The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should: • Include no more than 500 words of text, three authors, and five references. • Type with double-spacing. • See http://jtcvs.ctsnetjournals.org/misc/ifora.shtml for detailed submission instructions. • Submit the letter electronically via jtcvs.editorialmanager.com. Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity of offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.
The authors reported no conflicts of interest. The Journal policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.


REPLY: INTERNATIONAL PARTNERSHIPS TO HELP TRAIN THE WORLD’S CARDIOTHORACIC SURGERY WORKFORCE: Reply to the Editor:

The Letter to the Editor submitted by Vervoort and Velazco-Davilla is a response to an article by Nissen and colleagues describing an international overview of cardio surgical training in developed countries. The authors point out many of the well-known gaps and limitations in cardiac surgical training in low- and lower-middle-income countries (LLMICs).1 They argue that there are gaps in country-specific training in LLMICs. They suggest that sponsors of training programs in neighboring countries or in regional programs should tailor curricula to local and regional needs, many of which are unique and are not necessarily in the mainstream of cardiothoracic surgical education and training. It is hard to argue with the authors’ premise. Yet, there are some additional relevant facts worth mentioning that temper the authors’ message.

The authors focus on needs for specialized surgical trainees who can respond to country-specific surgical needs. They do not mention the unmet needs for ancillary medical services that are specific for cardiothoracic surgery. These ancillary needs are paramount and include nursing, perfusion, and intensivists among others needed to support surgeons within a cardiac program. In many LLMICs, these ancillary services may be even less available than surgeons.2,4 While there are some limited training programs available for cardiothoracic trainees in these underserved areas, there may be even less availability of training for ancillary services to support advanced surgical techniques and cardiac-specific care patterns.

The authors also point out the unique cardiothoracic needs of LLMICs and the relative absence of LLMIC-specific cardiac surgical curriculum in training programs. Again, it is hard to argue with this assertion. The authors provide some vague suggestions about filling the needs in LLMICs and even offer a model used in the Nordic countries. It would help to have some concrete, region-specific proven models to point to as possible ways forward. The sad fact is that there are few successful locoregional models that exist and even fewer models supported by LLMIC countries. The authors are stating an important and obvious message that needs to be heard. What might make a bigger impact is to produce some concrete recommendations using a region or several LLMIC countries as examples. Others have made similar observations to those of the authors. Often what is lacking in these observational efforts are proven solutions. Because of constraints on the manuscript length of Letters to the Editor, it was not possible for the authors to outline comprehensive plans for enhancing global cardiothoracic surgical care. The Commentary by Vervoort and Velazco-Davilla highlights some well-recognized global problems related to specialty surgical care. It would be refreshing to cite some concrete examples of a way forward. Unfortunately, the way forward is not clear and needs much increased interest on the part of local, regional, and worldwide cardiothoracic surgical workforces.

It is worth pointing out that the original article by Nissen and colleagues describing differences in cardiothoracic training in developed countries triggered a much-needed discussion of the worldwide disparities in cardiothoracic surgical care and education. It is a sad but critical fact that nearly one half of the world’s population does not have access to adequate advanced cardiac surgical care, much less specialty training programs. The number of deaths as a result of this limitation is incalculable, but enormous. As a specialty, we have avoided this fact to a greater or lesser extent, and Editorial Commentaries and associated Journal articles that draw attention to this consistent disparity in care are an important initial part of the process to gain international attention. This added attention could begin the process of fixing a problem that has existed over a very long period of time that is neither acceptable in the eyes of cardiac surgeons nor tolerable in the eyes of countries suffering from the lack of advanced cardiac care. I hope that the dialog created by this series of Commentaries will stimulate much needed efforts at change.

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References