

# *the* **bulletin**



Society for Cardiothoracic Surgery  
in Great Britain and Ireland

July 2008

*SCTS Database Committee*

*Nursing Involvement*

*Bypass Graft Enquiry*

*National Thoracic Report*

*NICE Guidelines*

*The Gritten Report*

*Annual Meeting 2008*



***Trans-catheter  
Aortic Valve  
Implantation -  
Here to Stay!***

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Designed & produced by CPL Associates, London

# President's Report

Leslie Hamilton



**This Bulletin, the first in my new role, gives me the opportunity to say thank you for the honour and privilege of being your President for the next two years. It is a huge responsibility, particularly in view of all the changes taking place not only in the practice of our specialty but also in the politics of the wider NHS. Let me emphasise at the outset that I view us a Society for Cardiac and Thoracic surgery with our strength being in unity – I will represent both. I see the role of President as being a fine balance between representation and leadership – the leadership aspect will require me to be aware of political developments and understand how they will impact on the service we provide to our patients.**

## Representative Board

I and the Executive can only represent you if we know your views. Aware that many of you felt distanced from the Society, the Executive last year undertook a major review (lead by Graham Cooper) of its relationship to the Society – thanks to all of you who contributed. As a result, the Executive has been “slimmed down” and a new separate “Representative Board” has been formed. This includes a nominated representative from every unit in each of the four countries. The Board will meet with the Executive twice per year (at the Annual meeting in the spring and then in the autumn) – you should look for feedback from them after the meetings. We hope this will improve communication with members. Another route for communication to the Executive is via your elected representatives – members elect two to the committee each year for a three year term i.e. 6 in total. Please use them - at present they are (in order of election):

- Tim Graham • Ben Bridgewater
- John Pepper • Jim McGuigan
- Neil Moat • John Duffy.

At the Executive meetings I will be looking to them in particular to bring your views.

## Outcome Measures

We should take pride in the fact that we have lead the way in monitoring the outcome of patients after surgery – I know

it has not been an easy or a comfortable process but it has been the right thing to do. Interestingly the Public Portal site receives 12,000 “hits” per month. As a profession, we have a moral responsibility to strive to improve the quality of care we provide by assessing outcomes.

My primary goal as President is to develop this quality of care agenda but in a way which moves us away from concentrating on an individual surgeon’s mortality figures – more of that later. However, this process requires us to collect data. The organisation and analysis of the data is a huge task. I would like to pay tribute to James Roxburgh who, in addition to his other duties as Secretary of the Society for the last 5 years, has managed this single-handedly. It is clear that it is now too much work and responsibility for one person. The Executive has therefore formed a Database Committee. Following advertisement and interview, Ben Bridgewater has been appointed to chair this group – the membership will be finalised at the next Executive meeting.

The remit of the group will not only be to oversee data collection and analysis with a view to producing the “Blue Book” but also to use the very valuable resource material in the database to raise the scientific profile of the Society. We hope to involve as many members as possible in various projects. Indeed if you have a research question which you think could be

answered using the database, approach the committee with a proposal – the database belongs to you the members.

## Quality and Safety

Providing the best possible care to our patients has to be our primary aim. Publishing data on post-operative mortality has set the scene but I do not believe it has helped us actually improve the quality of care significantly. We need to move on to look at aspects of care where we can make changes. I would propose that we look at post-op morbidity at unit level. I would expect more variability and it should be possible to identify areas of good practice from which we could learn. If you are interested in further details, have a look at the supplement to the April 2007 issue of the Annals of Thoracic Surgery. I will be asking the Database Committee to take this forward – we have data on morbidity in our database. It is my hope that this will take attention away from surgeon specific mortality figures and focus on improving care.

*continued on page 4*

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## President's Report *continued*

### NCEPOD Report

As part of our drive to improve quality of care and also to try and identify factors other than the technical surgery, we asked NCEPOD to analyse the care of all patients who died after first time CABG. Thank you to all who worked hard to complete the questionnaires and get the data returns as high as possible. The report was published on 4th June – Heather Cooper (who coordinated the study) gives details later in this Bulletin. The report raises a number of important issues which we need to take on board. Although it is sobering to reflect that only 38% of these patients received “good quality” care, in another 50% care was deemed to be “satisfactory” though with room for improvement.

### Consent

We need to re-visit the question of “consent”, especially in view of the new guidance published in June by the GMC. Sir Ian Kennedy, chairing a recent College meeting on outcome measures, said that

you should judge a surgeon not only on technical skills but also on the time spent with the patient. In only 19% of cases did the Consultant sign the consent form. Speaking at the launch of the report I highlighted the strong recommendation for an MDT forum to discuss patients undergoing revascularisation. I have approached both BCIS and the Cardiac Society in the hope that we take this forward.

### Revalidation

This will require a major change in mind set by all of us – at present we are on the Specialist Register for life unless the GMC decides otherwise. From mid 2009 we will be given, based on appraisal, a license to practice. With “re-certification” (which may be introduced in 2010) we will be on the Specialist Register for 5 years – every 5 years we will have to provide evidence that we are fit to stay on the Register. What evidence will be needed is currently under discussion but you might want to put “Maintenance of Certification” into Google

to get a flavour of what the American Board has introduced from this year. Some “outcome measure” will be part of it – cardiac surgeons will be able to use mortality. At the Thoracic Forum in January I asked the Thoracic Surgeons to come up with a proposal for an outcome measure – I hope progress is being made on that as firm proposals are needed for later this year.

### Annual meeting

I have had a lot of positive feedback after the meeting in Edinburgh – thanks and credit to our Meeting Secretary, Simon Kendall and our superb admin team of Isabelle and Rachael.

Finally, it is your Society – as President I am here to serve and so I would hope that you would feel free to contact me at any time on any issue of concern. The direct line to my secretary Gwen is 0191 2137309 and my home number is 0191 2850052. My email address (leslie.hamilton@nuth.nhs.uk) is on my SCTS home page.

## Prizewinners 2008

The Marian & Christina Ionescu  
Travelling Scholarship  
**David O'Regan**

The Society Scholarship for  
Thoracic Surgery  
**Ian Hunt**

The Society Scholarship for  
Cardiac Surgery  
**Enoch Akowuah**

Ronald Edwards Medal  
Best scientific presentation  
**Nigel Drury**

John Parker Medal  
Best clinical cardiac presentation  
**Rajamiyer Venkateswaran**

Society Thoracic Medal  
Best Thoracic presentation  
**Elizabeth Belcher**

Ethicon Prize  
Best CT Forum Presentation  
**David Quayle & Paul Hinchley**



# Secretary's Report

Graham Cooper



**In order to be trod on, you have to be lying down. Although it may not always have felt like it, as a specialty, we were not trod on with the public release of unit and surgeon results. By engaging we were able to influence the process. Data were released under terms imposed by SCTS and SCTS retains a strong voice in managing the data we collect through CCAD. Other specialties are under**

**irresistible pressure to collect outcome data for public release. It is clear that if they fail to engage this will be imposed, see [www.guardian.co.uk/society/2008/may/29/nhs.health1](http://www.guardian.co.uk/society/2008/may/29/nhs.health1). It is vital for SCTS to remain engaged in all areas but especially with revalidation.**

Revalidation is going to be a key area of work for us over the next few years and one where we are once again likely to be in the vanguard. Once again we have to stand tall and engage with the process. Only by engaging will we be able to influence the process. Steve Livesey outlined the issues around revalidation in the December 2007 Bulletin, available at [www.scts.org](http://www.scts.org).

## Sub committees

Recognising that revalidation along with the database and education issues will require a substantial commitment; we have created 3 sub-committees, one to cover each area. Steve Livesey and Ben Bridgewater respectively will chair the Revalidation and Database sub-committees. Ben along with 2 other applicants was interviewed for the post at the Edinburgh meeting. The Education sub-committee is a novel venture and is a joint committee between SCTS and the SAC in Cardiothoracic Surgery, it will be co-chaired by John Pepper, Education Secretary for SCTS and Tim Graham chair of the SAC. At the time of writing the details of membership and terms of reference are still being finalised but by the time that you read this they will be available at [www.scts.org](http://www.scts.org). We recognise that it is essential to keep the membership up to date with the progress of these areas and the introduction of Unit Representatives and the Representative Board is one part of improving communication. However the speed of events means that this will not always be an effective method of contemporaneous communication. Sunil Ohri has ambitious plans to develop the website to make this a powerful communication tool for all areas of the membership.

This is especially important for the associate members for whom an electronic communication network is an important benefit of SCTS membership. Since the hugely successful Edinburgh meeting the number of applications for associate membership has rocketed and I would urge you to encourage nurses, surgical

assistants, perfusionists in your units to apply, it costs only £25 per year. With its diversification the organisation of the Annual Meeting is becoming increasingly complex and we are delighted that amidst stiff competition Ian Wilson has been interviewed and appointed Deputy Meeting Secretary to support Simon Kendall, Isabelle and Rachel with the meetings organisation.

## Consent

There are two other important areas of work over the next couple of years. The first is updating the consent document produced in 2004. Once again David Richens will be leading on this, with special emphasis on producing guidance on obtaining consent of patients in whom there is the possibility of an open surgical approach or a percutaneous approach. A little known area of SCTS endeavour is review of new consultant job plans. All new job plans are screened by SCTS as well as The Royal College of Surgeons' Regional Advisors. This process involves duplication of effort and sometimes provides contradictory advice to Trusts. Graham Venn has been shouldering the task for SCTS and has gained approval from The College to merge the processes such that all job plans are reviewed only by a SCTS sub-committee which he chairs. The centralised review process has been remarkably successful. Over the last 12 months, only one correctly structured job description has been received in the 25 or so reviewed. In nearly all the source Trust has undervalued the posts typically at 10PA with the majority, following review and advice, receiving between 11 and 13 PAs in their final advertised form.

We have an ambitious and necessary program of work over the next couple of years. Especially with revalidation, we face the challenge of engaging with outside bodies to retain our credibility and influence whilst remaining sensitive to the needs of our membership. The duty to fulfil our responsibility as a professional organisation has to be balanced with our duty, as a membership organisation, not to subject our members to un-necessarily intrusive scrutiny. We have trodden this path before, I am confident that, together, we will do it again. If we stand tall it is difficult to be trod on.

**Once again we have to stand tall and engage with the Revalidation. Only by engaging will we be able to influence the process.**

# The SCTS Database Committee



**Recent years have seen a revolution in the way risk adjusted mortality data on patients undergoing cardiothoracic surgery is collected and used. The original model whereby the SCTS was solely responsible for collecting and publishing data has been superseded by a system whereby many players have become involved, including the Healthcare commission, the Department Health, the NHS information centre (CCAD), Dr Foster and other media organisations.**

These developments have not been easy for the SCTS in general and for a number of organisations and individuals in particular, but the result has been that cardiac surgical data collection and use is now ahead of most other areas in British medicine, and data in UK Cardiac Surgery is further progressed than it is in most other countries. With the involvement of so many different players in the game it is not surprising that the purpose of collecting and using cardiac surgical outcomes data has become confused; it was inevitable that a national newspaper collecting data via the Freedom of Information Act would have different views on the data from a surgeon or a hospital manager.

Over recent years the SCTS data management has been led by Bruce Keogh and more recently with the involvement of James Roxburgh as Honorary Secretary; both have worked hard with the Executive to keep the membership informed and involved with developments. Although, many of these have been thrust upon the Society and pre-empted the systematic developments, which have been planned. It has become apparent more recently that there needs to be a different structure for managing the 'data agenda' and so the SCTS Executive has agreed the formation of a Data Committee. It is planned that the Data Committee will report to the Executive and will be responsible for a number of issues related to the SCTS database project including ensuring the dataset and data quality are fit for purpose, providing data to help improve clinical quality, working with other organisations such as CCAD and the Healthcare Commission to ensure analyses

such as that for the public portal are robust, and developing a strategy to encourage academic output from the huge number of patient records which are now in the database.

## Ensuring the data is fit for purpose

This encompasses 3 issues; the specifics of the procedures included in the dataset, the collection of fields for the 'quality agenda' and improving data quality. The current SCTS dataset was developed nearly 10 years ago and was designed to be compatible with international data collection at that time. There have been several major changes since then including developments in surgical treatments of AF, use of devices for treating heart failure, and more recently percutaneous implantation of aortic valves. The current dataset as it stands cannot collect satisfactory data on these and we need to change it in line with these developments to be compatible with international

changes. This is seen as an important underpinning piece of work which we need to pursue with some priority. Our focus in the SCTS has been largely on the use of risk adjusted mortality as an outcome measure, but there is increasing interest around the World and in the UK on looking at measuring a balanced scorecard of quality, including reporting the absence of morbidity and compliance with various processes and prescription of appropriate medications, in addition to mortality rates. We will need to change the dataset to ensure that this can be done and develop better methods of feeding variance back to units to facility quality improvement.

One of the ongoing concerns that many inside the SCTS share is that of the quality of the data. There has been a series of site visits organised by Mark Jones to help units improve the quality of their data, but ensuring that data quality is 'fit for purpose' requires the data is collected correct at source, that it is transmitted to others to do the analyses without creating errors, and that the analyses are appropriate and performed to a high standard. Failures in any of these stages can lead to difficulties with the final output, and the Data Committee will need to understand these issues and we hope to actively manage the processes in the future, providing better and timelier feedback to units, to help to improve the quality of data.

**It was inevitable that a national newspaper collecting data via the Freedom of Information Act would have different views on the data from a surgeon or a hospital manager.**

*Ben Bridgewater*  
Chairman

## Working with others for external analyses

The major outputs of the SCTS data project in recent years have been the 'Blue Book' National database reports, the last of which was published in 2004, and annual updates to the Healthcare commission public portal since 2005. These have been conducted by Dendrite and CCAD respectively. The methodology for publication of hospital and surgeon risk adjusted mortality rates through the public portal has become complex. It was decided by a meeting of representatives of the SCTS and the healthcare commission that CABG, AVR and all surgery mortality rates should be published by unit, and that CABG and all surgery mortality should be published for individual surgeons. It has become apparent over recent years that the 'best' risk adjustment tool for this type of analysis is the logistics EuroSCORE, but it has also become clear that the logistic EuroSCORE in its originally published version significantly over predicts observed mortality in the UK. This has been debated at annual business meetings and the 2008 version of the public portal will compare units to a UK 'recalibrated' EuroSCORE and will compare surgeons to the original version, without recalibration. The recalibration of the EuroSCORE is complex and involves looking at the observed to expected ratios for each different operative type and then correcting for differences to better adjust for case mix and to give accurate contemporary peer group benchmarking. It has been done with high level statistical advice but has always been a retrospective process – we have not given members and units the ability to compare themselves with national data using the methodology. We need to review these issues and aim to provide a structure where the methods of analysis will be overt and robust, and provide feedback on a regular basis to members and units about their risk adjusted outcomes, along with alerts if there may be any case for further consideration.

The white paper 'Trust, assurance and safety' has recently changed the way healthcare professionals will be regulated. The outcomes of interventions will feed into this process and demonstrating satisfactory surgical results will form one part of the recertification process. The SCTS will be responsible for advising on the standards required for recertification, and data analysis will be important in this. It is not yet clear how this will be 'operationalised' and what will be the different responsibilities of the GMC, the Royal Colleges and the SCTS, but the SCTS Data Committee will need to understand these processes so that they can support the membership and the process.

## Encouraging academic output

There are now 300,000 patient records in the SCTS database within CCAD. This is smaller than the STS database in the US, but our database does have complete coverage of the UK and some of Ireland, has the ability to track long-term mortality and is able to map patients to postcode of residence, and is therefore major potential research resource. To date there has been output about changes in numbers of procedures, casemix and mortality, the incidence of various risk factors and their trends, along with methodologies of risk adjustment, analysis and presentation through the 'blue books' but we have not contributed to the scientific literature through peer review publication in a major way. The database now contains large numbers of patient who have undergone different procedures, such as mitral repair or major aortic surgery, along with their risk factors and outcome, and amongst the membership of the SCTS we have great expertise in the clinical management and the scientific understanding of these procedures. An important role of the data committee will be to provide a structure to facilitate high quality analyses and publication utilising information in the SCTS database, and we are keen to work with members on this. We have already produced an analysis about changing

practice of mitral repair, the preliminary results of which were presented at this year's Annual Meeting, and an analysis of 26,000 aortic valve replacements is currently underway. We would be keen to hear from members who would like to contribute to this analysis and publication.

## The proposed structure and terms of reference of the Data Committee

The Data Committee will have a large agenda, and will require significant complementary expertise to deliver all its goals. I was recently appointed as the Chairman, following interviews at the SCTS Annual Meeting, and the SCTS Executive have approved a structure which will involve the Honorary Secretary of SCTS and James Roxburgh as the past executive member with a responsibility for data issues, along with 1 executive and 2 non executive members, along with a dedicated thoracic surgical representative. We will be inviting expressions of interest via SCTS email for membership of the committee. We will also have representation from the data managers, and other organisations providing analysis such as CCAD and Dendrite. In addition to membership of the committee we also plan to work with members with specific expertise in the various parts of the agenda, and would be interested to hear from people who would like to become involved, particularly at this stage about revising the Dataset to ensure it is fit for contemporary purposes. The Data Committee will report to the SCTS Executive Committee who will be responsible for setting the direction of travel and overseeing its work, and the governance arrangements of the overall SCTS data project, which is via a tripartite arrangement between the SCTS, the Department of Health and the Healthcare Commission will remain in place.

Any questions or comments please  
contact Ben Bridgewater at  
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# Continued Expansion in Nursing Involvement with the Society

*Tara Bartley*  
Nursing Representative



**I am delighted to announce that the Cardiothoracic Forum held in Edinburgh March 2008 has been the most successful to date. In the December Bulletin I stated that the abstract submission had increased by 100% from the 2007 Manchester meeting. The review panel faced the difficult job of selecting presentations from the high quality that were submitted. This did however, mean that the final programme was varied and stimulating.**

There was a three fold increase in the number of delegates attending and this gave a refreshing buzz to the meeting. Under the theme 'How broad changes in the NHS are affecting service delivery with in the Cardiothoracic specialty' Maura Buchanan, President of the RCN gave the opening remarks and we heard from Gillian Matthews, Implementation Consultant for NICE who discussed the 18 week patient pathway initiative. The session highlighted the interface between cardiac surgery and cardiology when using guidelines to expedite the patient pathway, the delivery of cost effective care and the role NICE play in implementation and support for initiatives.

Wendy Gray from The Heart Improvement Programme fed back on the National Consent Project, which reviewed the personnel involved in the process and aspects of communication, documentation and the discussion of risk in creating good practice. The project has prompted us to reflect on our current practice and how this can be improved upon to meet the demands of the current ethical legal climate and to ensure that patients and their family have been exposed to all elements of this crucial process.

Julie Sanders, Nurse Specialist in Cardiovascular Research from The Heart Hospital, London gave an excellent lecture on the process of conducting research and getting published. The presentation was both informative and motivating, now all we need to do is find time in our busy schedules to incorporate it!

Power point presentations from these and the other speakers can be found on the nurses page of the SCTS web site

([www.scts.org/sections/nurses/index.html](http://www.scts.org/sections/nurses/index.html)) and include the successful implementation of a seven day physiotherapy service, a new approach to wound care, a varied selection of cardiac and thoracic clinical papers and a focus on new ways of working. The Cardiothoracic Forum also joined the main meeting to share in their excellent plenary sessions.

Congratulations go to David Quayle and Paul Hinchley for their paper 'F.O.R.W.A.R.D with weaning: An initial study of the focuses Oxford Respiratory Weaning and Response Direction Tool' which you selected as the winner of the Ethicon Best Forum paper. David delivered the presentation and was delighted to be awarded the £200 prize. Delegate evaluations of the meeting were positive and I note the desire for an increase in discussion time. I will incorporate this in the programme for our 2009 meeting.

## Quality Care

Next year we will be in Bournemouth at the BICC and the theme will be 'Quality Care; can we delivery?' The NHS document 'Our NHS, our future' calls for a fairer, personalised, effective and safe NHS for patients and users that deliver consistently high quality care. This is to be driven by a patient focused approach that incorporates technological change and has a flexible and productive workforce. Key stake holders such as the RCN, the Chief Nursing Officer and The Workforce Review team are eagerly awaiting the analysis of the document 'Towards a framework for post registration nursing careers: a national consultation' that has sort health professionals' opinion on post registration careers asking if nursing careers should be

organised around the patient pathway and what should underpin the framework for future nurse education. The report is expected to be published this July. We may have pre-empted some of this work with the National Workforce Survey conducted within the cardiothoracic speciality. This bench-marked current service frameworks, reviewed strategic planning for service delivery and identified the obstacles which will inform future development. A summary of this document has been sent to all Chief Executives in the cardiothoracic centres throughout the UK and Ireland and can be found on the SCTS web site. The original Workforce document is also available and a presentation of the survey results can be found on the nurses page in the section presentations from the Annual meeting 2008.

The cardiothoracic specialty has responded to the release of surgeon specific data into the public domain which has inevitable resulted in a focus upon mortality. There is now a desire to emphasize issues of quality and the new medical director of the NHS, Sir Bruce Keogh took the opportunity in his presidential address to state that the NHS would review its economic strategy in an attempt to reduce inequality and disparity. These initiatives will hopefully inspire you to share development, practice and research with delegates at the 2009 Annual meeting. With this in mind I would remind you that we shall call for abstract submission between 1st September and 5th November 2008.

The SCTS is currently reviewing the subscription rate and it is hoped that a competitive rate will be offered again for next years meeting. For those of you who are interested in becoming Associate Members of the SCTS I would remind you that details are on the web site and you will be entitled to a reduction on the meeting subscription.

I look forward to sharing the details of the 2009 Cardiothoracic Forum and further developments in the December Bulletin.

# The Heart of the Matter:

The Main Recommendations from the report of the National Confidential Enquiry into Patient Outcome and Death into Coronary Artery Bypass Grafting

*Heather Cooper*  
Clinical Researcher  
NCEPOD



Over the last three years the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has reviewed deaths following first time coronary artery bypass grafting (CABG). A panel of advisors consisting of cardiothoracic surgeons, cardiothoracic anaesthetists and cardiologists peer reviewed the questionnaires and extracts of casenotes relating to these patients. This article presents the principle recommendations of the report by chapter. The key findings upon which these recommendations are based may be obtained from the web link below.

## Recommendations:

### Referral and admission processes

Cardiothoracic units need to adhere to the requirement of the National Service Framework for Coronary Artery Disease and use protocols for referrals to their unit. These protocols should be standardised nationally for patients who require coronary artery bypass graft surgery. The degree of urgency of referral should be emphasised within these protocols.

Cardiothoracic units need to ensure that monitoring systems are in place to record nationally agreed audit data on referrals and the decision to operate. These systems need to identify patients who are in danger of breaching national agreed waiting times so that surgery can be expedited.

### Scheduling of operations

The scheduling of operations does not appear to have had any clinically significant detrimental impact on the quality of care.

### Multidisciplinary case planning

Each unit undertaking coronary artery bypass grafting should hold regular pre-operative MDT meetings to discuss appropriate cases. Core membership should be agreed and a regular audit of attendance should be performed.

### Patient investigations

There must be a system in place to ensure that preoperative investigations are

reviewed by a senior clinician and acted upon.

### Medical management

NCEPOD supports the guidance of the American College of Cardiology and the American Heart Association that clopidogrel should be stopped prior to surgery wherever practicable.

### Non-elective, urgent in-hospital cases

There should be a protocol to ensure timely and appropriate review of unstable cases that involves both cardiologists and cardiac surgeons.

A "track and trigger" system should be used to provide early recognition of clinical deterioration and early involvement of consultant staff.

### Comorbidities

Where pre-operative comorbidity exists, there should be a clear written management plan which is followed in order to optimise the physical status of the patient prior to surgery, and identify the need for specific postoperative support to be available.

### Anaesthetic process

Cardiac recovery areas/critical care units are best suited to managing the majority of patients who recover uneventfully. Patients

who are developing critical illness and additional organ failure should be managed in an environment with sufficient throughput of such patients to have the resources and experience to provide optimum outcomes.

Senior clinicians should be readily available throughout the peri-operative period in order to ensure that complications (which occur commonly) are recognised without delay and managed appropriately.

### Appropriateness of surgery

Where unexpected events occur during surgery, surgeons should have an adaptable approach, and modify the operation to suit the circumstances of the case.

### Communication, continuity of care and consent

Protocols must exist for handover between clinical teams and patient locations to ensure effective communication and continuity of care.

A consultant should obtain consent for coronary artery bypass grafting.

### Multidisciplinary review and audit

Morbidity and mortality audit meetings should be held in all cardiothoracic units. The majority of units should hold meetings at least monthly. If the numbers of cases performed in a unit are small, alternative arrangements should be made to incorporate these cases in other surgical audit meetings.

A common system for grading of quality of care of patients should be employed for all patients discussed in morbidity and mortality audit meetings. The peer review scale used by NCEPOD provides such a system.



The full report and further information can be found on the NCEPOD website:  
[www.ncepod.org.uk](http://www.ncepod.org.uk)

# Communications Update

I hope you are all enjoying reading the Bulletin which to date has been one of the main vehicles for communication between the membership and Society apart from our existing website and the Annual Meeting. The Society has evolved rapidly over the last 5 years from being a 'surgeons only' domain to becoming inclusive for all those that are involved in managing and delivering cardiothoracic surgical care.

We now have to match this evolution to efficiently communicate and serve this 'broader church', which is the Society. We also have to serve better our patients through the provision of readily accessible information and to have the ability to respond to their suggestions on how we deliver our care. You may have already read in this issue, that we need to develop measures to benchmark quality of care through our National Database; I believe that a communication strategy that serves our members and patients interests will go a long way to incrementally improving the quality that we offer.

These goals can only be delivered over the coming years through e-communication. We currently have a website (STCS.org) which is hosted by CTSNet. This is currently undergoing updating of various sections but will undergo a more radical makeover shortly as we develop our new

website (SCTSLTD.co.uk). As you are aware, as a Society with charity status, we cannot conduct commercial activity or workforce-related issues under the SCTS.org umbrella, hence the development of an alternative site. The two sites will be interlinked and eventually look and function very similar to each other. However. We will for the first time be able to use the new site to generate potential income streams for the Society. For example we are in the process of setting up a job centre for all health professionals working in cardiothoracic surgery in the UK, allowing Trusts to advertise for surgeons, nurses, anaesthetists, managers etc at one-stop site. I hope you will be able to support his venture and alert your HR departments when we go live later this year.

However it is important that we maintain our strong links with CTSNet, which over 10

years since foundation, has served well the needs of the global cardiothoracic community. CTSNet now has 52 organizations Worldwide, which link with CTSNet and/or use their servers for hosting their sites. The membership of CTSNet is certainly impressive with currently over 34,000 members registered of whom approximately 27,000 are surgeons; with over 1300 members from the UK alone. There is much we can learn from CTSNet, which in 2007 had, 11,736,010 sessions registered with an average time of 5 minutes and 14 seconds. The most popular sections visited were:

- Journals
- Job Centre
- Videos
- CTSNet Member Web Pages
- Events

Over the last 12 months, CTSNet has added new features to their site including:

## CTSNet Safety Reporting System

The system reports vignettes submitted anonymously by medical professionals that recount safety incidents and near miss

## EACTS launches International Atrial Fibrillation Registry

The European Association for Cardio-Thoracic Surgery (EACTS), in association with Dendrite Clinical Systems, launched in March 2008 the International Atrial Fibrillation Registry (IAFR). The IAFR is designed to capture data and report in patient outcomes following surgical treatment of atrial fibrillation. The goal is to collect data from across Europe to

enable us to make better-informed judgements on the appropriate surgical treatment approaches for the management of atrial fibrillation. The registry is chaired by Mr Steven Hunter. It is anticipated that the IAFR will develop as a follow on from the original registry that was launched in 2003 by Professor Melo.



The key objective of the IAFR is to accumulate sufficient data to allow the publication of a comprehensive reports which will be published by Dendrite Clinical Systems on the outcomes following atrial fibrillation surgery. This will be achieved through the collection of data at the individual patient level, which can then be used to track individuals and groups of patients. The reports will be made freely available to all contributors.



events in the operating theater. A team of safety experts provides an analysis of the reported event and presents recommendations to prevent the event from occurring in the future. The anonymity of the reporting process creates an environment that focuses less on blame and more on improving performance through an open discussion.

### CTSNet e-Learning Center

The main aim is to deliver effective e-learning modules on specific topics for target audiences of cardiothoracic surgeons. Currently, two modules are available. The first module, *“Off Pump Coronary Artery Bypass: Positioning and Stabilization,”* was developed by John D. Puskas. The purpose of the module is to educate cardiothoracic surgeons and trainees on the techniques and devices used in cardiac positioning and stabilization during the performance of off-pump coronary revascularization. The second module is *“Off Pump Coronary Bypass Debriefing,”* by Paul Sergeant. Both modules award CME credits, which may be registered on the Professional Portfolio.

### CTSNet Professional Portfolio

[www.ctsnet.org/announcements/announcement573.html](http://www.ctsnet.org/announcements/announcement573.html)

The Professional Portfolio provides a centralized, web-based resource for surgeons to assess their ongoing educational activities and facilitates the gathering, assessment, and reporting of competency activities to certification boards. The CTSNet Professional Portfolio provides a simple, user-friendly web system for surgeons to track and reflect upon their learning and practice improvement activities. The Portfolio provides tools to collect educational content, to participate in competency activities, to assess competency goals and objectives, and to report accomplishments and relevant information to certification boards. The Portfolio can help to aggregate information about a wide variety of CME and other activities, not just those that are available online. There is no intention to define the scope of the information that is collected since this will vary internationally depending on local certification requirements. The portfolio

provides an administrative tool for collecting and reporting information that is relevant to certification.

This latter development may be utilized for the future revalidation (re-certification and re-licensure) process in the UK, although at this point in time the Recertification Project Board has not defined how re-certification will be evaluated for cardiothoracic surgeons. It may be that SESATs will form a component of this process, which is again available on CTSNet as an on-line source.

Despite these milestones, from a UK perspective it has at times been frustrating to make the changes we need to our SCTS.org site at a rate, which is commensurate with our own evolution and direction. Although we will continue to maintain strong links with CTSNet, we have chosen to host our commercial site in the UK with local computer support, which should enhance the speed at which we can affect changes. As editor of the Bulletin, I am weary of hogging the space, but will endeavour to update you on what is a fluid area of the Society's development.

It is important to gather the data to understand where, how and why these procedures are being done and what type of devices is being used, and importantly, after follow up, how effective the treatment has been. Ideally, randomised controlled trials should be undertaken. However, with so many different devices and lesion sets treating different types of AF, it is difficult to standardise the data across so many different countries. Furthermore, with follow-up required for at least five years, running such a trial would be a formidable undertaking. Whereas, a registry with a database of thousands of patients, may show the efficacy of different procedures and devices and still be scientifically valid.

The IAFR can be accessed using a standard web browser, allowing registrants to enter data without the need to install additional software or perform any complex system

configurations. This web-based system allows the individual clinician to enter patient information onto a database whether at in hospital from an office-based practice or even at home. Clinicians can add as many cases as they wish and where possible they will be encouraged to put on retrospective data (if applicable).

All data collected through the registry will remain the property of the contributing surgeon and EACTS. Some of the key features on the Registry include:

- Comprehensive tracking of all forms of surgical AF treatment.
- Intuitive data capture with on line data validation.
- A “Download Document” option that allows users to download pdf. copies of the dataset questions, training manuals and other useful information.



- “Export my Data” – this feature allows users to extract their submitted data at any time to report/perform their own analysis. This ensures registrants at all times have easy access to their own data.

To register your interest in the IAFR, please complete the online registration form at: <http://iafr.e-dendrite.com>. Alternatively, email [registrationsupport@edendrite.com](mailto:registrationsupport@edendrite.com) or phone +44 (0) 1491 411 288.

# First National Thoracic Report

The creation in 1994 of the 'National Adult Cardiac Surgical Database' resulted in a vigorous and transparent approach to data collection. Not only did this provide a greater understanding of the many factors influencing outcomes, it also created an unprecedented range of clinical data, which is open for review for every cardiac unit in the United Kingdom and Ireland.

At the recent Annual Meeting of the Society for Cardiothoracic Surgery in Great Britain & Ireland, in Edinburgh, Scotland, 'The First National Thoracic Database Report 2008', published by Dendrite Clinical Systems, in conjunction with the Society, was presented for the first time. This is the first stage in an attempt to report on the variations in activity and surgical approaches between thoracic surgical units in the United Kingdom and Ireland.



Richard Page, Peter Walton and Bruce Keogh launch the report

This First National Thoracic Database Report is the first time data from the National Thoracic Registry has been put together in a comprehensive report, and has been led by Richard Page, UK Thoracic Surgical Audit Lead. The report puts into context how approach to thoracic surgery has evolved over the years, and demonstrates that the results of thoracic surgery in the UK have improved over time and compare very favourably with international standards.

The purpose of the 'The First National Thoracic Database Report 2008' is not only to report the number/type of procedures, but also to highlight the differing approaches to thoracic surgery between individual hospitals. The report includes:

- Data from over 340,000 individual patient records;
- Detailed information on the surgical management of lung cancer; and

- Activity from at least 95% (data from 36 of 40 centres) of thoracic surgical activity from the United Kingdom and the Republic of Ireland.

This comprehensive, 88-page report provides an overview from 25 years of national activity (1980-2005), detailing unit specific activity for a three-year period (2002-2005) and provides procedural activity in the following areas:

- Open and minimally invasive surgery (video assisted thoracic surgery [VATS]);
- Lung resection with details on activity for primary lung cancer;
- Pneumothorax surgery; and
- Oesophagogastric (upper GI) surgery with details on activity for primary oesophagogastric cancer.

Importantly, the report highlights several different approaches to treating thoracic disease, which clearly reflects the differing philosophical approaches to some complex and difficult diseases. For instance, the Registry highlights a clear

## National Selection for Trainees

The attendance at the annual SCTS meeting has increased and the discussion at the trainees meeting was more open than in previous years. This has to be encouraged and I hope that next year at least every NTN will attend. There was still concern about career prospects but notably less than previous years. There was discussion about onerous rotas and their impact on training. The advice from the panel was to keep in touch with the SAC liaison for the training programme and if objective evidence of a reduction in training opportunities can be produced then the SAC can address this with the programme directors. Certainly the NTN trainees of the future should expect (demand) preferential access to training

opportunities. Amazingly one view expressed by the floor was to support an onerous rota because it is more lucrative and "pays the mortgage"! While I would have sympathy if trainees were living in poverty I believe the primary goal of a trainee is to be trained and not to build a housing empire!

Late in November 2007 we had the approval to run national selection for trainees (entering in to ST3). Despite the tight deadlines enforced by MMC we managed to submit all the required information. Sion Barnard and I led the process. All the English programmes were invited by the SAC to bid for one of the 5 available posts. East Anglia and Oxford,

South West, North West, Yorkshire and Northern were successful. The West Midlands Deanery had agreed to host the selection process. The advert for the post appeared at the end of January and short listing took place on 18th February 2008 with selection on the 17th and 18th March. Despite protestations from their Deaneries and Trainers the assemblies of Wales, Scotland and Northern Ireland refused to be part of the national selection. Wales and Scotland decided to appoint a NTN to their programmes and fortunately the Northern Ireland assembly were persuaded not to appoint in 2008. Because we (the SAC) were convinced that the selection should be for the whole of the UK and this view was supported by the

## released at SCTS Annual Meeting

trend to a reduction in the proportion of pneumonectomies, which may indicate increasing recognition of the dangers associated with the procedure and a better selection of surgical patients.

Over the years patient selection for lung cancer has undoubtedly improved. Twenty-five years ago when a patient was taken to theatre for a lung cancer operation there was a 25% chance that the cancer would not be resected; this has been substantially reduced. This dramatic reduction in the “open and close” rate for lung cancer operations, has been fuelled by enhanced pre-operative imaging and staging with the advent in of computed tomography.

The report also shows the variations and changes in practice over the years (the majority of procedures for oesophageal cancer are now performed by upper GI surgeons), as well as how technological developments have changed practice. For example, video assisted thoracic surgery procedures, as a proportion of the total workload, increased from approximately 6% in 1981 to nearly 30% in 2004-2005.

The information contained within the report forms the basis of effective clinical governance and will serve to improve the outcomes for patients, as well as assist in the planning and implementation of future thoracic surgical services. By reporting procedure type/s and the locations where the surgery is conducted, it is hoped this first national audit will lead to better organisation of services and allocation of funding.

The first report contains no patient-specific details and is therefore not designed to compare and measure surgical outcomes between hospitals, but rather variations in surgical activity. However, the Society has agreed a minimum dataset to allow for a report on such issues within the United Kingdom and Ireland for thoracic surgical practice. The agreed dataset has been established for some four or five years and is easy to understand and uncomplicated.



Once the process has been established the dataset may be expanded in the future.

Dr Peter Walton, Managing Director of Dendrite Clinical Systems, commented, “We are delighted to publish ‘The First National Thoracic Surgery Report’, which we believe will be of tremendous educational value to both the Society, its members and other healthcare professionals

involved in thoracic surgical services. I would like to thank the SCTS for their support and in particular, Mr Page, for the enthusiasm, dedication and determination he has shown in producing the report. I would also like to pay tribute to all the contributors for their endeavours, without whom this report would not have been possible. We look forward to working with the SCTS in the future and publishing additional reports that will provide even greater insights into thoracic surgery in the UK and Ireland.”

### Steven Hunter Cardiothoracic Dean



Training Programmes of Wales, Scotland and Northern Ireland we invited the TPDs of the, so called, Celtic fringe to participate in the selection of the 5 NTN for the English programmes. The selection panel consisted of a representative from each of the UK training programmes, an academic cardiac surgeon, the Education Secretary of the SCTS, a representative from the Committee of Postgraduate Medical Education Deaneries and the panel was chaired by a lay person. Scoring templates were produced for all sections of the selection process including short listing. The two day selection was held in Birmingham and consisted of a structured interview, a review of the trainee’s portfolio, a presentation of a completed

audit project and three objective structured assessments of technical skills (OSATS). The successful candidates were informed by telephone by either Mr Tim Graham or me. The successful candidates and their allocated programmes were (in alphabetical order) Miss Allanah Barker to East Anglia and Oxford, Mr James Barnard to North West, Mr Phil Botha to Northern, Mr Neil Cartwright to Yorkshire and Mr Chanaka Rajakaruna to South West.

A separate analysis of the OSATS was performed by a group from the Department of Surgery at Imperial College London. This was not used as part of the selection but will be analysed to validate the assessors (selectors) and we can use this information

when organising the selection process for next year. A formal report of the whole process will be submitted to MMC and other interested parties before the end of July. My personal view, which is inevitably biased, is that this is the way forward for our specialty to select trainees. We may have to hold more than one selection next year as the early indication from the workforce review team suggests that we will be able to appoint over 10 trainees to ST3 in 2009. We sincerely hope that the assemblies of the Celtic fringe will agree to formally join the national selection process.

*continued on next page*

## National Selection for Trainees

continued

We already have the agreement of Professors Dark and Angelini that their Walport ACFs (Academic Clinical Fellows) for 2009 and 2010 will be included in the national selection process. This will obviously mean that the selection process for these will have to include a separate academic section and applicants will have to declare an interest in the ACF posts on their application form.

I hope that all involved in training are using the ISCP website and the assessment tools therein. I have been impressed by the short amount of time the completion of each of the assessments takes. I regularly use CPDs and mini-CEX assessments in the outpatient clinic and a PBA takes less than 10 minutes to complete.

There will be a new education committee for our specialty chaired by the SCTS Education Secretary, Professor Pepper. The remit of the committee will be to look at education for trainees and consultants, including revalidation and CPD. The committee will also have the responsibility for accrediting the many training/education courses that are available to cardiothoracic surgeons. Professor Pepper will be responsible for selecting the committee but I suspect at least the SAC Chair, Examination Board Chair and the SCTS Dean are likely to sit on this committee. This brings me to the future role of the SCTS Dean. I have yet to receive clarification of the future of the SCTS Dean as I approach the end of my 5 year term. I have written to the secretary of the SCTS to ask for this to be discussed at the next executive meeting so as you read this article you may have heard about the future of the role of SCTS Dean. This will not be my last article as Dean but I sincerely hope that I will not be the last Dean of the Society for Cardiothoracic Surgery of Great Britain and Ireland.

As always I can be contacted by email at [Steve.Hunter@stees.nhs.uk](mailto:Steve.Hunter@stees.nhs.uk)

# NICE Guidelines

## Prophylaxis against Infective Endocarditis: Prosthetic Heart Valves

**As chairman of a recent European Society of Cardiology (ESC) committee making recommendations for the management of patients after heart valve surgery (EHJ 2005;26:2463-71) and as a member of an ESC Task Force creating guidelines for the management of valve disease in general (EHJ 2007;28:230-68), I have been asked to comment on the NICE guidelines on prophylaxis against infective endocarditis as they relate to patients with prosthetic valves.**

Prosthetic valve endocarditis (PVE) is the most serious complication of valve replacement, associated with high mortality, greater than 50% in some series. A recent analysis from the International Collaboration on Endocarditis, based on data from 28 countries (JAMA 2007;297:1354-61), reported an average hospital mortality of 22.8%, although in some subgroups the mortality was higher, notably the elderly (37%) and patients on dialysis (40%). It is therefore of great concern that the recently published NICE guidelines recommend that antibiotic prophylaxis should not be given to any prosthetic heart valve patient undergoing dental treatment or other procedures associated with transient bacteraemia, irrespective of their risk profile, in effect seeking to reverse the established practice of decades and contradicting current guidelines from the British Cardiac Society (Clin Med 2004;4:545-50), the British Society for Antimicrobial Chemotherapy (J Antimicrob Chemother 2006;57:1035-42), the European Society of Cardiology (EHJ 2004;25:267-76, 2005;26:2463-71, 2007;28:230-68), the American College of Cardiology and the American Heart Association (JACC 2006;48:e1-148, Circulation 2007;116:1736-54).

No randomised trials have ever been performed to assess the efficacy of antibiotic prophylaxis in prosthetic valve patients and, given the high mortality of PVE, it is doubtful whether such a trial would ever be considered ethical. In the absence of randomised trials, NICE base their recommendations on small case series of endocarditis in general, containing relatively few patients with PVE, claiming that there is no conclusive proof that antibiotic prophylaxis is effective and that there is no consistent association between having an interventional procedure and subsequently developing endocarditis. However, they disregard the

fact that timing the onset or cause of endocarditis is extremely difficult because the patient may experience many weeks of vague non-specific symptoms before the diagnosis is eventually made. Furthermore, an association between endocarditis and both dental extraction ( $p = 0.03$ ) and scaling ( $p = 0.065$ ) has indeed been reported in some series (EHJ 1995;16:1968-74, Ann Intern Med 1998;129:761-9), although not in others.

Despite the fact that prosthetic valve patients are at much higher risk than patients with native valve lesions, NICE accords them no separate consideration or risk stratification in making recommendations. They claim that PVE is a rare condition, that on economic grounds antibiotic prophylaxis for endocarditis in general is not cost-effective and that the number of deaths from anaphylactic reactions to antibiotics might exceed those from PVE. In fact, PVE is not rare. A large compilation of 127 series from the prosthetic valve literature shows that the incidence varies from 0%/year in some small series to 1.74%/year with an average of 0.4%/year for mechanical valves and 0.6%/year for bioprostheses (Curr Probl Cardiol 2000;25:73-156). Risk factors for PVE have been identified as previous endocarditis, diabetes, renal failure, advanced NYHA class, older age and double valve replacement. Risk is also higher in the first 6 months after implantation, although many of these infections are probably acquired at the time of surgery. Importantly, the incidence of PVE reported in the literature is almost certainly based upon groups of patients who have been advised to take antibiotic prophylaxis for dental treatment and other interventional procedures. Without antibiotic prophylaxis, it is likely that the incidence would be higher. NICE bases assumptions about fatal anaphylactic reactions to penicillin on 1960's general

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## E-Survey of Members

**Do you agree that we should support NICE guidance & NOT give antibiotic prophylaxis to patients with prosthetic valve implants?**



Responders 90 out of 255 (35.3%)

- **No** 92 (91.1%)
- **Yes** 7 (7.8%)
- **Unsure** 1 (1.1%)

population data from the WHO. It is extremely unlikely that patients with prosthetic heart valves would never have encountered penicillin previously and be unaware of penicillin allergy. Furthermore, NICE have elected to ignore their own observation that none of the studies included in their review, that considered antibiotic prophylaxis against endocarditis, identified any episodes of anaphylaxis.

In making their recommendations, NICE rely heavily on a 35-page economic analysis appendix based on numerous ill-supported modelling assumptions and estimations, mostly related to the general population and not the population at risk, and using highly selective quotations from the literature. For example, they determine the risk of PVE as being 93 per million (per dental procedure) based on one French article (Clin Infect Dis 2006;42:e102-7) which extrapolated risk to the whole French adult population based on a survey of 2,805 adults which included 24 patients with prosthetic valves, 4 of whom had undergone an 'at-risk dental procedure', unprotected by antibiotics in 2 cases. In their economic analysis model, NICE also incorrectly assume that patients will be in NYHA class I or II following valve replacement for both native and prosthetic endocarditis based on two articles, neither of which relate to endocarditis; one describes long-term results following mitral annuloplasty with a bovine pericardial strip; the other describes long-term results with the Carpentier Edwards porcine bioprosthesis. Neither article specifically addresses the issue of outcome after valve replacement for endocarditis. The methodology of the health economists' analysis thus does not

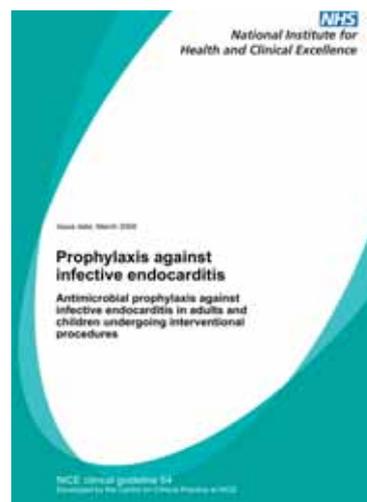
withstand scientific scrutiny and should be regarded with great scepticism.

All other current guidelines, both European and American, whilst acknowledging the lack of definite proof of the effectiveness of antibiotic prophylaxis, recommend antibiotic cover for dental and other interventional procedures in patients with prosthetic valves. Even the most recent, rather sceptical, guidelines from the American Heart Association, published in October 2007 (Circulation 2007; 116:1736-54) continue to recommend antibiotic prophylaxis for prosthetic valve patients undergoing "all dental procedures which involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa". NICE are thus seriously out of step with other expert opinion. Of the 10 professional members of the NICE Guidelines Development Group, only 4 had any literature publications relating to endocarditis, according to a MEDLINE search. The Guideline Development Group responsible for the recommendations consisted of 4 dentists/oral surgeons (including the chairman), 2 cardiologists, 2 microbiologists, 1 pharmacist, 2 patient representatives, but only 1 cardiothoracic surgeon. PVE has devastating consequences for the individual patient and, apart from pathologists conducting autopsies, only cardiac surgeons witness the extent of destruction of cardiac tissues

it causes, with peri-annular abscesses, intracardiac fistulae, damage to conducting tissue, etc., together with the complicated and prolonged postoperative course that patients often have to endure. If they escape mortality and recover from complications, they remain at risk of recurrent infection and/or paravalvular leak and the necessity for further surgery. Few regain their previous functional status and quality of life.

Absence of definite proof of the effectiveness of antibiotic prophylaxis in preventing PVE does not constitute proof of ineffectiveness. In a situation of inconclusive evidence, patient safety should be given greater priority than economic considerations. Whilst implementation of the NICE guidelines will undoubtedly save money for the NHS, it will almost certainly result in a higher incidence of endocarditis and many more deaths from PVE. Even if only a proportion of patients avoid PVE with antibiotic prophylaxis, it must surely be justified on clinical and ethical grounds.

On the first page of their document, NICE state that their "guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer". NICE therefore clearly distances itself from any damaging medico-legal responsibility consequent upon their published guidelines, and medico-legal accountability thus remains with individual healthcare professionals who will need to be able to defend their professional opinions and advice to patients. In a survey of members of this Society, 91% of those who responded were opposed to the NICE guidelines in respect of prosthetic valve patients. In my view, the Society should therefore officially reject this aspect of the NICE guidelines.



# The Gritten Report

## Potential Impact on Perfusion Services



The Gritten report was written following the death of a baby (BA) undergoing cardiac surgery at Bristol Children's Hospital in May 2005. The report is a root cause analysis of the events that occurred following the death of the baby and was completed in October 2007. The report also makes a number of recommendations for perfusion services locally and nationally and these will be discussed. The full report is available at [www.ubht.nhs.uk/documents/nov\\_mark\\_gritten\\_report.pdf](http://www.ubht.nhs.uk/documents/nov_mark_gritten_report.pdf)

### Summary of Events

The baby was born 10th December 2004 at 26 weeks weighing 3.45kg. She initially required respiratory support initially but was subsequently discharged home on oxygen. On 2nd May 2005 she was admitted to her local hospital with tachypnoea, desaturations and bradycardia. Her condition failed to improve and an echocardiogram showed right ventricular hypertrophy and pulmonary hypertension. Subsequently transferred to BCH where a cardiac catheterisation revealed a hypertrophic right ventricle, a small left ventricular cavity and a large ASD with a left to right shunt. It was decided that fenestrated closure of the ASD be attempted, thus allowing off-loading of the left side of the heart and encouraging growth. This was documented as being a high-risk procedure because of the raised pulmonary vascular resistance.

The surgery was deferred on two occasions because of concerns over sepsis. On May 25th the baby underwent partial closure of the ASD. There were concerns peri-operatively about hypertension and increasing lactic acidosis. On return from theatre she was found to have fixed dilated pupils, electrolyte abnormalities in potassium and calcium and an EEG revealed no electrical activity. She subsequently made no respiratory effort or signs of wakening when the sedation was stopped. On 27th May the ASD was fully closed without event. A CT head scan performed found massive cerebral oedema in her whole brain consistent with a severe hypoxic ischaemic or toxic insult and following discussion with the baby's parents treatment was discontinued.

The baby had suffered a severe insult peri-operatively while undergoing partial closure of her ASD on 25th May 2005.

A review of the perfusion records revealed some anomalies within the blood gas recordings taken during the operation and it was thought the most likely cause of death was from a fatally high dose of calcium being either administered peri-operatively in preparation of the CPB circuit or from donor blood (subsequently discounted). The matter was then referred to the Police and Coroner.

The Coroner was concerned that not only was this a possible error in the priming of the circuit but that there may have been an opportunity for the error to be recognised and rectified before any damage occurred. The coroner therefore also referred the matter to the police. The police report was considered by the Crown Prosecution Service who concluded that there should not be a prosecution for gross manslaughter and did not proceed with criminal proceedings.

The root cause analysis revealed a number of significant problems which are listed below:

- Regulation – Lack of regulation of Society of Perfusionists Scientists and individual perfusionists.
- Inconsistently applied perfusion protocols and guidance.
- Sources of ionised calcium in the operating theatre.
- Utilisation of crosschecking prior to drug administration.
- Utilisation of pre-bypass check lists within the operating theatre.
- Communication.
- Trust decision making.

### Recommendations & Action Plan

These were made under four headings, national, trust, paediatric cardiac surgical and perfusionist. The national recommendations are listed below but the complete version may be viewed on the internet at: [www.ubht.nhs.uk/documents/nov\\_mark\\_gritten\\_report.pdf](http://www.ubht.nhs.uk/documents/nov_mark_gritten_report.pdf)

#### National

- Regulation – A national review of the regulation of clinical perfusion scientists.
- Perfusion practice – Acceptable workload and level of staffing for clinical perfusion scientists.
- Review of clinical perfusion scientists & the administration of drugs.

## Report Conclusions

Much of the report discussed the influencing factors and the events in detail that occurred peri-operatively. The overall conclusions of the report included:-

- That this was a unique incident and that the error occurred during the preparation of the CPB circuit.
- The error was caused by inadvertent human error, perfusion system failures at local and national levels and other local system problems.
- The paediatric surgical outcomes from the BCH are favourable .
- There is a strong commitment within the unit to the delivery of a quality clinical service.
- The incident occurred because of weaknesses within both local (infrequent risk assessment, protocols and practice not updated, lack checklists and checking procedures) and national (regulation and guidance on perfusion practice in cardiopulmonary bypass) systems.

*Malcolm Dalrymple-Hay*

- Review of storage and requirement to locate certain drugs in operating theatres.
- Use of mandatory recorded check listing and perfusion protocols across perfusion practice.
- Human factors in error training.
- Incentives to increase awareness of human factors.

As a result of the publication of the Gritten report the Department of Health has convened a group which, is jointly chaired by Professor Sue Hill (Chief Scientific Officer) and Professor Roger Boyle (Cardiac Tsar) to deal with many of the issues raised. As an interim measure, to contribute towards the production of a guide on principles of how clinical perfusion should be practiced to include roles, accountabilities and responsibilities of medical staff specifically within the

cardiac surgical team but also other surgical teams until required changes to regulation and prescribing rights can be implemented. The guide will include responsibilities of Trust Boards and Commissioners.

The first drafts of the guide are in circulation now and it remains to be seen how completely they address the recommendations contained within the Gritten report.

## The Marian & Christina Ionescu Travelling Scholarship 2008

**I would like to thank the Society for awarding me the Ionescu Travel fellowship and I am extremely grateful to Mr Marian Ionescu for establishing this fellowship.**

I am absolutely delighted as the award is enabling me to consolidate and extend my clinical and business ideas. I developed a keen interest in the delivery of health care from a change I effected in my clinical practice. This had significant clinical and operational benefits and I therefore registered on an executive MBA program in 2003. I was awarded an MBA with distinction in 2005 - My thesis was entitled 'Why can't dinosaurs boogie?' The Ionescu Travel Fellowship will afford me an invaluable experience that will enable me to extend my managerial skills and business theories.

There is increasing recognition for the need for doctors to be more involved in the business of healthcare. I am not referring to quantity, targets and costs but quality frameworks. Indeed, industry has long recognised that if you focus on quality the costs look after themselves. Patient safety, risk management and quality frameworks that are incorporated into the systems and processes of health care institutions in the USA form the basis of the Saving a Million Lives campaign.

This is led by the Institute of Health Improvement in Boston and practiced by a number of institutions notably Johns Hopkins in Baltimore. The Virginia Mason Medical Centre in Seattle has introduced 'TOYOTA' thinking into the health care environment with significant clinical and operational benefits. They have demonstrated that we can learn an awful lot from car manufacturing!

I have already registered for the Executive Patient Safety Officer Program run by the Institute of Health improvement in Boston USA from 11- 17 September. Whilst in Boston, I am meeting with Professor Eugene Litvak who is the professor of health care studies and operational management at Harvard Business School - he has written extensively about managing variances in health care and has recently been invited to Great Ormond Street.

I have also confirmed a visit to Johns Hopkins Hospital to see first hand the work that Dr Peter Provonost has done on patient safety. Dr. Peter Provonost MD PhD is an internationally known safety expert. He is the Professor of Intensive Care Medicine and Director of the Centre of Innovation in Quality Patient Care. He is widely published on Patient Safety, Quality Frameworks and Interdisciplinary Teamwork in the health care setting.



*David O'Regan*

I am then going to visit the Virginia Mason Medical Centre in Seattle who has brought industry principles to life in the clinical setting. They are pioneers in this field and have a proven and published track record on systems and processes that benefit patient care. Indeed, Linda Hebish, a senior manager in the organisation is referred to as the KAIZEN officer - a term borrowed from Japanese industry. They have introduced the Patient Safety Alert System.

The European Working Time Directive, the change in the number and skills of the workforce on both medical and nursing side, together with a demand to meet an eighteen week target has meant that, as a department and a Society, we need to examine by whom, where and how our service is going to be delivered to meet these challenges. I believe this can be facilitated by a better working understanding of systems and pathways that will help all of us at every level deliver more effective, efficient and safe patient care.

# Trans-catheter Aortic Valve Implantation Here to Stay!

**Trans-catheter aortic valve implantation (TAVI) for calcific aortic stenosis (AS) has been shown to be feasible! Currently it is being applied to “high risk” patients. There are about 20 new devices in various stages of pre-clinical development which will undoubtedly address some of the limitations of the current 1st generation devices and will potentially make TAVI applicable to a broader patient population. TAVI is undoubtedly here to stay. What is the role of cardiac surgeons in TAVI?**

The Euro-Heart survey suggested that many patients with symptomatic severe aortic stenosis were not having an AVR. Like many UK surgeons I was sceptical of these data based upon the relatively small number of patients with severe AS whom we advise against having an operation based upon a prohibitively high operative risk. However, having been involved in a TAVI program for the last year, it is clear that there has been a population of patients with severe and symptomatic AS that were never referred for a surgical opinion. There is no doubt that both conventional AVR and TAVI have a role to play in this patient population.

TAVI requires careful clinical evaluation of the patient, an understanding of operative risk and scoring systems, multiple imaging modalities, specific catheter lab and surgical technical skills etc etc. No single clinician or speciality possesses all of the



necessary skills. It is a true example of where a multi-disciplinary approach is not only desirable but essential. No individual cardiac surgeon or interventional cardiologist should try (or be allowed by their local clinical governance system !!) to establish such a program.

Which patients are currently suitable for TAVI? Both commercially available devices have CE marks that restrict their use to a “high risk” patient population. This population has been defined (by the companies in their CE mark process)

predominantly using the logistic EUROscore to estimate operative mortality. This scoring system was never intended for such a purpose and not surprisingly has been demonstrated to be inadequate as have several others. In relation to individual patient selection there is no doubt, in my opinion, that the clinical judgement, gut feeling and the “end-of bedogram” are superior in predicting the risk of conventional AVR. However, the difficulty in precisely defining this population is, and will continue to be, a significant problem in the design of clinical studies and trials.

If patients are deemed to be “clinically suitable” they need to be evaluated to see whether they are “anatomically suitable” to be able to “fit” one of the limited choice of available devices. This includes an assessment of the most appropriate access route which may be femoral, apical or potentially axillary. Leaving aside the surgical input into clinical and risk assessment, the important role of the surgeon is clear. Two of these access routes are clearly surgical techniques and even femoral access may need a cut down or repair of injury to the vessel, an increasingly less common but still not infrequent

complication of the percutaneous trans-femoral approach.

The vast majority of UK and European units that have been involved in this area to date have been very responsible and have established a true multi-disciplinary program. However some senior members of the cardiology community are already advocating (at meetings such as EuroPCR) a rapid expansion of this technology by interventional cardiologists under LA in cath labs without any more surgical involvement except for “surgical cover” used for PCI. Although this is opposed by

many of the cardiologists with experience of TAVI, the same commercial influences that drove the dissemination of PCI are already being seen.

We are at a pivotal moment. There is an opportunity for TAVI to bring cardiac surgical and interventional cardiological colleagues to a much closer working relationship, to the benefit of both but most importantly to the benefit of the patient with severe AS. However there is also a risk that there will be widespread and relatively uncontrolled dissemination of this technology via a trans-femoral approach. We must hope that BCIS adopts the wise advice of their former President, Martyn Thomas, again at PCR in May: “..the surgeons should be the gatekeepers for TAVI..”. What can cardiac surgeons do? We must engage with this technology. TAVI is here to stay. Here are just a few ideas:

- Read the joint ESC/EACTS position paper on TAVI (EurHJ – on line) and use its recommendations with regard to your local program.
- Set up a MDT to manage high risk patients with AS.
- Involve colleagues who are collaborative rather than isolationist.
- Go on cath lab skills courses such as those run by industry or at TCT so that at least you understand the language of the cath lab and feel more comfortable in this environment.

**TAVI requires careful clinical evaluation of the patient, an understanding of operative risk and scoring systems, multiple imaging modalities, specific catheter lab and surgical technical skills.**

*Neil Moat*  
Elected Member, Executive

- Establish robust clinical governance arrangements locally that support, or preferably mandate, the MDT assessment and management of these patients.
- Ensure rigorous data collection.
- Make sure our trainees acquire cath lab/guidewire skills. I am sure you can think of many more.

What is the role of our Society? I believe we must urgently engage with BCIS and set national standards of practice, audit, training, data collection etc. This process is under way and I hope a sensible agreement can be reached regarding the dissemination of TAVI. I am sure this will be possible but if not a robust approach by the Society may be needed! Currently the limitations of the devices limit their application to a high risk population but this will change soon with improving technology.

The whole field of TAVI is an important and pressing issue for cardiac surgeons and our Society. It is even more important for the patients with severe AS. We have to date provided the sole (and very effective) interventional management for these patients. I believe these patients will be best served if we embrace this new field, work within a team structure, learning lessons from the development of PCI, and support the appropriate diffusion and rigorous evaluation of TAVI, whilst resisting widespread uncontrolled dissemination.

## The Society Scholarship for Cardiac Surgery

I am a 5th year trainee on the South West rotation currently working in Bristol. In July 2008 I will be commencing an Advanced Cardiac Surgery fellowship at the Royal Melbourne Hospital in Australia.

The Royal Melbourne Hospital is the largest teaching hospital in Victoria, performing over 1500 cardiac cases per year. The main interest of the unit is total arterial grafting, particularly using sequential, T-graft, and Y-graft techniques. Bilateral internal



mammary conduits are used extensively. Professors Brian Buxton (now retired), James Tatoulis and colleagues have published extensively on the techniques and long-term outcomes of arterial grafting.



I have now acquired extensive experience in off-pump CABG. In Bristol the proportion of patients undergoing off-pump CABG is over 60%. Bristol has been a forerunner of the development of off-pump CABG, and also in popularizing minimally invasive coronary revascularization via a left thoracotomy. I aim to complement my 'off-pump'



*"Melbourne world of sport...Four seasons in one day"*

experience in Bristol with the expertise in arterial grafting available at the RMH. These skills will benefit not just a small niche of patients but the vast majority of those who will be under my care as a consultant, enabling me to provide a high quality coronary revascularisation service.

In addition I am keen to develop my interest in aortic surgery. The RMH has a large endovascular thoracic aortic stent program with routine use of hybrid techniques to treat complex aortic pathology. This will allow me to further my interest in endovascular aortic surgery and hopefully provide opportunities for further research in this new but rapidly advancing field.

Perhaps most importantly, this fellowship will allow me to practice cardiac surgery in an entirely different environment from the one I am used to. I hope it will be an excellent training opportunity. I will be going to Melbourne with my wife and 2 year old daughter. Despite the 'four seasons in one day' reputation of the Melbourne weather, we are very excited about the possibility of getting to know a new city, particularly the opportunity to enjoy the prolific sporting calendar beginning with the Melbourne Cup in November, the Boxing day Test match, the Australian Open in January, The Grand Prix in March.....!

I am very grateful to the Society for this generous scholarship.

*Enoch Akowuah*





# Annual Meeting Report

Edinburgh was the host city for this year's **Society Annual Meeting** – another record attendance with over 450 delegates. The venue was the **Edinburgh International Conference Centre** where we also held our meeting in 2003 – the facilities are excellent with a great location in the heart of the city.



*Hunterian Lecture*



*Isabelle and Rachel*



*The President's Dinner*

In theory the transport links to Edinburgh are superb – but as ever the weather tried to disrupt the meeting with storms in the USA delaying our American guests, and the same weather front coming over to disrupt flights from London and Europe. Thankfully everyone arrived in the nick of time - which in turn tested Scott's abilities to make all the video clips in their presentations work as required.

The Sunday afternoon was breaking new ground:

Firstly we were welcoming the Association of Cardiothoracic Surgical Assistants (ACSA) to the meeting for the first time – their president Tony Jessop (Hull) had persuaded his colleagues to move their own AGM to our meeting and we were able to help arrange a workshop on Endoscopic Conduit Harvest – Malcolm Dalrymple Hay demonstrated vein harvest and Joe Zacharias displayed his skill with radial artery harvesting. Tony and his colleagues seemed very satisfied with the arrangements and we are delighted that they want to repeat the format next year.

Secondly we were also welcoming the Society for Clinical Perfusion Scientists, Great Britain and Ireland who held their committee meeting in the afternoon. They had joined us once before – in Llandudno – and it had not been a success, so it took quite some courage to venture back and see if the Society had sincerely changed its attitude. Their president Robin Jones (St Thomas') delivered a very positive verdict and, like ACSA, would like to repeat the exercise next year with the potential to add combined sessions.

Meanwhile Farah Bhatti and Sunil Bhudia were conducting the Trainees Meeting – Farah had arranged an

excellent agenda – Steven Hunter updated the group on national selection for ST3, Steven Livesey talked about the new curriculum and the session concluded with Sir Bruce Keogh's vision for the NHS.

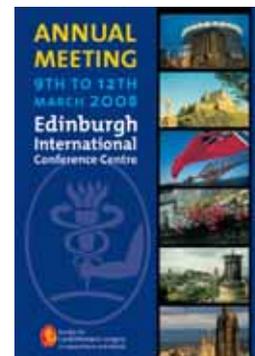
After tea we all gathered in the main Pentland auditorium to hear Ranny Chitwood, from North Carolina, update us on all the technological advances in cardiac and thoracic surgery – and he is a surgeon who has personally contributed to so many of the advances including robotic mitral valve surgery.

## Welcome

In a way the meeting really starts with the Welcome Reception in the evening – it's the time when we can start to relax and catch up with previous colleagues – some claimed that the occasion was sabotaged by the presence of Haggis and the Piper but it was a clear reminder that we were in Scotland – and that they had just humiliated England in the three nations! Sir Bruce Keogh welcomed everyone with a few well chosen words – and in particular welcomed the Perfusionists and ACSA.

Monday started early with a well attended scientific session, before the plenary session combining the surgeons, ACSA and the Cardiothoracic Forum.

CCAD kindly sponsor the Database Managers' Meeting – and this was already their third annual meeting – a unique opportunity for our colleagues to share good practice - the agenda was created by Tracey Smalles (Middlesbrough) and she received great support from Ben Bridgewater and David



# Edinburgh 2008

*Simon Kendall*  
Meeting Secretary



Cunningham – David is the main link between CCAD and the Society and in recognition for his immense contribution Sir Bruce Keogh awarded him honorary lifetime membership of the society.

In a way the Cardiothoracic Forum really 'came of age' this year – the number of delegates was amazing and the Sidlaw auditorium was a fitting venue for such a comprehensive agenda – the only complaint was that they had to walk from the Sidlaw auditorium to the Pentland auditorium – as it would have contravened Health and Safety to use the rotary mechanism to turn Sidlaw 1800 into the Pentland! Tara Bartley welcomed the audience and also welcomed back Maura Buchanan the President of the Royal College of Nursing who made the keynote speech.

## Science

The Scientific Programme Committee had met back in November – John Duffy, Malcolm Dalrymple-Hay, Brian Fabri, Adrian Marchbank, Stephen Clark and Andrew Parry – and it was their innovation that led to the new format in Edinburgh – scientific sessions split into sub-specialties and all presentations also displayed as posters around the venue - and so we had a per-cutaneous valve clinical session sharing the successes and pitfalls of these new techniques.

The support from industry was outstanding again – all the Exhibition stands were full, the Cardiothoracic Forum, ACSA and Database Managers all received sponsorship – and there were three symposia held by companies outside the timetable of the main sessions.

After lunch Richard Page reported on his progress with Thoracic Surgical Audit – and with the news that the first Thoracic Blue Book was now published and available. Ben Bridgewater updated us on the collection of cardiac surgical data before Roger Boyle, aka Heart Tsar, looked backwards and forwards with his vision of the 'Heart Programme' – he has been and remains a great supporter of

our profession and our Society, and Sir Bruce awarded him honorary lifetime membership of the Society.

The Thoracic surgeons welcomed Dr Doug Mathisen Chief of Surgery Mass General to their first session and also Dr Mick Peake UK Clinical Lead for lung cancer – this was a very stimulating session looking at training in the specialty as well as the trends in the UK for the treatment of lung cancer.

## Trouble

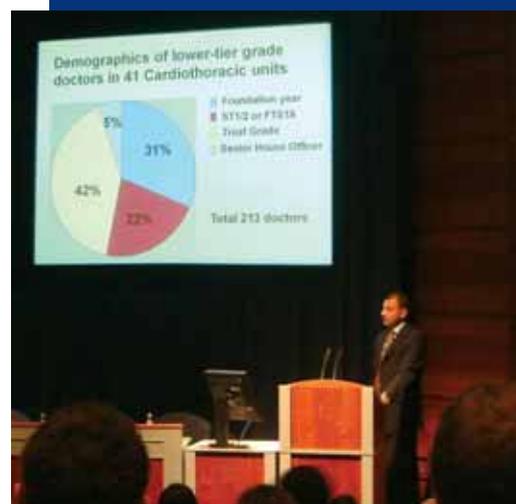
However – there was trouble ahead... It had seemed a good idea to hold a debate on the current role of PCI and CABG in coronary artery disease: the line up was prestigious with chairman Dr Nick Boon President of the Cardiac Society, for PCI – Dr Mark de Belder President of the British Cardiovascular Intervention Society and for CABG - Professor David Taggart President elect.

What we didn't know was that the cardiologists – lacking good evidence and any long term outcome data – would resort to Benny Hill humour – whilst David stuck to proven scientific method and won the debate with a completely unbiased audience.

Paul Sergeant from Belgium and President of EACTS then delivered the 'Coup de Grace' with his lecture on the various strategies for CABG and his excellent long term data. At one point we thought we might have to bring in Henry Kissinger to broker a peace deal...

We dispersed into the Edinburgh night to enjoy many of the fine eateries – the President's dinner was held at the College of Surgeons and our international guests were particularly impressed by the tour of the college and the museum.

On Tuesday we were joined by the congenital surgeons – another well attended session and another group who have asked for more time allocation next year – their programme was greatly



*Cardiothoracic Forum*



*Database Meeting*



*The Exhibition*



## Annual Meeting Report Edinburgh 2008



*Reception*

enhanced by the visit of Dr Andrew Cook – morphologist from the Child Health Institute – who brought some fascinating specimens to assist in a very educational anatomical session.

The Cardiothoracic Forum sessions continued to be very popular – with a very thoughtfully constructed agenda by Tara Bartley – including Gill Matthews from NICE and the results from the National Survey of Workforce planning.

The scientific/ clinical sessions continued with the sub-specialties of surgery of the aorta, the mitral valve, lung cancer, the pleura and the aortic valve – each session has two chairmen and two assessors – 60 individuals in total for the whole meeting who ensure the smooth running of the session, encourage good discussion and to score the presentations – the meeting is indebted to each and every one for their contribution.

There are some very tentative thoughts whether the Association of Cardiothoracic Anaesthetists might consider holding one of their own spring meetings at some future date along side our AGM. In the mean time we were fortunate to have ACTAs help in the form of Niall O'Keefe (MRI), Justiaan Swanevelder (Glenfield) and Henry Skinner (Nottingham) – they organised and ran the workshop on peri-operative trans oesophageal echocardiography which was a thoroughly educational session – there were numerous delegates who varied from mitral specialists to trainees. Hopefully this was the good start needed for further collaboration between the anaesthetists and ourselves.

### Complex Surgery

Doug Mathisen gave the thoracic lecture on 'Complex Thoracic Surgery' including his fascinating series of major tracheal surgery – after lunch the thoracic surgeons repeated the 2007 format of 'interesting case discussions' while the cardiac surgeons enjoyed a debate on the treatment of post-operative AF.

Leslie Hamilton gave us a fitting summary of Bruce's life and phenomenal achievements - the meeting then concluded with Bruce combining

his President's Address with the Tudor Edward's lecture – and as the first Medical Director for the NHS he presented his view of healthcare in England in terms of access and equity.

And that was it – time to collect the abstract scores and change into our glad rags ready for the annual dinner...

All the tickets had been sold – and with a Prohibition theme we needed a password to gain entry to the 'Speak Easy' hidden in the Caledonian Hotel. Most guests were harassed by a couple of gangsters and molls before they could get to the illicit hooch served in teacups – the Jazz band played hard and loud while the roulette and gaming tables buzzed with some very foolhardy and amateur gambling – thankfully the chips were for fun only. The party was just beginning to swing before the police swooped and their sirens meant we had to seek refuge in the dining room.

The dinner was concluded with the awards for the best scientific presentation: Nigel Drury, best cardiac presentation: Rajamiyer Venkateswaran and best thoracic presentation: Elizabeth Belcher.

### And finally...

Mr Donald Ross was awarded a Lifetime Achievement Award from the Society and Heart Research UK – we listened in awe as Sir Bruce described his professional achievements and there was an extremely respectful silence as Mr Ross addressed the assembled company with some reminiscing and some wise words.

He also commented that he couldn't remember the AGM ever being so jolly!

And indeed the meeting had been jolly – it had been better attended than ever before – and it had included more professional groups from our specialty than ever before, appropriate to the Society's change of name.

If you came to Edinburgh we hope you enjoyed the meeting and benefited from the educational sessions – and if you weren't there we hope you might consider coming to Bournemouth next year – March 22nd – 24th.

See you there!  
[Simon Kendall](#)



*The Ross Lifetime Award*



*ACSA Meeting*



*The Exhibition*

# Society Scholarship for Thoracic Surgery 2006

*JG Edwards*  
Consultant Thoracic Surgeon  
Northern General Hospital  
Sheffield

I was delighted and surprised to be awarded the Society Scholarship for Thoracic Surgery at the Annual Meeting in March 2006. Rather than facilitate a fellowship at a single institution, I wished to spend time in an observational and research capacity at a number of centres with expertise in malignant mesothelioma research and treatment.

The first leg was to Perth, Western Australia, but I was able to attend the International Mesothelioma Interest Group conference in Chicago en route. My brief in Perth was to familiarise myself with the Tumour Immunology Group, overseen by Professor Bruce Robinson. Established in 1984, the TIG has a distinguished track record and is at the forefront of mesothelioma immunotherapy research and clinical trials. Time was spent with each of the research groups within the TIG, familiarising myself with research techniques and discussing potential research and treatment strategies. In addition, several sessions were spent in the thoracic surgical operating theatre. By chance, my first day in Perth coincided with the launch meeting of the National Research Centre for Asbestos Related Disease. This virtual centre was created with Federal funding of over AUS\$6 million, supporting 11 major three year grants at four institutions across Australia. The meeting was addressed by the Federal Minister for Health, with significant press coverage. I was invited to participate in the first Investigators Meeting which followed, allowing an excellent insight into the mechanics of the Centre and the projects funded.

The second leg involved a month's stay in New York, with my time divided equally between the Memorial Sloane-Kettering Cancer Centre (Dr Valerie Rusch) and the New York University School of Medicine (Dr Harvey Pass). Both faculties were extremely welcoming and allowed me

access to interesting theatre cases on a daily basis. In addition to mesothelioma surgery at both sites, I was able to observe many VATS lung resections (including Da Vinci Robot-assisted lobectomies), Pancoast tumour resections and endobronchial ultrasound (EBUS), in addition to many more regular cases. It was with some trepidation that I delivered a lecture to the MSKCC Thoracic Service Faculty on the shortcomings of the AJCC/UICC staging system for mesothelioma given that it was written by Dr Rusch! I was able to present new analyses, from a multi-institutional dataset on which I was working, in support of a review of mesothelioma staging.

The third leg of the Scholarship took me to Houston and Boston. My visit to the MD



*JG Edwards (in his presentation stetson) with the Faculty of Thoracic Surgery, MD Anderson Cancer Centre, Houston*

Anderson Cancer Centre in Houston was as a bone-fide Visiting Professor. This was a surprise and an honour allowing me open access to the unit, one to one faculty meetings, a guest lecture, faculty dinner and the gift of a black Stetson. Given the stage of my career, this felt rather early, but it has created intellectual and social links which will be profitable for many years to come. At the Brigham and Women's Hospital in Boston, I was able to see David Sugarbaker perform an EPP and a radical pleurectomy/decortication (both with intraoperative intracavity hyperthermic chemotherapy), in addition to meeting the clinical and laboratory research teams. Furthermore, my excellent host (you know

who you are!) was able to secure access to the Massachusetts General Hospital Thoracic Course and its faculty dinner.

It cannot be stressed enough that, on completion of SpR training, there are great benefits to be realised from observing experts in different units in the operating theatre. One doesn't necessarily need to spend time as an overseas clinical fellow in a single institution to pick up a great number of tricks of the trade. I certainly absorbed a myriad of technical tips from my time spent observing in six surgical centres in very different healthcare systems to the NHS. In Perth, Houston and Boston, I met senior thoracic surgeons who had spent fellowship years in the UK in the 1980s and 1990s, which, in itself, was interesting.

The Society Thoracic Scholarship allowed me to fulfil all my objectives and doors continue to open. As a result of being able to visit eminent centres and surgeons, it has been possible to bring together groups of surgeons to share mesothelioma data. With the help of David Waller, I organised a satellite symposium at the STS in January 2008, leading to the establishment of the IASLC/IMIG Mesothelioma Staging Project, of which I am co-chair with Valerie Rusch. A

significant grant has been received from the Mesothelioma Applied Research Foundation towards this. Bruce Robinson and I presented to the All Parliamentary Group on Occupational Safety and Health at the House of Commons in May 2008, setting the ball rolling for the establishment of a centrally-funded, UK National Centre for Asbestos Related Disease. Since starting as a consultant in Sheffield, we have been working on a protocol of a phase I immunotherapy trial for mesothelioma, which is completing regulatory approval. The support of the Society in allowing my academic interests to bear their first fruits is greatly appreciated.

# Society Thoracic Fellowship in Hong Kong

*Juliet King, Consultant  
Guys & St Thomas' Trust London*



**In January 2007 I took up a six month position as a post-CCT fellow in minimal access thoracoscopic surgery. This was based at the Prince of Wales Hospital in Shatin, Hong Kong, under the supervision of Professor Anthony Yim. The Prince of Wales hospital provides thoracic surgical services to the northern part of the Hong Kong mainland and all the New Territories, along with its sister department in the North District Hospital, Sheung Shui. It also has a strong academic base through its association with the Chinese University of Hong Kong (CUHK).**

Professor Yim is recognised as one of the early pioneers of VAT surgery, and in particular VAT lung resection for cancer. Over 90% of all lung resections in his department are undertaken by VATS, indeed the trainees there rarely get any experience of open surgery. In addition to conventional VAT surgery, the department also undertakes robotic surgery and Professor Yim is the only surgeon licensed to insert endobronchial valves for the management of heterogenous emphysema in the Far East.



*Juliet King with Professor Anthony Yim*

Although I had been to Hong Kong before (a week's holiday just before the handover back to China in 1997), there was still a greater element of "culture shock" than I expected when I first arrived. One of the first things I had to get used to was the difference in the way healthcare is provided compared to the UK. The healthcare system in Hong Kong is a hybrid one, with features of both the NHS and American private healthcare. The public system provides healthcare to all Hong Kong ID card holders for a small daily fee and is well-staffed and resourced. However, the parallel private healthcare system is far more lucrative, which has implications for many aspects of patient management. For example primary care is essentially only available privately, and many diagnostic services e.g. radiology, are almost wholly based in the private system. From a practical point of view that meant no GP's (so huge clinics for us as all patients are followed up long term) and out-patient CT scans and PET scans will

take more than 3 months unless you can pay for them. Having just got used to the addition resources in the UK for cancer treatment, it felt as though I had gone back to the "bad old days" of 10+ years ago.

The other assumption I had made was that everyone spoke English! Medicine is taught and practised in English, and all the ward rounds are undertaken in English so most clinical aspects of the job were not a problem. What I hadn't appreciated is that most of the patients using the public system don't speak much English! This had both good and bad implications. I found it quite frustrating to not be able to speak to the patients as much as I would like, and I had to have a medical student or houseman with me in clinic as a translator, which slowed things down. The benefit was that I could legitimately argue that being on-call as a registrar having to clerk in patients and arrange admissions etc was problematic, so was essentially on call from home as a consultant. Although full of good intentions to learn some basic Cantonese, my vocabulary had barely got into double figures by the end of the six months, and my colleagues took much delight in my terrible accent and constant mistakes.

There were other features of practising medicine in Hong Kong that I hadn't appreciated. I upset several people when I prescribed saline nebulisers for a patient in my first week. The Prince of Wales hospital was at the epicentre of the SARS epidemic a few years ago, and the infecting pathogen was spread from the index case to other patients and staff by the use of nebulisers. Several of my colleagues had contracted SARS, and nebulisers are still not used to this day. The high incidence of TB means that the protective clothing worn for our weekly flexible bronchoscopy list resembled something out of Porton Down.

The surgical aspects of the job were a delight. As previously mentioned almost all thoracic surgery is undertaken using minimal access techniques.

Lung resections are performed using 2 standard-sized VAT ports and a 5 cm mini-thoracotomy with no rib-spreading for delivery of the specimen. The equipment was fabulous: high definition 300 telescopes, 50 inch plasma screens so everyone could see what you were doing (not always such a good thing), a Da Vinci robot and excellent secretarial and IT support. The department also has one of the greatest experiences of using the Dumont stent for complex tuberculous tracheo-bronchial stenoses.

There was a good post-graduate academic programme, and during my six months the CUHK enjoyed a visit from Professor Buckberg, and hosted the 3rd Annual Meeting of the Chinese Association of Cardiovascular Surgeons, The Royal College of Surgeons of England and the College of Surgeons of Hong Kong Conjoint Scientific Congress, and the 2nd World Congress on Robotic Surgery.

I thoroughly enjoyed my time in Hong Kong. This fellowship opened my eyes to what can be achieved with VAT surgery. I am now much more confident in taking on complex VAT cases and I believe I picked up lots of tricks of the trade. I also learnt valuable awake bronchoscopy and stenting skills. On a personal note I feel that being pushed outside my comfort zone, having to work in a new and unfamiliar environment with a team used to doing things a different way, was hugely beneficial. Although painful at first I hope it has made me more patient and flexible. I have also found that having to adjust to life in a busy and vibrant city like Hong Kong has made my move to London far less stressful than it might have been. As before, I would like to thank the Society for their generosity in awarding me their thoracic surgery fellowship. I would also like to thank all the Staff in the department of surgery at the CUHK, particularly Anthony Yim, Malcolm Underwood and Andrew Van Hasselt for making me so welcome, and Tim Graham, Steve Rooney and the West Midlands Regional Training Committee for making this fellowship a reality.

# Workforce Planning in Cardiothoracic Surgery – Where are we now?

*Sunil Bhudia*  
Trainee Representative  
& *Tim Graham*  
Chairman SAC

This review summarises the current situation with workforce planning in cardiothoracic surgery for those in training and those who have recently obtained a Certificate of Completion of Training (CCT).

In 2004 a survey was undertaken to predict workforce requirement in cardiothoracic surgery. There were 132 Type I trainees in posts with about 80 aspirants in so-called “holding posts” awaiting a training number. A further 18 trainees were post CCST waiting for a consultant post. Predictions were made that there would be up to 90 CCST/CCT holders without a substantive consultant post by 2010. This surplus was after taking into account consultant vacancies which was predicted to be only a maximum of 33 posts by 2010.

This grim picture was painted on a background of the demise of cardiac surgery due to advancing technologies in the field of interventional cardiology. Drastic measures were required to avert a large excess of fully trained cardiothoracic surgeons without substantive consultant posts. These measures included, reduction in recruitment into training posts, robust record of in training assessments (RITAs) in order to improve the quality of trainees and their appointability to consultant posts, and if possible increase in consultant posts. In March of 2008 a survey of CCST/CCT holders from the beginning of 2005 to date was undertaken to quantify the impact of these previous predictions and the measures undertaken up to this time. The results are summarized in the graph below. These figures are for England, Scotland, Wales and Northern Ireland.

## CCST/CCT Holders

In total 63 trainees have obtained CCST/CCT and 48 (76%) have secured a substantive consultant post either in the UK or abroad. Of note is that no-one is unemployed or employed outside of the specialty.

In late 2004, 2005 and 2006 a widespread moratorium was put on NTN recruitment. In 2007 only 9 national trainees were recruited across England, Scotland, Wales and Northern Ireland and in 2008 the number was reduced to 7.



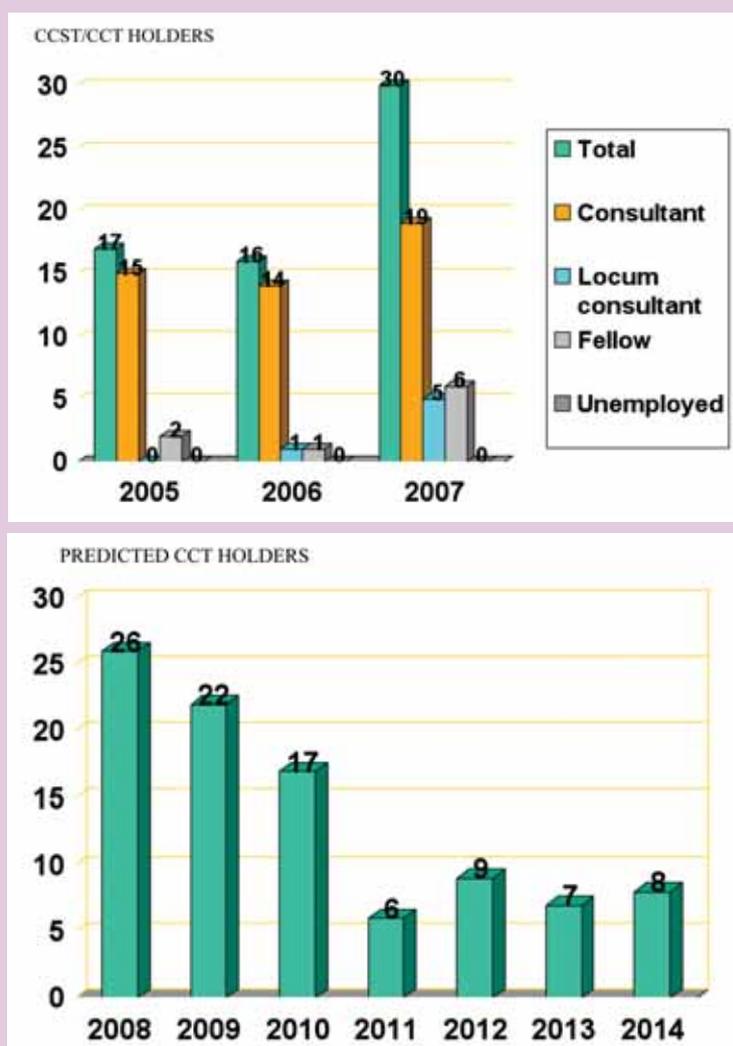
The 5 for England were appointed via the national selection and recruitment process.

This recruitment limitation will have an impact from 2011 onwards on the number of CCT holders in the specialty. The numbers obtaining CCT will be reducing prior to 2011 following the bulge occurring during this year. The graph below shows predicted CCT holders by year out to 2014.

## Predicted CCT Holders

The SAC have suggested to the NHS Workforce review team that there should now be a gentle expansion of recruitment into the specialty from 2009 onwards (possibly 12 to 15 vacancies across the UK) to ensure that there is an adequate number of CCT holders to meet the Consultant workforce need in 2015 and beyond.

There are many factors such as, European Working Time Directive, changes in casemix and evolving technologies, sub specialty developments, professional accountability, and professional slippage, which may have an impact on this specialty workforce planning. These cannot be accurately accounted for now and will be kept under annual review so that NTN recruitment numbers can be varied accordingly. In addition successful Article 14 candidates on the specialist register will be able to apply for consultant posts and will potentially need to be taken into account in future years.



# Trainees Update

*Sunil Bhudia*  
Trainee Representative



First of all I would like to thank Miss Farah Bhatti for her contributions as National Trainee Representative. Second, thank you for electing me as your Trainee Representative and I will endeavour to perform duties to my best. We have exciting times ahead, but we need work together to achieve a fruitful and brighter future.

We had a very successful and lively Trainee Forum at the Annual Meeting in Edinburgh. A total of 52 trainees attended of whom 28 were NTN holders. Mr T Graham gave an overview of the SAC and summarized the current cardiothoracic workforce. Number of CCT holders from 2005 through 2007 and their current status were presented. The general concern of a large mis-match of trainees successfully obtaining CCT and consultant posts has not materialized (see article that follows this report). This information surprised most but was well received. The number of trainees to obtain CCT over the next years was also presented and future plans for recruitment into the speciality outlined. The work is ongoing regarding the cardiothoracic workforce and information will be disseminated when available. Mr R Jeffreys gave an overview of the FRCS(CTh) examination entry requirement and summarized the pass rate of recent examination results. As in previous diets of the exam, NTN holders performed better than other entrants. Sir Bruce Keogh provided an overview of the NHS

and how Cardiothoracic Specialty fits into future planning. Messrs Graham, Jeffreys and Hunter participated in a question-answer session where only trainees were present. Topics discussed included, workforce and consultant post numbers, FRCS(CTh) examination, European Working Time Directive and the impact it will have on Cardiothoracic Surgery services, post CCT fellowships, and the impact of Article 14 on the current workforce.

I hold a regular meeting with the SAC Chair, Mr T Graham to discuss various issues and planning and I would encourage all trainees to raise issues that are impacting their training and wellbeing. I also invite constructive suggestions to any issues or dilemmas we face. I would also like to remind trainees that Mr Steven Hunter as the Cardiothoracic Dean is available for advice and guidance on both a general and personal level.

On a lighter note, I am resurrecting The Young Cardiothoracic Club. This will be open to all trainees and consultants up to 3 years since appointment. I envisage that we will have one annual meeting with emphasis on a informal gathering. I look forward to representing you and hopefully together we can influence future training and employment prospects.

## New Appointments

Name	Hospital	Specialty	Starting Date
John Edwards	Northern General Hospital	Thoracic	March 2007
Max Codispoti	Papworth Hospital	Cardiothoracic	May 2007
Mr Jagan Rao	Northern General Hospital	Thoracic	July 2007
Steven Stamenkovic	Freeman Hospital	Thoracic	Aug 2007
Gianluca Casali	Southampton General Hospital	Thoracic	December 2007
Suku Nair	Papworth Hospital	Cardiothoracic	February 2008
Fraser Sutherland	Golden Jubilee Hospital	Cardiac	April 2008
Antonio Martin-Ucar	Glenfield Hospital	Thoracic	April 2008

## Other Appointments

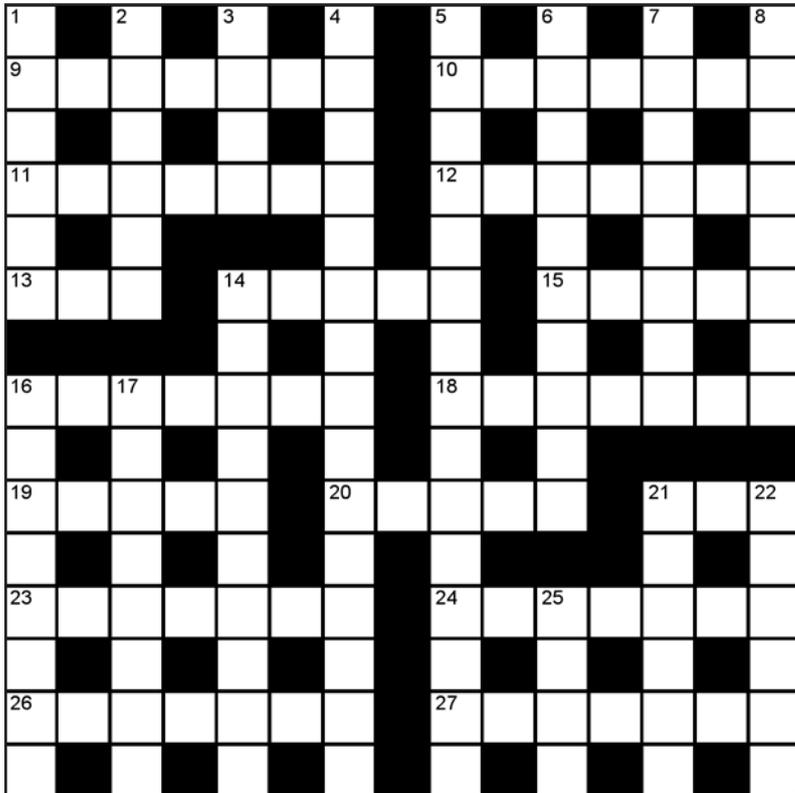
Name	Hospital	Specialty	Starting Date
Hemanth Kaukuntla	Wythenshawe Hospital	February 2008	Locum Consultant
Christos Alexiou	Blackpool Victoria Hospital	March 2008	Locum Consultant



# Diary of Forthcoming Events

- 
- Date: 23 - 25 July 2008  
Meeting: **The Edinburgh Thoracic Symposium: Focus on Advanced Lung Cancer**  
Venue: The Royal College of Surgeons of Edinburgh, Edinburgh, UK  
Contact: Lorraine Judge  
Phone: +44 (0)131 668 9218  
Fax: +44 (0)131 668 9218  
Email: information@rcsed.ac.uk  
Website: <http://www.edinburghthoracic.org>
- 
- Date: 24 - 26 July 2008  
Meeting: **Cardiac Surgical Unit Advanced Life Support**  
Venue: North Lakes Hotel, Penrith, UK  
Contact: Joel Dunning  
Phone: +44 780 154 8122  
Email: joeldunning@doctors.org.uk  
Website: <http://csu-als.com/>
- 
- Date: 16 August 2008  
Meeting: **Thoracic Masterclass: Chest Wall Resection and Reconstruction Heart of England NHS Trust**  
Venue: Birmingham, UK  
Contact: Babu Naidu  
Phone: +44 121 4242562  
Fax: +44 121 424 0562  
Email: babu.naidu@heartofengland.nhs.uk  
Website: [www.qualityvenues.co.uk](http://www.qualityvenues.co.uk) or [www.thoracicsurgery.co.uk](http://www.thoracicsurgery.co.uk)
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- Date: 3 September 2008  
Meeting: **Difficult Scenarios In Cardiac, Thoracic & Oesophageal**  
Venue: The Cardiothoracic Center, Liverpool, UK  
Contact: Mike Poullis, M.D.  
Phone: +44(0) 151 228 1616  
Fax: +0151 600 1696  
Email: mike.poullis@ctc.nhs.uk  
Website: [www.mpoullis.com/courses.htm](http://www.mpoullis.com/courses.htm)
- 
- Date: 4 September 2008  
Meeting: **Terms and Techniques In Aortic Surgery For Trainees**  
Venue: The Cardiothoracic Center, Liverpool, UK  
Contact: Mike Poullis, M.D.  
Phone: +0151 228 1616  
Fax: +0151 600 1696  
Email: mike.poullis@ctc.nhs.uk  
Website: [www.mpoullis.com/courses.htm](http://www.mpoullis.com/courses.htm)
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- Date: 11 - 12 September 2008  
Meeting: **David Sharpe Memorial Symposium, Managing Aortic Valve Disease**  
Venue: Lancashire Cardiac Centre, Blackpool Victoria Hospital, UK  
Contact: Lorraine Richardson  
Phone: +44 (0)1296 733 823  
Fax: +44 (0)1296 733 823  
Email: lrassociates@lycos.co.uk
- 
- Date: 13 - 17 September 2008  
Meeting: **22nd EACTS Annual Meeting**  
Venue: Lisbon Congress Centre. Lisbon Portugal  
Contact: EACTS Executive Secretariat  
Phone: +44 1753 832166  
Fax: +44 1753 620407  
Email: info@eacts.co.uk  
Website: [www.eacts.org](http://www.eacts.org)
- 
- Date: 19 September 2008  
Meeting: **2nd Meeting Towards Safer Repeat Cardiac and Thoracic Surgery**  
Venue: Hosted by The Heart Hospital, at The Royal Society of Medicine, Wimpole Street, London, UK  
Contact: Lorraine Richardson  
Phone: +44 (0)1296 733823  
Fax: 01296 733823  
Email: lrassociates@lycos.co.uk
- 
- Date: 25 - 27 September 2008  
Meeting: **IMIG/EACTS Joint Meeting**  
Venue: Congress Centre De Meervaart, Amsterdam, Netherlands  
Contact: International Mesothelioma Interest Group  
Website: [www.imig-online.com/congres/](http://www.imig-online.com/congres/)
- 
- Date: 2 - 5 October 2008  
Meeting: **Birmingham Review Course In Cardiothoracic Surgery**  
Venue: Education Centre, Heartlands Hospital, Birmingham, UK  
Contact: Lorraine Richardson  
Phone: +44 1296 733 823  
Fax: +44 1296 733 823  
Email: lrassociates@lycos.co.uk  
Website: [www.birminghamreviewcourse.com](http://www.birminghamreviewcourse.com)
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- Date: 8 October 2008  
Meeting: **VIVA practice for part III FRCS(CTh)**  
Venue: The Cardiothoracic Center, Liverpool, UK  
Contact: Mike Poullis, M.D.  
Phone: +0151 228 1616  
Fax: +0151 600 1696  
Email: mike.poullis@ctc.nhs.uk  
Website: [www.mpoullis.com/courses.htm](http://www.mpoullis.com/courses.htm)
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- Date: 13 - 18 October 2008  
Meeting: **European School for Cardio-Thoracic Surgery, Thoracic Course level C**  
Venue: Villa Elios, Bergamo Italy  
Contact: EACTS Executive Secretariat  
Phone: +44 1753 832166  
Fax: +44 1753 620407  
Email: +44 1753 620407  
Website: <http://school.eacts.org>
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- Date: 24 - 25 October 2008  
Meeting: **Society of Clinical Perfusion Scientists of Great Britain and Ireland Congress 2008**  
Venue: Midland Hotel, Manchester, UK  
Abstract submission deadline: 12 September 2008  
Contact: Kate O'Brien  
Phone: +44 (0) 131 242 3105  
Email: kate.o'brien@luht.scot.nhs.uk  
Website: [www.sopgbi.org/](http://www.sopgbi.org/)
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- Date: 7 November 2008  
Meeting: **Yorkshire Chest Imaging Course**  
Venue: Radiology Academy, Leeds General Infirmary, Leeds LS1 3EX UK  
Email: radiologycourses@hotmail.co.uk
- 
- Date: 19th-20th November 2008  
Meeting: **British Congenital Cardiac Association Annual Meeting 2008**  
Venue: Birmingham Children's Hospital, Birmingham, UK  
Contact: Lorraine Richardson  
Phone: +44 (0)1296 733 823
- 
- Date: 27 - 29 November 2008  
Meeting: **Cardiac Surgical Unit Advanced Life Support**  
Venue: North Lakes Hotel, Penrith, UK  
Contact: Joel Dunning  
Phone: +44 780 154 8122  
Email: joeldunning@doctors.org.uk  
Website: <http://csu-als.com/>  
Email: lorrainerichardson1@btinternet.com
- 
- Date: 31 July - 4 AUGUST 2009  
Meeting: **IASLC 13th World Conference on Lung Cancer**  
Venue: The Moscone Center, San Francisco, USA  
Contact: Khara Robertson  
Phone: +1-604-681-2153  
Email: wclc2009@meet-ics.com  
Website: [www.2009worldlungcancer.org](http://www.2009worldlungcancer.org)

# the crossword



by Samer Nashef



## Across

- 9 Money & co? (7)
- 10 Ring here for aristocrat with honour (7)
- 11 Crime of dealer in stolen goods (7)
- 12 Report of underwear present in Cyprus (7)
- 13 Admirer (of Lady Windermere's?) (3)
- 14 Come in to open terrace (5)
- 15 Music essential to cooperation (5)
- 16 Piquant energy for each unknown (7)
- 18 Bruce, so twisted and dark (7)
- 19 Faithful 1 out of practice (5)
- 20 Love to change sex organ (5)
- 21 Intimidate the beast (3)
- 23 With a roof, 1 is shaded (7)
- 24 Ringing 1 hunch (7)
- 26 Capital droops, drinking French wine (7)
- 27 Appropriate (in effective treatment) (7)

## Down

- 1 Toffee pudding as starter of course (3,3)
- 2 Loudly clearin' the throat box (6)
- 3 Prick with 1 instrument (4)
- 4 Graves depicted this for him, his dry poetry? (15)
- 5 Artist screwed Caroline? No, David! (8,2,5)
- 6 Politely, good vehicle is returned with promise to pay - sneaky (10)
- 7 Train 1 philosopher (8)
- 8 Apart, see? (8)
- 14 Drug the real McCoy, that's all (10)
- 16 Pure cash may be needed for this (8)
- 17 Yes, assume I have... (8)
- 21 ... set to halve clinic queues (6)
- 22 Like a barrister, 1 understood (6)
- 25 Held by skeptic (4)

**Send your solution to:** Samer Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744 by 31 August 2008. Solutions from areas over 10 miles from Cambridge will be given priority.

### Last issue's winners:

The winners for the December 2007 were Joel Dunning and Andy Goodwin

**Please note:** We have put the crossword here on the back cover, which is printed on laminated glossy paper. If you prefer, please photocopy this page and complete the crossword on the photocopy.



the  
bulletin



Society for  
Cardiothoracic Surgery  
in Great Britain and Ireland