



# THE BULLETIN

JANUARY 2003

The 2003 Annual Meeting is to be in Scotland at the Edinburgh International Conference Centre, right in the hub of the city. It starts on Sunday 16th March with the St Jude Postgraduate Day and goes through to finish at lunch time on Wednesday 19th. The Honoured Guest, who will deliver the National Heart Research Fund Lecture on The Current Status of Lung Transplantation, is Dr Patterson from St Louis, USA.

Last year's meeting in Bournemouth was felt by many to be our best ever in almost every respect! Abstract quality increased again (as with previous years), the symposia were excellent, the exhibition was the biggest and best supported of all time, and, despite some initial concerns, the venue was fantastic. Only the weather let us down. Much of the success was the result of taking over the conference management from our previous organisers and making it an in-house affair. It also saw some new innovations from what had become a somewhat stale format. Graham Cooper, Rob Lamb and Isabelle Ferner are again working

## Come to Edinburgh in March

hard to stay innovative in 2003 and give our annual meeting a fresh feel. So, as with last year's very successful meeting, there are again changes.

For the first time in the history of the postgraduate day there will be no wet lab. This is not because of a lack of previous success - quite the contrary. This year the St Jude Postgraduate Day concentrates on the mechanics of training with sessions on assessment and appraisal, the end of the apprenticeship, and why your paper is rejected.

The Business Meeting is again in two sessions but has been extended further to allow for even more debate.

There is a second guest lecturer with Prof Crossman giving a talk entitled, 'Coronary Artery Bypass Surgeons will be unemployed by 2010'. If this doesn't send a chill down the spine of everyone apart from pure thoracic and paediatric surgeons, nothing will!

The Welcome reception on Sunday night will not be held in the exhibition hall but in the main reception area of the conference centre. This allows the delegates and exhibitors

alike to meet in less formal surroundings and to be entertained in a unique way for our Society - be there or miss a treat!

Although the bones of the meeting are similar to last year we are again having two symposia covering topics which we hope will be both novel and entertaining for a group of surgeons often under the gaze of politicians and the public - 'our relationship with the media' and 'hours of work'.



The Edinburgh International Conference Centre

There will be no black-tie dinner this year! We all enjoyed last year's entertainment by the three GPs from Devon but we wanted to try something really different for 2003. After a 'wee dram' we will all go on a walking mystery tour of oldest Edinburgh. There are a few themes to the hour long tours including medical - Burke and Hare et al - which can be chosen at the meeting. Afterwards, we will all meet again for a 'haggis, neaps & tatties' supper (or bangers and mash for the faint hearted) to be washed down with the '80 shilling' beer provided. Dress code will be 'smart casual' and obviously something warm will almost certainly be appropriate. There will be brollies available should the weather prove to be wet.

On-site Day Registration will be introduced at the request of many last year. In addition, registration fees are held to the same level as 2001 - so the same fees for three years running!

The Annual Meeting is increasingly the focal point of the year for UK Cardiothoracic Surgeons, so please do make every effort to come to Edinburgh - you will not be disappointed!



## PROFESSIONALISING THE SOCIETY Bruce Keogh, Honorary Secretary

Initiatives. Everywhere you look there are new initiatives and new targets. Some are more realistic than others, some are downright crazy. In 1995 Tom Treasure grimly depicted the Dunkirk spirit that existed in cardiothoracic surgery as we tried to meet the demands imposed on us to deliver ever more laudable targets.

The analogy is now closer to preparations for the Normandy landings – on one beach anyway. At last there are proper plans to implement a revascularisation strategy throughout these isles (realistic clinical guidelines and targets have been set through the NSF and its equivalents in Scotland and Wales), real estate and hardware have been acquired and re-inforcements are on the way. More surgeons have been appointed and more training posts have been approved, but nursing and other professional troops remain in short supply. Foreign lands have been scoured for cardiac mercenaries of officer material whose training turned out to be less impressive than the regulars.

But things are slowly improving. We have embraced change. New duties are shared between different ranks. New surgical strategies such as VATS and off-pump surgery are refined and implemented and new medical treatments and interventions which influence our practice are accommodated.

In thoracic surgery we desperately need more recruits so Peter Goldstraw, on behalf of the Society, is guiding another international recruitment drive by the Department of Health. With an eye to the future, thoracic surgical training is being reconsidered by the Society, the Cardiothoracic SAC and the General Surgical SAC.

In paediatric surgery Jim Monro has co-chaired a review of paediatric cardiac services, detailed by Leslie Hamilton in this issue, which will present some difficult decisions for politicians. But one of the key advances is that our Society is now involved in many key strategic decisions which will influence our futures. But dark forces continue to transmit and publish propaganda in which we are all too often cast as the villains of the piece. We're clearly protectionist, greedy and lazy and all have good golf handicaps. Only we can change the perception.

Never has it been more important for us to present a united, rational, coherent and reasonable front if we are to influence the battle plan. Over the last three years your Executive Committee has tried to professionalise the Society and turn it

into an organ for debate and a channel for communication to the high command. We have declared UDI from our previous administrators and established a frontline command post at the Royal College of Surgeons of England, run by our own Society administrator, Isabelle Ferner. To improve communication with the troops we have entered cyberspace at [www.scts.org](http://www.scts.org) and re-introduced the Bulletin. We have more time for debate at our annual business meeting, which is now engineered to the highest specifications by our new Meeting Secretary, Graham Cooper. To make sure our platoons are in the highest state of readiness we have established a Quality Accreditation Programme and to tackle unnerving propaganda we have openly published data on our performance. Andrew Murday is heading a working party to investigate the development of an alliance with other battalions (anaesthetists, nurses, cardiothoracic intensivists, etc) within the cardiothoracic regiment so that co-ordinated campaigns can be adopted.

But we remain under pressure. The spectre of surgeon-specific data hangs over us. It is still not clear how this will play out but collection of the dataset published in the "Blue Book" is our only protection. Letters have been sent to all CEO's in England from Lord Hunt, Minister of Health, Colin Hilton and Peter Hutton, Chairman of the Academy of Medical Royal Colleges reminding them of their obligations in this area.

There is also a perception that we are too introspective. So as a first step towards becoming "patient friendly" we are jointly publishing a "Good Heart Guide" with Dr Foster, aimed at explaining heart disease and its treatments to our patients. This should be available in the first quarter of 2003.

I will be retreating from the 'front line' in 2004. The Executive aims to appoint a secretary-elect so that the transition is as smooth as possible. Ideally, the appointee should have previous experience of

the Executive, have a tenacious character and skin like a rhino! If you would like to be considered please let Isabelle Ferner know ([sctsadmin@scts.org](mailto:sctsadmin@scts.org)). She will then give you more information on the selection process. We would like to be in a position to propose the appointment to the membership at the business meeting in Edinburgh.



**Never has it been more important for us to present a united, rational, coherent and reasonable front if we are to influence the battle plan**

# INTERNATIONAL FELLOWSHIPS AND THE EXPANSION OF CONSULTANT PROVISION FOR THORACIC SURGERY

The shortage of Consultants in Thoracic Surgery has been quantified by a joint working party of our Society and the British Thoracic Society (BTS) and highlighted in an editorial by the President of the BTS. The call has been taken up by patient interest groups such as McMillan Cancer Relief and the Roy Castle Foundation. In response to this, some, including the President of the Royal College of Surgeons of England, have proposed that General Surgeons be trained to perform Thoracic Surgery. We clearly have to respond and ensure that measures undertaken to correct the current shortage do not compromise the quality of patient care. The SCTS, the Specialist Advisory Committee in Cardiothoracic Surgery (SAC) and the Intercollegiate Speciality Board in Cardiothoracic Surgery (ISB) established a joint working party to consider the options available. This group has prepared a report that will be considered by the sponsoring bodies over the next few weeks. Once agreed, it will be widely circulated for discussion within the profession.

The report will place emphasis on the environment that is appropriate for such surgery and consider the options for future provision. It will emphasise that Thoracic Surgery should only be performed within Thoracic units that have adequate workload, staff and infrastructure, along the lines identified in a recent report from the European Societies. Such units should be led by a core of Thoracic Surgeons who will require support from others to provide adequate on-call arrangements. This support will certainly include Cardiothoracic Surgeons but we should consider new conscripts such as Thoracovascular and Thoracogeneral Surgeons. The profession will have to define the minimum workload and training standards for all of these groups with the involvement of the Colleges and the ISB. There are initiatives in place to provide the core Thoracic Surgeons from UK training programmes but this will take time.

The Department of Health has proposed that the next phase of the International Fellowship Scheme should include the recruitment of thoracic surgeons. This scheme offers an attractive

relocation package for surgeons coming to this country for periods of up to two years and help with the process of gaining entry to the GMC Specialist Register. The first round of this scheme was successful in attracting applicants for consultant posts in histopathology, psychiatry and radiology, but the cardiac initiative met with limited success. The media has blamed this lack of success upon xenophobic attitudes amongst the profession. In truth there are already sufficient UK trainees with a CCST for the Cardiothoracic posts that have been advertised. However, UK trainees do not find “pure” thoracic posts attractive and their training in this area has consequently been neglected. They are concerned that on-call commitments are arduous and the financial rewards restricted. Therefore, we should welcome the International Fellowship initiative and study the proposals carefully. Such recruits could help “pump prime” the Thoracic units before returning to their own country after the two year period (there are financial inducements within the scheme to encourage them to do so). We should emphasise to our Trusts that they can opt to offer fixed term contracts to fellows from the outset. If fellows wish to stay in the UK permanently they should apply for Consultant posts in open competition with those UK trainees coming on stream at that time. If these safeguards are in place the provision of Thoracic Surgery in this country will be assured without compromising the career opportunities of those UK trainees who have invested their future in this area of our speciality.

Further information on the Fellowship Scheme can be found on the Department of Health website [www.doh.gov.uk/international-recruitment](http://www.doh.gov.uk/international-recruitment) and the website for candidates, [www.nhs.uk/fellowships](http://www.nhs.uk/fellowships).

**Peter Goldstraw**  
**Chairman of the SAC in Cardiothoracic Surgery**  
**Chairman of the Joint Working Group**  
**of the SCTS, SAC and ISB**

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## INVOLVING OUR COLLEAGUES

There are over 5000 nurses in the UK who work within the field of cardiothoracic surgery. This includes theatre nurses, surgical assistants, cardiothoracic ITU nurses, ward nurses and outpatient and liaison nurses. At present there is no specific national forum for education and development for these healthcare workers. At the same time, more and more of the care of patients in cardiothoracic surgery is taking place in a multidisciplinary environment. As a result the barriers demarcating different healthcare professions are thankfully being broken down.

As a first step towards widening the role of the Society we would like to encourage more nurses to attend the annual meeting.

**What can you do to speed this process?** Firstly, each of us can explain to our nursing colleagues that the meeting is relevant to them, and can also be quite good fun! Secondly, as soon as you finish reading this article send Andrew Murday ([andrew.murday@btinternet.com](mailto:andrew.murday@btinternet.com)) the contact e-mail address of the lead nurse in your unit. He will create a database from which we can provide a forum that will have an input into the content of the annual meeting in 2004.



## Subscriptions for 2003

Consultant	£225	Overseas	£115
Trainee	£115	Associate	£60
JTCVS	£110		

Subscriptions for 2003 will be collected with the registration for the annual meeting. If you are not going to Edinburgh then you must still use the same form to pay your subscription. The Treasurer is currently in the process of setting up direct debit which will hopefully be in place for 2004 fees.

## Congratulations on your Consultant Appointment

Mr M Dusmet*	Royal Brompton Hospital, London
Mr F Sogliani	Victorial Hospital, Blackpool
Mr A Owens	James Cook University Hospital, Middlesbrough
Mr P Kriasiak	Wythenshawe Hospital, Manchester
Mr Q Abid	North Staffordshire Royal Infirmary

\* Correction to July 2002 bulletin

## Cardiothoracic Courses

Introductory Cardiac Surgery  
HST 1-3  
22-24 January 2003, RCS of England

Applied Basic Science for Cardiothoracic Surgical Trainees  
HST 4  
10-11 April 2003, RCS of England

Introductory Thoracic Surgery  
HST Any  
8-10 July 2003, RCS of England

For further information on either of these courses email the Cardiothoracic Courses Assistant at:  
cardiothoracics@rcseng.ac.uk

## Intercollegiate Examinations

At the recent examination in Leeds 67% of the candidates entered were successful. The next examinations are set for:

28th - 29th May 2003	15th - 16th October 2003
Liverpool	Belfast
(applications close 19.3.03)	(applications close 6.8.03)

## Dates for your Diary

### 39th Annual Meeting of the Society of Thoracic Surgeons

31st January – 2nd February  
San Diego, CA, USA  
Email: sts@sts.org

### Annual National British Thoracic Oncology Group Meeting

20th – 21st February  
Hinckley, UK  
Email: dawn.mckinley@uhl-tr.nhs.uk

### 21st International Cardiovascular Surgical Symposium

22nd February – 1st March  
Zürs am Arlberg, Austria  
Email: congress@herzchirurgie.at

### 23rd Annual San Diego Cardiothoracic Surgery Symposium:

Pathophysiology and Techniques of Cardiopulmonary Bypass  
27th February – 1st March  
San Diego, CA, USA  
Email: cref@amainc.com

### SCTS 2003 Annual General Meeting

16th March – 19th March 2003  
Edinburgh, UK  
Email: sctadmin@scts.org

### 26th World Congress of the International Society for Cardiovascular Surgery

6th – 10th April  
Maui, HI, USA  
Email: iscv@sprri.com

### International Society for Heart and Lung Transplantation

23rd Annual Meeting  
9th – 12th April  
Vienna, Austria  
Email: ishlt@ishlt.org

### 83rd Annual Meeting of American Association for Thoracic Surgery

4th – 7th May  
Boston, MA, USA  
Email: aats@prri.com

### The European Society for Cardiovascular Surgery

- 52nd International Congress  
9th – 12th May  
Istanbul, Turkey  
Email: info@interium.com.tr

### The Sheffield Seminar 2003 (General Thoracic)

- officially approved by EACTS  
15th – 16th May  
Sheffield, UK  
Email: lesley@mecnghospital.fsnet.com

### Preoperative Assessment Of Lung Cancer - A Focus On Mediastinoscopy

16th May  
London, UK  
Email: j.hardy2@rbh.nthames.nhs.uk

### Society of Cardiothoracic Surgeons of South Africa 6th Biennial Meeting

13th – 16th June  
Kruger National Park, South Africa  
Email: nina@confeo.co.za

### Heart Failure Update 2003 (European Society of Cardiology)

21st – 24th June  
Strasbourg, France  
Email: webmaster@escardio.org

### Second Biennial Meeting of The Society for Heart Valve Disease

28th June – 1st July  
Paris, France  
Email: secretariat@shvd.org

### Haematologists Associated with Cardiac Surgery Third Meeting

10th October  
London, UK  
Email: Carolyn.hill@papworth.nhs.uk

## PAEDIATRIC CARDIAC SURGERY The Future

The Department of Health has finally (at the BPCA meeting on 21.11.02) released the report of the Paediatric and Congenital Cardiac Services Review Group for consultation. Set up in response to the Bristol Inquiry, the Group was chaired jointly by Jim Monro (then President of SCTS) and a senior civil servant David Hewlett. It had a representative from each of the units in England, Wales and N. Ireland and two parent representatives (one being the chair of the Children's Heart Federation); there were surgeons, anaesthetists, cardiologists, paediatricians and nurses as well as managers and chairs of Trusts/PCTs.

Professor Kennedy and the Inquiry team recommended that national standards of care should be established, including the crucial issue of defining the minimum size of a surgical unit needed to maintain high quality care - as you might imagine, this proved to be the most difficult. After a lot of work and discussion the Group concluded that a minimum of 300 cases per year should be the standard. How was that figure reached?

The literature has many papers (including some specifically related to paediatric cardiac surgery) that conclude that outcome is related to volume (bigger is better) and intuitively, I presume, we would all agree. However when authors have tried to define "bigger", the evidence is not particularly robust - numbers of cases per unit per year of 100, 300 or more have been suggested. In the end the Group, having considered this evidence, had to take a pragmatic approach and asked three questions:

1. \* of the parents : "What is the minimum number of cases you would expect the surgeon operating on your child to be doing per week?" Answer: three (Kennedy actually suggested four surgical "sessions" per week)
2. \* of ourselves : "What is the minimum number of surgeons needed to provide high quality care 24/7/365?" (allowing for CPD, junior doctors hours, European working time directive, rota etc). Answer: three

If a surgeon does three cases per week and works for 42 to 44 weeks per year (taking into account annual leave, CPD, audit, bank holidays, official duty etc) this equates to approximately 120 cases - if you allow for surgeons operating together (the cardiologists propose double counting but this is not a surgical approach), the three surgeons in a unit should achieve a minimum of 300 cases (the Group felt it important not to be excessively restrictive). This ties in surprisingly well with the report of the EACTS Congenital Heart Surgery Subcommittee - 125 cases per surgeon.

3. "Can risk stratified audit demonstrate quality of care on a small number of cases?" Answer: no

The Review Group achieved a consensus and the Report was backed unanimously by all members. Recognising that at present only four units do more than 300 cases reconfiguration of surgical services would be necessary. Reconfiguration may not be a great vote winner but was felt to be best for the children of the future. This, according to the BRI Inquiry, was the advice given to the Department of Health as early as 1967 and many times since (see Bristol Inquiry report chap 8 para 12) but no action has been taken. Hence the concern when the Minister, in her address to the BPCA, said, "the Government is not persuaded of the Review Group's proposals ... the Government wishes to consult more widely on this issue." The Report has been released with little publicity (no press statement) and therefore I have been asked by the Executive to bring the Report to your attention - you will find it at [www.doh.gov.uk/childcardiac/](http://www.doh.gov.uk/childcardiac/) and Bruce has now posted it on our Society web site ([www.scts.org](http://www.scts.org)).

Comments please to Colin Hilton by 10.02.03 so that he can respond to the Department of Health on our behalf.

**Leslie Hamilton**

## MENTORING SCHEME FOR NEW CONSULTANTS



**Kelly Mason,**  
**Mentoring Workshop**

Having someone of experience outside the immediate confines of his or her unit will give a newly appointed surgeon the chance to discuss difficult issues with a totally independent party. Without this facility problems may remain unspoken, unresolved, and have in the past led to friction between colleagues. It works in other professions, and may prove to be valuable in ours.

On Sunday 16th March at the next annual society meeting in Edinburgh, twelve consultant members will have the opportunity to participate in a half-day mentoring workshop. This is to be run by Kelly Mason who has considerable experience in this area with other professions. Having completed the workshop successfully, consultants will then be available to act as mentor to any new consultant in the UK. I should emphasize that the scheme is not only completely confidential, but also entirely voluntary.

Places at the first workshop are strictly limited to twelve. If you hold a consultant post and would be interested in taking part in both the workshop and the scheme please contact me at [andrew.murday@btinternet.com](mailto:andrew.murday@btinternet.com) and I will send you more details.

**Andrew Murday**



# ABSTRACT ASSESSMENT PROCESS FOR THE ANNUAL MEETING

Over the last three years we have refined the process by which abstracts are assessed and accepted for the annual meeting. Selection is now transparent and as objective as possible. This article describes the process and some reasons why your abstract may fail, irrespective of its scientific merit.

<b>Adult Cardiac</b>	<b>Sam Nashef Steve Livesey</b>	<b>Cambridge Southampton</b>
<b>Thoracic</b>	<b>Richard Page</b>	<b>Liverpool</b>
<b>Experimental &amp; Miscellaneous</b>	<b>Malcolm Underwood</b>	<b>Bristol</b>
<b>Congenital</b>	<b>Victor Tsang</b>	<b>London</b>
<b>Transplantation</b>	<b>Bob Bonsor</b>	<b>Birmingham</b>

**Table 1: Lead Reviewers for 2003 - 2005**

Abstract submission is electronic and is accessed on the SCTS homepage ([www.scts.org](http://www.scts.org)). Submission opens at the beginning of September and closes precisely at midnight GMT on 5th November. There are five categories: adult cardiac, thoracic, experimental and miscellaneous, congenital and transplantation. The rules regarding style and length are published on the abstract submission page. Each abstract is scored by three consultant members of the Society, a lead and two co-reviewers, for each of the five categories (as 'adult cardiac' is such a large category there are two teams of reviewers assessing half of the submitted abstracts each). The lead reviewers for the meetings in 2003 to 2005 are shown in table 1. Each lead reviewer appoints two co-reviewers (who may be different each year). At the end of their three-year term the lead reviewers nominate their successor who will have been at some point one of their co-reviewers.

Criteria	0	1	2	3	4	Total
Impact	■					
Originality				■	■	
Design/Data Analysis				■	■	
Conclusions			■	■	■	

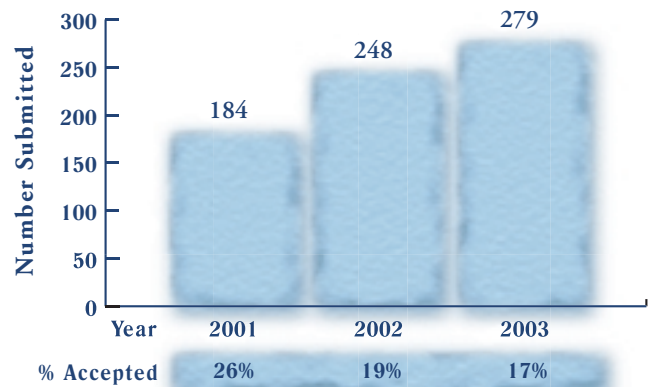
**Table 2: Abstract Assessment Matrix**

Assessment is blind in that reviewers do not see the authors or institution. Abstracts are scored using an assessment matrix (table 2). This matrix was adopted by The European Society of Thoracic Surgery for their 2002 meeting. In order to achieve maximum scores the abstract should have: direct clinical relevance (impact); be completely original (originality); be of a randomised or controlled nature and have clear data analysis, appropriate statistics and allow for confounding variables (design/data analysis); clear and supported conclusions (conclusions). Individual total scores are collated and abstracts ranked.

The Programme Committee meets towards the end of November. Its members are The President, Vice-President and Honorary Secretary, the lead reviewers and the Meetings Secretary who chairs the meeting. Forty eight abstracts are currently accepted for presentation, the numbers submitted for the past three years are

shown in table 3. A cut off score is identified above which lies the largest proportion of the highest ranking 48 abstracts. This year this score was 6.3 with 46 abstracts scoring 6.3 or above. These abstracts are then further reviewed by the Programme Committee, checking for duplicates and adherence to the submission rules. Four of these 46 abstracts were excluded for these reasons this year. In order to select the remaining abstracts (this year six), the Programme Committee reviews abstracts which received the next highest score, 6.0 this year, and any that lead reviewers feel are meritorious but have scored badly (because they do not fit into the assessment matrix structure). The final abstracts are chosen from these with regard to the overall balance of the scientific content of the meeting.

The programme committee allocates abstracts to sessions and designates them as oral or interactive presentations. Sessions are arranged to provide a mix of presentations throughout. Abstracts are selected for interactive presentation on the basis that they will generate interesting discussion, regardless of their score. In early December authors are notified and the final programme is published on the SCTS homepage.



**Table 3: Abstract Numbers**

Assuming you have a good piece of work you will improve your chances of acceptance if you follow a few easy rules:

- Write your abstract simply and clearly.
- Keep to the word count - one abstract submitted this year was 388 words, maximum allowed 250.
- Do not try to beat the word count by excessive hyphenation.
- Do not identify the institution from which the work originates in either the title or text.
- Do not try to submit your abstract after midnight on 5th November.
- Do not leave submitting you abstract to the last minute. This year 100 of the 279 abstracts submitted were uploaded between 18.00 and 24.00 on 5th November. The server was overloaded and some people were unable to gain access.

Given the increasingly high standard of abstracts, for the 2004 Annual Meeting we will consider increasing the number of abstracts accepted.

**Graham Cooper, Meetings Secretary**

## SITUATIONS VACANT

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### SAC

#### - Joint College Representative

There is a vacancy available for a surgeon with an interest in Higher Surgical Training to act as a Joint College Representative on the **SAC in Cardiothoracic Surgery**. The post is available for 3 years commencing March 2003.

Representatives are expected to supervise the training of individual trainees, on behalf of the certifying authority (STA), inspect training posts and make recommendations regarding their suitability for training and provide advice to Postgraduate Deans.

Job Description, Person Specification and Application Form are available for downloading from the JCHST website, [www.jchst.org](http://www.jchst.org).

Closing date for applications is **13th January 2003**.

All completed application forms must be returned to:  
Miss Sarah Beecroft, Specialty Manager, Cardiothoracic Surgery,  
JCHST, 35-43 Lincoln's Inn Fields, London WC2A 3PE

Further information is available from Peter Goldstraw, Chairman SAC.

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### Honorary Treasurer-Elect

Robert Lamb leaves office in 2004 when he starts his ten month sail around the world with the Global Challenge. The Executive would like to consider applications for an honorary treasurer-elect who would help Rob during his last twelve months in post. The aim would therefore be one of increasing involvement over that period in order to ensure a seamless transition of the 'old' and the 'new'.

The society now has a turnover in excess of £200,000. The post should ideally be filled by a member who has the time, desire and energy to become responsible for all of the financial issues of the Society. Knowledge of accounting processes, VAT and the Charity Commission procedures will be an advantage.

Further information on the selection process is available from Isabelle Ferner who can be reached on Mondays, Tuesdays and Wednesdays (best between 0830 and 1400).  
Tel: 020 7869 6893; Fax: 020 7869 6890;  
Email: [sctsadmin@scts.org](mailto:sctsadmin@scts.org)

The Executive would like to be in a position to propose the appointment to the membership at the business meeting in Edinburgh, March 2003. In order to meet this deadline your interest must be made known by **January 15th 2003**.

### Honorary Secretary-Elect

Bruce Keogh leaves office in 2004. The Executive would like to consider applications for an honorary secretary-elect who would help Bruce during his last twelve months in post. The aim would therefore be one of increasing involvement over that period in order to ensure a seamless transition of the 'old' and the 'new'.

The post should ideally be filled by a practicing consultant surgeon who has the time, desire and energy to become deeply involved in the sometimes delicate issues of the Society. Previous experience of the Executive would be considered an advantage.

Further information on the selection process is available from Isabelle Ferner who can be reached on Mondays, Tuesdays and Wednesdays (best between 0830 and 1400).

Tel: 020 7869 6893

Fax: 020 7869 6890

Email: [sctsadmin@scts.org](mailto:sctsadmin@scts.org)

The Executive would like to be in a position to propose the appointment to the membership at the business meeting in Edinburgh, March 2003. In order to meet this deadline your interest must be made known by **January 15th 2003**.

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### St Jude Scholarship - £10,000

The society is in the happy position to invite applications for the 2003 St Jude Medical Scholarship. It may be awarded according to the following conditions:

- As a contribution towards the expenses of working abroad in cardiothoracic surgery or related research – this may cover either part or the entire cost to the candidate.
- The Scholarship will be for a period of any length to be commenced within one calendar year of its award.
- The closing date for applications is strictly **February 14th 2003**.
- The decision of the society relating to the award of the scholarship is final. It will be announced at the annual scientific meeting in Edinburgh 16th to 19th March 2003.
- The successful applicant will agree to any reasonable publicity relating to the award of the scholarship by either the Society of Cardiothoracic Surgeons of Great Britain & Ireland or St Jude Medical Ltd.

Application forms and further information can be obtained from Isabelle Ferner - [sctsadmin@scts.org](mailto:sctsadmin@scts.org)

# THE FUTURE TODAY

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