

*the*  
**bulletin**



Society for Cardiothoracic Surgery  
in Great Britain and Ireland

December 2011

***Annual Meeting Manchester 2012***

***SCTS University***

***National Fulfilment System for Heart Valves***

***The Heart-Team Approach***

***Get Funding for Basic Research***

***Birmingham Professional Development Course***

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# Report from The President

Professor D P Taggart,  
MD, PhD, FRCS

## Dear colleagues

**I find it almost impossible to believe that I have now almost completed my two year office as President demitting to James Roxburgh at the next annual meeting.**

Over this period I have been privileged to be President during the publication of the Professionalism book and more recently, publication of the Thoracic Blue book. This very important publication has already been brought to the attention of the Health Minister and points out the increasing number of lung cancer resection operations, the decreasing mortality associated with this and the potential number of lives saved as a consequence of this surgery. Indeed the best estimates are that for every person who dies as a result of lung resection for cancer there are an additional 35 survivors. However, more still needs to be done as there are still substantial inequalities across the UK and perhaps there should be a further drive to increase the number done through video-assisted procedures.

The safe and sustainable issue has continued to cause division within both the Executive and our membership. While SCTS supported the principle of the review it had much less involvement in the process and perhaps in retrospect this was an error. Certainly in terms of the reconfiguration of GUCH Services SCTS would aim to be more involved.

*From an adult cardiac prospective we are potentially in the best situation we have been for the last two decades with considerably mounting evidence of the benefits of CABG over stents*

From an adult cardiac prospective we are potentially in the best situation we have been for the last two decades with considerably mounting evidence of the benefits of CABG over stents as illustrated in the 4 year outcomes of SYNTAX Trial (showing a strong survival advantage for CABG for almost 80% of 3 vessel disease and 2/3 of left main stem disease). Of course the cardiac surgical community has been arguing this very point over the last decade so it is reassuring to see it confirmed in a large randomized trial. In the early summer the dogged persistence of the Executive, accompanied by the outstanding efforts of our irreplaceable late patient representative David Geldard (see obituary in this issue), finally convinced NICE to over turn their initial proposal which effectively would have allowed/encouraged interventional cardiologists to take on any severity of coronary artery disease if they alone considered the anatomy suitable and without any reference to the surgical opinion. Not only was this potential recommendation completely at odds with the ESC/EACTS guidelines but it would have been of major detrimental value both to the safety of patients and to the future of cardiac surgery. However there is much more work

to be done and particularly in trying to persuade commissioners that they should not fund any intervention that does not follow approved guidelines or has otherwise been discussed by an MDT to explain why an alternative strategy is being pursued. I was particularly concerned that for a Society, who considers itself to be held in such high regard by external parties, we were almost brushed aside by NICE.



Another issue is the continued ongoing scrutiny of results which has, I believe, at least for now, reached "a natural limit". There is little evidence of the majority of the medical profession being persuaded to follow us and it really is now time to allow others to catch up. While transparency in results is clearly important and fundamental (just as I want the right to know my MP's expense claims) the current format of publication inevitably encourages risk averse behaviour. I would personally favour a system that basically judges performance on standard/low risk patients with everything else deemed 'high risk'.

Equally so, I remain very concerned that cardiac surgical units operate in potentially increasing hostile environments where it is all too easy to hold the surgeon accountable for poor outcomes even when systems failures may have contributed. Indeed, SCTS is currently drawing up a document "Safe Surgery" under the chairmanship of Prof Marjan Jahangiri, and this should hopefully define minimum standards of what is safe surgery in terms of personnel, equipment and working environment.

You will all be aware by now of the slight increase in annual fees and this is absolutely necessary to keep our books balanced and to prevent the Society from running into persistent deficits. However, if you consider the true added value of SCTS e.g. in terms of SCTS annual meeting and university, the small increase in fees is not punitive or with out added value. On a very positive note our next meeting, for the first time, is being held in conjunction with ACTA and, if as likely, proves a successful event may become a regular 'fixture'. This is a particularly important initiative because increasingly cardiac surgeons and cardiac anaesthetists face similar problems. Consequently I would be grateful if you could make every effort to reduce activity as much as possible for that period to give consultants and trainees and allied staff every possible opportunity to attend.

Finally, I would like to thank all the members of the Executive for the great work that they consistently do and would encourage all members of the Society to seek to be as actively involved as possible.

Wishing you all the best for the festive period!

**David Taggart**  
President

# Honorary Secretary's Report

Graham Cooper

I first met David Geldard at the British Cardiovascular Society meeting in Manchester in 2008. He described the meeting as an interview, I thought that we were just having a coffee and chat. It marked the end of a search for a patient representative for SCTS. Turning up at the SCTS Executive for the first time is a testing experience for any of us, more so for a non surgeon. David did not flinch and his persistent championing of the views of patients was at times challenging for us and also for others; his intervention with NICE arguing that their proposed guidelines on stable angina denied patients choice was crucial.

Whilst the NICE stable angina is a balanced statement about the role of CABG in the treatment of coronary artery disease, to be effective it has to be implemented. In the face of the changes to commissioning in the NHS at present this will be a challenge. The SCTS Commissioning Working Group aims to provide comprehensive guidance for commissioning of adult cardiac and thoracic surgery. To do this effectively is ambitious. The guidance must put clinical guidelines into the wider context of the NHS.

We have split the working group into four streams:

## 1. NHS Evidence accreditation, led by Jo Cripps from the Royal College of Surgeons in England and Ian Hunt.

NHS Evidence is a service that enables access to authoritative clinical and non-clinical evidence and best practice through a web-based portal. NHS Evidence accreditation certifies that guidance produced is fair, authoritative and can be trusted. The benefits for SCTS in achieving NHS Evidence accreditation are that the Accreditation Mark as a recognised sign of quality, increased visibility for our Commissioning Guidance on NHS Evidence and that only accredited guidance is used to develop NICE quality standards. We are working with the Royal College of Surgeons in England to achieve NHS Evidence accreditation. Accreditation will certify the process we develop for writing the commissioning guidance.

## 2. Adult Thoracic Surgery, led by David Waller and Marco Scarci.

Using the process developed by the NHS Evidence accreditation workstream this group will develop commissioning guidance for adult thoracic surgery.

## 3. Adult Cardiac Surgery, led by Adrian Levine.

This workstream will perform the same function for adult cardiac surgery.

## 4. Implementation, led by David O'Regan.

The implementation workstream will develop a strategy for ensuring that Clinical Commissioning Groups are aware of and use our guidance.

We have 22 members involved in the four workstreams, if any one else would like to be involved please contact the relevant workstream lead or me.

The finding in the Second National Thoracic Surgery Activity & Outcomes Report 2011 that there has been a 60% increase in lung cancer resections with an almost halving of mortality between 2001/02 and 2009/10 is a significant achievement that reflects the prominence given to thoracic surgery by both SCTS and the SAC in the past decade. Richard Page deserves congratulation on the significant effort that he has put into producing the book.

John Pepper has been SCTS's first Education Secretary and has excelled at leading the broad and at times complex agenda associated with this role. He is standing down due to the pressure of other commitments and we are extremely grateful to him for all the effort put in on SCTS' behalf.

Also coming to the end of their terms of office are David Taggart and Simon Kendall. Simon Kendall has broadened the Annual Meeting and overseen its continued development. The last meeting that he will be organising is a joint meeting with the Association of Cardiothoracic Anaesthetists, pulling this off is a significant achievement. It has been a great privilege to be Honorary Secretary during David's Presidency, his fierce commitment to members interests and what he believes in have been great strengths for SCTS.

The various mechanisms required to fill these posts and that of David Geldard are running and successors will be announced at the Annual meeting in April 2012.



*An almost halving of lung cancer resection mortality between 2001/02 and 2009/10 is a significant achievement that reflects the prominence given to thoracic surgery*

## Annual Meeting 2012

# 1st Joint Meeting SCTS & ACTA

*Simon Kendall*

**MANCHESTER CENTRAL – Wednesday to Friday, April 18th – 20th 2012**



Association of  
Cardiothoracic  
Anaesthetists



Society for Cardiothoracic Surgery  
in Great Britain and Ireland

## Dear Colleagues

**For our first Joint Meeting with ACTA (please note it's a Wednesday to Friday this year!) we are hoping units might consider reducing to an urgent service only to allow any colleagues to attend if they wish.**

As you may well recall we used to be the Society of Cardiothoracic Surgeons – but to reflect the changing multi professional nature of our specialty we changed our name to the Society FOR Cardiothoracic Surgery. Recent meetings have included many aspects of our multi professional specialty: the Perfusionists; the Specialist nurses; the Surgical Care Practitioners; the Database Managers and more recently the Patients' forum.

However there's a major gap in this portfolio – and over the years patient care in pre-assessment, theatre, ITU and HDU has become more and more shared with our anaesthetic colleagues. It is a credit to Donna Greenhalgh (Wythenshawe) and Niall O'Keefe (MRI) that they volunteered their Manchester spring ACTA meeting to be joined with the SCTS AGM. If successful we hope to repeat the joint venture in Dublin 2015.

And this is also an opportunity to congratulate Donna Greenhalgh on being elected Chairperson of ACTA – equivalent to the role of President in our society – so she will be host and Chairperson at this first combined meeting.

This has been in the making for three years – and we hope that you will find the programme covers many of the areas where there is shared interest between us all.

**The SCTS University will be scheduled for ALL of Wednesday April 18th.**

For members (including affiliated forum members / members of ACSA / members of ACTA / members of SOPGBI) there is a fee of £25 to book an 'educational stream' and for non members £50. You can read Ian Wilson's superb plans for the university in this bulletin.



## In the main meeting there will be three plenary sessions:

- **How Does Team Working Improve Clinical Outcomes?** – to mark our first joint meeting we will hear how coordinated and shared care improves patient care and outcome.
- **How Will We Deliver the Out of Hours Service?** – there are several areas of tension: emergency surgery; re-openings; ITU; HDU and the ward. Should trainees use working hours on call? Do you need a surgical registrar resident for the ITU? Is a critical care practitioner able to be first on call for ITU? Do you need a specialised thoracic team on call? Steve Livesey and Jon MacKay are coordinating speakers to present the evidence from the surgeon, anaesthetist, specialist nurse and trainee.
- **Have we surpassed the physiological reserve of our elderly patients?** Just because we can doesn't necessarily mean we should – and major T4 lung resections or complex cardiac procedures may be too much for the very elderly – and if complications arise who decides when enough is enough?

Annual Meeting 2012 MANCHESTER CENTRAL – Wednesday to Friday, April 18th – 20th 2012

## SCTS & ACTA 2012 *continued*



### The Thoracic sessions will focus on:

The role of ITU in postoperative recovery including a focus on non-invasive ventilation;

- Review of strategies for post operative analgesia;
- How best to perform pre-operative assessment of the thoracic patient – the investigations and the role of the surgeon and anaesthetist.

We are delighted that our surgical guests include **Dr Sugarbaker** who will deliver the thoracic lecture as well as presentations by **Professor Detterbeck** from Yale and **Professor Grunenwald** from Paris.

### In Cardiac Surgery the sessions will be on:

- Organ protection focussing on brain, GI tract and kidney;
- Extra corporeal support on the ITU - balancing resources with ECMO, Renal and Circulatory support;
- Stopping the bleeding – will publishing bleeding rates facilitate the optimisation of patient care?;
- SIRS – can we use too much vasopressor?

Our surgical guests include **Dr Andrew Wechsler**, Philadelphia, and **Professor Thoralf Sundt III** Boston.

The programme for congenital surgery is still in progress but as with thoracic and adult cardiac surgery there will be sessions with shared interest.

**Thank you to everyone who submitted an abstract. They have each been scored by six reviewers – a total of 48 reviewers with an anaesthetist on each of the surgical topics and a surgeon on the anaesthetic / ITU group.**

The programme committee meets on the 19th December to allocate the best abstracts to the appropriate sessions, and the final programme will be online in the New Year.

All scientific and clinical presentations will be five minutes long, leaving five minutes for questions. After the success of last year we will again request ALL presenters to bring a poster that can be displayed in the exhibition area during the meeting.

### The Cardiothoracic Forum

The Cardiothoracic Forum is now a firmly established and popular part of the AGM. The theme this year is 'Gold Standard Care in Cardiothoracic Surgery'. The forum will be opened by the medical director of the NHS, Professor Sir Bruce Keogh and has an excellent programme as described by Tara Bartley in this bulletin. This year we are offering units the opportunity that **for every 5 registrations for the forum this gives one extra registration for free.**

### The Database Managers

The Database Managers have elected to continue to hold their Annual Meeting in conjunction with SCTS for the sixth consecutive year. They are a vital part of our specialty with an increasing role in thoracic and congenital surgery. Several submitted abstracts relate to data quality and risk stratification.

### The Perfusionists

The Society of Clinical Perfusion Scientists, Great Britain and Ireland, are holding their committee meeting in association with our AGM. Furthermore they are introducing a 'Techno Area' to the exhibition, where specialist perfusionists and industry representatives will give hands on sessions with equipment such as ECMO, LVAD and other Circulatory assist devices.



### Student posters

Last year over 50 medical students submitted posters for presentation – this will be repeated in 2012, also open to students with an interest in anaesthesia. We are grateful to **David McCormack** for organising this aspect of the AGM that encourages potential future colleagues to join our meeting. The prize for the best poster is the **Patrick Magee Medal** – he was a great supporter of this venture and this is one of several ways the Society will respectfully remember his major contribution to the specialty

### Thursday Dinner

A change! – the Annual Dinner will be held on the Thursday evening. We have enjoyed giving you evenings to remember – the Guinness Storehouse / Old Trafford / Prohibition theme / Race nights etc. This year we have put together an evening of entertainment including a chance for your table to win the Mega Quiz – to see if surgeons and anaesthetists really make the dream team.

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

Registration will open on January 1st and for those who are medically qualified there is a considerable saving for early registrants before February 1st.

**We look forward to seeing you there.**



# SCTS University

Ian Wilson

Wednesday 18th April 2012 – Manchester Central



Following its launch in 2010 the SCTS University is now established in the Society's annual meeting as a dynamic multidisciplinary educational programme.

The SCTS University 2011 attracted over 450 participants and evaluated well.

The educational material covered is aimed at all members of the Society, and is also directed towards affiliated groups, including Perfusionists, Advanced Nurse Practitioners, and Cardiothoracic Surgical Assistants. This year the SCTS annual meeting is combined with the Association for Cardiothoracic Anaesthetists, and thereby offers an opportunity to add further impetus to this exciting initiative.

Involvement in the educational programme will extend across the full extent of all the multidisciplinary groups involved in cardiothoracic surgery, and this will prove to be an enormously dynamic cross fertilization of knowledge and opinions, alongside visionary comment on areas for future development.

Such a contemporary review of the most contentious topics within the specialty is an immense offering of on-going educational support for all people involved in the clinical arena.

Sessions are designed as small group parallel programmes covering controversial topics at the forefront of development within the cardiothoracic surgical specialty. The SCTS University programme covers a full day's educational content, and is followed by the opening of the Exhibition Hall, as the launch of the Inaugural Joint SCTS / ACTA Annual meeting.

With the launch of the SCTS University site on the new SCTS web site, an educational tool is being developed on the site to further explore the topics covered within the SCTS University day, and this exciting venture offers the opportunity for attendees of the SCTS University 2012 to gain from the educational material in parallel Educational Streams and Lunch Box sessions that they could not attend.

## The International Faculty includes:

- **Andy Wechsler**, Drexel University, Philadelphia
- **Thor Sundt III**, Massachusetts General Hospital
- **Michael Borger**, University Leipzig
- **Davy Cheng**, University Western Ontario
- **Manuel Castella**, University Barcelona
- **Frank Detterbeck**, Yale Cancer Centre
- **David Sugarbaker**, Brigham and Women's
- **Marco Ranucci**, San Donato Milanese
- **Alain Combes**, Hopital Pitie, Paris
- **Patrick Perier**, Herz und Gefass Klinik
- **Jean-Louis Vanoverschelde**, Cliniques Universitaires, Leuven
- **Jorg Ender**, University of Leipzig
- **Dominique Grunewald**, University of Paris.

This, alongside a dynamic national faculty, promises a hugely educational day.

## Activities

This year's programme of activities includes:

### 10 Educational Streams

- Anticoagulation and Bleeding in Cardiac Surgery: Optimal Management in Shifting Sands
- Adult Right Sided Heart Disease: Often Forgotten but Can't be Ignored
- Transcatheter Valve Surgery: A Rapidly Evolving Field
- Minimising Surgical Invasion: Innovative Techniques Offer Advances in Therapeutic Options
- Coronary Artery Surgery Just Got Interesting: Understanding the Data
- Intraoperative TOE and Decision Making in Cardiac Surgery
- Congenital Heart Surgery Master Class
- Lung Oncology: Contemporary Practice and Advances
- Complex Mediastinal and Airway Surgery
- State of the Art Thoracic Anaesthesia

**SCTS**   
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# SCTS University *continued*

## Activities continued

### 9 Lunch Box Sessions

- Bicuspid Aortic Valve Disease and Bicuspid Aortopathy
- State of the Art Aortic Stenting
- Complex Mitral Valve Disease: Tackling Challenging Variants in Day-to-Day Clinical Practice
- Cerebral Protection in Cardiac Surgery
- Extra Corporeal Membrane Oxygenation: Clinical Applications and Practical Tips
- Atrial Fibrillation Surgery in Congenital Heart Disease Surgical Strategies
- Mediastinitis: Contemporary Advances in Prevention and Cure
- How to do it: Complex Thoracic Surgical resection
- How to do it: Management of Complex Airway Disease / Tracheal Resection

The multidisciplinary nature of the programme will add to the University's dynamic structure, and I am confident that this year will see the SCTS University progress in its development as a pivotal tool in the educational focus of our Society.

Further iterations of development are inevitable as the programme develops in future years, and we would welcome your involvement in the SCTS University 2012 educational day which will assist maturation of the SCTS University project.

The Programme is available on the SCTS Web Pages and early application will ensure places can be offered for the Educational Streams and Lunch Boxes of your choice.

*Involvement in the educational programme will extend across the full extent of all the multidisciplinary groups involved in cardiothoracic surgery,*

**SCTS**   
**UNIVERSITY**

# Nursing Report

*Tara Bartley*  
Nurse Representative

The 2012 meeting will be held at The Manchester Central Conference Centre. This will be the best forum yet! This first combined meeting with ACTA gives all cardiothoracic nurses the best opportunity to be able to attend because many units are intending to reduce to urgent work only AND the offer of one free registration for every five booked.

To be combined with ACTA makes the sessions more relevant than ever for nurses from ITU, theatre and HDU. To this end our forum sessions will be focussing on the themes that are relevant to all of us in this demanding speciality:

Our opening remarks will be delivered by Sir Bruce Keogh, Medical Director of the NHS. It is always a pleasure to have Sir Bruce join us, not only is he fully versed in issues close to our hearts but he is an excellent speaker. The 2012 Cardiothoracic Forum couldn't let the Olympic year pass without formal recognition so we will be celebrating the 2012 Olympics with the theme 'Gold Standard Care' and I am delighted to say our first plenary session will be delivered by the Gold Medallist, British Bobsledder, Tony Nash.

*For the Annual Meeting to be combined with ACTA makes the sessions more relevant than ever for nurses from ITU, theatre and HDU.*

We will join with the Patient Forum to deliver a true multidisciplinary session presenting the patients perspective as a contrast to that of their surgeon, nurse, anaesthetist so hope. Specifically Baroness Billingham, a proponent of the NHS has been invited to recount her recent experience of being a thoracic patient and her surgeon Mr Eric Lim and members of the MDT will join her to present the health professionals perspective.

With concern around the image of nursing the RCN have undertaken a major piece of work defining the 'Principles of Nursing Care'. Janet Davies, FRCN who has worked for the RCN since 2005 and was recently elected the first National Chair of the Clinical Guidelines Centre Management Board has lead this work will share the impact this document is having within the NHS and how the CQC are referencing in relation to standards of care.

On Friday Dame Gill Oliver will deliver a plenary talk entitled 'From the Ward to the Board'. Dame Oliver is a Fellow of the RCN and has made an exceptional contribution to the NHS over many years so reflecting upon her experience will be invaluable to all.

Earlier this year I had the opportunity to visit the American Association of Critical Care Annual Meeting in Chicago, as part of a team teaching the CALS course. During the meeting I meet Jill Engel, Director of Advanced Practice at Duke Heart Centre, USA. Jill's work at Duke University hospital, Carolina has seen the implementation of an innovative Advanced Nurse Practitioner workforce within the Cardiothoracic department. She will share the underpinning educational framework that has been developed and the roles that are carried out.



We are also inviting speakers to inform us about the Social Care and Health Care Bill which will significantly impact how we deliver care.

Thank you for submitting your abstracts - submission closed on 1st December so the selection committee have been busy reviewing papers for acceptance at the Forum. The meeting will be in April next year to allow us so to join with the Anaesthetists and our colleagues in critical care for the first Joint ACTA & SCTS meeting. As a result the deadline for abstract submission was a month later than in previous years hence we are still pulling this aspect of the programme together.

I am confident that the programme will be of interest to all nurses and Allied health professional, there will be the opportunity to hear how current issues in the NHS are affecting our speciality and in addition there will be a large number of papers from your colleagues that will be relevant to clinical practice. We look forward to seeing you in Manchester.

## Other news from Nursing and Allied Health Professionals;

This years SCTS Advanced Cardiothoracic Course took place on 4th & 5th of November at Heartlands Hospital, Birmingham. Delegates came from throughout the UK and Ireland. We were also delighted to welcome seven colleagues from the Netherlands. The Thoracic day included lectures on lung cancer, surgical management and post-operative complications. The wet labs gave delegates the opportunity to simulate VATS, insertion of minitrachs and insertion of chest drains to name a few. The Lectures on the Cardiac day included coronary heart medication, management of common microbiology issues and choice of antibiotic treatment for endocarditis. There were wet labs reviewing cardiac anatomy with surgical techniques and line insertion. Delegates also worked in small group workshops reviewing coronary angiograms, CT scans, Chest X rays, lung function, echo, listening to heart sounds and managing case presentation. None of this would be possible without a fabulous faculty who travel from various areas of the country for which we are very grateful. The day was well evaluated and our thanks go to Sorin and Kevin Austin for their support and sponsorship, which not only enable a great course but one that is affordable to delegates.

# Nursing Report *continued*



## Joint RCS & SCTS Cardiothoracic Advanced Examination

Work is progressing with this venture. We have met with the RCS and are now moving forward with the key tasks around the syllabus, examination and Q&A process to establish a recognised standard of knowledge and practice for individuals undertaking advanced roles.

## EACTS

Christina and I attended the Nurses forum at EACTS. I was involved in putting the programme together along with Leslie Hamilton and the EACTS committee. The programme included sessions on Wound management, Advanced Practitioner roles, Transplantation, Hybrid techniques, a CALS demonstration and a number of papers. Both Chris and I were invited to chair and I gave a paper on the SCTS's work around advanced practice and the joint course Paula Agostini and I have developed. Paula also presented on Thoracic issues and as the Best Paper award winner of the SCTS Cardiothoracic Forum 2011 Sandra Laidler was invited to present her Reflections on the Implementation of a Nurse Practitioner training programme at the Freeman. Other presentations from UK speakers included Mr Wrightson for Newcastle who discussed the role of the nurse practitioner with Left Ventricular devices. The meeting was a huge success and it would seem that the post-graduate nurses programme has now been fully adopted into the meeting.

## Nursing Issues

With fiscal restrictions being imposed within the NHS there is concern within the RCN and in the wider health community about how we train our professionals for the future? Not only are there issues about delivering the correct training and clinical competence but much of this relies on current health professions assessing their colleagues in training. If these individuals are not being supported to undertake professional development or given the opportunity to keep abreast of current developments within their speciality can we really expect them to objectively appraise and develop their colleagues? It seems that while mandatory training is imperative trusts struggle to move beyond this baseline of education for large numbers of the health care workforce. This issue has been highlighted in The NHS Future Forum and related to patient care by advocating joined up thinking when tackling issues around patient safety and delivering quality care. This has resulted in the launch of 'The harm free care programme to reduce harm from pressure ulcers, falls, urinary catheters and venous thromboembolism. The rhetoric would suggest that Trusts should look towards emphasising the importance of local partnership between the NHS and higher education. While local partnerships can target what is relevant, lack of direction and underpinning governance at national level leaves trust open to individual interpretation that may mean education loses out within the current competitive nature of the NHS climate and challenges our ability to sustain quality care delivery.

## Social Care and Health Care Bill

In September I was fortunate to be invited to the House of Lords to hear the second reading of the Social Care and Health Care Bill. Dame Audrey Emerton, the only Peer in the House of Lords with a nursing background kindly invited several of the RCN Fellows to hear hers and other Peers comments on the bill. Sir David Nicholson, NHS Chief Executive is quoted as saying: "Building this new system over the next two years, while delivering for our patients, increasing productivity and improving the quality of care, is a major challenge. But I firmly believe that what we are trying to achieve a stronger, more innovative and more coherent commissioning system that will be critical to sustaining the NHS in years to come." The central role of the new Board will be to improve patient outcomes, by supporting, developing and performance managing an effective system of clinical commissioning groups. It would seem then that nursing must play a fundamental role in informing commissioning groups. The significance of the work Dame Audrey is undertaking is crucial in representing the nursing profession within legislative aspects is vital as the input at regional level has not equated with that of other health professionals.

## Farewell

Finally I would like to say that this will be my last bulletin as the SCTS Nursing Representative before Christina takes over from me in the spring following next year's Annual meeting. I wish her all the best and am confident she will do a great job. I am very grateful for the opportunity to have held the position, which has allowed me to work with some fabulous colleagues on the Executive and around the UK and Ireland. Specifically I would like to mention the members of the organising committee who work enthusiastically to ensure the Annual meeting is a success. Thank you Simon Kendall, Ian Wilson, Tilly Mitchell, Christina Bannister and of course Isabelle Ferner – Isabelle its been a real privilege to work with you.

**Tara Bartley**  
Nursing Representative

# Trainees' Group Report

Betsy Evans

**As the end of 2011 approaches one inevitably looks back over the year to reflect on the major events that have occurred.**

This year has been a very busy one. Helping to organise the trainee session at the annual meeting in March was both enjoyable and informative. I think that the meeting was the best attended that I have seen over the last decade. The involvement of trainees presenting papers that had direct relevance to the group was appreciated by the audience. It was good to get personal views from a spread of trainees covering various topics – national selection process, preparation for the FRCS (CTH) exam and the changing role of trainees within cardiothoracic departments. Feedback from trainees revealed that they had learnt from the meeting and also felt empowered to return to their units with ideas to propose to their training programme directors regarding the balance between service and training within the constraints of EWTD compliant rotas.

## Symposium

Additional to the trainees meeting I was invited to present in the symposium organised by Prof Marjan Jahangiri on the EWTD. This session was attended by many, despite being at the end of the meeting program, and a balanced series of presentations was given addressing the views of a wide range of professionals on EWTD – managerial, senior clinicians, trainees and overseers of our training (Royal College and SAC) were represented. I believe that despite this topic being discussed on numerous occasions this was the most insightful symposium that I have been to on the subject which hopefully will inspire people to keep addressing the plight of surgical trainees in an era of restricted working time.

At the annual meeting it was announced that Ethicon would be sponsoring four senior trainees to spend 6 months at the end of their training in an area of specialist surgery. This opportunity would enable the trainees to gain additional expertise in a field of cardiothoracic surgery that they wished to take to their prospective consultant post. The Ethicon scholarships were very popular with a competitive interview process determining the successful applicants. The four individuals chose to spend their time in Liverpool, Middlesbrough, Belgium and Hong Kong. I look forward to hearing the presentations on how their time is being spent at the forth-coming annual meeting in Manchester next year.

## Trainee Selection

In April the national selection for cardiothoracic trainees was moved to Southampton from Birmingham and the process followed a similar format with three days of interview, presentation and simulated surgical tasks being assessed. In total there were twenty eight successful candidates awarded a national training number, congratulations go to all of these individuals. Cardiothoracic surgery still attracts many high calibre people and hopefully will always continue to do so. It is the strength of our trainees together with the commitment of

trainers and members of the SAC that continue to produce a top quality surgeon at the end of the program and we must always endeavour to achieve this.

## Training Differences

This June the summer cardiothoracic section of the Royal Society of Medicine was organised for the final time by Prof John Pepper, the title for the meeting was “The Future of Cardiothoracic Surgical Training in the UK”. The day was spent discussing training differences between the UK, Europe and the United States, the relevance of simulation in cardiothoracic training in addition to the need for trainees to be open minded about how to achieve the best from their time as a trainee with a reflection on the history of surgical training. Overall the day was packed with informative, stimulating presentations offering open discussion in a relaxed setting. This day again stressed to me that as a trainee we must step back and appreciate that there are many people who take our training seriously we just need to tap into these very useful resources!

*Feedback from trainees at the AGM reveals that they felt empowered to return to their units with ideas to propose to their training programme directors*

Exciting times are ahead for training in our specialty with GMC recognition that congenital cardiac surgery is now a subspecialty of cardiothoracic surgery; this will hopefully have a beneficial effect on any persons wishing to train in this field. The intercollegiate examination can now be sat at the end of the fourth year of specialty training thus enabling future trainees the flexibility to tailor the last two years of their training to an area of specialist interest including congenital cardiac surgery. Issues regarding the nature of the clinical aspect of the examination with regards to cardiac and thoracic interest of the trainee are being discussed and continued feedback is crucial from individuals who have recently sat the examination to assist this process.

A final note, I hope that trainees believe that I am representing the group effectively at various committee meetings that I attend I obviously am acutely aware of numerous requests made of trainees but really can not stress enough the importance of communication! At the next annual meeting I will be passing on the role of trainee representative. I am confident that this important role will be taken on by an enthusiastic trainee. It is anticipated that e-mail will be the medium used for the voting process and that this will occur sometime in February so to ensure my successor can be announced at the Annual meeting in April.

# An Overview of the National Fulfilment System for Heart Valves

*Dr Akila Chandrasekar  
(Chair, Clinical Advisory Group)*

*Mr Prem Venugopal  
(Consultant Surgeon in  
Clinical Advisory Group)*

Heart valve allografts (homografts) are commonly used for the repair of diseased and damaged heart valves. Heart valve homografts are available from 6 independent heart valve banks within the United Kingdom (UK) which until recently made locating suitable grafts time-consuming for the requestors. Under the leadership of NHS Blood and Transplant (NHSBT), a national centralised system has been created to facilitate quick and easy access to all currently available grafts. This article provides an overview of the current system and explains briefly how it operates for the benefit of the cardiothoracic surgeons.

The National Fulfilment System (NFS) is a centralised inventory of all heart valve homografts available within the UK. It was established in October 2011 by NHSBT in agreement with the other heart valve banks as a means of achieving a centrally co-ordinated supply of heart valve homografts. The core objective of the NFS is to provide a transparent and equitable supply of heart valve homografts for all patients in the UK.

## Background:

There are currently six heart valve banks in the UK. Two are part of the national blood services (the Scottish National Blood Transfusion Service (SNBTS) tissue bank based in Edinburgh, and the NHSBT tissue bank based in Liverpool). The others are hospital/ university managed banks set up alongside cardiac units at Bristol, Royal Brompton, Oxford and Birmingham. NHSBT employs Specialist Nurses in Organ Donation who, in addition to consenting donor families for organ donation, also consent for the donation of heart valves for banking.

Traceability of donations from donor to patient is a legal requirement under the Human Tissue Act (HTA). Prior to the implementation of the NFS the UK lacked a centrally co-ordinated system for recording homografts from donation

*The core objective of the NFS, a centralised inventory established this year, is to provide a transparent and equitable supply of heart valve homografts for all patients in the UK.*

through to transplantation. In addition, there was no central register to establish the actual demand for heart valve homografts. It was evident that a co-ordinated process for capturing national demand and managing the UK supply of heart valve homografts was required to meet our obligations to transplant centres, patients, regulators and more importantly, donor families.

## Drivers for Change:

- Requirement to understand the national demand for homograft heart valves
- Equity of provision of heart valves across the UK
- Requirement for a centralised nationally co-ordinated inventory to provide transplant centres with one point of access
- Standardisation of the quality and safety of heart valve homografts to nationally agreed best practice



*The NFS records all information relating to a heart valve from the point of consent to issue for transplantation. The NFS database is updated on a daily basis with information provided by each heart valve bank.*

# The National Fulfilment System for Heart Valves continued

## How does the NFS work?

Specialist Nurses in Organ Donation based in Scotland refer donors to SNBTS, those in the North & Northern Ireland refer donors to NHSBT (Liverpool) and those from Midlands, South West, London & South East regions continue to refer donors to the hospital based heart valve banks. The receipt, processing, testing and subsequent storage of heart valves continues to be undertaken by the six UK heart valve banks. The NFS records all information relating to a heart valve from the point of consent to issue for transplantation. The NFS database is updated on a daily basis with information provided by each heart valve bank.

There is a single national order line **0300 200 2003** managed by NHSBT Customer Services for both enquiries and heart valve requests. Requestors are sent data sheets detailing suitable valves via email or fax. If there is more than one suitable valve the surgeon may select the most appropriate homograft for their patient. The heart valve homograft will then be reserved for the patient on provision of a hospital order number by the requesting hospital. The order is passed on to the relevant bank to dispatch the graft directly to the requestor and the database is updated.

The allocation of heart valves is restricted to hospitals in the UK.

## Advantages of NFS:

One telephone call to the NFS provides the requestor with access to all suitable valve homografts available in the UK. The surgeon has the opportunity to select the most appropriate graft for their patient.

The NFS has the capability to provide a clear picture of national demand for heart valve homografts in the UK. In addition, this can be extended to capture transplant outcomes over time.

## Monitoring the system:

A Heart Valve Bank Management group comprising of representatives from all the heart valve banks has been established. They meet regularly to review operational aspects of the NFS.

NHSBT will continue to work closely with the team of experts in the Clinical Advisory Group to consider their views to ensure that the NFS delivers the services needed for their patients.

## Contact:

If you have any queries regarding NFS please contact Dr Akila Chandrasekar or Mrs Helen Gillan on 0151 268 7090.



*Blood and Transplant*



# Heart-team approach for managing patients with ischaemic heart disease

H Luckraz\*

M Norell†



**The management of patients with ischaemic heart disease (IHD) is aimed at improving symptoms and prolonging life with an armamentarium which includes medical therapy, percutaneous coronary intervention (PCI) and coronary artery bypass (CABG) either in isolation or combined [1]. At the start of this century, there was a revolution in terms of the number of patients offered PCI as compared to those referred for CABG with an outcry from the surgical world in terms of patient's benefit.**

In an attempt to address this issue the SYNTAX trial was set up to assess the benefit of PCI or CABG in patients with multi-vessel coronary artery disease [2]. Since then, the ESC and EACTS have jointly issued guidelines on the management of patients with IHD [1]. One of the main recommendations includes the creation of a "Heart-Team" approach to managing patients with IHD. This should at least include non-interventional and interventional cardiologists as well as a cardiac surgeon with an evidence-based decision which is then related to the patient's wishes.

The Heart Team approach is the equivalent of a medical multi-disciplinary team (MDT) meeting which is extensively used in the management of cancer patients. Its remit has now been extended to the management of patients with diabetes, stroke and COPD [3]. Although there are no RCTs to confirm the benefit of MDTs, these meetings provide an evidence-based approach to decision making. They also ensure a better team working, co-ordinated patient care and provide a great platform for education and training [3].

The necessity for a cardiac MDT or heart-team (HT) approach is further consolidated by (a) the recent publication by Hannan et al [4] and (b) the report by Lee et al [5]. The latter conducted a survey of patient's perception about why PCI was carried out. One third of patients thought that their treatment was an emergency despite the PCI being carried out as an elective procedure. Two-thirds thought that the PCI would prolong their life with just under half thinking that it has saved their lives. These attitudes certainly reflect an incomplete information for the patients. Hannan et al showed that if a cardiologist felt that the patient would benefit from PCI, then in 94% of patients a PCI was carried. On the other hand, if a cardiologist (Interventional no doubt) felt that the patient would benefit from CABG, then only 53% of patients actually underwent CABG.

Hence the need for a heart-team could ensure an evidenced based approach for patient's treatment. Since its inception, the Heart & Lung Centre in Wolverhampton has embraced a HT approach to managing patients with IHD (over 6 years experience). This has enabled us to refine and modify our meetings so that we are able to run two weekly sessions which are attended by cardiologists (Interventional and non-interventional), cardiac surgeons, allied professionals (radiologists, cardiac anaesthetists) and junior medical & surgical staff. The meetings are minuted by our MDT coordinator who also ensures that all the paper-works are available and

ready for the meeting (angiogram, echo, DSE, CMRI ect.). On a yearly basis we discuss around 900 patients with IHD. The meeting is chaired alternately by a cardiac surgeon and a cardiologist (either interventional or non).

Our experience was presented at the EACTS 2011 meeting in Lisbon [6] and confirmed that in 86% of patients the decision of the heart team was carried out. The most common reason for aberration was patient's decision not to proceed with either PCI or CABG. We also re-discussed the same patient's data after a year and in 76% of patients the same decision was reached. In the remaining 24% of patients the different decision reflected the fact that for certain coronary pathologies, there was no overwhelming evidence to favour either PCI v/s CABG or PCI v/s medical treatment. We certainly feel that the Cardiac MDT provides a transparent and an evidence-based approach to managing patients with IHD.

It is important that the cardiac community in the UK embrace the HT approach (under the aegis of SCTS and BCIS/BCS). This, however, will only become possible when these meetings become part of the Consultants' PAs. The meeting needs to be appropriately supported by the necessary staff. We are also embarking on an electronic format which we hope will provide data for audit and research.

We are organising a day forum on the Heart team approach next spring so that units around the UK could share their experience and learn from others to develop their local HT further.

\* Consultant Cardiothoracic Surgeon,

† Consultant Cardiologist,

Heart & Lung Centre, New Cross Hospital, Wolverhampton

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# How to get funding for basic research

*Gianni Angelini*

*British Heart Foundation Professor of Cardiac Surgery, Bristol University and Imperial College London*

**When I was a young trainee rather a long time ago, I went to see one of my mentors and told him that I was interested in doing some research, even though I had no idea where to start! He advised me “to identify a clinical problem you face every day in your practice, understand the mechanisms of action by using basic science and, with a bit of luck, you may be able to take the solution back into your clinical practice”.**

This was the most important advice that I ever received in my academic career. It is still relevant today for anyone who wants to carry out what is now fashionably called ‘translational research’.

## So how do you go about it?

First, you need a good idea or, more scientifically, a “working hypothesis”. The next step is to do some serious background reading as, otherwise, you risk “reinventing the wheel”. It is most important to understand what is already known in order to be sure that question you are interested to answer is still worthwhile answering – don’t be surprised if you find the answer from the literature without doing any research! Once you are clear in your mind that you have a solid hypothesis which is going to involve basic science, look around in your institution to see if there are any scientists who may have a similar interest.

*You have to ask yourself a very honest question. Are you doing this because you have a genuine interest in research?*

I would then advise that you meet them and present your ideas. In my experience, basic scientists are always very keen to collaborate with clinicians for the very simple reason that they usually do not have access to patients. So, if you can give them the opportunity to have access to tissue samples from patients (i.e. blood samples, a piece of vein, a muscle biopsy, etc.) and, of course, clinical information about the same patients, you will find you are knocking at an open door.

At this stage it is important not to think you are in charge simply because you happen to be the one with the idea or because you have a medical degree and the basic scientist has only a PhD! My advice is not to think too much about “me, me, me...” but more about “us... as a team”. This is not just pragmatic, but essential if you are going to build a successful collaboration since you as a clinician have no idea about basic science, let alone research methods or the infrastructure which is going to be required. Nowadays, research is no longer for amateurs; most of the techniques, e.g. biomarker assays, gene expression

profiling, etc. are very sophisticated, often very expensive and require a considerable level of knowledge, expertise and dedicated facilities to ensure valid results.

So, you have now a basic scientist who is willing to collaborate, a working hypothesis, an understanding of what’s known and what is not, and an appreciation of research methods that are appropriate to tackle your question. All you have left to do is to write the protocol and grant application. At this point, you need to talk to one or two senior members of your department including a statistician (since it would not surprise me if you are unfamiliar with the principles of sample size calculation) who may be able to help by commenting on your proposal and directing you towards the most appropriate research funding body.

## Make a contribution

Once you have successfully negotiated these steps, you have to ask yourself a very honest question. Are you doing this because you have a genuine interest in research? Do you want to understand better the challenges you face in your every day clinical practice and find better ways of tackling them? Or are you doing research because you have to tick another box in your CV? If your heart is not in the task, you are unlikely to make a worthwhile contribution however hard you work. There is already enough rubbish research published every day of the week, which is wasting money and time, so there really is no need for more of the same.

Now that we have established that you are doing it because you have curiosity and a genuine interest in research, you are ready to put your application to the most appropriate funding body and to wait anxiously for the outcome.

My final message is that, if you fail at the first attempt, don’t give up because this, I’m afraid, has happened to all of us. You are up against lots of other people applying for research funding and even the most successful researchers expect to be awarded only 1 in 3 of the grants they apply for. Remember that the most important things in research are dedication, commitment and perseverance.

Good luck from an old, and hopefully wise, academic who has seen it all and still believes that the satisfaction and reward are worth the pain and tribulations.



# Birmingham Professional Development Course

Joel Dunning

**If you want to go on any management course go on this one, it is outstanding! The Birmingham Professional Development Course is held annually and this year it was on the 10th and 11th of November at the Lygon Arms Hotel. Several delegates were a little late however, especially those who got flights to Birmingham airport and got a big surprise as the taxi drivers drove 39 miles south to the Hotel which is in fact nearer to Oxford and Worcester than Birmingham!**

The course's main strengths are that it is designed specially for cardiothoracic surgery (with a few cardiologists thrown in), it is absolutely star studded with outstanding speakers, it has a very small numbers of delegates and a large numbers of faculty, and there is not a single manager there!

The aim of the course is to prepare you to be a consultant, and it does this to perfection, adding in all the important issues that you have completely ignored as a more junior registrar as you wrestle instead with other conundrums such as the difference between a David Type III and IV and whether atrial flutter is more commonly clockwise or counterclockwise. Here are some of the highlights.

## Dealing with complaints

The first talk was by Malcolm Dalrymple Hay who gave an outstanding account of his first 2 years as a consultant and a particularly difficult patient complaint that despite his meticulous treatment, excellent clinical care and consent of the patient, caused him a huge amount of trouble and stress involving a weekly flood of legal letters for more than a year. It was a very honest and sobering account and I encourage anyone next to him in a bar who hasn't heard the story to buy him a stiff drink and ask him about it sometime!

This set the scene for a discussion about dealing with complaints by the newly appointed and heavily moustached forum member, Professor David Richens, who is the professional advisor to the Ombudsman. A great deal of the discussion centred on issues of consent and thus it was fantastic to have Sir Donald Irvine, ex-chairman of the GMC, at the course for the whole two days. He gave a great account of the time recently when he went into hospital to accompany his niece who was having a gallbladder operation. The junior doctor spent quite a long time discussing the procedure, its risks and complications and at the end as the doctor left, Sir Donald followed him outside and said to the junior doctor that he thought he had done a very good job with the consent. The doctor, who perhaps did not recognise the person in front of him as the author of the GMC's guide to good medical practice, said 'Well we have to do all that kind of stuff these days'.

## Performance Monitoring

Ben Bridgewater gave an excellent talk on performance monitoring and what it means to you as a new consultant. He was very sensible and practical, and on the discussion as to what constitutes safe practice he said, 'if it looks like a duck, flies like a duck and tastes like a duck then you have just eaten a duck, similarly people know when surgeons are safe and when they are not once they have reviewed any cases or mortalities that you have had to give you a higher than expected mortality'. Malcolm gave a talk on the future of service provision. He had obtained all the costings of every aspect of his and his colleagues clinical practice, down to the rate of CXR requests, and blood tests, and found some amazing discrepancies. He used this information together with correcting a huge amount of incorrect information to turn a perception that they were loss making, into being a very profitable part of the hospital. He warned that if we didn't do this ourselves then all our managers are going this way already and will look more and more into every aspect of our costs.



*This is a course that is absolutely star-studded with outstanding speakers - and not a single manager there!*

## Media studies

Prof Wallwork came along and brought his head of corporate affairs, Kate Lancaster. She is basically an ex journalist who talked about handling the media. She told us about how they broke the recent story of the first patient with a Syncardia total artificial heart. She said they planned to release it on a friday to get the weekend papers. She said that the media is not interested in whether it is a genuine first or how big the scientific value was, they just wanted the word 'first' and then much more importantly they need a patient to interview with a great story to tell. The patient in their case was Matthew Green a 40 year old who was happy to talk for hours about the operation and his experience. Once the story broke, Kate had prepared a new 'take' on the story every single hour of that friday as the media demand something new at that rate these days. She set surgeons up for interviews, advising never to be interviewed in old scrubs so that the media can see the results of your surgery down your front, and to pick your position so you are not under a sign to the mortuary. She also said that if you were follically challenged you must put some talcum powder on your head to stop the shine!

*continued overleaf*

## Birmingham Professional Development Course continued

Anyway in 18 hours their story was on the billboard in Time Square in New York which she found particularly amusing as 600 Synchronia Hearts have already been put in there!

### Work the ladder

Mike Lewis told us about how to prepare for the consultant interview, by describing his own experience. He said that you must be prepared and you must meet as many people as you can. He said that he met 32 people before his consultant interview, and made notes on every person he met. He also strategically met the most junior people first and worked up in order to be better informed as he went up the ladder of importance. He said that research has shown that people listen to people with red ties more so that's what he wore! There was then a very good session with Leslie Hamilton, Domenico Pagano David Richens and a Lawyer, looking at various court cases, where we tried to guess whether the case succeeded and how much the settlement was. We got several surprises and the Lawyer on one case said 'well an 89 year old is not worth a lot of money to a lawyer' summing up a lot of what is wrong with the system.

### The Coroners Court

Aiden Cotter the Coroner talked about the incredible problems there are with the coroners court system in the UK which has basically not changed since 1194. Every coroner can do exactly what they want, post mortem requests by coroners across the UK vary from 23% to 88% of all cases and the number coming to the court vary greatly also. Unfortunately the Coroners Justice Act of 2009 which was nearly ready for enactment to fix all this was ditched in the 'bonfire of the Quangos' when the coalition came in.

There were several more excellent talks. Mark Jones talked about dealing with problematic colleagues. He said that 'teamwork makes for dreamwork' but I think at the end everyone agreed that there is no easy way to deal with a really problematic colleague and that this is one of the most difficult problems that can be faced. David Richens suggested that sometimes you can get problematic colleagues moved to other jobs or even bumped up the chain of importance, to which Tim Graham stated that he would like to personally congratulate him on his new Professorship!

So what will I take away from my time at this course? Well after the medico legal cases, I am going to make sure that all consent signatures are much clearer in future and I am going to dictate a letter after every telephone consultation. I am also going to go and shadow our chief executive for a few days and see if I can see the exact costing calculations that the managers have on us. Steve Livesey summed up the course for me by saying '*There are two courses that I never miss, the Birmingham review course and this one.*'

So well done to Steve Rooney and everyone involved in the organisation. For more information for next year contact jane.brindley@uhb.nhs.uk, and apologies for not mentioning all the excellent faculty members that were also there, like Pala Rajesh, Ehab Bishay and many cardiologists who made for very lively debates.

**Joel Dunning**  
[www.ctsnet.org/home/joeldunning](http://www.ctsnet.org/home/joeldunning)  
[www.csu-als.com](http://www.csu-als.com)

# 6th London Thoracic Ultrasound Course

Wednesday 8 February 2012

Towards Level 1

An intensive and practical one day course organised by Infomed Research & Training

**Date:** Wednesday 8 February 2012,

**Venue:** W12 Conference Centre, Hammersmith Hospital, 150 Du Cane Road, London W12 0HS

**Details:** [www.infomedltd.co.uk/events/12\\_o2\\_thoracic6/about.htm](http://www.infomedltd.co.uk/events/12_o2_thoracic6/about.htm)

CPD approval being sought from RCP.

## Programme

08.30 – 09.15	Registration
09.15 – 09.30	Welcome and Introduction by chair
09.30 – 10.00	<b>LECTURE 1: USS – WHY AND WHEN</b>
10.00 – 10.30	<b>LECTURE 2: THE RELEVANT ANATOMY</b>
10.30 – 10.45	<b>LECTURE 3: SETTING UP THE MACHINE, KNOBOLOGY AND SCANNING TECHNIQUES</b>
10.45 – 11.00	Tea and Coffee Break
11.00 – 12.30	<b>PRACTICAL SESSION A: SECTIONAL AND USS ANATOMY</b>
12.30 – 13.15	<b>LECTURE 4: IMAGING OF THE PATHOLOGIES</b>
13.15 – 13.45	Lunch
13.45 – 15.00	<b>PRACTICAL SESSION B: PATHOLOGY RECOGNITION</b>
15.00 – 15.30	<b>LECTURE 5: US INTERVENTIONS – CASE SCENARIOS</b>
15.30 – 15.45	Tea and Coffee Break
15.45 – 17.00	<b>PRACTICAL SESSION C: INTERVENTIONS</b>
17.00 – 17.30	<b>PANEL DISCUSSION ON CASE SCENARIOS</b>
17.30	Close and Collection of Certificates of Attendance

## Applications invited for the Ionescu Travelling Fellowship

### Requirements for applicants

The Ionescu Travelling fellowship, also for £10,000 is directed at Young Consultants (normally within 5 years of appointment) wishing to add on 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 AGM Scientific Session. Similar requirements, with the exception of a reference from Chief of Service, are expected from this recipient. Please contact Isabelle Ferner at the Society Office for more details.

# David Geldard MBE

## A tribute to David Geldard MBE by Ken Timmis MBE JP LCIE, President of Heart Care Partnership (UK)

David Geldard MBE, Trustee and past President of Heart Care Partnership (UK) as well as a leading light in many National and Manchester local Cardiac bodies, died suddenly on Friday 2nd September. He had seemed to be well on the road to recovery after a recent serious operation but sadly suffered a relapse.

David had for many years effectively championed the patient cause in heart disease and was well respected wherever he went. He was a “big man” in every sense of the word with a big character, full of warmth and humour, and he was eager to encourage others, always ready with a word of praise and generosity in his dealings. He came alongside clinicians and was always supportive of the work that they were doing and was so positive in his comments. He stood out so far among others as he championed patient representation and his achievements were recognised by all with whom he came in contact. In addition to his work with Heart Care Partnership (UK), he served as a patient representative with the Royal College of Physicians, MINAP, BHF, Department of Health, NICOR, Society of Cardiothoracic Surgeons, Greater Manchester and Cheshire Cardiac Board, as well as BCS and his cycling charities.

His death will leave a huge gap in all the areas in which he worked so tirelessly and he will be greatly missed. It seems such a cheat to have failed to beat this illness when he had fought the cardiac disease so well. Our heartfelt condolences go to David’s family.

### Prof Huon Gray:

“David gave so much, so generously, over so many years, and did such a great deal to enhance patient & public involvement in cardiovascular healthcare issues. He will be missed hugely, as will his personality and great good humour, which so often brightened meetings and discussions.”

### SCTS President David Taggart:

“I wish to acknowledge on behalf of SCTS the tremendous work that David Geldard has done on behalf of all patients and cardiac patients in particular. He truly was a patient champion. Over the last few months I worked particularly closely with David in challenging the original proposals from NICE on revascularization. David lobbied very hard at NICE and with important figures behind the scenes to complain that NICE were in effect recommending that patients no longer be given all treatment options. Indeed his last communication to NICE prior to his surgery was particularly influential in helping SCTS to get NICE eventually to change its recommendations. For any of you who had the opportunity to interact with David you will remember him as a down to earth, plain speaking character who was enormously approachable, genuine and full of warmth. All the awards that David received on behalf of his efforts championing the cause of patients never went to his head. I had spoken to David several times before and after his operation and last week had seemed his usual optimistic and positive self. He will be sorely missed”.



# Matthias Paneth 1921-2011

Cardiothoracic Surgeon, The Brompton Hospital

Matthias Paneth (universally known as MP) died peacefully on 1st September 2011 after a brief illness. He was born in Amsterdam on 30th April 1921, where his father, a doctor, was on a course in tropical medicine. The family then departed to Sumatra where Paneth senior was Medical Officer to a Dutch rubber plantation. As was customary with expatriate life, MP was sent to school in the United Kingdom at the age of 13. A fellow pupil at Gordonstoun School in Scotland was the Duke of Edinburgh.

Following school, he went up to Christ Church, Oxford to read Medicine. On completion of his undergraduate training he served short stints as a houseman and senior house officer at the Radcliffe Infirmary in Oxford, the Royal Cancer Hospital and the Hammersmith Hospital. On moving to the Brompton Hospital he was house surgeon to Lord Russell Brock and Oswald Tubbs. He was appointed Senior Registrar at the Brompton in 1957. Two years later he joined the staff as a Consultant, to remain there for the rest of his professional career.

For almost 30 years he strode the corridors and wards of the Brompton as an intellectual and professional giant. Physically he was imposing too. He was a man of great charisma, always immaculately attired and possessed of a reassuringly booming voice. He was admired by all who worked with him and the mutual respect that existed between him and his colleagues was one of the factors that led to the development of the Brompton as a centre of clinical and educational excellence. Although many of his colleagues may not have always seen eye to eye with him - and vice versa - his presence was such that the Brompton surgeons always presented a united front in the face of any "outsider".

On soliciting the views of several of my contemporaries, I was constantly reminded of his surgical skill, the dedication to training young surgeons, the seamless and continuous nature of the way that he cared for his patients, the intellectual sharpness allied to great wit, loyalty and paternal instinct. He possessed great style. Despite being well over six feet tall, he looked completely at ease with the seat right back in his Porsche. A man and his car in perfect harmony!

The year that he spent as a Fulbright Scholar in Minneapolis in 1955 undertaking research into the development of the heart/lung machine and techniques of cardiopulmonary bypass made him a leading figure in the development of open-heart surgery at the Brompton and the evolution of surgical techniques for valve replacement and repair. This enabled him to dispense with spending hours oxygenating bags of blood on a Sunday in order to be able to perform "smash and grab" aortic valvotomies in infants in the absence of cardiopulmonary bypass. As trainees we heard endless stories of his early experiences of the pre-bypass era. Despite the fact that his career began in the pre-coronary artery grafting era, he quickly became expert in all the new techniques that were emerging. He was always willing to pass on his knowledge to those who worked with him.

He used to hold court every morning in the theatre manager's office next to the operating theatres. This was an opportunity for junior surgeons to highlight concerns, seek advice on patient management or simply discuss one's career options. His work-rate was difficult to keep up with - ten operating sessions a week, daily ward rounds on the ITU at 7.00 am during weekdays and 11.00 am at weekends. We started the mornings in ITU and progressed to the wards. If phone calls came we were able to say that he was on Elizabeth now but would be with Rose later. He had a totally disarming sense of humour, which never left him, even during the middle of an emergency operation. On one occasion when a patient had to be returned to theatre for bleeding, the Senior House Officer whose ligature on a side branch of the saphenous vein had slipped was suitably admonished and naturally nicknamed "side branch". This moniker has stuck to this day - and the SHO is now a leading congenital cardiac surgeon.



His training of junior surgeons was rigorous and he led by example. Once he judged the skill of the trainee he was magnanimous and patient in allowing the registrars to "spread their wings". He was above all a kind and generous man. This side of him extended to staff outside the surgical fraternity. An ex-theatre nurse remarked to me recently how much of an impact MP had on her life. When she got married in the chapel at the Brompton hospital, MP readily agreed to give the bride away since her family were living abroad and unable to attend the wedding. "I have been waiting to give you away for a long time Vicky," he quipped. Never an opportunity missed for that humour.

Matthias Paneth leaves behind his wife Shirley, daughters Claire and Sarah and two grandsons. In addition, countless numbers of cardiothoracic surgeons who were trained by him over the years owe a great debt of gratitude and consider it a privilege to have known him. Mr Matthias Paneth was a colossus.

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**Mr Ravi Pillai**

Consultant Cardiothoracic Surgeon

# Patient Representative

## Vacancy for Patient Member of SCTS Executive

TERM: 3 years renewable

SELECTION: By 3 Trustees

### Job Description

The Society for Cardiothoracic Surgery (SCTS) is a vigorous, multi-professional society committed to improving standards of care for patients undergoing cardiac and thoracic surgery ([www.scts.org](http://www.scts.org)).

David Geldard MBE was our patient representative until recently and we wish to replace him with one or possibly two patient representatives.

The SCTS patient representatives will have undergone cardiac or thoracic surgery and have the ability to bring a broad patient's, carers and public perspective to this high profile national role.

Other duties include:

- Attending Executive Meetings and Representative Board Meetings
- Representing the views of patients, carers and the public in other arenas when necessary
- Taking part in working groups and / or sub-committees as necessary
- Liaising with Meeting organisers to arrange and run the Patient / Carer Stream of the SCTS annual Meeting

The SCTS Executive and Board of Representatives meet 4 times a year at the Royal College of Surgeons of England. In addition the Annual Meeting takes place once per year over 3 days. Expenses are payable for attendance at these meetings.

Further details from Isabelle Ferner [sctsadmin@scts.org](mailto:sctsadmin@scts.org) or 020 7869 6893



# Membership

## Dear Members

SCTS is facing increasing financial difficulties and to stay financially viable proposes a small increase in membership fees (see table below) as well as the following measures with immediate effect:

- Bulletin to become PDF – Saving £9240
- Suspension JAG membership £1750
- Reduction SCTS travel expenses circa £5000 (all second class booked in advance)
- SCTS Exec own sandwiches (rather than RCS lunch) £1200
- **Total savings of approx £17,000**

Other initiatives underway are:

- fund raising
- patient contribution
- new charity and trust funds

	Joining Fee	Annual Subscription 2011	Annual Subscription 2012
Consultant	£265	£262.50	<b>£302.50</b>
Trainee	£130	£110.25	<b>£127.00</b>
Associate	£30	£26.25	<b>£30.00</b>
Overseas	£130	£110.25	<b>£127.00</b>
Life Overseas	£130	On application	N/A
JTCVS		£120	<b>£150</b>

While it is disappointing to have to raise membership fees at all in the current economic climate please note that this increase in consultant membership fees of £40.00 will take the cost of membership to approx £300 which is still less than GMC, College and BMA subscriptions. Considering the threats to our specialty membership of SCTS is still professionally important and good value for money considering all the associated benefits including eg the SCTS University at the annual meeting.

Best wishes

### David Taggart

President, Society for Cardiothoracic Surgery in Great Britain and Ireland  
Professor of Cardiovascular Surgery University of Oxford

# Diary of Forthcoming Events

Date: 10 - 11 January 2012  
 Town: Edinburgh United Kingdom  
 Meeting: **Intermediate Skills in Cardiac Surgery**  
 Venue: The Stewart Skills Laboratory, Quincentenary Hall,  
 The Royal College of Surgeons of Edinburgh  
 Contact: Heather Anderson  
 Course Coordinator  
 The Royal College of Surgeons of Edinburgh  
 Nicolson Street, Edinburgh, EH8 9DW  
 Phone / Fax: +44 (0)131 6689239  
 Email: H.Anderson@rcsed.ac.uk

Date: 30 January - 1 February 2012  
 Town: Fort Lauderdale, FL United States  
 Meeting: **48th Annual Meeting of The Society of Thoracic Surgeons**  
 Venue: Greater Fort Lauderdale-Broward County  
 Convention Center  
 Contact: The Society of Thoracic Surgeons  
 633 N. St. Clair Street, Suite 2320  
 Chicago, Illinois 60611-3658  
 Phone: +001 312 202 5800  
 Fax: +001 312 202 5801  
 Web: [www.sts.org/annualmeeting](http://www.sts.org/annualmeeting)

Date: 16 - 20 January 2012  
 Town: Windsor, United Kingdom  
 Meeting: **2nd Leadership Course for Cardiovascular and Thoracic Surgeons**  
 Web: [www.eacts.org](http://www.eacts.org)

Date: 18 - 20 April 2012  
 Town: United Kingdom  
 Meeting: **Association of Cardiothoracic Anaesthetists & Society for Cardiothoracic Surgery in Great Britain and Ireland - 2012 Annual Meeting and Cardiothoracic Forum**

Date: 28 - 29 January 2012  
 Town: Fort Lauderdale, FL United States  
 Meeting: **STS/AATS Tech-Con 2012**  
 Venue: Greater Fort Lauderdale-Broward County  
 Convention Center  
 Web: [www.sts.org/education-meetings/sts-annual-meeting/sts/aats-tech-con-2011](http://www.sts.org/education-meetings/sts-annual-meeting/sts/aats-tech-con-2011)

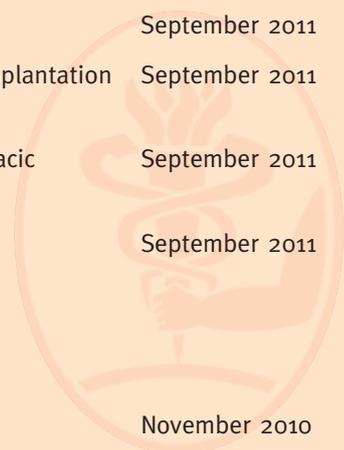
Venue: Manchester Central  
 Contact: Isabelle Ferner  
 Phone / Fax: +44 (0) 20 7869 6893  
 Email: [sctsadmin@scts.org](mailto:sctsadmin@scts.org)  
 Web: [www.scts.org/](http://www.scts.org/)

## New Appointments

Name	Hospital	Specialty	Starting Date
David Healy	Saint Vincent's University Hospital and Mater Misericordiae University Hospital	Transplantation	April 2011
Elizabeth Belcher	John Radcliffe Hospital, Oxford	Thoracic	July 2011
Eveline Internullo	Nottingham City Hospital, Nottingham	Thoracic	July 2011
Ronan Ryan	St James' Hospital, Dublin	Thoracic	September 2011
Karen Redmond	Mater Misericordiae University Hospital Dublin	Thoracic & Lung Transplantation	September 2011
Jonathan McGuinness	Our Lady's Children Hospital and Mater Misericordiae University Hospital	Congenital Cardiothoracic	September 2011
Kalyana Javangula	Blackpool Victoria Hospital	Cardiac	September 2011

## Other Appointments

Ramana Dhannapuni	Alder Hey Children's Hospital, Liverpool	Congenital Cardiac	November 2010
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# the crossword

by Sam Nashef

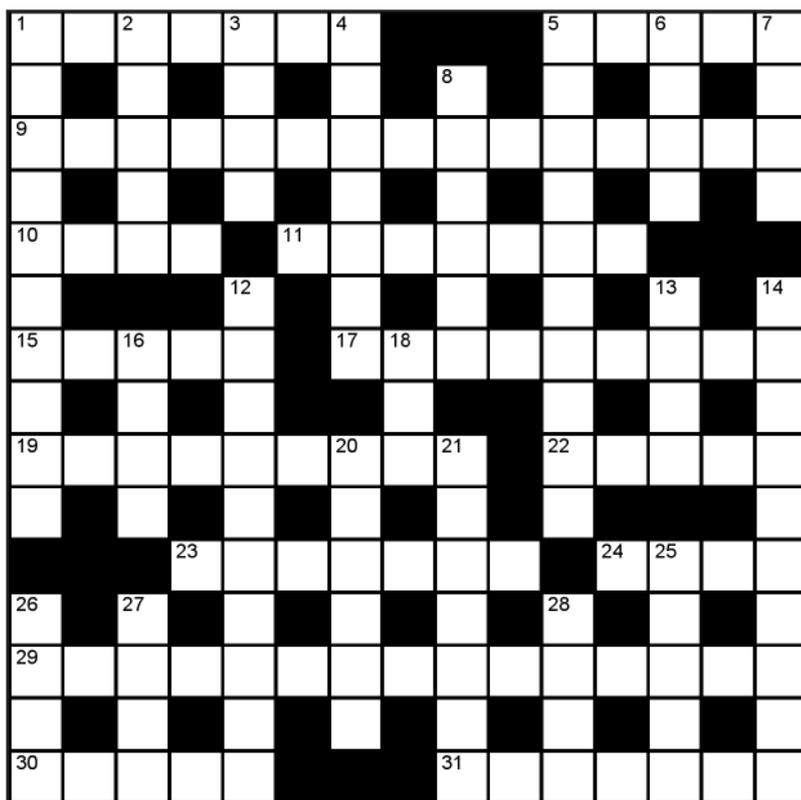


**Across**

- 1 Smart boy's a coward (7)
- 5/31 Why 1 across did this is a mystery in angry McCarthy's book (5,3,4)
- 9 Fairy tale kitten spills rum cocktail (15)
- 10 Some loner droning on about computers? (4)
- 11 To cut a long story short, you need a spanner (7)
- 15/20 Mother follows audience's heart and sadly returns for 1 across (5,6)
- 17 Makes teenagers go wild (9)
- 19 Fold first to last, preparing meals for lovers, once (3,6)
- 22 Keen to see mountain with a substitute for one (5)
- 23 Sisters briefly inject drug for wimps (7)
- 24 Rock band's currents swinging both ways (2/2)
- 29 Where to find Madam Ivy's shoes (7,8)
- 30 May be Homer's spice mixture (5)
- 31 See 5

**Down**

- 1 1 across king-making (10)
- 2 Is only audible in Turkey (5)
- 3 Quickie visit's 1 across (4)
- 4 Food container began so badly (7)
- 5 Tom, for example, to join leaderless political party classes (10)
- 6 Movie kiss regularly screened by uncultured people (4)
- 7 Basin kept partly in kitchen (4)
- 8 Skirt-wearing subordinate? (6)
- 12 Usually red for trouble left in hose (4,6)
- 13 Horny type of party (4)
- 14 1 across Ted somehow banned (10)
- 16 Children's jokes (4)
- 18 River sounds like one of 19 (3)
- 20 See 15 Across
- 21 Don having taken exam outside, gets abuse (5,2)
- 25 Doctrine found in a mediocre document (5)
- 26 Love and honour without instrument (4)
- 27 Some music often rises several points (4)
- 28 Present? Hear hear! (4)



**Send your solution to:**

Sam Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744 by 31 July 2012.

Solutions from areas over 10 miles from Cambridge will be given priority.

**Last issue's winner:**

**Mr Alan Bailey,**  
Winchester

