the Society and ensure that adequate funds are available to run the day to day activities of the Society whilst administering the funds for Society Scholarships and the other areas, eg the financial support to the Cardiothoracic Tutor at the RCS England. All decisions relating to major expenditure are presented to the Executive for discussion and authorisation. The main sources of Society income derive from members annual subscriptions and the income from the Annual General Meeting. The main expenses are the organization of the AGM and the maintenance costs of our

administration office, including employment of Isabelle Ferner and Rachel Woolf. During my time as Honorary Treasurer we have been able to maintain a steady current account balance despite the plethora of new initiatives and the expenses inherent in these developments. The costs of membership have, in real terms, fallen significantly during this time and even though your Executive has recently authorised a small increase in next year's annual subscription, the actual amount of money paid by the membership, especially those paying by direct debit, is no higher than that received in 2003. The Treasurer presents the financial status of the Society at the AGM and any member may, on direct application in writing, receive a copy of the Society's audited accounts.

The Hon Treasurer has to sign off the VAT submissions on a quarterly basis and is responsible for administering the payroll for our staff. I have delegated part of this function to our auditors but an understanding of the mechanics of VAT is a requirement for any person undertaking the Hon Treasurer role.

The Hon Treasurer is a member of the Executive of our Society and, as such, attends meetings 4 times yearly. This is an invaluable opportunity to contribute not only a financial perspective for the benefit of other members of the Executive but also to actively help to determine the future direction of our Society.

How are our funds managed?

As indicated above, our funds derive primarily from the membership and the AGM. An important development over the past five years has been the funding of a Scholarship by Mr and Mrs Marian Ionescu. Their generosity, enhanced by gift aid tax reclaimed by the Society, currently



provides a fund of approximately £240,000 which is restricted entirely to the provision of the Ionescu Scholarship. These funds may not, by law, be used for any other purpose within the Society. A number of our members have benefited from this generous Scholarship (£10,000 per year). I would like to take this opportunity to encourage members to consider donating funds to the Society, either in the form of gifts (which can be on a lump sum or an annual recurring basis) or by means of legacies. If any member wishes to discuss the practicalities involved in this type of donation I would be happy to discuss the matter with them.

The remaining part of our current funds are either maintained on deposit at the Bank or are invested in equities. The decision to invest on a diversified basis was taken by the Executive following advice from our auditors and the Charity Commission. The principle of our Investment Strategy has been conservative (with a small c!) and I took a decision to limit the amount invested in the equities market to a total of £150,000 despite other advice that we could consider a larger investment. These funds have shown a small loss in recent months – unsurprising in view of the global economic downturn – but I will continue to review this aspect of our financial strategy with our Brokers and hope, given the nature of our portfolio, to demonstrate a reasonable profit within the next 18 months. The balance of our cash funds, approximately £128,000 is held on deposit with a view to achieving the highest return.

A new part of our financial strategy is due to emerge as this article goes to press. One of the necessary arrangements when the Constitution of the Society was rewritten was to form a limited company – SCTS GB and I Ltd. The purpose of this company is to enable the Society to engage in activities, which cannot be conducted via our charity, for instance developing advice on job contracts. We are looking to access new sources of income in order to support the activities of this company and therefore, ultimately,

the Society as a whole. The first major initiative agreed by our Communications Secretary Sunil Ohri and myself is to set up a job centre on our web pages which will, hopefully, be used by medical and nursing staffing offices to advertise their posts. We hope to develop further new fiscal initiatives in due course.

The Future

Who can predict the financial future? Evidently not the Banks or the market! Within our current resources I believe that

we are well placed to take advantage of new opportunities for the benefit of our membership and our patients. The development of new initiatives will, I hope, enable us to prosper but these will always be dependent upon adequate long-term funding. I believe that it is possible to achieve this at a relatively low cost for individual members (especially when you remember that subscriptions are a tax deductible expense), and I hope that my successor will find this job as enjoyable and stimulating as I have done.

National Selection for Trainees: Posts to Increase in 2009

Steven Hunter
Cardiothoracic Dean

The report of the national selection for ST3 posts in cardiothoracic surgery, which was held in March, has received praise from the Department of Health and MMC. We have the approval to continue with national selection. Next year we will appoint 16 trainees. This will include Scotland, Northern Ireland and Wales.

It will also include two Academic Clinical Fellows (AFC) one for the Northern Deanery working with Professor Dark and the other for the South West working with Professor Angelini. The selection process will be administered by the West Midlands Deanery and short listing will take place in February with selection in March. Candidates will be invited in January to apply for the posts and the short listed candidates will be asked to rank the programmes in their order of preference. The SAC is currently receiving bids from all the training programmes so that the successful programmes will appear in the adverts. The successful candidates will be matched with their ranked training programmes, if a candidate declines the programme, which is offered they will be passed over, and the programme (and NTN) will be offered to the next in line. My advice, therefore, to the applicants is to be prepared to relocate if you want a career in cardiothoracic surgery.

Currently there are no unemployed cardiothoracic surgical CCT (CCST) holders. Not all are in consultant posts but this is a great achievement considering the concerns of five years ago when we appeared to have far too many trainees. There continues to be a steady number of new consultant posts annually and hopefully we have now achieved a balance with new trainees and predicted consultant posts. The SAC and the workforce review team will be assessing the required training posts annually. My concerns are

that the young would be cardiothoracic surgeons do not know that our specialty will be appointing new trainees (ST3) annually and they are being advised by their mentors to look at other specialties. Indeed I have spoken to medical students who are being told that there will be no career prospects in cardiothoracic surgery. This is simply not true and I urge those of you who are involved with medical schools to spread the word that our specialty is recruiting. We will never be recruiting large numbers and the competition will be strong but we want to appoint the best (of the best!). ST2/CT2 trainees should be encouraged to apply as the “lost tribe” of the higher degree holders is diminishing.



The 2009 SCTS meeting in Bournemouth is my last meeting as Dean for the Society. It has been an interesting 5 years and I have enjoyed the challenges that have been laid before me. My term of office ends in August 2009. When I began as Dean one of my personal goals was to see every trainee at the Annual Meeting but I fear this goal will not be achieved. I would have liked attendance at the Annual Meeting to be a requirement for every trainee's RITA (ARCP). The meeting is the only opportunity where trainees can meet with the Dean, the Chairman of the SAC and the Chairman of the Intercollegiate Examination Board to freely and openly express their opinions. I hope, therefore to see a great turn out in March 2009.

As always, contact me at Steve.Hunter@stees.nhs.uk.

The Marian & Christina Ionescu Travelling Scholarship 2009

*David O'Regan
Yorkshire Heart
Centre, Leeds*

I have now returned from the United States having spent 5 weeks looking at some of the best examples of quality and patient safety. I have met the great and the good. These have been interesting times what with the Wall Street crash and the elections. More significantly, on 4th October the HMO organizations announced that they are now only going to pay for and reward quality. This is a paradigm shift in the delivery of healthcare in America and it will have a significant impact on us in due course.

Cardiac Surgeons crossed the Rubicon when our mortality data entered the public arena. I believe that we need to move beyond bean counting and look at quality. A good way to make an impact in our mortality and morbidity in the short to medium term is to examine how we deliver our services. It is not about working harder it is about working smarter. Gary Kaplan, CEO of the Virginia Mason Medical Centre in Seattle has removed all the non-value added waste in the patient pathway. Moreover, Gary and others are designing their services around their patients and not for their own convenience. Actually, staff are happier because there is less time wastage and they get home earlier!

The Executive Patient Safety Officer Programme run by the Institute of Health Improvement in Boston is one of the best courses I have ever attended. I was privileged to meet the faculty and personally talk to Don Berwick, the President of the Organization and to 'Chuck' Denham CEO of Leapfrog and NQF. It complimented all the principle learning of my MBA. People have been overwhelming in their generosity of time and advice. They have tolerated questions about anything and everything and answered with candor. Consequently, I have 31 formal interviews on file. These are filled with wisdom and experience. The journey from East to West Coast has been an odyssey as well as a personal epiphany.

We are often compared to airline pilots. To take this metaphor further we should seriously consider why the risk to a person flying in an airplane is 1 in 3,000,000 where as the risk to a person entering our

hospitals is 1 in 300. We need to recognize our systems are not reliable. We take it as an affront to our clinical autonomy when we begin to talk about standardizing. However, the only way that we are going to improve our systems and the delivery of healthcare is to consider standardizing some of our processes. This is being done - Peter Provonost's work in intensive care has made him Time magazine man of the year. He is leading the USA on blood stream infection. Geisinger Healthcare are now offering a 30-day warranty on all elective cardiac surgery.

The most striking thing when talking to people is the alignment of all (regardless of their specific positions or roles) to the strategies of patient safety, quality and experience. They work and focus on conversations and communications in the form of play back in ITU, SBAR (Situation Background Assessment Recommendation) in clinical environments and crew resource management in theatres. Briefing and debriefing in theatres is mandatory at Johns Hopkins and has been proven to improve patient safety through teamwork - Chuck Denham refers too this as the JERK factor and implores us not to be jerks! This does not cost money and requires minimal effort.

There are only 256 Cardiac Surgeons looking after a population of 66 million in the United Kingdom. As a talented and very able group of people we have the capacity to lead and change our organizations. The quality agenda will enable us to put the 'P' back in professionalism and enable the Society to continue to lead. It is not difficult but it does require a different way of thinking - "because it has always been done like that around here" is not tolerated in the hospitals I visited. I would like to ask anybody who is interested to contact me, so that we could trial some of these initiatives and learn together from our experience.

My American experience has had a significant impact on me and will change my practice forever. I would like to thank Mr. and Mrs. Ionescu and the Society for giving me this award. My blogs are available on the following URL:
www.cihm.leeds.ac.uk/themes/managers/Doctor%20manager%20USA



Charles R Denham, Chairman, Leapfrog Group, NQF Safe Practice Program



*Gary S. Kaplan, MD
Chairman and CEO, VMMC*



*Amy Edmonson and Anita Tucker
Professors, Harvard Business School*



*David B Nash, MD MBA
Chair, Department of Health Policy,
Thomas Jefferson*



*Donald M. Berwick KBE MD, MPP, FRCP,
President and CEO, IHI*

The SCTS Cardiac Scholarship

Jo Chikwe
Attending Surgeon,
Mount Sinai Medical
Center, New York, USA



Had I known quite how much would be involved in securing a fellowship position in the United States, I might have embarked on a simpler task, such as mapping the human genome!

My six-month “to-do” list prior to leaving for the US included passing the United States Medical Licensing Examination, publishing a book, and sitting the final Fellowship exam (which, like waterboarding, simulates a near-death experience in order to elicit every last piece of information you may know on a topic), in addition to completing the reams of paperwork required for national, state and institution credentialing in America. Hence the first of many thanks are due to my family, and to Messrs Fountain and Townsend at Harefield Hospital, without whose support and forbearance over those six months I would have failed miserably at the first of these hurdles.

The effort was certainly well worth it. I have enjoyed a superb time at Mount Sinai Medical Center in New York, as well as a stint at the Universität Leipzig Herzzentrum. Ani Anyanwu, a Harefield trainee who completed a fellowship at Mount Sinai under Dr David Adams, and then accepted a position there two years ago as Director of Heart and Heart-Lung Transplantation, wrote a comprehensive account of his fellowship experience in the December 2005 edition of the Bulletin. His article closely reflects my experience, so I will not duplicate his comments here. I hope it suffices to say that his account of his fellowship operative experience as first surgeon at Mount Sinai, which included VADs, transplants, complex mitral valve reconstruction and advanced aortic root and arch surgery, was the primary reason I

applied for the same fellowship; and talking to senior fellows at institutions ranging from the Harvard teaching hospitals to the Cleveland Clinic has emphatically confirmed the exceptional nature of the operative teaching here.

I planned to spend one year at Mount Sinai, but extended it to two years because of the unparalleled learning opportunity, and I am very grateful for this chance to thank the superlative clinicians and teachers with whom I was lucky enough to work. I owe particular thanks to Dr Paul Stelzer whose focus is aortic root surgery and who helped me to do Bentall, David and Ross procedures; Ani who enabled me to do complex, re-operative VADs and transplants; Dr Randall Griep who taught me the principles of thoracoabdominal, arch and aortic root work; cardiologist Dr Valentin Fuster who has been unstinting in his support; and finally Dr David Adams who, even more importantly than teaching me how to plan and perform complex mitral, tricuspid and aortic valve reconstruction, has been an absolutely phenomenal role model, mentor and supporter.

My original intention was also to incorporate a three-month endovascular fellowship at the Cleveland Clinic into the fellowship year, funded by the Cardiac Scholarship of the Society for Cardiothoracic Surgery in Great Britain and Ireland, as I thought that this would complement my UK training in minimally invasive and robotic surgery. I am extremely grateful to the Society for its generosity and also for its flexibility when I requested support for a change of plan. With the help of Dr Adams and the Society I was instead able to spend the time under Professor Friederich Mohr at his outstanding unit in Leipzig, where he leads highly successful, high-volume transcatheter and trans-apical aortic valve replacement and minimally invasive mitral valve surgery programs. This tremendous experience has enabled me to take on a role focused on developing minimally invasive mitral repair and transcatheter aortic valve programs at Mount

Sinai. The latter has become particularly relevant as Dr David Adams was recently named as the primary investigator of the pivotal FDA trial of percutaneous aortic valve replacement with the CoreValve® Device.

When planning this fellowship I never considered the possibility that I would take a consultant post in the US; and so accepting Dr Adams’ offer to stay on at Mount Sinai required careful thought. I am therefore very grateful for the help and advice I had from so many people, particularly Mr Alan Wood, Mr Patrick Magee, Mr Thanos Athanasiou, and Professor John Pepper, as well as my Programme Director Mr Anthony de Souza. There is so much to learn from spending time with experts in another healthcare system, in another country, particularly when those experts see teaching and mentoring as a key priority and are able to devote real time and resources to it; and I would be very happy to talk to any trainees who want to explore fellowship options. I am incredibly excited by the opportunities and challenges presented by taking up this consultant post, and I cannot thank the Society enough for helping to make this happen.



*Repairing a mitral valve with
Dr David Adams*

This fellowship year was also funded by an HCA International Travel Award

Here to the North Pole

Reflections on a Thoracic Fellowship in Alberta, Canada

Ian Hunt
 Minimally Invasive
 Thoracic Surgery Fellow,
 University of Alberta,
 Edmonton, Alberta,
 Canada

Choosing to spend a year abroad particularly if you have a family can be difficult enough but where to go is always tricky. Internationally recognized centres with a proven track record are a safer option but concerns about ‘small fish big pond’ situations must be considered.

The first thing is to decide what you want, a busy job with more operating room (OR) time than you can imagine or a prestigious institute on the CV. Of course they are not necessarily mutually exclusive, but as one fellow with one resident working with 3 surgeons the odds of being needed (actually needed!) in the OR were pretty good in Alberta and few of the ‘big’ centres offer such a nice ratio. Next is to work out what skills you want to acquire and whether you are looking for a broad case experience or super-specialized (again a personal choice but consider what you own practice is likely to be). Edmonton because of its location and set up has to offer the full general thoracic repertoire including procedures typically performed by the gastroenterologist and interventional respiratory physician in the UK. In fact when I asked where we covered as a thoracic surgery service, my boss quipped “pretty much everywhere from here to the North Pole” and he wasn’t kidding!

Knowing what a unit’s practice is like can be tricky as it requires a little inside knowledge. Again, a simple browse of the current issue of the Annals may give you some clues to your likely operative



exposure and seeing the ‘big cases’ is a very reasonable motivation in choosing your institute. But do you really think you are going to be performing a robotic-assisted thorascopic carinal resection in your daily practice? Talking to previous fellows is an obvious thing to do (being the first thoracic fellow in Edmonton did cause me a few sleepless nights!).

What the 3 surgeons in Edmonton offered beyond more work than they knew what to do with (180 lung resections and 50 oesophagectomies a year for starters) was the opportunity to learn VATS lung resections. I knew Eric Bedard, one of the 3 surgeons in Edmonton when he was Dr Rob Mckenna’s fellow at Cedars in LA and I also knew that Eric was trying to develop a reputation as a leader in minimally invasive thoracic surgery in Canada. He has probably performed more VATS lung resections than any other surgeon in Canada. All 3 surgeons now perform around 60% of lung resections minimally invasively. Their approach is unified and easily reproducible. They are all eager to teach (personally I suspect a desire to teach combined with nobody to teach is the single most important attribute when choosing your out of training experience!). The unit’s approach to many of the minimally invasive procedures carried out by thoracic surgeons is refreshing and well thought out, typically reflecting a unit that

performs a high proportion of pretty complex thorascopic techniques. Even if you do not believe VATS lobectomy is a ‘proper cancer operation’ (whatever that means considering the variability you see amongst surgeons performing ‘open’ lobectomy) an opportunity to develop the skills needed to approach and perform advanced thorascopic procedures is invaluable.

What else have I learnt, in the long time preparing my out of training experience and the brief time I have had in Edmonton? The obvious first: decide what you want from the experience both personally and professionally; then do your own homework (that means find out about the surgeons you will be working with and most definitely visit before committing yourself to a place); seek advice (but take that advice ‘on face value’); secure funding; and finally remember to ask your partner if you can go! Pack warm. email: ianjhunt@gmail.com

**Decide what you want
 from the experience;
 then do your
 homework.**

Nursing Report

Tara Bartley
Nursing Representative

The programme the Cardiothoracic Forum 2009 has now come together with the theme 'Quality Care: can we deliver'. We congratulate Maura Buchanan on her re-election as the President of the RCN for a further term and are delighted that she will return to deliver the Forum opening remarks. The plenary sessions for 2009 are exciting and topical.

I have pleasure in confirming that Lisa Kitteridge who you may have read about in the national press will join us. Lisa developed cardiomyopathy while pregnant with her second child April 2008. Following an emergency caesarean at thirty-five weeks gestation she had an LVAD implanted. She and members of the clinical team from the Queen Elizabeth Hospital Birmingham are going to share their experience.

The document **'Towards a framework for post registration nursing careers: a national consultation'** has sought health professionals' opinions on post registration careers. It asked if nursing careers should be organised around the patient pathway and what should underpin the framework for future nurse education. Clearly this document is of major significance to health professional so I am proud to announce that Dr David Foster, Programme Director for Modernising Nursing Careers from the Department of Health, will be speaking on the impact of MNC on postgraduate career pathways and Christina Pond, Executive Director of Standards & Qualification, Skills for Health will discuss the strategic impact of changing the workforce.

The pressure for trusts to meet the 18-week target has led the Heart Improvement Programme to initiate a national project with pilot sites around the UK. Wendy Grey, the lead for this venture will outline to project.

I am also delighted to underpin the theme of quality care with a presentation from Dr Ann Keogh on the National Patient Safety Project and its impact on practice.

For the thoracic delegates in particular Mr Eric Lim will present the new BTS guidelines on Cancer staging, and review the impact this will have on surgical decision-making process.

In addition to the plenary sessions there will be eleven presentations that have been selected from the plethora of abstract submissions. There is a wide range of subjects that will, I believe, make the 2009 Cardiothoracic Forum Meeting stimulating and thought provoking. We will of course be amalgamating with the surgeons' meeting to complement the programme.

Rates

May I take this opportunity to remind you that for the second year running the Society has agreed extremely competitive subscription rates for non-medical delegates. They are as follows;

- £50 for one day for associate member
- £75 for two days for associate member
- £80 for one day for non-associate member
- £110 for two days for non-associate member

So I look forward to seeing you and your colleagues in Bournemouth to share in an exciting conference. The Midlands Cardiothoracic Forum has delayed their annual cardiothoracic study day. It is to be rescheduled and will have lectures and workshops looking at autogel wound management and echo among other subject. I would also like to inform you about an exciting development taking place at Birmingham Heartlands Hospital. They have developed a one day 'Thoracic Surgery Practical Course' combining lectures with clinical wet lab sessions enabling delegates to familiarise themselves with chest anatomy, surgical procedures and disease process. The course is open to nurses, doctors, physiotherapists, surgical care practitioners and other members of the multidisciplinary team. It is held twice a year in January and July. Currently there are a few places left on the 30th January 2009 course and they will shortly taking



reservations for the course to be held 19th July 2009. For further information contact paula.agostini@heartofengland.nhs.uk

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

Membership

I also encourage you to take advantage of the greatly reduced Associate Membership of the SCTS. From 2009 the annual fee is £22, which ensures that you receive the Bulletin issues, reduced rate to the Annual meeting and other benefits, which are on the SCTS web site.

Finally I am hoping to review role development throughout the Cardiothoracic Centres so I will be contacting you in the near future to seek information about how nursing and surgical care practitioner roles are expanding to meet the European Working Time Directive and accounting for the impact of Modernising Medical Careers.

We congratulate Maura Buchanan on her re-election as the President of the RCN for a further term and are delighted that she will return to deliver the Bournemouth Forum opening remarks.

Carpentier-Edwards Physio II™ ring

Physio heritage

Etiologic design



Ease of implantation

Reshaping mitral repair



Society Cardiac & Thoracic Scholarships

Requirements for applicants are:

- Age – usually under 35 years
- Eligibility – must be a member of the Society
- Tenancy – any University Institution or Institutions recognized for training in Cardiac or Thoracic Surgery
- Purpose of visit – 3 or 4 paragraphs summarizing the intended work to be undertaken and the reasons for wishing to visit there
- CV of applicant to be enclosed
- Other sources of funding – to be stated
- Receipts required – eg international plane ticket
- Other documentation required – statement from host institution of willingness to accept candidate
- Letter of support from current Chief of Service in support of the application.

All successful candidates are expected to provide the Society with a summary report of their visits/s and may, if requested, be required to present their experience at the Annual Meeting of the Society

The Ionescu Travelling Fellowship

This is for the sum of £10,000 which is directed at Young Consultants (normally within 5 years of appointment) wishing to add to their educational experience and in particular for the purpose of bringing new techniques back to their department.

The recipient is expected to provide a report and/or a presentation to the Society's Annual General Meeting Scientific session. Similar requirements, with the exception of a reference from Chief of Service, are expected from applicants.

New Appointments

Name	Hospital	Specialty	Starting Date
Shilajit Ghosh	University Hospital of North Staffordshire	Thoracic	June 2007
Tim Bachelor	Bristol Royal Infirmary	Thoracic	May 2008
Hasnat Khan	The Essex Cardiothoracic Centre	Cardiothoracic	Aug 2008
Indu Deglurkar	Golden Jubilee Hospital, Glasgow	TBC	August 2008
Arjuna Weearasinghe	The Essex Cardiothoracic Centre	Cardiothoracic	September 2008
Onyekwelu Nzewi	Royal Victoria Hospital Belfast	Cardiothoracic	October 2008
Heyman Luckraz	New Cross Hospital, Wolverhampton	Cardiothoracic	October 2008
Fraser Sutherland	Golden Jubilee Hospital, Glasgow	TBC	TBC

Other Appointments

Name	Hospital	Specialty	Starting Date
Karen Redmond	Harefield Hospital	September 2008	Locum Consultant

WOULD YOU LIKE TO SIMPLY "PATCH UP"....

.....PULMONARY AIR LEAKS?

.....MINOR BLOOD LEAKS?*

.....MINOR FLUID LEAKS?*



TissuePatch™3
the rapid barrier

Your 'STRAIGHT-OUT-OF-THE-PACKET' alternative to glue

Simply hold TissuePatch3 on the tissue for 30 seconds and the patch will;

- Bond to the surface proteins more strongly than liquid glues
- Form a strong 'elastic skin' over the leak
- Flex with the inflation/deflation of lung (and it doesn't require deflation to apply)
- Disappear over 50 days

To see for yourself how TissuePatch3 fits into your practice
please contact:



CARDIO SOLUTIONS (UK) LTD

Tel: 01423 875787

E-mail: customer.services@cardiosolutions.co.uk

*INDICATIONS

Tissuepatch3 is indicated for use to seal and reinforce against air leakage in thoracic surgery, e.g. lung resection, and against leakage of low pressure or oozing bleeding or fluid leakage following surgical procedures on soft tissue, e.g. liver and splenic resection, splenic injury. Tissuepatch3 is intended for use as an adjunct in thoracic and general surgery and is not intended to replace sutures or staples, as appropriate, in tissue approximation.

Diary of Forthcoming Events

Date: 16 January 2009
 Meeting: **Yorkshire Advanced Chest Imaging Course**
 Venue: Radiology Academy, Leeds General Infirmary, Leeds LS1 3EX
 Town: LEEDS UNITED KINGDOM
 Contact: Dr R J H Roberson, Consultant Radiologist
 Email: radiologycourses@hotmail.co.uk

Date: 22 - 23 January 2009
 Meeting: **Valve Technology Symposium -**
 Day One: Transcatheter Aortic and Aortic Valve Intervention - Day Two: Mitral Valve, Atrial Fibrillation & Ventricular Disease
 Venue: St. George's Hospital, at the Royal Society of Medicine
 Town: LONDON UNITED KINGDOM
 Contact: Frances Williams, Symposium Administrator
 Phone: +44 20 8725 2652
 Fax: +44 20 8725 5173
 Email: fwilliam@sgul.ac.uk
 Additional information: www.valvetechnology-sgh.co.uk

Date: 6 February 2009
 Meeting: **Introduction to Cardiothoracic Surgery**
 Venue: Royal College of Surgeons of Edinburgh
 Town: EDINBURGH UNITED KINGDOM
 Contact: Laura McQuade
 Course Co-ordinator
 Phone: +44 (0) 131 668 9238
 Fax: +44 (0) 131 668 9241
 Email: l.mcquade@rcsed.ac.uk

Date: 25 - 26 February 2009
 Meeting: **4th Advanced Video-Assisted Thoracoscopy and Thoracic Endoscopy Course**
 Venue: St James University Hospital, Institute of Oncology
 Town: LEEDS UNITED KINGDOM
 Contact: Lorraine Richardson
 L R Associates
 Phone: +44 (0)1296 733 823
 Fax: +44 (0)1296 733 823
 Email: lrassociates@lycos.co.uk
 Additional information: www.vatscourse.com

Date: 13 MARCH 2009
 Meeting: **Emergency Support of Heart and Lungs**
 Venue: National Heart and Lung Institute, Imperial College – Royal Brompton Campus, Dovehouse St, London, SW3 6LY
 Town: LONDON, UNITED KINGDOM
 Contact: Lorraine Richardson
 L R Associates
 Phone: +44 (0)1296 733 823
 Fax: +44 (0)1296 733 823
 Email: lorrainerichardson1@btinternet.com

Date: 22 - 24 MARCH 2009
 Meeting: **Annual Meeting of the Society for Cardiothoracic Surgery in Great Britain & Ireland**
 Venue: Bournemouth International Centre
 Town: BOURNEMOUTH, HAMPSHIRE, UNITED KINGDOM
 Contact: Isabelle Ferner
 Phone: +44 020 7869 6893
 Email: sctsadmin@scts.org
 Additional information: www.scts.org

Date: 3 April 2009
 Meeting: **Functional Ischaemic Mitral Regurgitation (FIMR)**
 Venue: National Heart and Lung Institute
 Town: LONDON UNITED KINGDOM
 Contact: Karina Dixon
 Dovehouse Street, National Heart and Lung Institute,
 Phone: +44 (0) 20 7351 8172
 Fax: +44 (0) 20 7351 8246
 Email: academicevents.nhli@imperial.ac.uk
 Additional information:

www1.imperial.ac.uk/medicine/about/conferences/nhli_events/shortcourses/events/fimr/

Date: 17 April 2009
 Meeting: **Coronary Artery Surgery Workshop**
 Venue: Royal College of Surgeons in Ireland, Dublin
 Town: DUBLIN, IRELAND
 Contact: Orla Mockler
 Email: omockler@rcsi.ie

Date: 22 - 24 JUNE 2009
 Meeting: **The Edinburgh Thoracic Symposium. Minimally Invasive Management of Lung Cancer: An Update**
 Venue: Royal College of Surgeons of Edinburgh
 Town: EDINBURGH UNITED KINGDOM
 Contact: The Edinburgh Thoracic Symposium
 c/o Lorraine Judge, Head of Education Section
 Phone: + 44 (0)131 668 9209
 Email: administrator@edinburghthoracic.org

INNOVATIVE PRODUCTS FOR LESS
INVASIVE SURGERY

VASOVIEW™ ENDOSCOPIC VESSEL HARVESTING SYSTEMS

CARDIOVASCULAR



Endoscopic Vessel Harvesting, also known as EVH, is a minimal invasive technique used to obtain healthy blood vessels for coronary bypass surgery. It was pioneered in America, where it is now used in over 80% of cardiac bypass procedures.

Following its acquisition of Boston Scientific's cardiac and vascular business, Maquet is now making this innovative system available in Britain.

- Efficient harvesting of saphenous vein or radial artery
- A less-invasive 2cm incision
- Significantly less risk of infection and wound complications
- More rapid recovery
- Less postoperative pain
- Minimal scarring for improved cosmesis
- Excellent conduit quality and haemostasis results

MAQUET - The Gold Standard

MAQUET LIMITED
14 - 15 Burford Way
Baldon Business Park
Sunderland
Tyne and Wear
NE35 9PZ
tel: 0191 519 6200
fax: 0191 519 6201
email: info@maquet.co.uk
www.maquet.co.uk

**WE LOOK FORWARD TO SEEING YOU ON STAND NO. 27/28 AT THE
ANNUAL MEETING 2009, BOURNEMOUTH INTERNATIONAL CENTRE**

MEMBER OF THE
GETINGE GROUP

John Anthony Morgan

December 1946 - September 2008



Tony grew up around Cardigan Bay in South Wales before becoming a scholar at Epsom College in Surrey. His love of organ recital music took him to Cambridge University where he was Duckworth Exhibitioner of Jesus College. He also found time to study medicine and did his clinical undergraduate training at Guys in London. After his

graduation in 1971 he trained in general and cardiothoracic surgery in London but moved to Groote Schuur Hospital in Cape Town in 1976 to continue his training. It was there that he became a consultant in thoracic surgery, a post he was to hold for six years. In 1987 he moved again, this time to Germany. After several positions, he settled in Frankfurt/Oder as head of the Department of Thoracic and Vascular Surgery.

During the late 1990s, there were major changes in the Department of Thoracic Surgery in Bristol as the specialty moved from its historical base at Frenchay Hospital to join cardiac surgery at Bristol Royal Infirmary. At the same time, "Jey" Jeyasingham retired. Tony moved from Germany to join the department, but when Chris Forrester-Wood also retired several years later he found himself working single-handed and trying to cover a huge geographical area. However, he still managed to develop his two main areas of expertise - endobronchial therapy and pectus surgery.

During his later years in Bristol he was joined first by Mark Yeatman and then by Tim Batchelor. Having now re-established the department, his death was both sudden and untimely. He has left a huge gap not only in the service but also in the lives of those that worked closely with him. As is typical of many surgeons of a certain age, there was a degree of inflexibility in the way he worked, particularly in his encounters with managers (or "bean counters" as they were always referred). What was always clear, however, was his deep commitment to patient care and his rapport with his patients. They, too, have mourned his death.

Tony was a bon viveur who lived his life until the moment he died. His passions included organ and classical music and fast cars. He died in Scotland, a place he loved, while on holiday with his wife Ann. He is survived by his three children to whom he was devoted.

Tim Batchelor
Mark Yeatman

CALL FOR APPLICATIONS

SCTS Honorary Treasurer



Society for
Cardiothoracic
Surgery
in Great Britain
and Ireland

Applications are invited from Full Members of SCTS for the post of Honorary Treasurer.

B Sethia leaves office at the Annual Meeting in 2010, we will appoint his replacement at the 2009 Annual Meeting. The appointee will shadow B Sethia in the intervening year before taking full responsibility from 2010. The term of office is 5 years.

This is an exciting opportunity; with the formation of our limited company SCTSGB Ltd, the potential now exists for innovative approaches to fund raising. The appointee will work closely with the Communications Secretary to increase revenue and strengthen the financial base of the Society.

The Honorary Treasurer is a Trustee of SCTS and as such is required to run SCTS according to the rules laid down in the Constitution (www.scts.org/sections/society/constitution/index.html)

The Honorary Treasurer will have responsibility for all financial matters relating to the Registered Charity The Society for Cardiothoracic Surgery in Great Britain and Ireland and the limited company SCTSGB Ltd.

A job description is available from Isabelle Ferner sctsadmin@scts.org.

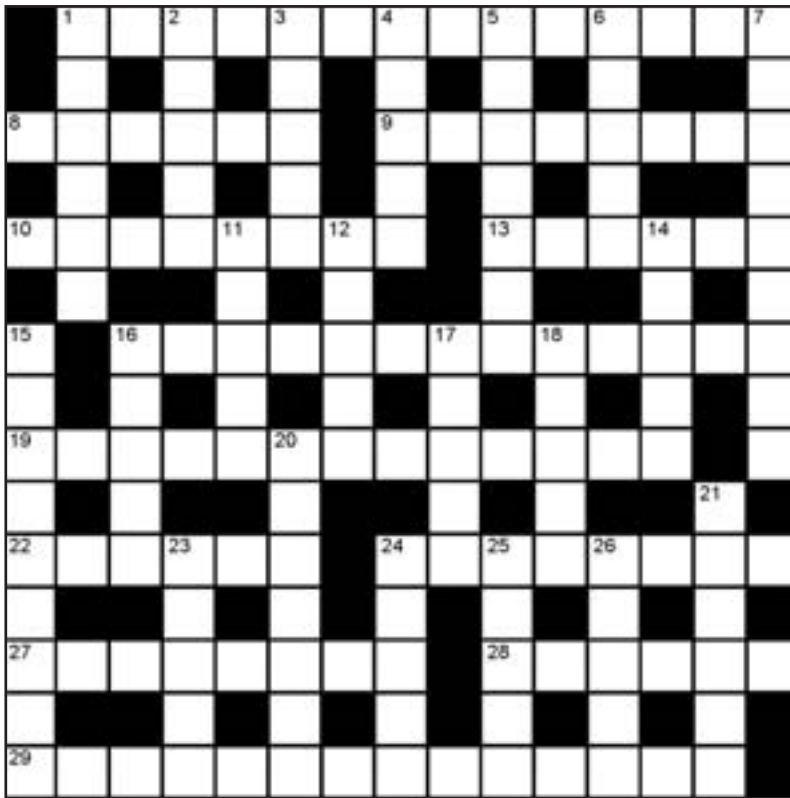
Informal discussions may be held with Leslie Hamilton (President), B Sethia (Honorary Treasurer) or Graham Cooper (Honorary Secretary).

Applications should consist of a brief CV and a short statement outlining the qualities that make you suited to the post and your vision for the role.

Please send applications to sctsadmin@scts.org by 30/1/09, shortlisted candidates will be informed by 13/2/09 and interviews will be held at the Annual Meeting in Bournemouth between 22/3/09 and 24/3/09.

the crossword

by Samer Nashef



Across

- 1 16 across family enquiry (4,4,6)
- 8 Back in the CIA, someone recognised a pattern (6)
- 9 Singing in action jewellery (8)
- 10 OK, done, with mushroom included (8)
- 13 Has a go at compositions (6)
- 16 Indecently clad - like pants off for a bit of this? (4,3,6)
- 19 Pilsner beer, he's drunk: that's disgraceful (13)
- 22 Glad of July break (6)
- 24 1, 16, 29 across online (8)
- 27 Beast of a worker has run away (8)
- 28 River virago (6)
- 29 16 across is something else (1,3,2,3,5)

Down

- 1 Illicit booze bit of a hoot; cheers! (6)
- 2 Western healthy sperm, for example (5)
- 3 Cathy capsized boat (5)
- 4 Regularly turns weird, being single (5)
- 5 Brew essential to windsurfer mentality (7)
- 6 Roof turnstile (5)
- 7 Notes boy with ugly sister (9)
- 11 Calm exercise champion (5)
- 12 Take out opponents on time (5)
- 14 Low joint where some drank lemonade (5)
- 15 Pot-plant (9)
- 16 Agent takes in work that's emotional (5)
- 17 Girl embarrassed to be sexy (5)
- 18 Wobbly bum that is about to fill (5)
- 20 Hothead, getting on, turned to resist (4,3)
- 21 Diary note I read first (6)
- 23 Fast boats (5)
- 24 European rumour of threat to king (5)
- 25 Well done eggs served up on trains of yesteryear (5)
- 26 15 may be in this pest (5)



Send your solution to: Samer Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744 by 31 January 2009. Solutions from areas over 10 miles from Cambridge will be given priority.

Last issue's winners:


The winner of the July 2008 Crossword is Richard Milton, St James University Hospital, Leeds

the
bulletin



Society for
Cardiothoracic Surgery
in Great Britain and Ireland

Epicor™ LP
Cardiac Ablation System



CONTROLLED
ENERGY DELIVERY
FOR MORE SUCCESSFUL,
REPRODUCIBLE OUTCOMES*



ST. JUDE MEDICAL
MORE CONTROL. LESS RISK.

* Ninet, Riquelme, Seitelberger et al. J Thorac Cardiovasc Surg Sept 2006; 130:80

Epicor LP, ST. JUDE MEDICAL, the nine-squares logo and MORE CONTROL, LESS RISK, are trademarks of St. Jude Medical, Inc. or its affiliates. ©2008 St. Jude Medical. All Rights Reserved. Not available in all markets.

Autologous Fibrin Sealant



The safe alternative:

- No exogenous thrombin
- No aprotinin
- No bovine components

The fully automated Vivostat® system prepares 5-6 ml of autologous fibrin sealant from only 120 ml of the patient's blood in just 23 minutes.

The system is straightforward and easy to use and does not require any thrombin or bovine components (e.g. aprotinin).

The Vivostat® system offers a variety of different disposable application devices. They are designed for the delivery of fibrin sealant to the surgical site in a precise and targeted

manner, without experiencing the blockage that is common in conventional sealant systems.

Clinical studies and comparative tests have demonstrated that Vivostat® Fibrin Sealant is superior to conventional fibrin sealants on important parameters such as time to haemostasis, elasticity, adhesion to tissue and impact on tissue.

For more information please visit www.vivostat.com

The unique Spraypen® provides the surgeon with unparalleled freedom during application of fibrin sealant

