The Society for Cardiothoracic Surgery
in Great Britain and Ireland

DECEMBER 2005

THE bulletin

PRESIDENT'S REPORT

Patrick Magee

I have no doubt that the most pressing issue facing our specialty at the moment is the growing imbalance between Consultant vacancies and the number of young trained surgeons seeking posts. We, as a Society, have already met with Rosie Winterton, Health Minister, and the Heart Team and have highlighted this issue and the concerns of all our members. There will now be a special meeting of the Executive with the SAC and Roger Boyle and the Heart Team on the 16th November to discuss this issue and to seek possible solutions. My own feeling is that there will be no single solution but rather we will need to come up with a variety of incentives to encourage creation of vacancies. This meeting will have taken place by the time this Bulletin is published and Chris Munsch, Chairman of SAC and myself will communicate the outcome of the meeting directly to members.

James Roxburgh has done an enormous amount of work reviewing the constitution of the Society and ensuring that our Charitable status is secure. He will report on this separately but the Society will change its name and become the Society for Cardiothoracic Surgery in Great Britain and Ireland rather than the Society of Cardiothoracic Surgeons. This will reflect the widening interests of the Society and our desire to include the wider circle of professionals involved in the practice of our Specialty.

The spectre of public disclosure of individual surgeon's mortality rates, which has hung over us since Bristol came to a head last year with the Guardian publication supported by the Freedom of Information Act. Although the accompanying article was reasonably balanced and well informed the data was heterogeneous and presented in different ways for different trusts. Given that public disclosure seems to be here to stay we agreed at the last ABM to work with the Healthcare Commission to present data collected through CCAD in a standardised, risk adjusted fashion which will be fair to surgeons and meaningful to patients. The Commission have appointed a project manager and engaged professional web designers to help take this forward. A pilot group of audit leads have met with the designers and project manager to advise on a pragmatic mode of presentation. This work is ongoing and will be presented in Dublin.

Plans for the meeting in Dublin in March are well advanced and I am sure it will be excellent. Graham Cooper, Simon Kendall, Isabelle and Rachel have as always been working hard to ensure so. Our Honoured Guests will be Tim Gardner, former president of AATS and Chief in Philadelphia and Doug Wood from the University of Washington in Seattle. I know that they will contribute enormously to both the scientific and the social aspects of our meeting. I trust we will get a large attendance and hopefully everyone will enjoy visiting Dublin. Previous meetings in Dublin have been very successful and you may have already noticed that the meeting runs from the 13th – 16th March. The next day, the 17th, is St Patrick's Day so some of you may consider staying over, pinning on some shamrock and enjoying the craic! ■

The Web Portal, Connecting for Health & the New SCTS

James Roxburgh, Honorary Secretary

Several years ago Bruce Keogh told me the job was very busy in the run up to the annual meeting, but for the rest of the year it quietened down considerably. This was of course was a lie! The Executive and the SAC will be reporting in these pages a wide range of topics and so I shall just concentrate on some of the areas I have been particularly involved in.

Web Portal for Cardiac Surgery Outcomes

At the last ABM it was agreed by the membership that we would, in conjunction with the Healthcare Commission and other bodies, develop a public portal to provide information about cardiac surgery and its outcomes. It was proposed that we set up a pilot group with a dozen or so units from around the country who volunteered not only their units' specific data, but allowed us access to surgeon specific data. The idea was that these units would be heavily involved in the development of this web-based portal and would be able to have a major say in how the Society and the Healthcare Commission presented outcome data to the public. The price they paid for this was an agreement that we would be able to use their individual surgeon data within the pilot project, so that we could demonstrate real unit and surgeon specific data to other interested parties, such as other media and patient groups and the politicians. I am pleased to say that we have made extremely good progress in this and have had immense support from the Healthcare Commission, who have behaved extremely responsibly in what is an extremely difficult and contentious area. In particular, they have employed a firm of 'web architects' who have very quickly demonstrated that they have understood very many of the complex issues that surround the problems of public presentation of surgical outcome data. We have recently had a very successful meeting where the first prototype of this website was demonstrated and the various members of the pilot project are now working hard to develop a version with real data and supporting text to demonstrate to patient organisations, media representatives and other interested parties. Once we have collated the feedback and upgraded the website we will give members access to a secure server on which the pilot version of this public portal will be hosted. I hope that this will be early in the New Year and there will be a healthy response from the membership! I anticipate presenting a finished version of this website to the Annual Business Meeting in Dublin in March 2006. Those of us in the project group realise that the public presentation of surgeon specific outcome data is still a difficult and contentious issue; however, the publication last year by the Guardian has opened Pandora's box and if we don't take the lead in presenting this data in a controlled and responsible manner, others will inevitably use the Freedom of Information Act and publish the data in a manner which may neither be controlled nor responsible. I am sure that when you see the version in the New Year, you will agree that this has been a worthwhile venture.

Central Cardiac Audit Database

The backbone for the data presented in the website is, of course, the Central Cardiac Audit Database for Adult Cardiac Surgery. Over the last 18 months there have been

enormous changes to this project, which was until then lying dormant. Once we, as surgeons, obtained direct access to CCAD and, in particular, the very talented team of developers, the whole format of the project changed considerably and as a result there are now 170,000 patients in the database. In early November this year we upgraded the software in response to the feedback from audit leads and data managers within the UK. I am pleased to say that the programme of development continues and we plan to incorporate logistic Euroscore, graphical reporting and more detailed morbidity analysis in the next upgrade, which I hope will be in early 2006. The most important development for units using CCAD is that now, not only are they able to compare their unit performance against National figures, but all the surgeons within the unit can see how their data quality, case-mix and outcomes compare to their colleagues and to the national picture. It is now possible for all surgeons within the unit to have a 'view only' version of the CCAD programme installed on their own desktop so that when they login they can see, in near real time, their results, case-mix, Euroscore, pre and post-op length of stay and so on. The success of CCAD would not be possible without the hard work and dedication of the data managers around the units in the UK. We have, therefore, arranged with CCAD to provide an all-day support and training session at the Annual Meeting in Dublin and I would encourage you to support your data managers in attending this innovative session.

Connecting for Health alias NPfIT

CCAD and the public portal project with the Healthcare Commission are, I believe, one of the few examples of a successful integrated IT project within the NHS in the United Kingdom. I am sure many of you, as I do, view the government's IT project for the NHS with a considerable degree of scepticism. NPfIT has now changed its name to Connecting for Health and I am always somewhat wary of Government organisations that change their name for no obvious good reason. In order to try and put the case of the specialty to this project which is, I believe, the world's biggest IT project, I have spent the best part of 12 months trying to contact those in charge. Finally, after many months of being sent from 'pillar to post' I have secured a meeting with 2 clinicians who have been appointed to act as liaison between doctors and those that run the project. I think it is vital that as a specialty with perhaps the most advanced clinical data collection and analysis system in the NHS, we should play a pivotal role in setting the standard for this project. Certainly, we do not want to find ourselves in a position of having to accept dumbed-down data collection and electronic patient records for the sake of political and financial expediency. I hope, by the time of the annual meeting, to have something of substance to report back to the membership.

The New SCTS

Finally, the creation of the new SCTS continues apace and, by the time you are reading this newsletter, the Society for Cardiothoracic Surgery in Great Britain and Ireland will have been set up as a limited company and, hopefully, the Charity Commission will have accepted our application for it to be registered as a charitable organisation. We are in parallel to this setting up a stand-alone commercial organisation which will undertake all those activities that we currently should not be undertaking within the present charitable organisation and nor should we be doing so in the new Society. This would include, for example, job planning, negotiations with private insurers, common defence organisations and so forth. From the point of view of the membership, this will become an administrative and legal vehicle and the membership will still be dealing with a single organisation. However, once all of this is in place, it is vital that we act on the recommendations from Graham Cooper's Working Party so that the Executive is able to provide the Society that you, the membership, need. The future direction of the Society and the services that you wish it to provide for the membership, will form a significant part of the debates at the Annual Business Meeting and I would, therefore, encourage you to attend as the views of all the membership will be vital if we are to make some real and lasting changing to our Society.

As always, feel free to contact me and I look forward to seeing you at the bar in Dublin! ■

Balancing Training with Service Delivery

Steven Hunter, Cardiothoracic Dean

What will the future hold for training in our specialty? Training is changing. The MMC (Modernising Medical Careers) has begun with all 2005 medical school graduates entering into the foundation year programme. This as I am sure you are all aware replaced the PRHO year. It extends for 2 years after which young doctors will make a career choice. Those with surgical aspirations will enter the Specialty or Surgical training year 1 (ST1), which is a one year rotation through 3 specialties. There will be around 2000 posts in ST1 for the whole of surgery. At the end of this year they will be required to sit the first part of the MRCS examination. They will then be ranked using their performance in the examination and their assessments throughout ST1. The top 25% (around 500) will be offered specialty training; which specialty will obviously depend on availability. They will progress through the specialty of their choice encountering competence assessments and further examinations, which will be co-ordinated through the RITA (Record of In-Training Assessment) programme. PMETB (The post Graduate Medical Education Board) will oversee the process and when training is complete grant acceptance onto the specialty register. And finally, a consultant post will beckon. Simple!

Reality is unfortunately not so simple. Currently there are a large number of SHOs who will be competing for ST posts (year 1 and 2). There are a number of research and clinical fellows hopeful for training posts in their chosen specialty, who will be allowed to compete for entry onto training programmes. The mathematicians amongst you will have noticed the drop from 2000 to 500, so what will happen to the 1500? Some will be allowed to repeat ST1 and the rest will have to choose another career. Harsh! Perhaps! Will the system be fair after we have resolved the manpower issues? In five years time I believe that there will be no more than 1 to 2 trainees per unit (on average, as some units may opt out of training). With frequent, at least every 2 years, manpower reviews we can train the correct number to compete for available consultant posts. But with so few trainees, we will have to reconsider how to provide a service.

Service provision in the new era of training is something that the Society should investigate. I have my own views but there are many models around the world that we could look at. Nurse Practitioners, Nurse Specialists, Surgical Care Practitioners (SCP), overseas trainees, Trust Grade Doctors are all options but realistically we have little time to consider the options before trainee numbers will diminish and trainees will be dissociated from a large part of service provision. Many of the current trainees feel threatened by the expanding nursing roles and the introduction of Surgical Care Practitioners; but they should not. The SCPs are a valuable resource to training. In the units with well established SCPs, they are used to support training. They can teach/train basic surgical techniques to the junior surgeon. They are excellent first assistants and when trainees perform their first solo case the SCPs are often their first choice when selecting a first assistant. We have all learnt from nursing staff. I defy any cardiothoracic surgeon to say they have never taken clinical advice from a nurse. The expanding roles for nurses are finally giving recognition for what the nurses have been doing for years and allowing them to directly influence patient management rather than using inexperienced trainees as "mediums"! We (consultants and trainees) should never miss an opportunity to learn even if it is from none-medical staff.

I look forward to seeing every trainee at the annual meeting in Dublin and as always I can be contacted by email at steve.hunter2@virgin.net. ■

Trainee Numbers and Future Consultant Posts

Chris Munsch, Chairman SAC in Cardiothoracic Surgery

In 1999, as part of the NSF for coronary heart disease, the then Secretaryof State declared the intention to create 80 new consultant cardiothoracic surgeons. In preparation for this expansion but largely against its better judgement, the SAC was obliged to create 60 new training posts in the speciality. However, and at least in part due to unregulated activity in interventional cardiology, this expansion has not taken place. As a result it is calculated that by 2010 there could be as many as 80 CCT holders (2/3 of all trainees) without consultant appointments. Clearly the speciality now faces a genuine crisis. An extraordinary meeting of the Society Executive, the SAC and the DoH Heart Team was held on the 16th November specifically to explore ways to manage the problem. There is no single answer, however, and it is clear that a wide variety of tactics will need to be employed. Some of the potential solutions will be difficult or possibly even unpopular to implement, and are likely to involve reconfiguration and modernisation of the whole cardiothoracic workforce. We expect to be in position to report the outcome of these discussions to the Society at the AGM in Dublin.

JCHST Curriculum project

After what has seemed to be an interminable gestation period, the new competency based curriculum has now been delivered. Come and visit the newborn on www.iscp.ac.uk. The syllabus is complete and I would encourage all trainees and trainers to take a critical look at it. As the syllabus is competency based and progressive, it should be used to formulate objectives for training posts. I am happy to receive feedback if you notice anything you like or don't like. It is worth emphasising, however, that the project is more than just a syllabus and is being developed into a web based, total training package. The website will contain all the paraphernalia of training such as logbooks, training agreements, portfolios and the newly developed assessment tools. Trainees will be able to register (there will be a small annual administrative charge) and all training needs will then be addressed through the website. The next stage in the project is to integrate the curriculum into surgical practice, including a process of training the trainers. The curriculum is now being piloted in three deaneries before being rolled out as a robust and useful tool for surgical training.

The Wet Lab Project

We are now in the process of distributing all the educational material that supports the project. The material consists of: a guide to establishing and running a wet lab, a series of DVDs that demonstrate 18 common wet lab procedures, and a workbook for use in the wet lab. The material is available free of charge to all trainee and trainer members of the society. As we have previously explained the aim of the material is to support self directed learning and repeated practice in the wet lab environment. It remains our objective that every cardiothoracic unit in the UK should have its own permanent wet lab in which this self directed learning can take place, and we would encourage you to do what ever you can to get your own wet lab established.

In addition to the material, the project involves faculty development (a purpose made training the trainers course) and an evaluation process. John Wright has kindly agreed to chair an evaluation committee and will be working with the Department of Medical Education from Dundee and the Open University. I should point out that a condition of getting the material is that you agree to participate in the evaluation process.

It has become clear since the inception of the project that the idea of totally self-directed learning needs some modification, and we have devised a way of placing wet lab learning within the context of structured training, whilst abiding by the principles of adult learning and skills acquisition. Guidance on how to do this will be distributed with the rest of the material and will be available on the society web site.

If you do not have the material, or only received the first instalment, and if you would like it, please contact Pauline Maden at the Raven Department of Education, Royal College of Surgeons, London, and she will be happy to supply you. ■

Education & Training Update

Jonathan Hyde, Cardiothoracic Tutor

The changes affecting our speciality are not restricted to issues involved with training numbers and the European Working Time Directive. The new curriculum has begun and the first cohort of trainees will have completed Foundation Years (FY) one and two by August 2007. They will enter our speciality as Surgical training (ST) year one trainees and will need to enrol in the Cardiothoracic Core Skills course, which along with its course materials and handbook, is currently under development. The Pilot Core Skills course in Cardiothoracic Surgery is scheduled for November 2006. This will have an automatic knock-on effect on the introductory and advanced skills courses already in existence, which will need to change their content in order to accommodate this. These changes are currently in progress, and a Core Skills Working Party has been assembled to maintain standards and continuity with the new curriculum.

Although the Core Skills project is a large one, it does not detract from the range of other courses that the College offers, either already established or newly developed. These are largely practical skills based and some are now becoming regionalised instead of always being College based. A brief summary of the courses currently on offer is outlined below. The teaching faculties for courses are not fixed, and although places are in high demand, I would always welcome expressions of interest from anybody who feels that they have something to contribute. It is always useful to have a large pool of faculty for each particular course so that replacements can be made if somebody needs to drop out.

One criticism that I often encounter is that the courses are too expensive. I firmly believe that they are very good value for money, which is borne out by the consistently high scores on feedback. The extremely high faculty to participant ratio underpins this quality, which is often as high as one to one. In addition, the amount of behind the scenes work and organisation by both the faculty and the co-ordinators should not be underestimated.

To get back to gloomier issues, it is not entirely clear what the future holds for trainees and exactly how many are going to be passing through the speciality. The SHO grade as we know it is disappearing fast and there is a suggestion that total trainee numbers may well need to decline over time. This will clearly affect the numbers of courses that will run, but until then the balance seems to be right although any feedback is more than welcome.

Course	Date
Introductory Cardiac Surgery	1st - 3rd February 2006
Introductory Thoracic Surgery	1st – 2nd June 2006
Advanced Cardiac Surgery	15th – 16th December 2006
Advanced Thoracic Surgery	11th-12th January 2006
Applied Basic Science (Cardiothoracic) (Collaboration between The Royal Colleges of Surgeons of Edinburgh and England)	5th – 6th April 2006
Surgery of the Aorta Masterclass	Date TBC
Surgical approaches to Atrial Fibrillation	8th March 2006
Intra Aortic Balloon Counterpulsation	11th November 2005 (Birmingham) 15th February 2006 (Manchester) 13th June 2006 (Middlesbrough) 12th July 2006 (London)

Surgeons need to promote CABG Urgently!

David Taggart, Executive Committee Member

The current threats to CABG exemplify the dangers when a multi-billion dollar industry challenges evidence based medicine. Earlier this year in an article entitled 'Surgery is the best intervention for severe coronary artery disease' (BMJ 2005; 330:785-6) I summarized the scientific evidence which still strongly supports CABG over PCI as the superior treatment for patients with multi-vessel coronary artery disease. Shortly after this, at the post graduate course of the AATS in San Francisco, Dr Martin Leon, an interventional cardiologist, argued that PCI was superior to CABG and implied the virtual end of surgery in such patients. To my amazement and alarm there was no formal surgical rebuttal of Dr Leon's disingenuous presentation of the available data but during the ensuing discussion I commented from the floor that if American surgeons were not even prepared to debate the issue, then undoubtedly their CABG practice would be increasingly lost to interventional cardiologists "believing their own hype". We increasingly face the same threat in the UK and Europe and I believe that this issue should be debated vigorously within our society before PCI becomes the established default treatment for patients with multi-vessel disease.

It is beyond the scope of this brief article to cover all the data, which clearly supports the superiority of CABG over PCI, but there are a few key points with which all surgeons should be familiar when speaking with cardiologists and patients:

1. There is simply no evidence that PCI is as effective as CABG. The 15 randomised trials comparing PCI and CABG, which showed equal survival (but far superior symptom relief with CABG) were based on only around 4% of the total potentially eligible population. More importantly, the trials were intentionally designed to be inherently biased against the known prognostic benefits of surgery. This was achieved by largely enrolling patients in whom it could be predicted that there would be no survival benefit from CABG ie most of the trial patients had normal left ventricles and two vessel disease (of whom only 40% had proximal LAD disease), a population in whom it had already been clearly established that surgery was not superior to pharmacological therapy (Yusuf S et al, Lancet 1994). In other words the trials largely excluded more typical patients known to benefit from CABG (those with left main and three vessel disease, occluded vessels and impaired left ventricular function). Nevertheless the results of these highly atypical trials have been used to justify PCI in all patients with multi-vessel disease.

2. Several large registries (ie representing the real world) have reported that in propensity matched patients with triple vessel disease CABG has a markedly superior survival benefit. This was confirmed again recently in the New York registry of almost 60,000 patients with two or three vessel disease, showing that an initial strategy of CABG rather than PCI resulted in absolute respective 24% and 36% reductions in the risk of death within three years (Hannan et al NEJM 2005). The superiority of CABG over PCI is almost certainly because it deals not only with the 'culprit' lesion but 'future culprit' lesions.

3. The promise that drug eluting stents (DES) eliminate re-stenosis is simply more hype, driven by a very powerful interventional industry. Real world registries show that the true rates of re-stenosis with DES vary from 10% in the simplest lesions to 30% in more complex lesions within a year (never mind twenty year follow-up!!). Furthermore, around one third of PCI procedures results in a peri-procedural infarct of which a quarter involves a substantial loss of myocardial tissue (Selvanaygam et al Circ 2005). Finally, even a year after DES, there is a significant risk of myocardial infarction in patient stopping dual anti-platelet medication because of a failure of re-endothelialization.

Despite the evidence in favour of CABG we are all aware that fewer patients are being referred for surgery. To many of us it is increasingly clear that at least some members of the cardiological interventional community are simply no longer interested in real data. Professor Robert Califf, Head of Interventional Cardiology at Duke University, addressed this issue in a recent editorial in the Journal of American College of Cardiology (2005) when he wrote "it is likely that most people undergoing coronary angiography are not told the entire story when a decision is made about undergoing PCI" attributing this to conflicts of "self referral…and..financial incentives" and that "without surgical opinion the patient is in no position to have rational input into the decision".

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MARS Trial is Launched

Tom Treasure, President of the European Association of Cardiothoracic Surgery

The MARS trial is open and recruiting. MARS stands for Mesothelioma and Radical Surgery and the trial seeks to discover if extrapleural pneumonectomy (EPP) has anything to offer patients with malignant mesothelioma. The primary outcomes are survival and quality of life. In the trial EPP is sandwiched between induction chemotherapy and radical radiotherapy as that is the setting in which the best survival rates have been achieved by David Sugarbaker. The control arm also offers full active trimodality therapy; every treatment is available to the patient short of EPP. Those randomised to not have EPP will receive the same induction chemotherapy, are eligible for any palliative of debulking surgery considered appropriate, and radiotherapy should be given to any port sites or drain sites. Thereafter full supportive care will be given in both arms including any chemotherapy and or radiotherapy deemed clinically indicated. A trial which looks like a lot versus a little is hard for doctors and patients, hence the attempt to balance the arms.

This trial has been extensively discussed in National and International meetings on many occasions during its development phase. It has passed through all the hoops to gain scientific and ethical acceptance and funding by Cancer Research UK (CRUK) as a feasibility study. It has been presented in the dissemination phase on many occasions from regional to international level.

There is a perception amongst physicians that this is a rare cancer but it kills more people a year than either melanoma or cancer of the cervix (CRUK data) the death rate is still rising. About 60,000 new cases are projected in the UK over the next 45 years, according to Julian Peto. If surgery had a clear and self evident role it would have been established a long time ago; surgery was introduced into practice in the 1970s by Eric Butchart. It is now generally accepted that surgery is ineffective on its own and only appropriate in selected limited stage disease. We are left with the question is the operation (EPP) beneficial at all?

Some surgeons do not want to randomise patients because they believe that EPP is already of proven benefit in carefully selected patients. For evidence they point to the results of Sugerbaker. This depends on a subset of 31 patients had the all three of the prognostically significant variables (epithelioid cell type, clear resection margins, no positive extrapleural nodes) and had survived thirty days from surgery in order to enter this analysis. This most favourable group of this series had a median survival of 51 months. Those who believe that EPP is of proven benefit find these results sufficiently persuasive to believe that patients such as these should not be randomised to a 50% chance of being denied surgery. We MARS trialists are not convinced that the case is made. There is wide range of survival for individual non-operated and indeed non-treated patients. We all know of patients who have lived years from the original diagnosis without resection.

There are many colleagues who argue that the benefit of EPP is so improbable that patients should not be put through EPP even within a trial with an unlikely prospect of useful additional survival and quality of life. What we do know is when we embark on this aggressive trimodality therapy, we will take six to nine months to complete the treatment. During this time the patient is in and out and travelling between different hospitals to undergo this complex treatment. But to take a nihilistic approach in the face of this disease is no longer acceptable to patients or doctors. Why should a doctor with a particular point of view or a set of preconceived ideas, deny active treatment for a patient with a lethal cancer without the evidence to back up that decision, any more than an enthusiast should put patients through extreme treatment on the basis of a judgement made outside the evidence? Whichever of these two opposing points of view is espoused, however well intended, the evidence is simply not there to support either. There must always be two ends to a spectrum of opinion but at present the ends are polarised and neither have the evidence to shift those in the middle ground.

When it is a complex treatment programme such as trimodality therapy which is under consideration in the management of a disease with a variable pattern and time course the factors and outcomes are too many and varied to be assimilated and turned into a clinical opinion based an individuals “experience”. The MARS trialists do not believe that the evidence is there to advocate EPP in any subset but neither can we prove that the advocates of radical surgery are wrong. That is the reason for the trial. At Guy’s we have agreed that EPP will only be offered within the trial. There is good precedent for this approach. Medicare and Medicaid funding for lung volume reduction surgery was only available within the NETT trial. Finally we would be concerned if individuals, however respected by the team, are allowed to effectively veto the trial in their area, whether on the grounds of science or ethics. These issues have been extensively consulted upon and debated through CTAAC, NCRI and MREC and the issues are too important and too complex to be in the clinical judgement of a few individuals. ■

Launch of the UK Lung Cancer Coalition

Roger Vaughan, Member of UKLCC

The United Kingdom Lung Cancer Coalition (UKLCC) was launched on the 7th November. UKLCC is a powerful new coalition of the UK's leading lung cancer experts, senior NHS and Department of Health professionals, charities and healthcare companies. It is the UK's largest multi-interest group in lung cancer. It has been established to launch the nation's largest-ever assault on lung cancer. All UKLCC members believe that lung cancer research, diagnosis, treatment, public awareness and patient information are currently inadequate. Lung cancer is the UK's biggest cause of cancer deaths, killing over 33,000 people annually. This is more than breast, prostate, bladder cancers and leukaemia combined. Half of all people diagnosed with lung cancer are dead within 6 months.

Despite improvements in services, there is a wide variation in survival rates across England. Currently, a lung cancer patient is four times more likely to survive from lung cancer in Chelsea, Stockport and Solihull than in Northumberland, Rotherham or Sunderland. What is uncertain is to what extent this is related to socio-economic factors or a result of inadequate health care provision. The best 5-year survival figures from the 2002 National Performance Indicators [which were based on patients diagnosed between 1993 and 1995] are 8% or above (8.9%, 8.2% & 8.0%); the worst are a little over 2% (2.2%, 2.3% and 2.6%)).

Whatever the reason for this discrepancy, lung cancer is considered a poor relation when compared to other cancers. Despite accounting for 25% of all cancer deaths, lung cancer only receives 3% of all current UK cancer research funding. This is a travesty.

The UKLCC was launched at a reception for MPs at the House of Commons on Monday, 7th November. The Coalition has the support of the NHS National Cancer Director, Prof Mike Richards, and is looking to work with senior parliamentarians to help raise awareness of lung cancer and place the disease firmly on the UK health agenda. Patients with lung cancer were also invited to the launch, which received newspaper and television coverage. The UKLCC wherever possible will act in partnership with senior policymakers, using our expertise to help deliver real improvements for patients. As a first step, a series of workable actions have been developed, which, if implemented, would provide considerable support towards the NHS realising its aim of doubling survival. ■

Further information can be obtained from the website. www.uklcc.org.uk

Surgeons need to promote CABG Urgently! Continued

The problem is that while the cardiologist is the 'gatekeeper' the patient may no longer have access to the best and most effective treatment. In my BMJ article I wrote that "The current tendency of some cardiologists to exclusively investigate and treat patients with severe multi-vessel disease without a surgical opinion not only undermines the traditional multidisciplinary approach but also ensures that the best and most balanced advice is unlikely to be consistently offered. Most importantly, by effectively denying patients the opportunity of making a fully informed choice, it falls far short of this practice".

What is the solution? It is my view that, for the reasons outlined above, cardiac surgeons have probably already lost the debate with a significant proportion of interventional cardiologists. It is now time, therefore, for European and American surgical colleges to bring the issue into the public domain by recommending that a multi-disciplinary team should treat all patients with multi-vessel coronary disease. Few clinicians with the genuine interests of the patients *at heart* could take serious issue with such a recommendation which would also sit well with ethical and political pressures to ensure that patients are not only fully informed of all the available options but are likely to receive the best treatment. At least as importantly, it would add a medico-legal component to the current framework for intervention in such patients and return some sense of check and balance to those interventional cardiologists who currently boast that they "no longer refer patients for CABG". I believe that there is some urgency to this recommendation before our position is irretrievably lost.

What are your views? If you would like to write, in support of David's article or have other suggestions how we can make it a more level playing field for Cardiac Surgeons. Send me your article or 'thoughts' to: sunil@ohri.co.uk ■

Staffing & Training in the Future Cardiothoracic Unit - The Middlesbrough Model

Simon Kendall: The Trainers View

We set up our unit at the James Cook University Hospital with 4 registrars brave enough to join our venture, and a rotating cardiology SHO to look after the basic ward duties.

The original surgeons, Hedley Brown and John Wallis, immediately established regular cases for supervised training- and when I arrived 10 months later the registrars thought the training would decrease because I wanted to do three cases a day!

We ran a 'firm' system where one registrar worked with us for 6 weeks at a time and the fourth one 'floated', covering the ITU. As consultants we were either doing the cases or taking the vein / helping with the case, and our presence in theatre ensured prompt opening and closure of the cases. Our registrars worked hard, gained a lot of experience in a short time and were able to develop their surgical skills.

These first principles haven't really changed over the 12 years we have been training, but the infrastructure to support training and patient care has increased considerably. When Steve Hunter joined us three years on we were teaching on 30-40% of our 1000 cases per year, but he made really significant improvements in the structure of our training, combined with John Wallis becoming programme director of the Northern rotation. Steve introduced education contracts for each 3 month attachment, training portfolios, and a monthly wetlab session. Moreover he gave the trainees the opportunity to complete an anonymous assessment of their trainer's performance! After there were 10 assessments on each trainer it was possible to give feedback to the individual trainers.

The Freeman surgeons and ourselves improved our communication regarding the trainees progress, which was significantly helped by the RITA forms being completed in a more transparent manner. The rotating cardiology SHO was never a good solution for our inpatients, and in general they had a miserable time putting up with a busy surgical programme (particularly as they were physicians!).

Steve worked hard to introduce Nurse practitioners to our unit - we were able to recruit/ promote some of our own senior nurses and they now provide an invaluable service to the inpatients, relieving the SHO and the registrars of onerous service commitments. At the same we promoted three theatre nurses to a surgeons assistant degree course - and our aching backs were relieved from taking conduit whilst we could supervise IMA harvesting / cannulation.

More importantly these nurse practitioners helped solve the dilemna of EWTD. We now have a couple of registrars who have learnt their skills in the wetlab *prior* to doing their first cases - this is a wonderful improvement on the 'gluteal clonus' that would occur taking someone through their first few cases. Chris Munsch, Steve Hunter and Jonathan Hyde have put together a very practical method to learn surgical skills in the wetlab prior to exposure in the operating theatre. Our trainees really can develop their skills in the wetlab, so that they can make even better use of their opportunities in theatre.

Over a decade as a trainer I still regard the 'firm' system as fundamental in providing training to the registrar and continuity of care to the patient. But conditions have improved: our registrars now work less hours with an improved work/ life balance; they have really only had to sacrifice the tedious service duties which are now being taken on by nurse practioners and surgeons assistants; the assessment of trainees and trainers is becoming better documented, and we are now on the verge of competence based assessment helped by the wetlab project.

At James Cook I think we are all still really enjoying training further helped by Andrew Owens and Andrew Goodwin joining the team. Of course we have been fortunate to have been able to start afresh 12 years ago, but since then there has been a real commitment from all staff groups to support our training environment and to maintain our progress.

Joel Dunning: The Trainees View

I am a second year LAT registrar, and I have now worked in Middlesbrough for 9 months. My surgical experience on arrival was one CABG and 31 LIMA harvests.

In those 9 months I have now performed 38 operations including 3 aortic valve replacements, a mitral valve replacement and removal of a left atrial myxoma.

The key to the success of Middlesbrough as an unrivalled institution for training has many elements to it, but at its core is the enthusiasm of every single consultant to registrar training. As a result, solutions to the multiple pressures on our time have always been found that prioritise our surgical operating time over service commitments.

There are 8 registrars here to 'serve' our 5 consultants. We run a rotational firm system where each registrar is allocated to a

consultant for 3 months. One registrar covers all thoracic surgery, (attending all thoracic surgical operations also), and the remaining 2 registrars cover nights and annual leave of other registrars.

There are currently a wide range of systems in place that allow much improved time for surgical training which may be broken down into 3 areas: the ward; the intensive care and theatre.

We have a novel system of ward cover whereby one registrar will do a ward round of all the patients on our 2 wards, supported by a Nurse Practitioner and a Cardiology SHO. There are around 40 patients to review which takes until about midday. The registrar rotates on a daily basis but the Nurse Practitioner and SHO are present every day and therefore know the patients well. This system allows the other registrars to go straight to theatres for an 8:30am start. Also if a registrar is away or on nights, his consultant's patients will always be seen without any special arrangements being required. The ward registrar covers the ward for the day, and carries the on-call pager, but the Nurse practitioners use a computer based discharge summary to perform all discharge letters and TTO prescriptions. Registrars thus never have a pile of discharge summaries to dictate in their office or long lists of medications to re-write.

In the intensive care we now have a consultant anaesthetist, often supported by an anaesthetic registrar present on the unit all day. He is also available for HDU and wards. Thus together with the ICU consultant anaesthetist and a registrar on the ward there is never any need for registrars to be called out of theatre to go to ICU or the ward.

Thirdly in theatre we have 3 surgical assistants. As well as vein harvest, they come to clinic and see and discharge patients post-surgery. The surgical assistants are an important component of allowing registrars to progress as this allows us to take down the LIMA and cannulate with the consultant either observing or 'leaving you to it'. As a group of registrars we are also happy to come and harvest vein for each other. Due to the systems in place on the ward, there are often spare registrars available for this. I should also mention that I have regularly taken down the LIMA with my consultant taking the vein which was a first for me!

A further key element in theatres to allow increased training time is the prompt arrival of the patient in theatre. Patients routinely arrive in theatre intubated, cannulated and ready to go at 8:30am! In addition, turn around from the end of the operation to the next patient's arrival in theatre is routinely less than one hour. Thus we often do 3 cases in one day with the second case as a training case, but it is rare to be in theatre after 6:30pm. Of note all our theatre staff are paid to be present in theatre until 7pm and thus there is never any pressure to get finished in order to avoid the 'on-call' staff having to take over.

The 'greatest' change that we have seen this year is the changeover of the registrar rota from a 24-hour rota to a shift system. This caused much anxiety over loss of operating time, and in combination with consultant's leave, registrar's leave and now a week of nights some felt that they would never see their boss! Well 3 months into the new system, it probably does lose you the occasional week of operating every 2 months but it has certainly had less effect than feared.

I think the consensus among registrars is that a week of nights isn't easier for us than the old system in terms of work intensity, it is unsociable and annoying but that's the system we have now so we are getting on with it.

In Middlesbrough there is one quite unique system that markedly minimises the effect of nights, consultant leave and registrar's leave on our training that I have never previously seen in other hospitals. When a consultant finds that his usual registrar is not present or a consultant is covering another on leave, that consultant does not regard this list as a day where he does not train. It is usual practise for that consultant to continue to let their temporary registrar do as much as he would do with his own consultant. Thus although the firm system is the cornerstone of our system, it is the ability to easily depart from this system but continue to train that is a real strength here.

I have not yet mentioned that we do not operate on Fridays. This allows us all to meet every week for academic presentations combined with the cardiologists, it allows us all to attend: the Thoracic MDT every week, a monthly wetlab with 6 pigs hearts, a monthly research meeting where we discuss our research projects and the list goes on. I found this

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system curious initially, packing all our operating into 4 days, but it enables the theatre staff to stay until 7pm and all our meetings are very well attended at all levels, and how many centres can honestly claim that?

So how do you create a system whereby you comply with the ever-changing pressures on registrars and consultants without affecting training? Well the answer is easy. You just need a group of consultants who are committed to training. If the ethos of the unit is to assume that registrars will progress and not just assist, and that there is a training case on every list then registrars will get trained. However, if training is considered as an optional luxury it will always be squeezed out by service pressures.

Andrew Owens: The Clinical Director's View

Despite having previously been a trainee at the James Cook University Hospital, Middlesbrough, and now practicing there as a consultant, I will try to give a 'management view' of the training philosophy at the unit. There are probably three main areas that need to be considered – clinical governance, organisational issues and finance.

In terms of clinical governance, the issues that we face are common to all other units in the country - the commitment to training in the unit doesn't change that, as it is matched by an equally strong commitment to quality. All consultants remain responsible for their practice and we have a rigorous system of real-time and quarterly performance monitoring. The fact that a significant number of cases are undertaken registrars as first operator is not relevant. If anything, it may serve to increase the trainee's understanding of clinical governance and encourage them at a relatively early stage in their career to take an active interest in outcome monitoring, since it has already become an intrinsic part of modern day practice. Our trainees are exposed to all aspects of the clinical governance agenda – we have registrar representation at Directorate meetings and clinical review meetings. These forums expose trainees to discussion of surgeon-specific outcome data and to the validation processes of our data collection systems, with user-specific reports regarding data quality and completeness.

In terms of clinical outcomes we have recently reviewed, in particular depth, the training of registrars in first-time CABG with cross-clamp fibrillation. This demonstrated that more than 50% of the cases were performed by a trainee, the vast majority with the consultant as first assistant, with comparable demographics of consultant cases, except trainees had a lower EuroSCORE (3.3 0.09 vs. 4.0 0.14, p=0.001) and fewer cases with poor LV function. Total ischaemic times were on average only 3 minutes greater in registrar cases. There were no differences in hospital stay or re-opening rates; registrar cases had a slightly lower mortality. This basic data lends support to our training program in that we can maintain quality and train on more than 50% of 'benchmark' procedures.

The organisational issues are inextricably linked to the way in which the unit was established and has subsequently developed. Simon and Joel have both mentioned the throughput we achieve in theatres – this is only possible because the entire team share our training philosophy. Key to this are our anaesthetic colleagues, who work closely with us as part of the Division of Cardiothoracic Services, and thus enjoy a close and open working relationship with the surgical team. We firmly believe that good communication with all members of the team is critical to enabling a positive training philosophy to be applied whilst still maintaining high levels of throughput. Crucially, the training philosophy does not just apply to surgical registrars – we are proud that anaesthetic registrars, military SHO's, medical students and all grades of nursing staff have also enjoyed working in our unit and come away feeling that they had gained valuable experience.

Perhaps the most challenging issue faced as a CD is the financial one. In common with a lot, if not the majority, of other units around the country, we have been put under significant financial pressure within the Trust as it strives to achieve financial balance. As with clinical governance, I don't believe that our attitude to training has any particular bearing on this, we know that trainees performing cases with consultant assistance does not have a significant impact on throughput or productivity, nor is it associated with higher morbidity rates. The biggest financial challenges have been due primarily to the EWTD. We increased our registrar numbers to 8, in tandem with the planned expansion of the unit but despite this, and although currently compliant, the rota we have will not be acceptable when the 48 hour limit is imposed. We plan to address this by looking even more carefully at how and when we train, and perhaps by increasing the numbers of our nurse practitioners. The main problem with this is financial – there is simply no extra money available that I am aware of dedicated to dealing with continuing demands of the EWTD. With the introduction of payment by results we will have to find the funding for extra staff within tariff, which will reduce Trust's income – even if they had the funds, PCT's are unlikely to agree to more long term funding commitments. This issue is further complicated by the current uncertainty surrounding the national requirements for trainees, with the ongoing moratorium on NTN appointments and perceived shortage of consultant posts for current trainees.

To summarise, I believe that a positive attitude to training can be comfortably integrated with a desire to maintain quality and productivity, but only with the support of the whole team. ■

A Letter from America

Ani Anyanwu, Clinical Fellow in Cardiac Surgery, Mount Sinai Hospital, New York, NY,USA

With the current depression in the job market, trainees in the latter half of their training need to plan how they will spend the almost inevitable post-CCT wait for a consultant appointment. Trainees should consider using this delay to enhance their clinical/ non-clinical repertoire. Using this gap period to perform more independent first-time CABG procedures as a senior SpR may become a predominantly service rather than a training experience. One option is to pursue a Fellowship abroad. In this article, I report my experience and offer some guidance to trainees who may be considering a US fellowship.

Timing

The best period to visit the US is probably towards the end of one's training period (year 6). This is a period when one has almost fully trained and operating independently will maximize the utility of the fellowship year. American surgeons respect the surgical maturity and excellent training of most British trainees, and provide British fellows privileges and opportunity commensurate with their experience. Fellowships in the US generally run from July to June.

Planning

The planning process is arduous and somewhat complicated with several bureaucratic hurdles to overcome. The trainee should set aside at least a year from their intended commencement date, with those thinking of a 2007 Fellowship starting now!

a) *Finding a suitable position*

This should be the first step as without a definite offer there is no incentive to see through the rest of the process. The best way to find an appointment is by word of mouth and direct contact. As in Europe, the USA now controls the hours that accredited residents work, such that most academic centres have a need for additional fellows to stop-fill the gaps (similar to LAT, LAS and other similar NHS posts). Sending a CV to the chairmen of chosen units should result in some interest. If selected, the job will be given to you without any advertisement or open competition. British and Australian trainees in particular are well regarded in the US and few departmental chairmen will turn down the opportunity to grasp a British trainee, as they are effectively getting a fully trained independent surgeon on a fellow's salary. Not all hospitals in the US offer a good training fellowship, so the trainee should make direct enquiries to both previous and existing fellows. Some centres also have research opportunities, but the US resident/fellow is usually too busy with clinical work.

b) *ECFMG certification*

The 2nd step is acquisition of the Educational Commission for Foreign Medical Graduates (ECFMG) certification. Overseas doctors are required to obtain certification before they can be licensed as a physician in the US. Certification requires satisfactory performance in a series of examinations by the United States Medical Licensing Examination (USMLE). The Step 1 examination covers basic sciences, while the Step 2 examination covers clinical knowledge. These exams can be taken in the UK but one component of the Step 2 exam (Step 2 CS) must be taken in the US as it involves practical history taking and examination of simulated patients. These exams require preparation. The time required for preparing for these exams will depend on one's basic medical background, medical school training, and exposure to basic sciences and non-surgical clinical practice after graduation. I would recommend you put aside 3 to 5 months to prepare for Step 1, and 1 to 2 months for Step 2, bearing in mind that you will also be working fulltime and have other conflicting commitments. Trainees in years 1 to 3 might consider sitting these exams now at their leisure as it would give them the option of a US fellowship at the end of their training. ECFMG certification also requires a transcript from your medical school, which has to be certified by the current dean.

In rare instances it has been possible to obtain a limited license in certain institutions without ECFMG certification. Such licenses are very limiting. In general if you want to be taken seriously, or want to be marketable, then ECFMG certification is essential.

c) *Obtaining a visa*

After completing the series of ECFMG examinations, your centre will sponsor you for a J1 exchange scholar visa, enabling you to work as a US Fellow. The process for obtaining this visa is relatively straightforward and requires sponsorship by your chosen institution and assurance by the UK Department of Health that there is a need for you as a specialist in the UK, and that you will return to the UK on completion of your fellowship. The major limitation of the J1 visa is the requirement to return to your home country for at least 2 years on completion of training; so the option of extending stay in the US does not exist. This 2-year rule can be waived in specific circumstances. To avoid this restriction one can opt for a H visa, (which does not require a return to one's country), but this will often require sitting another examination (USMLE Step 3) to allow full licensure in the USA.

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Ani Anyanwu (right) performing videoscopic examination of a mitral valve with Professor Adams (left) and Professor Carpentier (centre)

d) *Obtaining a license to practice*

The licensing system in the USA is cumbersome because licenses to practice are issued individually by State Medical Boards, with each state having its own licensing rules and requirements. Before settling on an institution it is important to check the licensing requirements for that state as some states are more demanding of foreign medical graduates than others. Typically, prior to granting a license, most states will first verify your credentials including your identity, birth certificate, passport, medical school, the various jobs you claim to have done, and also your educational qualifications. This process will require many communications to various institutions some of which may be in the distant past. This process typically takes 3 months. Several states use the Federation Credentials Verification Service. This process can be started concurrently while preparing for the USMLE examinations. Once your credentials are verified and you have been granted a visa then the State Medical board will issue a license.

Once all these have been completed then you can go to the US to take up the fellowship. The process is costly both in terms of time and money; you should set aside one year and up to ?4,000 to meet all the costs. The process took me just over a year to complete.

My experience at Mount Sinai Medical Centre in New York

I enrolled for a one-year advanced fellowship in adult cardiac surgery starting in July 2005, but later extended this to 2 years. At the time of writing, I have completed 16 months. Mount Sinai is a moderately sized unit undertaking 900-1000 cardiac cases annually. The department chairman is Dr David Adams who succeeded Dr Randall Griepp 4 years ago. The two major specialist programs in the department are mitral valve repair lead by Dr Adams and aortic surgery lead by Dr Griepp. The caseload in the hospital is somewhat atypical as majority of operations are complex or high-risk cases making it an ideal place for training in advanced surgical techniques. Isolated CABG accounts for only 25% of the practice with the majority being valvular operations and aortic surgery. About 20% are redo procedures and it is not uncommon to encounter patients having 2nd or 3rd time REDOs. Many patients are elderly with assorted co-morbidities and it is rare for patients to be turned down for surgery based on co-morbidity. Interestingly, patients here are not screened for pulmonary function or vascular disease, unlike the UK, becuase regardless of the result they would go to surgery anyway! Age is not a barrier to any form of surgery and octogenarians frequently undergo redo surgery and complex arch or descending aortic surgery.

Working day

The first observation on arriving in the US is that doctors work much longer hours compared to the UK. The hours are long partly because of demands of the system and also, to some degree, inefficiency. Because funds are not limited in the manner seen in the NHS, there is little pressure on time or resources for those patients who can pay for healthcare. The medico-legal climate forces an attention to detail well beyond that I have seen in any UK hospital. For a surgical trainee the working day typically starts at 6 a.m. with ward rounds. The first patients are usually in the operating room by 7 am and surgery starts between 8 am and 8:30 am. Operations here are prolonged mainly because of the aforementioned attention to detail, importance given to training, and the absence of pressure on time. This pays off because the morbidity rate related to technical issues is extremely low. For example re-operations for bleeding are rare, with a rate of 1.4% last year; this is extremely low especially considering that 20% of procedures were REDOs and 20% were major aortic procedures. The drawback is that operations often lasting 6 to 8 hours. Even with an 8 am start it would be unusual to have the first case completed by 1 am. Because there are no anesthetic rooms the turnover between cases is protracted and a second case can start as late as 4 p.m. and last till 9 p.m or even midnight if complex. The working day can therefore ranges from 12 to 18 hours or longer. Initially this seems unbearable but one easily adapts. Saturdays and Sundays are not regular working days.

The work of the fellow is largely limited to care of patients in ICU and operating rooms (you would usually be operating four or five days a week). Fellows do not generally have time to attend clinics and there is no protected time for research. Call duties are similar to those in the UK and we run a shift system where we do a week of nights.

Operative experience

Operative experience obtained in the US, I think outstrips that in the UK in both quantity and quality. This is partly because of the shorter training period (2 or 3 years) in the US. In the US there are no *'consultant cases'*, every case is a potential training case. This is notable considering that the bulk of patients are self-funding or insured patients. Procedures no matter how complex and patients no matter their wealth or status are training cases. A re-operative type A dissection in an 80 year-old at 2 am, will still be done by the trainee, as would a multi-millionaire self-paying patient who needs an elective CABG. The only real limit to what the trainee does is what he or she can achieve. This is why it is preferable to come to the USA at the end of one's training, as the attending surgeons would let you do most procedures. However a year 3 SpR would be too in-experienced to be taken through a complex re-operation. It is unusual to have the attending surgeon stand at the right side of the table except for mitral valve surgery (where you both stand on the right) or complex arch surgery (which would often be done by the attending till the trainee is sufficiently trained to embark on such cases). As a trade-off, many operations are shared (or the attending surgeon would lose their skills!) such that in a bypass procedure the attending surgeon might do one of the distals or proximals from the left side or in an AVR he might take the sutures on the non-coronary annulus from the left side. Indeed working in the US is also a good lesson on how to train. One soon learns that almost everything can be achieved from the left side of the table and a consultant can leave an even inexperienced trainee on the right side and yet do 80% of the procedure himself. The attending surgeons generally treat you as a co-surgeon rather than an assistant such that you contribute to the decision-making and progress of the operation with the trainee and consultant complementing each other. All operations are consultant supervised during the period of aortic clamping so there is no scope for independent operating although the consultant may sit back on a stool or periodically un-scrub while the fellow operates.

Case breakdown

My main focus has been acquiring advanced training in valvular heart surgery and surgery for heart failure. In my period at Mount Sinai I have been trained in Carpentier techniques of mitral valve repair by Dr David Adams. I have also had the opportunity to assist Professor Carpentier himself on several occasions. Professor Carpentier is a visiting professor on our faculty and visits every month. I have also performed a comprehensive array of surgery/REDO surgery on all heart valves including mitral valve repair, surgery for valve abscesses, pulmonary valve surgery, and valve-sparing aortic root replacement. I am the fellow responsible for heart transplantation and mechanical support, and currently perform most of the transplants and ventricular assist devices. The breakdown of cases I have performed as primary surgeon is found in the table. Obviously as in any apprenticeship model, what one achieves as a fellow varies from person to person and depends on knowledge, technical skill, interpersonal skills, and relationships with the trainers.

Advantages of working in the United States

There are opportunities to enhance one's operative experience and expose oneself to less common procedures that may not be practiced regularly in one's base UK institution. There is also a different approach to surgical management including cardiopulmonary bypass, myocardial preservation and peri-operative care. Learning varied approaches to surgical management broadens one's repertoire and educates the

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surgeon as to areas in his or her practice that could be modified. Surgery on high risk or traditionally inoperable cases helps one learn the boundaries of what is achievable. At the present time, the US is the world leader in our specialty such that working in a leading US centre places the trainee closer to the leadership and cutting edge of cardiac surgery. You will be exposed to contemporary innovative procedures and recent surgical advances and will be provided the opportunity to use devices and technology that are not widely accessible in the UK. You will also gain experience in operations that you may not have had opportunity to perform as an SpR, but which you will nevertheless be expected to handle as a consultant, such as repair of aortic dissection or aneurysms and complex REDOs.

By working close to leaders in the specialty, academic openings emerge and you will have opportunities to contribute chapters to leading textbooks, write reviews or editorials for major journals and speak in academic forums. If you are so inclined there are numerous opportunities for publications and presentations; as is well known, submissions from North American institutions have a high probability of acceptance in meetings and journals.

Another benefit of working in the US is that the system is more meritorious than the UK which is driven by NHS service requirements. Above average and hard-working trainees will usually be rewarded with greater responsibility and more opportunities. Because of the prolonged training, British trainees are often more skilled, experienced and clinically decisive than their North American counterparts, so tend to stand out. British trainees will often receive offers of employment to stay on and pursue a career in the US. The possibility of future employment makes a fellowship in the US even more attractive, with the dearth of jobs in the UK, trainees should be prepared to consider career opportunities elsewhere rather than give up Cardiothoracic Surgery all together.

Working in a different healthcare system broadens one's exposure and enables one to learn ways to improve our local systems. There are several lessons doctors in the NHS can learn from the medico-legal and consumer driven health system in the USA such as better public relations and greater recognition and involvement of patients and their relatives. For example, immediately after every operation the surgeon meets the next of kin and debriefs them on the operation, a practice that is infrequent in the UK. Better patient information improves patient satisfaction and reduces complaints and likelihood of litigation.

Disadvantages of working in the United States

Obvious disadvantages relate to relocation with its numerous implications. There are also severe financial implications as the salary for a fellow generally ranges between $50,000 and $60,000. Several visiting fellows have had to supplement their income with savings from the UK. Professionally, one works within tight constraints with little independence. The attending surgeon scrutinizes even the minutest of things (as they will ultimately be answerable if the cases end up in court). In the operating room the attending surgeon virtually controls all your technical moves like a robot such that you have to replicate exactly the same operation he or she would have performed as it is his name and not yours on the record. This is less important for a surgeon who has already operated independently, but for less experienced trainees, it can stifle their ability to make independent decisions. UK trainees will find themselves paying excessive attention to what they may consider as irrelevant detail and will be slower at performing operations. The power of the relatives and patients means you will be answerable and controlled by them in a way you are not accustomed. The nurses here have far less extended roles than in the UK so you will find yourself undertaking several 'mundane' tasks such as removal of chest tubes, wheeling patients to or from operating rooms or CT scanners, and dressing changes. Some aspects of the work you might consider degrading or a misuse of your skills but are simply a reflection of the system rather than abuse of the fellow. ■

Further information

Educational Commission for Foreign Medical Graduates www.ecfmg.org

United States Medical Licensing Examination www.usmle.org

Federation of State Medical Boards www.fsmb.org

Federation Credentials Verification Service www.fsmb.org/m fcvs.html

US Department of State (visa information) travel.state.gov/visa

Table: Summary of logbook for 16 months

	Primary	Redo	All
CABG on-pump	25	0	25
CABG off-pump	11	1	12
Single valve replacement	17	1	18
With CABG	11	1	12
MV repair isolated	22	3	25
With CABG	8	0	8
With tricuspid	28	4	32
Multi valve replacement	11	11	22
Aorta	7	3	10
Other	6	1	7
Heart Transplant	4	8	12
Ventricular assist device	6	2	8
TOTAL	156	35	191

Coronary Artery Bypass Grafts – NCEPOD review

Marisa Cullinane

sAs highlighted in previous Bulletin issues, NCEPOD is undertaking a review of all deaths in hospital following first time, isolated CABG. The study is being performed following a request from the Society for Cardiothoracic Surgery. The aim is to provide an in depth review of each case and be able to identify remediable factors that may have contributed to the death of the patient, other than recognised clinical risk factors, such as organisational and communication issues.

The study will review all deaths between 1st April 2004 and 31st March 2007. Where possible we will also match each case to two controls. The control patients will be those patients that underwent the same procedure but survived. We will be using the Central Cardiac Audit Database (CCAD) data for matching the majority of cases but for those centres that do not supply to CCAD then we have requested the data separately.

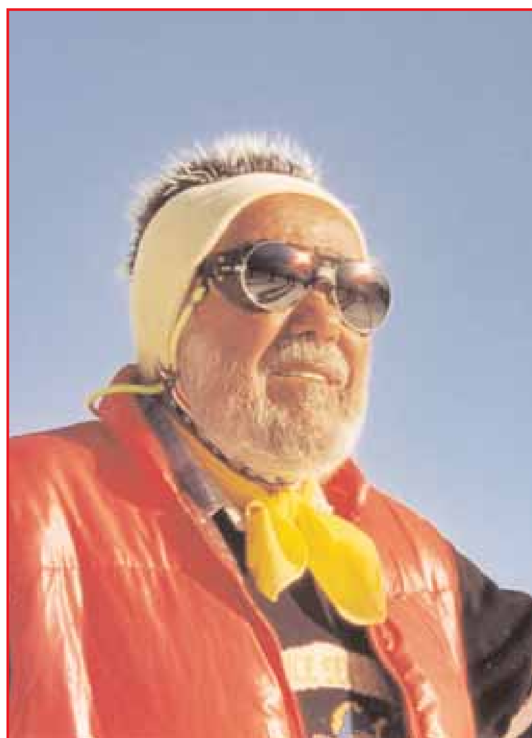
To date we have had 480 deaths reported for the first year of the study of which 81 did not fit our inclusion criteria. While centres have been very good at supplying us with the case information we have been disappointed with the return rate of the associated questionnaires and moreover the return of the extracts of case-notes. As at 10th October 2005 we have only 222 complete sets of questionnaires and case-notes, which is 56% of the cases. Only by reviewing the notes can we make strong recommendations that will support the work of Cardiothoracic Surgeons.

Please ensure that if you do receive a questionnaire that it is completed promptly and that the requested copies of case-notes are returned with it. Similarly if you are aware of a death between April 2004 and March 2005 that you have not received a questionnaire for please let us know.

We are currently sending out questionnaires for the second year of the study as deaths are reported to us and we will shortly be sending out questionnaires for the controls for the first year. ■

cardiothoracic@ncepod.org.uk
Tel: 020 7920 0999

Society Scholarships



The Marian & Christina Ionescu Travelling Scholarship

Through the generous endowment of Marian & Christina Ionescu, the Society will be awarding for the second year this Scholarship for the sum of £10,000. This award is earmarked for newly appointed consultants who are in the developmental stages of their career. The stipend is a contribution towards travelling expenses.

Society Thoracic Fellowship

The thoracic fellowship 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 Fellowship

This fellowship has been made available for a number of years by the generosity of St Jude Medical. A total of £10,000 is awarded to one or divided between 2 individuals for a cardiac fellowship abroad. Applications must be members of the Society and assessment is made of both the strength of the applicant as well as the applicant's proposal.

Deadline for all Scholarships is strictly 14th February 2006. Application forms and further details may be obtained by contacting Isabelle Ferner at sctsadmin@scts.org. ■

Treasurer's Report

B.Sethia, Honorary Treasurer

The last year has been an interesting time for your Hon. Treasurer. First I would like to acknowledge the huge amount of work undertaken by my predecessor Rob Lamb. His policy of accruing funds for our longer-term benefit has been very successful and has helped to place the Society on a strong financial footing. We have also been able to increase our office staffing and most of you will by now have met Isabelle and Rachel, both of whom contribute so much to the smooth running of the Society and the AGM. Last year, as reported by the President in the last newsletter, our funds were further increased by £155,000 as a result of a generous endowment from Marian and Christina Ionescu. These funds are solely restricted for the ongoing award of an Annual Scholarship, first awarded at this year's meeting to Domenico Pagano.

At present we have nearly £400,000 in our reserves and we are actively considering options for the best use of these funds over the next few years. The Charity Commissioners require that we demonstrably utilize our resources in line with the stated aims of the Society. This effectively means that we can use funds for further educational purposes, for infrastructural support or for capital investments, which benefit the Society in the longer term. At our December Executive meeting we will be debating a number of options, all of which seek to consolidate our long-term financial position whilst increasing the value of benefits to the membership.

I have two specific items of good news to share with you. The first concerns Income Tax relief, a subject which has caused a problem for a number of our members. You will be happy to know that Society Annual subscriptions are now formally approved by the Inland Revenue for Income Tax relief from 6th April 2004. As our name still does not appear in the Revenue's approved list of qualifying professional bodies you may need to quote reference SAPP/T1644/11/2005 when applying for this relief. The second issue relates to payments by Direct Debit. Most members now pay by Direct Debit as this is more efficient for the Society. It is however essential that members PLEASE notify Isabelle Ferner (sctsadmin@scts.org) promptly whenever they change their banking arrangements. With effect from January 2006 the Annual Membership Fee for payment by Direct Debit will be reduced by £20- this means that Consultant members will pay £215, Trainees £100 and associates £45 per year.

On that happy note I wish you all a Happy Christmas! ■

Diary of Forthcoming Events

Meeting: Advanced Thoracic Surgery
Date: 11 - 12 January 2006
Venue: Royal College of Surgeons of England
Contact: Cardiothoracic Courses Administration Team
E-mail: cardiothoracics@rcseng.ac.uk

Meeting: Valve Technology Symposium
Date: 19 - 20 January 2006
Venue: St. George's Hospital, John Parker Lecture Theatre
Contact: Miss Frances Williams, Symposium Administrator
E-mail: frances.williams@stgeorges.nhs.uk

Meeting: 42nd Annual Meeting of The Society of Thoracic Surgeons
Date: 30 January - 1 February 2006
Venue: Chicago, IL United States
Contact: The Society of Thoracic Surgeons
E-mail: sts@sts.org

Meeting: Introductory Cardiac Surgery
Date: 1 - 3 February 2006
Venue: Royal College of Surgeons of England
Contact: Cardiothoracic Courses Administration Team
E-mail: cardiothoracics@rcseng.ac.uk

Meeting: SCTS Annual Scientific Meeting 2006
Date: 13 - 16 March 2006
Venue: CityWest Hotel and Conference Centre, Dublin, Eire
Contact: Isabelle Ferner
E-mail: sctsadmin@scts.org

Meeting: Applied Basic Science for Cardiothoracic Surgical Trainees
Date: 5 - 6 April 2006
Venue: Royal College of Surgeons of England
Contact: Lorraine Judge
E-mail: l.judge@staff.rcsed.ac.uk

Meeting: Charing Cross 28th International Symposium - More Vascular & Endovascular Controversies - Incorporating The Global Endovascular Forum
Date: 8 - 11 April 2006
Venue: Sherfield Building at Imperial College
Contact: Chris Timmins, Richard Steele or Mary Kennedy
E-mail: info@cxsymposium.com

Meeting: 55th International Congress of The European Society for Cardiovascular Surgery
Date: 11 - 14 May 2006
Venue: St. Petersburg, Russian Federation
Contact: Professor Claudio Muneretto, Secretary General
E-mail: munerett@master.cci.unibs.it

Meeting: Introductory Thoracic Surgery
Date: 31 May - 2 June 2006
Venue: Royal College of Surgeons of England
Contact: Cardiothoracic Courses Administration Team
E-mail: cardiothoracics@rcseng.ac.uk

Meeting: Heart Failure 2006
Date: 17 - 20 June 2006
Venue: Helsinki Fair Centre
Contact: Stephan Siboni, Congress Manager
E-mail: ssiboni@escardio.org

Annual Scientific Meeting Dublin, 13-16 March 2006

Isabelle Ferner, Society Adminstrator

The annual scientific meeting, the fourth to be run by the Society itself is going to be held in Dublin between 13th and 16th March 2006. Home of Guinness, James Joyce and Molly Malone, whatever your interests or tastes you will find that Dublin has something to offer. As one of the oldest cities in Europe, Dublin provides a multiplicity of cultural riches, from the ancient to the avant garde: from history, architecture, literature, art and archaeology to the performing arts. Monuments in literature and stone mark the history of writers, poets and the people of Dublin.

The meeting itself will be held at the CityWest conference centre and hotel which obviates the need to walk or hang around waiting for transport every morning during the conference. Unless of course you want to stretch your legs on the 18 hole professional golf course. There will be coach transfers to and from Dublin airport and each evening, complimentary transport will be provided to take you into the heart of this enchanting city.

We recognise the importance of expanding and developing the meeting each year, and for 2006 we are introducing forum sessions which will contain abstracts that present clinical series. Scientific sessions will contain abstracts reporting research data. Further details are available at www.scts.org. We are also welcoming the inaugural Forum for Cardiothoracic Surgical Practice to recognise that the delivery of care to patients undergoing cardiothoracic surgery is increasingly multidisciplinary. This will take place between 14th and 16th March and this year is aimed at database managers and nurses but any non-medically qualified staff will be welcome. The meeting will close with a symposium considering cardiothoracic surgery from the point of view of the patient, speaking at this will be Harry Cayton, the National Director for Patients and the Public.

Our guest speakers are Dr Doug Wood and Dr Tim Gardner who will be delivering keynote speeches as well as taking an active part in the postgraduate sessions.

No meeting would be complete without the annual dinner and this year we urge you to book your seats as soon as possible upon the opening of registration to ensure that you won't miss out. The event will be held on Thursday 16th March at the Guinness Storehouse and you will be entertained from the moment you step from the coach and enter this historic and beautiful working museum. After a tour of the exhibition you will be taken by glass elevator up to the Gravity Bar where you will receive a pint of Guinness whilst you take in the simply breathtaking views afforded by the 360 degree glass surrounded bar. A sumptuous 3 course dinner with further entertainment will be followed by the annual prize giving and farewell speech by our outgoing President, Mr Patrick Magee. Although as usual we would like gentlemen to wear a dinner suit, you might like to consider wearing a spotted bow tie to fit in with the mood of the event.

Organising a successful annual meeting has become one of the key goals of the Society and we realize that it is imperative that the handover from one meeting secretary to the next is handled as professionally and smoothly as possible. Subsequenly, a deputy meeting secretary post has been created which will allow the incumbent 3 years to learn the minutiae of meeting organization and enable a seamless handover. The initial incumbent is Mr Simon Kendall who will take the post until March 2007 when he will replace Mr Graham Cooper.

Registration will be open from 1st December 2005 and will be online only. Log on to www.scts.org and follow the links. Accommodation will be onsite and rooms can be booked directly with the hotel at a favourable rate (tel: 00 353 1 401 0500). Please remember to quote the annual meeting when booking. Further details about the facilities provided at the CityWest hotel can be found by logging on to http://www.citywesthotel.ie.

If you have any questions regarding registration or about the meeting itself, please contact Isabelle Ferner in the Society Office at sctsadmin@scts.org or by telephone at 020 7869 6893.

We look forward to welcoming you in Dublin. ■

AGM Programme Dublin 2006

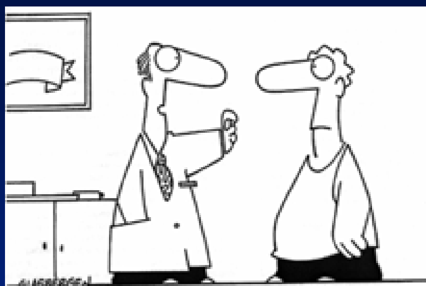
Monday 13th March

13.00 to 14.00	Lunch **Trainee Members Only**
14.00 to 17.00	Training in Cardiothoracic Surgery
17.00 to 17.45	Lecture: 'From the Ephemeral to Utopia' Marian Ionescu
18.00 to 19.30	Annual Business Meeting 1 **Members Only**
19.30 to 21.00	**Welcome Reception**

	SCIENTIFIC MEETING	FORUM FOR CARDIOTHORACIC PRACTICE
Tuesday 14th March		
09.00 to 10.00	Session 1 (Oral)	
10.00 to 10.45	**Tea & Coffee**	
10.45 to 11.45	Session 2 (Interactive)	Data Use in Cardiothoracic Surgery Supported by CCAD
11.45 to 12.30	Pulse Lecture: 'Lung Volume Reduction Surgery: Before and After the National Emphysema Treatment Trial' Doug Wood	
12.30 to 13.45	**Lunch**	
13.45 to 15.15	**UK Activity and Practice**	
15.15 to 16.00	**Tea & Coffee**	
16.00 to 17.00	Session 3 (Adult Cardiac Clinical Practice)	
17.00 to 18.00	St Jude Post-Graduate Session 1: 'Beating Heart CABG Surgery' Tim Gardner	

	SCIENTIFIC MEETING	FORUM FOR CARDIOTHORACIC PRACTICE
Wednesday 15th March		
09.00 to 10.00	Session 4 (Congestenital Clinical Practice)	
10.00 to 10.45	Tea & Coffee	
10.45 to 11.45	Session 5 (Interactive)	Nurses Meeting Supported by Ethicon
11.45 to 12.30	Heart Research UK Lecture: 'Cardiac Surgery and the Brain: What we Know and What we Should do About it?' Tim Gardner	
12.30 to 13.45	Lunch	
13.45 to 15.15	Annual Business Meeting 2 **Members Only**	Nurses Meeting Supported by Ethicon
15.15 to 16.00	Tea & Coffee	
16.00 to 17.00	Session 6 (Adult Cardiac Clinical Practice) St Jude Post-Graduate Session 2: 'Surgical Management of T3/T4 Non-Small Cell Lung Cancer' Doug Wood	Nurses Meeting Supported by Ethicon
18.00 to 20.30	UK Medical Symposium	
Thursday 16th March		
09.00 to 10.00	Session 7 (Thoracic Clinical Practice)	
10.00 to 10.45	Tea & Coffee	
10.45 to 11.45	Session 8 (Oral)	Nurses Meeting Supported by Ethicon
11.45 to 12.30	President's Address: Pat Magee	
12.30 to 13.45	Lunch	
13.45 to 15.15	Symposium: 'The Patient's Contribution to Cardiothoracic Surgery'	
15.15 to 16.00	Tea & Coffee	
18.00	Coaches Leave for Annual Dinner	

PCI... An Alternative View



"I'm going to stick this piece of metal inside your artery, blow it up, expose you to a bit of radiation with may be 3 or 4 drugs on board… believe me it's all very non-invasive"

"I will give it to you straight….. you're a diabetic smoker with crappy heart function and no vessels to speak of…. so I'm going to refer you to a surgeon"

"I'm going back next week for some more stents"

"With this new drug-eluting stent, tissue forms on the outside, thus preventing in-stent stenosis"

Please send crossword answers to **Sam Nashef** who incidentally is also a winner, obtaining the highest studio score for the BBC Test the Nation Know Your English Test. Well done Sam for promoting the image of Cardiothoracic Surgeons being highly intelligent, gifted yet modest individuals!.

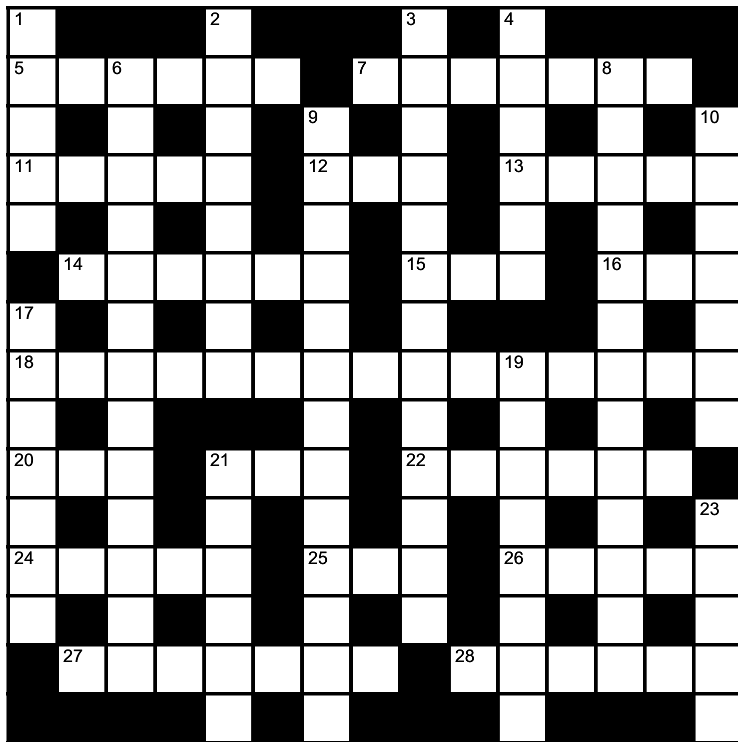
Edited by Sunil Ohri,
Publishing Secretary
Contact: sunil@ohri.co.uk

New Consultant Appointment

Congratulations to Patrick Yiu who was appointed consultant at New Cross Hospital to commence in Dec 2005.

Designed & Produced by CPL Associates, London

CROSSWORD



Across

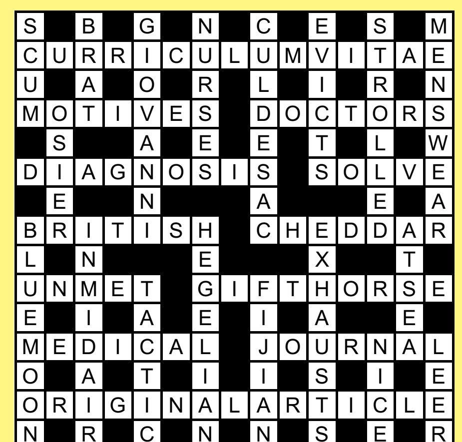
5 Day nursery crew and chef without tails (6)
7 Secretary wearing shred is the model of perfection (7)
11 Crime of churchman losing head (5)
12 Anger in the heart of the siren (3)
13 Previous lot to return praise (5)
14/15 Bottom solver: pantomime baddie is here (6,3)
16 Trouble Titanic encountered? Partly (3)
18 Enema kept gasman running from boardroom babble (10,5)
20 See 19 down
21/21down Spooner's girl trades these on the beach (3,6)
22 Gaffer in marathon, choking (6)
24 Rubbish organs (5)
25 Poem sounds outstanding (3)
26 Story starts from a big literary editor (5)
27 Horns cause sternal disruption (7)
28 Tricks house shortly before a sex change (6)

Down

1 Big 21 in viva voce and written exams (5)
2/8 Slim monarch unpacked creativity in 18 (8,7,3,3)
3 See 19
4 Sweet exit with gold (6)
6 Reorganise ten fragmented health authorities (and get this back?) (7,6)
8 See 2
9 Naughty nurse amid some naughty acts (13)
10 Nice weather (18 for the type of 2, 8) (4,3)
17 I am one gallery ape (7)
19/20/3 Give similar message in 18 - choir usually does (4,4,3,4,4,5)
21 See 21 across
23 Be a saint or an animal (5)

Previous winners:

Steve Livesey & Jonathon Hyde (Champagne on route chaps! courtesy of Edwards Lifesciences)



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