The Society of Cardiothoracic Surgeons
of Great Britain and Ireland

DECEMBER 2004

THE bulletin

President's Report

Patrick Magee

September 10th came and went – "not with a bang but certainly not with a whimper". The release of this year's Blue Book on that day generated very positive publicity for our Society. There was inevitably some mild disappointment in parts of the press at the absence of league tables but overall comments both in the press and from other sources such as Colleges, Politicians and Speciality Associations were extremely favourable. I know that many members of our Society had anxieties about this exercise but I have no doubt now that the way it has been handled has only brought credit to our Society. We all owe a debt of gratitude to Bruce Keogh for all he has done in producing this series of Blue Books. We are also grateful to Robin Kinsman and Peter Walton of Dendrite Clinical Systems for their continuing support.

The Thoracic Surgical Database is not yet at such an advanced stage. Tom Treasure is leading on this project and the Executive is now considering ways of helping him take this forward. The best solution may well be the incorporation of all the thoracic data in a separate section of the Blue Book which would then be an indicator of all our Society's clinical workload.

Arrangements for the next annual meeting of the Society in Olympia, London on March 5 – 8 are well advanced. Graham Cooper and Simon Kendall, our new Commercial Secretary, have been busy planning what I am sure will be an excellent meeting, both scientifically and socially. The success of any meeting is ultimately dependent on the delegates, so hopefully we will have record turnouts both at this meeting and the following one in Dublin.

There are full details elsewhere in this Bulletin of Scholarships available through the Society for members. St Jude Medical continues to sponsor their award of £10,000 per year and we are grateful for their continuing support of our trainees. At the last meeting of the Executive it was

decided that the Society itself would provide a £10,000 Society Thoracic Scholarship for a trainee wishing to pursue a career in thoracic surgery. We were able to do this because of the recent good stewardship of our Society by Rob Lamb and because of the continuing support of the Society and especially the Annual Meeting by our members and by industry. Finally we are delighted to offer the Marian and Christina Ionescu Travelling Scholarship to a Consultant in the earlier stage of his or her career. This award, worth £10,000 per year, is available because of the great generosity of Marian and Christina Ionescu who have set up a fund for the Society which will enable us to make this award annually for the foreseeable future. As I am sure most know Marian Ionescu was a very successful and well renowned Cardiac Surgeon, Scientist and Innovator in Leeds. Not all may be aware, however, that his wife Christina was an eminent Consultant Cardiologist, also based at Leeds General Infirmary. We are very grateful to both of them for their great generosity in funding this award and are delighted that we now have an award specifically directed at Consultants in the earlier part of their career which will allow them to perhaps study or learn a new technique which can then be applied to patient care here.

Continued on page 3

New software for CCAD, NCEPOD & Consultant Contract

James Roxburgh, Honorary Secretary

It is now 6 months since the Annual Business Meeting in Guernsey and several of the projects we launched at that meeting are now beginning to come to fruition. Data submission to the Central Cardiac Audit Database (CCAD), the NCEPOD study and the Ombudsman's Project on Consent are the most notable projects the Executive and Society members are involved in. There is, of course, the ongoing issue of the implementation of the new contract.

The CCAD needed both revisions to its actual software and radical revision of the lines of accountability for those involved in the project. I am pleased to report that all the concerns that we had regarding accountability and professional responsibility reference the data and its control have been resolved and that CCAD is under the strict control of the Tripartite Group, (comprised of members from the Society: James Roxburgh & Ben Bridgewater, the Healthcare Commission: Bruce Keogh & Jonathon Boyce and the Heart Team: Roger Boyle & Gavin Larner). The Tripartite Group meets on a quarterly basis and has given the Society a free hand in undertaking a major revision of CCAD software for presenting data to various units. Ben Bridgewater and I have worked closely with an enthusiastic and capable software development team at CCAD and we expect to have the final product for testing in mid-November with anticipated rollout following approval by year-end. We plan to utilize the 6-monthly audit lead meetings held with CCAD and the Society to hold a new software workshop. The new software will not only provide risk-stratified breakdown of operation groups, but also the information on postoperative morbidity. Additionally it will provide a statistical overview of unit performance against national parameters with SMRs and information on data quality submitted using quality index measures. Hopefully, this software will enable units to assess their case-mix against the national background to benchmark their performance both in terms of outcomes and data quality. This will not replace the 'Blue Book' but provide basic near real-time data for units, which will be supplemented by the annual report.

The NCEPOD study, led by Steve Livesey, is a major commitment by the Society to demonstrate that assessment of cardiac surgery in this country does not rely simply on individual surgeon mortality. We have now confirmation of 3 years guaranteed funding and once we start collecting data, we will be able to demonstrate very clearly to the politicians and the press that our commitment to performance review is second to none for any medical or surgical specialty. Once again we can claim we are setting the standards for other specialties and countries to follow.

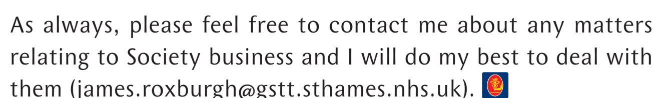
The joint project between the Society and the Ombudsman's Office on developing a detailed model for cardiac surgery will benefit patients and surgeons alike. The ability to define, at a national and specialty level, the consent process is of great appeal to the Ombudsman's Office and they aim to use the experience gained in cardiac surgery when rolling this process out across other specialties. Cardiac surgery does, of course, lend itself to this process with available risk scoring, such as Euroscore, which facilitate the objective assessment of operative risk and subsequent incorporation into the model for patient information and consent. This process will be replicated for thoracic surgery when similar risk modelling system becomes available.

The new consultant contract continues to cause concern. A recent meeting of the Surgical Sub-Committee at the BMA highlighted several problem areas within the new contract. Firstly, it seems that implementation is extremely varied,

both in the extent to which surgeons have been signed up to the new contract and also in the interpretation of contract intricacies. In particular, it was noted that Trusts were beginning to come to terms with the fact that they could no longer expect to get work from consultants 'free and gratis'. Indeed in one hospital, in an unrelated specialty, there is a major dispute between the consultant body and the Trust regarding their refusal to undertake work that is not within the signed off job plans. It may not be long before some of our members have similar discussions with their management teams. Until recently it has been difficult to draw up a stylised 10 PA job plan for cardiac or thoracic surgery due to the considerable variations in local interpretation with still many job plans not been formally signed off. I hope now that, as we approach this part of the procedure, it will be possible to collate job plans from various units and produce an ideal 10 or 11 PA job plan for thoracic and cardiac surgery. I would, therefore, be very grateful if any members have a satisfactory job plan, to forward this on to me, so I may collate these job plans and provide the Membership with an ideal version to support their annual job plan negotiations.

It is important to note that the BMA highlighted that when back pay is considered, it is vital that Trusts do not take into account extra-contractual payments made for waiting list initiatives or cross-cover payments. My understanding of the regulations is that unless the new contract the surgeon has signed, contains a PA or parts thereof for prospective cover, the Trust cannot offset previous earnings from these sources to reduce the amount of back-pay. It is, therefore, in everyone's interest not to include PAs in this first round of job plans for prospective cover, as it could significantly affect the amount of back pay. If you have any concerns regarding the job plan I would advise you seek advice from either the BMA or the Hospital Consultants and Specialist Association.

The Annual Business Meeting in London is fast approaching and I would welcome suggestions from the Membership for topics for the 2 debates that we have, as part of the 2 formal business sessions at the annual meeting.



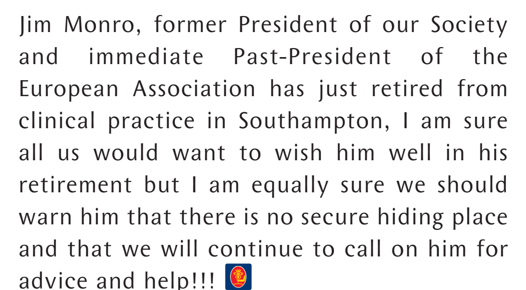
As always, please feel free to contact me about any matters relating to Society business and I will do my best to deal with them (james.roxburgh@gstt.sthames.nhs.uk).

President's Report - Continued from front cover

There have been a number of personnel changes within the Society and the Executive. Steve Hunter has been elected as Cardiothoracic Dean to succeed Leslie Hamilton who has recently taken over as Chairman of the Intercollegiate Examination Board. The Cardiothoracic Dean's post is elected by the trainees. As mentioned above, Simon Kendall has taken over as Commercial Secretary.

Chris Munsch has finished his time at Cardiothoracic Tutor for the Royal College of Surgeons of England. Jonathan Hyde was appointed as his replacement following competitive interviews. Chris Munsch fortunately remains a member of the SAC and with Peter Goldstraw continues to lead on both the Curriculum and MMC projects. Peter Goldstraw's time as Chairman of the SAC will finish next March and for the first time his successor will be appointed following competitive interview. I personally feel there has been little wrong with the system to date whereby the Chairman of the SAC was appointed from within the Committee, but I suppose the new system will give at least an appearance of greater democracy. The Society will of course be represented in this appointments process.

Finally, I would like to congratulate, on behalf of the Society, Peter Goldstraw who has been appointed to the Chair of Thoracic Surgery at Imperial College and David Taggart who has been appointed to the Chair in Oxford. Both of these appointments are fully deserved and are great personal achievements. In addition however, I think they are great for the profile of our specialty and Society.



Jim Monro, former President of our Society and immediate Past-President of the European Association has just retired from clinical practice in Southampton, I am sure all us would want to wish him well in his retirement but I am equally sure we should warn him that there is no secure hiding place and that we will continue to call on him for advice and help!!!

Future Challenges facing the new Cardiothoracic Dean

Steven Hunter

I would like to take this opportunity to thank those of you who voted over the summer. The role of Cardiothoracic Dean is quite extensive but primarily I am an advocate for the trainees and consequently only trainees are entitled to vote.

For those of you unfamiliar with me, I would like to briefly introduce myself. I am a Yorkshireman who qualified from Nottingham University Medical School in 1986. I was introduced to Thoracic surgery in Nottingham and Cardiothoracic surgery in Sheffield. I then trained at St Georges, Hammersmith and Papworth Hospitals. I have been a Consultant in Middlesbrough since 1997 and my clinical interests include minimal access mitral valve repair, stentless aortic prostheses and surgery for atrial fibrillation. I was fortunate to be trained by some of the most enthusiastic trainers in the country – this is obviously a biased view – and this encouraged me to include training as a part of my practice. I have been Training Programme Director and Chairman of the Specialty Training Committee for the Northern Deanery.

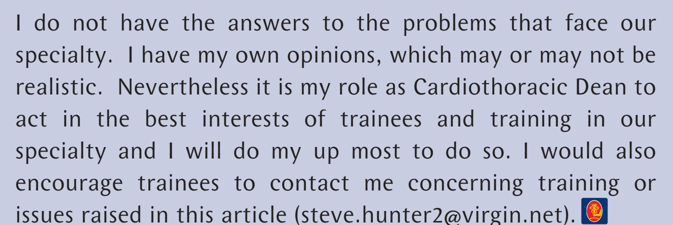
I start my 5-year tenure as Cardiothoracic Dean when our specialty faces a number of challenges. The consultant posts predicted 5 years ago have not appeared and as a consequence CCST holders may face unemployment. I could attempt to point the finger of blame but what good would this do? The SAC and SCTS warned of the excessive increase in numbers but it was a political imperative to meet waiting list targets and it was believed at the time that this required more cardiac surgeons. How can we balance the numbers between trainees and the predicted number of available consultant posts? This has to be addressed annually so that the numbers can be adjusted to match trainees entering our specialty. This is nothing new and it is undertaken quite successfully in Holland. We should not have to reinvent the wheel every time we face a problem. The Modernising Medical Careers (MMC) agenda is moving ahead at pace and Chris Munsch discusses this at length in another article. However it will be introduced in 2006 and we need to be clear how many trainees we can accept as well as their mode of selection. I have many views on training and how it can be successfully achieved in "less time" but I will present these in a future article. All I will say here is that we need to stop confusing training with service provision and start to address each separately.

Can we accommodate all the current trainees? I do not know if this can be answered. We do not know what will be the full impact on our waiting lists. Clearly, if we do not have any patients then we will not require surgeons. Trusts cannot justify employing more surgeons if the targets are being met. These target driven policies have resulted in the current situation but will the targets or the policies change? In cardiology the largest waiting lists are for diagnostic angiography, which have now also been given a target. This will inevitably lead to more patients being referred for surgical revascularisation but proportionally less than predicted 5 years ago because of the almost exponential increase in PCI. Will or when will EWDT effect consultant practice? If we are to abide by European rules then there must be an increase in consultant numbers but when? It is cheaper for the Trusts to pay consultants to do extra work than to employ new consultants. Most affected are cardiac posts and trainees are encouraged to take a greater interest in thoracic and cardiothoracic surgery. We are nationally short of thoracic surgeons but this will not provide the solution for all our trainees.

There are too many questions to which the answers are unknown or as yet unavailable but that does not help the trainee who is concerned about his/her future employment. Trainees need to look hard at themselves. To be competitive for a consultant post a trainee must have a strong CV. Trainees should also be critical of their training and ask their trainers to be equally critical. I know that appraisals should begin with a positive critique but deficiencies need to be addressed if they are to be improved. You know what your peers are doing, you should aim to better than all of them!

There are too many trainee assessment forms that have all the boxes ticked as satisfactory; this is unrealistic. We should not allow the poorer trainee to progress simply because it is easier than confronting the trainee with the truth. If there are trainees who are consistently weak then they have the right to know as soon as possible; it is far easier to change careers if the trainee is year 1 or 2 than year 5 or 6. Honesty is the key to trainee (and trainer) assessment. I have always endeavoured to give honest (sometimes brutally honest) opinions and I would encourage everyone to do so.

I do not have the answers to the problems that face our specialty. I have my own opinions, which may or may not be realistic. Nevertheless it is my role as Cardiothoracic Dean to act in the best interests of trainees and training in our specialty and I will do my up most to do so. I would also encourage trainees to contact me concerning training or issues raised in this article (steve.hunter2@virgin.net).



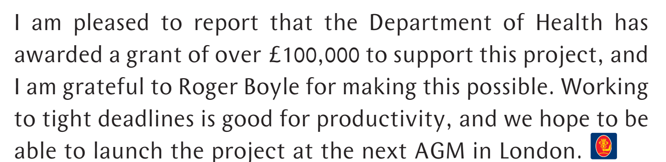
Work in Progress

Chris Munsch, Former Royal College of Surgeons Cardiothoracic Skills Tutor

I took on the role of Cardiothoracic Skills Tutor at the Royal College of Surgeons in October 2000. During the last 4 years we have developed a portfolio of educational courses, which have been well received by trainees, underscoring the value of surgical skills training via a structured workshop-based approach. This has been a team effort and I am greatly indebted to many members of the Society, who supported, developed and taught on the courses.

Jonathan Hyde has been appointed to the post, and I expect he will bring fresh ideas to further develop the skills programme. I am sure he would welcome practical help and suggestions from anyone who would like to teach or become involved in course development. Despite handing over to Jonathan, there remains one important matter of unfinished business; The Wet Lab Project.

Formal courses are limited by their inability to provide the repeated practice necessary for acquisition of competence. The plan is to facilitate self-guided and repeated learning in skills laboratories based within individual cardiothoracic units across the country. We intend, therefore, to develop a package of educational supporting materials for the use of trainees and trainers, thereby supporting the development and running of their own skills workshops. These materials would include a series of CD-ROMs demonstrating a range of surgical techniques, workbooks and assessment sheets and guidance on how to set up and run a skills lab. The materials will be sent to every cardiothoracic trainee and trainer in the UK, for utilisation by trainees to guide and support their own self-directed skills learning. Purpose designed Training the Trainers Courses would also provide support for those who would like to teach in skills labs. The preparation of these educational aids will take place at The Royal College of Surgeons, and Jonathan Hyde and Steve Hunter will join the team who will deliver this project. As always, we would welcome enthusiastic and talented volunteers and I would be pleased to hear from anyone who would like to make a contribution.


I am pleased to report that the Department of Health has awarded a grant of over £100,000 to support this project, and I am grateful to Roger Boyle for making this possible. Working to tight deadlines is good for productivity, and we hope to be able to launch the project at the next AGM in London.

Update on Modernising Cardiothoracic Training

Chris Munsch, Member of SAC

There have been important recent changes in education and training involving the whole of medicine. These changes are controversial and still evolving. Whatever the final outcome there will be a major impact on our specialty, and it seems appropriate to update trainers and trainees on recent developments and what might be expected in the future.

Modernising Medical Careers

The starting point for this scheme is the replacement of the pre-registration house officer year by a two-year Foundation Programme. The objectives of the programme will be essentially educational, with the acquisition of a variety of skills that will be both generic and transferable. It is proposed that the Foundation Programme will then lead directly to specialist training.

This presents all branches of medicine with a serious dilemma, namely: 'How do we select the right people out of Foundation Programmes and straight into specialist training, without previous experience or exposure in our specialty?'. There is no doubt that, within our specialty, there are many people who will be uncomfortable with this development, and that there are those who believe that time spent in SHO, Trust doctor and Clinical Fellow jobs is time well spent. Whilst many will lament the passing of the Basic Surgical Training Programmes, there are many others who would question the quality and value of the current basic surgical training – our own BSTs, for example, often come with no surgical expertise, having spent six months holding a camera in the minimally invasive surgical unit. Their first operating is often closing the leg wound.

Continued on page 6

Continued from page 5

Therefore we are already providing basic surgical training within, and relevant to, our own specialty.

The compromise (already described in the national press) will almost certainly lie with a third year in the 'generality of surgery' followed by an MRCS type exam in basic sciences relevant to surgery. This will guide a national selection process into the specialty, involving the type of selection procedures seen in industry and finance, using formal selection centres and evaluating a range of relevant skills and attitudes. It will also be important to allow movement from one specialty to another within the first year or two of specialist training, and we are exploring the concept of 'transferable educational credits' with allied specialties such as cardiology and vascular surgery.

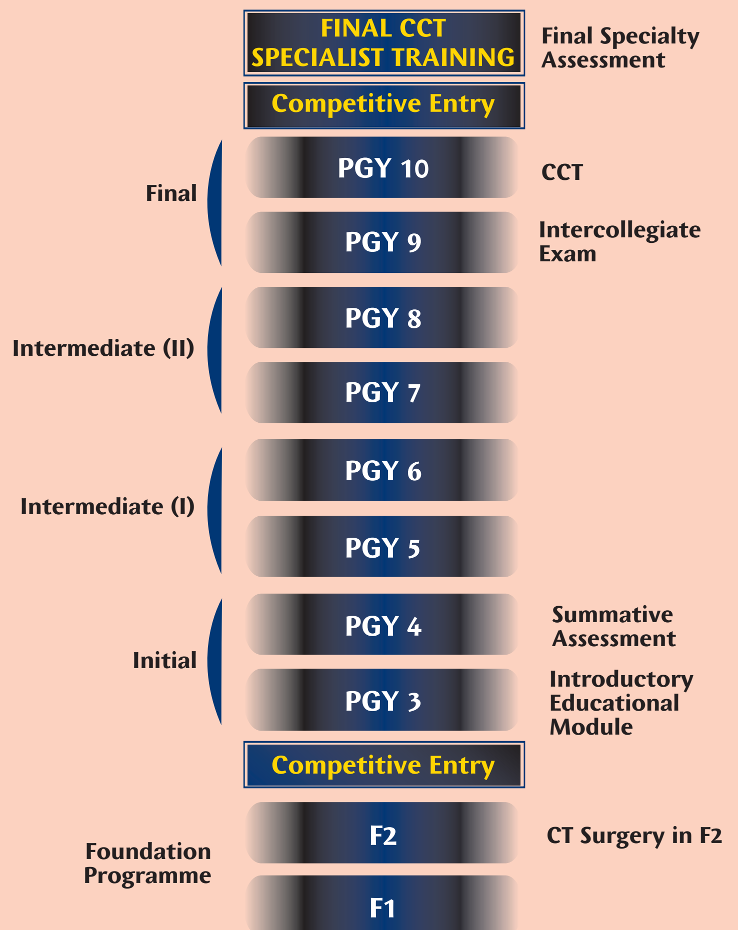
The imperative, however, must be to avoid the persistence of 'The Lost Tribe' of all those doctors waiting (in various states of expectation and anticipation) for training posts in a specialty for which they may be unsuited but from which they are unable to exit.

The first Foundation Programmes are due to commence in **August 2005**, with selection into specialist training to take place in **October 2006**!

The work done by the SAC has convinced the MMC team that our speciality welcomes change and has a genuine interest in reform as long as it leads to improvement.

Specialist Training

In order to sustain this modern concept of a 'run-through' programme there has been a major review of the structure of specialist training within each specialty. In doing this we have had to be guided by the requirements of the Postgraduate Education & Training Board (PMETB), the statutory body now responsible for medical education. In discussions with PMETB, we have upheld the view that the end point of training should remain equivalent to the current CCST, and we have resisted any attempts to shorten training simply for the sake of it. We have also emphasised the need for flexibility in the face of the rapidly changing nature of our specialty. The SAC took the lead in initiating discussions with the DoH and PMETB and after a number of constructive discussions we have agreed a structure to our training programme, which is illustrated. The programme is progressive but also modular, leading after a suitable period of training to a Certificate of Completion of Training (CCT) in the specialty of Cardiothoracic Surgery. The postgraduate years of training represent indicative years only, as the programme is competence rather than time based. Following completion of CCT some surgeons may select (or be selected) to undertake further super-specialist training, for example in congenital cardiac, oesophageal or transplant surgery.



Education, Education, Education

As one might predict, there are real concerns that these reforms (like the previous reforms) are going to be under-resourced in terms of both time and money. Trainers, as well as trainees need support, encouragement and training. Training the Trainers and similar courses provide a starting point only – but a valuable one nonetheless. Trainees cannot remain passive consumers of training, but have to take a more constructive role. Trusts will need to recognise the 'training burden', and consultant job planning needs to make this explicit. In modern cardiothoracic training everyone now has a responsibility for training and must take this responsibility seriously.

Competence-based Curriculum

Naturally a competence based training programme requires a curriculum, which sets standards and defines progress. Along with other surgical specialties we have been constructing our own competence-based curriculum as part of the JCHST Curriculum Project. The curriculum describes the specialty specific knowledge and clinical skills required to make progress in training in cardiothoracic surgery and also defines the final competences required to obtain a CCT. In addition, a major part of the project has been the need to identify general professional or generic competences required for surgical practice. The project has now completed Phase One and a pilot version of our curriculum is now available to view on the Web site (www.curriculum.jchst.org). By building a web-based curriculum, it progresses from being simply a list, to becoming a full, interactive training package.

Our specialty has lead in developing the competence-based curriculum; an enormous amount of work has been undertaken by members of the SAC to produce it, and I would welcome any comments or criticisms. Phase Two of the project is now underway, with the aim of developing this training package further to include assessment tools, learning contracts, and all the other paraphernalia of training that currently we seem to find so difficult to administer.

‘No Time to Train’

By now we must all be aware of the major concerns over the reduced time available for training. We are also all aware of the reasons for this reduction. For the most part, the reasons are statutory and therefore outside of our control, and, like it or not, we have to find a way to provide training within these constraints. As a result we must focus on the quality of training and not simply the quantity. Formal educational resources, including the wet-lab project will help, but do not provide all the answers. The emphasis must be on properly constructed workplace training, using all the educational support provided by the curriculum and the tools, including learning contracts and assessment methods that were described in the Calman Reforms 7 years ago! Now is the time to take training and education seriously.

We face a particular problem with the way in which, as a specialty, we run our postoperative intensive care units. In the current environment, many trainees on shifts are spending as much as 25% of their available training time in providing a ICU service, usually at night. There is no denying that we all value the expertise and the continuity of care that we think this arrangement offers, but we must question whether this is best use of limited training time and whether there is a better way of providing ICU cover? Many units already run well without resident cardiothoracic surgical trainees. Now may be the time to think the unthinkable!

Update

PMETB board will release regular updates which may be tracked on the website below. Recent decisions by the board include:

- **Trainees to be represented on all sub-committees**
  Representation of trainees on all its current sub-committees.
  To set up a trainees reference group to capture the views and concerns of trainees.
- **Defined the principles for postgraduate training assessment**
- **Published papers on curriculum development**
  These papers are:
  - **Standards for Curriculum Development: Background paper** – setting out the background against which the PMETB statement of standards for curricula has been developed
  - **What is curriculum** – setting out the PMETB definition of curriculum
  - **Standards for curricula** – setting out the standards that curricula should reach if they are to be effective in guiding learning, teaching and experience.

Further information can be obtained from:
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/PostgradMedicalTrainingBoard/fs/en

Society Scholarships

The Marian and Christina Ionescu Travelling Scholarship

As mentioned by Pat Magee in his report we are both grateful and indebted to Marian & Christina Ionescu for gifting the Society a substantial sum of money which has allowed the creation of this new Scholarship.

In view of the currently available Society Scholarships, this new award will be earmarked for Consultants in good standing with the Society. The Society's Awards Committee will allocate £10,000 annually as a contribution towards travelling expenses to the consultant judged to have the most deserving application. The Ionescu Scholarship will favour newly appointed consultants in the developmental stages of their career, who are within the first 10 years of appointment.

Applications should be submitted to the Society for this and other Scholarships by 14 February 2005 so they may be processed in time for awards to be announced at the next Annual Scientific Meeting in London.

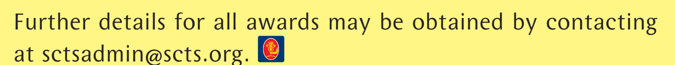
Society Thoracic Scholarship

The very first Society Scholarship was awarded in Guernsey and pending prudent management of our funds and support from industry we hope to continue this on an annual basis. This is available for trainees who have been Society members for at least 2 years and require financial support to undertake a Thoracic fellowship.

St Jude Scholarship

We are grateful to St Jude Medical who has provided this cardiac fellowship for many years supporting numerous trainees in cardiac fellowships abroad. The £10,000 available has on occasions been divided between 2 applicants. Trainees again need to be members of the Society and assessment of applications is made on the basis of both the strength of the applicant and the applicant's proposal.

Further details for all awards may be obtained by contacting at sctsadmin@scts.org.



Retired Members Group

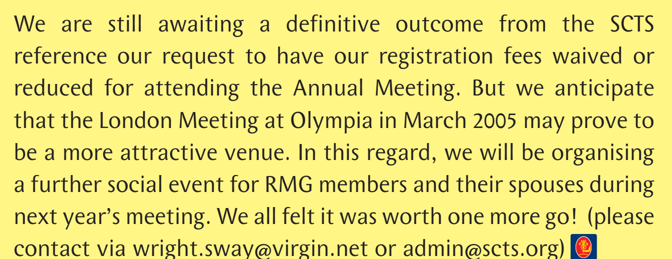
John Wright, Philip Deverall & Iain Breckenridge

The first meeting of the retired members group (RMG) was held on Sunday afternoon during the SCTS Annual Meeting in Guernsey. Exactly three members attended, but this was more than compensated for by our enthusiasm!

The low attendance may have been due to the location of the meeting, which was not the cheapest place to visit, particularly if one was not attending the whole meeting. In addition several members had other scheduled events but intended to attend the next RMG meeting. We also recognise that some individuals were not notified because they are not registered as 'retired members', who we now intend to personally contact. Finally, of course, it is possible that the idea is a 'non-starter'.

We are pleased to report that the three retired members plus one spouse and one potential member had a pleasant dinner following our meeting. All of us stayed on for a very enjoyable and worthwhile Annual Meeting.

We are still awaiting a definitive outcome from the SCTS reference our request to have our registration fees waived or reduced for attending the Annual Meeting. But we anticipate that the London Meeting at Olympia in March 2005 may prove to be a more attractive venue. In this regard, we will be organising a further social event for RMG members and their spouses during next year's meeting. We all felt it was worth one more go! (please contact via wright.sway@virgin.net or admin@scts.org)



Annual Meeting 2005

Graham Cooper, Meeting Secretary

The 2005 Annual Meeting will run from Saturday 5th March to Tuesday 8th March 2005 at The Olympia Conference Centre. This is a fantastic, modern venue adjacent to the Olympia Exhibition Centre. The programme format that we used in Guernsey was very popular and will be the same in 2005. The honoured guest is Professor Andrew Wechsler who will give the National Heart Research Fund lecture; 'Our former president has an operation'. Professor Walter Weder will give the Pulse lecture. Both Professors Weschler and Weder will take part in the St Jude Post Graduate sessions. The detailed programme will be available from early December 2004. The meeting has been recognised for 24 hours of CPD.

This year the Nurses Forum, on the afternoon of Monday 7th March, is supported by Ethicon. There is an advance registration rate of only £75 for nurses and other professions allied to medicine. At 18.00 on Monday 7th March CLS Medical will be holding a symposium entitled 'Endocarditis: Surgical Strategies' with Professor Marko Turina as guest speaker. There will be a buffet following the symposium.

The annual social event on Tuesday 8th March will be a black tie dinner at the Royal College of Surgeons. This will be preceded by a reception in the Hunterian Museum of the College. Transport to and from the Hilton London Olympia hotel will be provided.

The Hilton London Olympia, two minutes walk from Olympia Conference Centre, is offering preferential rates for delegates. These rates are only available until 5th February 2005 and must be booked using the enclosed form. Copies of this can also be downloaded from www.scts.org.

The two months before the meeting are frenetic. To reduce the workload for Isabelle and Rachel in the Society's office, advance registration this year will only be available electronically. This can be accessed at www.scts.org. We are using the company who run electronic registration for EACTS and so the process should be familiar to most of you. On-site registration will be available (see table).

	Early	Late	On-Site	One Day Only
Member	£200	£275	£350	£120
Non-Member	£300	£400	£500	£200
Nurse, PAM	£200	£275	£350	£120

Registrants should note that if a Direct Debit for 2004 has not been completed they will not be entitled to member rates. Tickets for the annual dinner will cost £50 including wine and entertainment.

Finally, the current lead abstract reviewers end their terms at this meeting. Thanks go to Bob Bonser, Steve Livesey, Samer Nashef, Richard Page, Victor Tsang and Malcolm Underwood for their hard work. Their successors, for 2006 to 2008, are Steve Clark (transplantation), John Duffy (thoracic), Adrian Marchbank (experimental), Andrew Parry (paediatric).

The detailed programme, registration venue and hotel details can be found at www.scts.org.

An invitation to attend the UK Thoracic Surgical Forum

Richard Page, Executive Member

The UK Thoracic Surgical Forum is now a well-established meeting. The inaugural meeting took place in 1998 since then it has steadily increased in popularity with over 50 surgeons attending the 2004 meeting. The meeting is open to all surgeons interested in the specialty, from both thoracic and cardiothoracic surgical backgrounds, including consultants and trainees. Other delegates who may be invited include interested consultants from other disciplines such as chest medicine, oncology and upper GI surgery.

The meeting is always based within a hotel in the central part of the country. Delegates gather on Friday evening over dinner to catch up with issues in a relaxed setting. The formal part of the event runs over the whole of the Saturday, until about 4 o'clock.

The Forum has no constitution other than that implied within its name, which is to provide an opportunity for UK thoracic surgeons to get together to discus matters of mutual interest. It has no committee structure and the only "officer" is the local organiser who has the responsibility for producing the agenda. The local organiser co-ordinates the various presentations, but any delegate who wants to raise a particular issue can do so if the organiser agrees it to be relevant. Subjects for discussion are usually of general rather than academic interest, and have always included

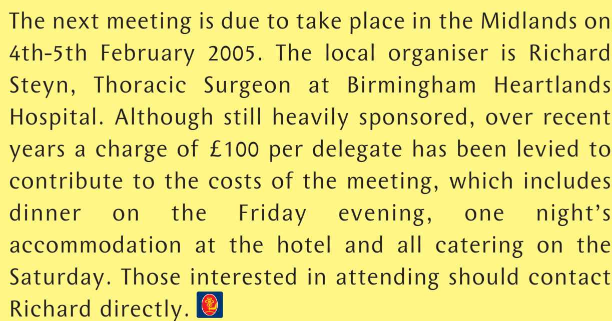
Continued on page 10

Continued from page 9

issues of training and assessment, consultant numbers, structure of thoracic units, relationships with cardiac surgery and increasingly the overall role of the Forum and how this relates to that of the SCTS. In addition various clinical dilemmas have been discussed such as chemotherapy and lung cancer surgery, organisation of oesophageal surgical services, and the treatment of mesothelioma. We have discussed the idea of submitting abstracts for presentation but have not adopted this format as yet, preferring to keep presentations more informal to encourage maximum discussion.

Particularly encouraged to attend are all trainees interested in a career in thoracic surgery, including those who have not achieved SpR status. As a standing item on the agenda there has been a presentation from thoracic trainees reporting on detailed aspects of their training. From this it is intended that consultant delegates would have information on who would be able to fill the consultant thoracic surgical posts of the future.

The next meeting is due to take place in the Midlands on 4th-5th February 2005. The local organiser is Richard Steyn, Thoracic Surgeon at Birmingham Heartlands Hospital. Although still heavily sponsored, over recent years a charge of £100 per delegate has been levied to contribute to the costs of the meeting, which includes dinner on the Friday evening, one night's accommodation at the hotel and all catering on the Saturday. Those interested in attending should contact Richard directly.



New Consultant Appointments

Name	Hospital	Starting Date
Giles Peek	Great Ormond Street	July 2004
Phillip Hornick	Hammersmith Hospital	Aug 2004
Marcello Migliore	Papworth Hospital	Aug 2004
Stephen Billing	New Cross Hospital	Sep 2004
Ian Morgan	New Cross Hospital	Sep 2004

Edited by Sunil Ohri, Publishing Secretary
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Diary of Forthcoming Events

Meeting: **HST Intermediate Cardiac Surgery**
Date: **15th – 16th December 2004**
Venue: Royal College of Surgeons of England, London
Contact: Raven Department of Education
E-mail: cardiothoracics@rcseng.ac.uk

Meeting: **41st Annual Meeting of The Society of Thoracic Surgeons**
Date: **24th – 26th January 2005**
Venue: Tampa FL, United States
E-mail: sts@sts.org

Meeting: **HST Introductory Cardiac Surgery**
Date: **26th – 28th January 2005**
Venue: Royal College of Surgeons of England, London
Contact: Raven Department of Education
E-mail: cardiothoracics@rcseng.ac.uk

Meeting: **Cardiothoracic Research Club Meeting**
Date: **5th February 2005**
Venue: Nottingham, United Kingdom
E-mail: ifronczy@ncht.trent.nhs.uk

Meeting: **The 11th Cardiothoracic Techniques & Technologies Meeting**
Date: **3rd – 5th March 2005**
Venue: The Contemporary Resort Walt Disney World Parks & Resorts
Contact: Teri Valls, CMP, CMM, Executive Director
E-mail: tvalls@meccine.com

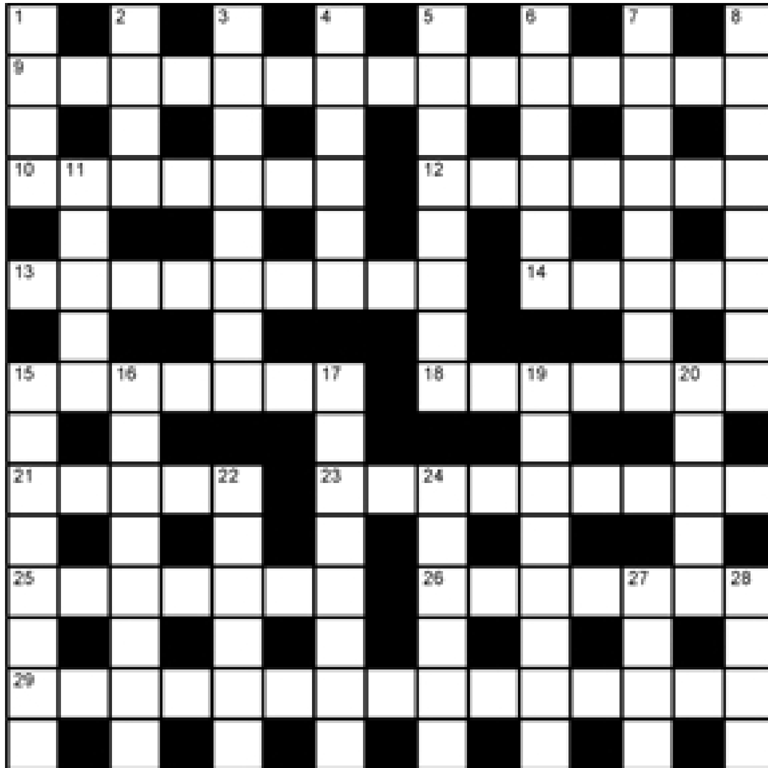
Meeting: **SCTS Annual Scientific Meeting**
Date: **5th – 8th March 2005**
Venue: Olympia Conference Centre, London
Contact: Isabelle Ferner
Email: sctsadmin@scts.org

Meeting: **Applied Basic Science for Cardiothoracic Surgical Trainees**
Date: **28th – 29th April 2005**
Venue: Royal College of Surgeons of Edinburgh
Contact: Lorraine Judge
Email: l.judge@rcsed.ac.uk

Meeting: **15th World Congress Of The World Society Of Cardio-Thoracic Surgeons**
Date: **19th – 23rd June 2005**
Venue: Vilnius, Lithuania
Email: wscts@balticconference.com

Meeting: **31st Annual Meeting of the Western Thoracic Surgical Association**
Date: **22nd – 25th June 2005**
Venue: Victoria BC, Canada
Contact: Megan Tainer

CROSSWORD



Across

9	Outrageous flirt, not a ritual 12 for 21,26 (15)
10	Branch I'll claim regularly provides rods (7)
12	See 13
13/12/27	Antihypertensive treatment, one for the very ill (9,7,4)
14	Molten earth core (5)
15	Devious about state bondage (7)
18	Pass outside American stop (7)
21/26	Serious complication of an earlier flu outbreak (5,7)
23	Offers low for unruly nude birds (9)
25	And not his invaders (7)
26	See 21
29	This type of operation requires an instant patrol deployment (15)

Down

1	Queen leaves figure without feeling (4)
2	Love spasm of the ear (4)
3	Car panel is damaged, so to speak (8)
4	Two-piece island (6)
5	Good man speaks (badly?) (8)
6	Removes with a lisp (as the Lord may do away) (6)
7	Give car a thrashing at clergyman's residence (8)
8	Trapped in Regency St editorial office (8)
11	Girl left a record (5)
15	Power of concentration (8)
16	Mrs Major in lab? Most unusual (8)
17	Yes, flour is adulterated for solver (8)
19	Pertaining to us, perhaps and chopping us garlic (8)
20	Poorly positioned drain at the lowest point (5)
22	Link from East Anglia is expected (6)
24	State the meaning of the penalty from Jamaica (6)
27	See 13 Across
28	Runny nose for a long time (4)

Previous winners:

Chris Munsch & Edward Brackenbury

Please send your answers to Sam Nashef who has created the crossword for the Bulletin. Edwards Lifesciences have agreed to send champagne to the first 2 correct entries. ***Good Luck!***

THE FUTURE TODAY

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