SAC News update

Tim Graham, Chairman SAC

First of all I would like to congratulate the previous chairman Chris Munsch on his appointment to chairman of JCST which is now the Joint Committee for Surgical Training encompassing the previous JCHST and now core/basic surgical training. Chris has done a great job as chair of the SAC during a difficult and turbulent period. He was primarily responsible for the cardiothoracic curriculum which is held in high esteem by the surgical community.

I was appointed as chair of the SAC following an interview in October. Other personnel changes on the SAC have occurred. John Pepper has been appointed the Educational Secretary and he will now attend the SAC instead of the Secretary. The trainee representative Farrah Bhatti has successfully been appointed to a consultant post and a new trainee representative will be attending the meeting on 14th December. There will be 2 SAC vacancies from February 2008 to replace Chris Munsch and Jim McGuigan (who I would also like to thank for all his hard work over the past 3 years). The SAC welcomes applications from consultants with appropriate educational and training backgrounds to fill these vacancies. Steve Hunter continues in the important role of Cardiothoracic Dean for the next 2 years and has taken the lead with recruitment and selection into the specialty. Steve Livesey has taken on the role as deputy chair of the SAC.

Selection into the specialty 2008

For the MMC 2008 round of recruitment there will be 5 NTN vacancies in England, at the ST3 level (this is a total of 7 for 2008 as 2 ST2's are already in place). Scotland, Wales and Northern Ireland will probably also recruit 1 NTN each. The SAC will undertake national recruitment and selection and person specifications, details and criteria for short and long listing have been submitted to MMC. The SAC and Programme Directors will be involved in selection and one of the national deaneries has agreed to undertake administration of the process in 2008.

The recent ruling regarding the status of highly skilled migrants means that issues related to medical immigration will continue and make medical manpower planning difficult for the foreseeable future.

Whilst we are on MMC - the recent Tooke Report has been put out to consultation and the SAC has reported back to JCST and a joint response from them and the colleges is being submitted. In brief the findings and recommendations of the Tooke Report were welcomed but we are unsure if there is the political will needed to implement the recommendations fully. For the time being MMC is still with us and the ST1-8 system remains in place.

Manpower

There appears to have been some improvement in manpower problems with currently fewer CCT holders unemployed than previously predicted. This is due to a combination of CCT holders going into non consultant posts and other unforeseen factors. It may be that the problem has simply been postponed due to relatively large numbers of trainees having RITA E's to either overcome deficiencies in training or to delay their CCT date. The SAC is currently in the process of undertaking a UK survey to identify the exact numbers of HST trainees by type, year and region and the number of CCT holders who are currently not in consultant posts or other employment.

The recent ruling regarding the status of HSMPs (Highly Skilled Migrant Programme) means that issues related to medical immigration will continue and make medical manpower planning difficult for the foreseeable future.

Other News

The PMETB survey of trainees is due to be re-run in 2008; some specialty specific questions have been added for cardiothoracic trainees. In the previous survey there was some potentially serious issues raised but the methodology and distribution of the survey was flawed and we hope the 2008 survey will be a more accurate reflection of the current state of cardiothoracic training.

There has been some tightening up of the administrative procedures for trainees undertaking out of programme experiences (OOPE). There must now be prospective PMETB and SAC approval and we would recommend that contact with the SAC is made as soon as possible if this is being considered by any of the trainees (scipriano@rcseng.ac.uk).

Steve Livesey is the lead for the continuing development of the intercollegiate surgical curriculum. The SAC firmly believe that cardiothoracic surgical training in MMC must be linked in with the curriculum and its assessment tools. However all surgical trainees should be encouraged to register with ISCP and encourage their trainers to do so as well!

The SAC continues to consider article 14 applications and reassuringly PMETB has agreed with all the cardiothoracic SAC recommendations. There are several outstanding applications and the administrative process remains painfully slow, prompting JCST to suggest a more streamlined simpler process for dealing with these applications.

Professor John Wallwork has taken on the role of academic lead for the SAC and he is developing an academic curriculum as research remains a core element of the cardiothoracic syllabus. Two Walport lecturers have been appointed to the West Midlands programme (these were both existing NTN holders) and 1 has been appointed to the Northern programme. Professor John Pepper is currently reviewing the situation regarding academic clinical fellows being appointed to the specialty.

I can be contacted by email tim.graham@uhb.nhs.uk

Can I encourage as many of the trainees as possible to attend the trainees meeting on the Sunday afternoon of the SCTS meeting in Edinburgh (9th March 2008)- this is a real opportunity for you to air your opinions and be updated on the current training situation.

Update on The Intercollegiate FRCS(CTh)

Robert Jeffrey
Chairman, Intercollegiate Specialty Board in Cardiothoracic Surgery

The examination continues to evolve and I am grateful for the enormous contribution of my predecessor in this position, Mr Leslie Hamilton. The standard at which the examination is set is now considered to be at the level one would expect from a first day consultant.

Under Leslie's guidance, the exam now comprises of two sections. Section 1 is a multiple choice paper with 110 single best answer questions and 135 extended matching questions. It is sat some three to four months ahead of section 2 and following the examination, a rigorous standard setting exercise takes place and the pass mark is set. Those who are successful are then eligible to sit section 2 which comprises a clinical and oral part. Both cardiac and thoracic surgery have long and short cases. Short cases are supplemented with stations where candidates may be questioned on investigations, instruments, angiography and echocardiography. In the oral exam basic science has been dropped as this can be more consistently examined in section 1, and we now only have cardiac and thoracic orals. Each segment of section 2 lasts 30 minutes and candidates are examined by two examiners who should not be the candidate's current trainer. No candidate should see the same pair of examiners again but an examiner may be partnered with a different examiner.

Section 2 of the examination therefore has six parts, and candidates are marked over six domains in each part. The standard close marking scheme continues, i.e. 4 for a poor fail, 5 for a just fail, 6 for a just pass, 7 for a good pass, and 8 for an outstanding performance. In addition, the examiners now mark independently and are encouraged to use the full range of marks since a 5 in one part needs a 7 elsewhere to compensate and allow the candidate to pass. To pass the exam candidates need a total of 432 (6 x 36 x 2) and an overall pass in the clinical part. Once a year, the McCormack Medal is awarded to the highest scoring candidate over both diets of the exam. The medal is only available to those sitting the examination for the first time.

To further enhance the fairness, robustness, and professionalism of the exam, there is now a clear quality assurance programme in place. Each examiner is observed by one of the quality assurance panel, and his performance is fed back to him following the examination. The candidates should perhaps feel more comfortable in the knowledge that not only are they sitting an examination, but the examiners themselves are being observed to ensure objectivity, courteously, equality and impartiality.

For further information about the examination go to www.intercollegiate.org.uk. The closing dates for entry to the examination, the dates and sites of the exams are available by following the calendar link.

Once again, I should like to acknowledge the considerable input by Leslie in making this examination fit for purpose, and I wish all prospective candidates the very best when they come to sit this exam.