

the **bulletin**



Society for Cardiothoracic Surgery
in Great Britain and Ireland

July 2014

***The Cardiothoracic Surgeon is dead;
Long live the Cardiothoracic Surgeon***

Visit to Memorial Hermann Texas Medical Centre

***The Patient, The GP and the Primary Care Team:
Relationships on Trial***

SCTS Education: NCCG Course

Outcomes Data

***Professionalism: Developing a
True Cardiothoracic Surgeon***

Cardiothoracic Surgery: Career Workshop

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Presidential Address: James Roxburgh

James Roxburgh



Final Report

There was until recently, a long-standing tradition in the Foreign Office that a retiring Ambassador would submit a final report to the Foreign Secretary. This



report could cover a variety of topics but was intended to summarise the current situation in that particular country and give a view on the future problems that Her Majesty's Government might expect. However in practice it was often a vehicle to vent frustrations, express anger and at times be wonderfully politically incorrect. It was, right up to the time of its demise in 2006, known in typically archaic civil service terminology as the Valedictory Dispatch, even though they were no longer hand-written. Indeed it is ironic that it was the fact that this final Valedictory Dispatch was widely distributed by e-mail that led to the banning of the practice by the then Foreign Secretary, Margaret Beckett.



Sir Ivor Roberts

Sir Ivor Roberts's was Her Majesty's Ambassador to Italy and it was his final dispatch in 2006 that caused so much trouble. He wrote:

'Too much of the change management agenda is written in Wall Street management-speak which is already tired

and discredited by the time it is introduced. Synergies, VFM, best practice, benchmarking, silo-working, roll-out, stakeholder, empower, push-back and deliver the agenda and fit for purpose are all prime candidates for a game of bullshit bingo, a substitute for clarity and succinctness. A personal aversion is the Utopian mission statement (so 1980s)'.

He goes on to say when talking about the use of management consultants in the Foreign Office that:

'in recent years there has been an explosion of the use of consultants many of whose recommendations do little more than the reverse recommendations of the previous consultants'

You might say that this sounds frighteningly like the current NHS but I couldn't possibly comment. Anyway I hope that my Presidential address doesn't lead to future Presidential Valedictories being banned!



A surgeon requires mental ability, physical stamina as well as a highly developed set of psycho-motor skills. In this regard a surgeon is not dissimilar from a musician, a sportsman or an airline pilot - to whom we are often compared. I would like to draw upon these professions as well as others to look at the career of a surgeon.

It can be argued that in any of these careers there are three phases; become good, stay good and get out while you are

still good! I would like to look at these three phases using work by psychologists on a wide range of situations and then draw it together at the end to show how I think the NHS needs to change the way it deals with individuals.

10,000 hours

In the early 1990s, a team of psychologists in Berlin studied violin students by examining their practice habits from childhood, through to adolescence, and adulthood. Each violinist was asked

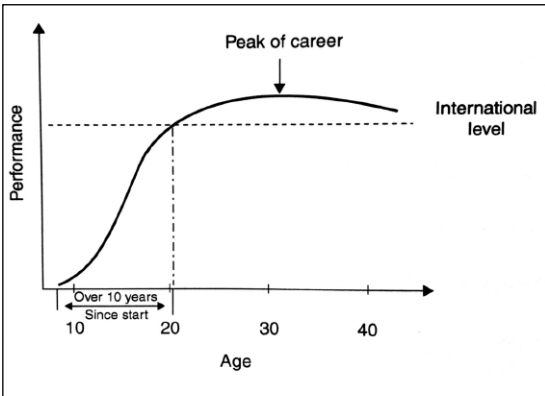


'Over the course of your entire career, ever since you first picked up the violin, how many hours have you practiced?'

All of the violinists had begun playing at roughly five years of age with similar practice times. However by the age of eight, practice times began to diverge and by the age of twenty, the elite performers averaged more than 10,000 hours of practice each, while the less able performers had only 4,000 hours of practice.

This 10,000 hour or 10 year rule was popularised by Malcolm Gladwell in his book 'Outliers' and was further expanded upon by Matthew Syed in 'Bounce - the science of success' but it is a very well established principle in modern psychology and has been championed by Prof Ericsson in the States. They all argue very persuasively that "Natural Talent" is largely a myth.

Presidential Address: James Roxburgh *continued*



This graph shows improvement in performance over time, in this case it is for an international chess player but it can be applied to any complex psychomotor skill. Performance reaches a plateau, in this case International competition standard, at around 10 years. A peak is reached sometime after that and then performance begins to tail off.

However it is important to note that it is not simply putting in the hours that counts. I drive to work everyday and on average I spend 2½ hours a day driving in and out of London. It took 19 years of commuting before I clocked up 10,000 hours of driving to and from St Thomas' but I haven't turned into Stig's cardio thoracic cousin!

What is required, in addition to the 10,000 hours is deliberate practice and feedback. Deliberate practice is focused and structured training that concentrates on tasks beyond your current level of competence and comfort. In other words you arrive at a seemingly unattainable level of expertise in small incremental steps each one being difficult but not impossible to attain. At the same time though the fledgeling expert must continue to hone the skills they already have.

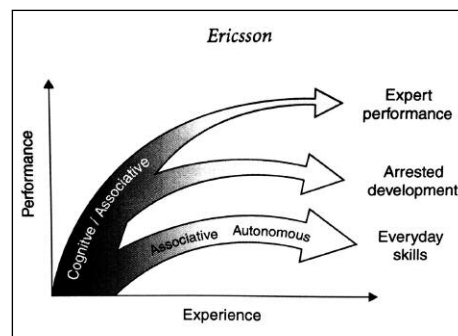
However deliberate practice without feedback is, in the words of Matthew Syed, like going to the driving range at night. It doesn't matter how many balls you hit and how good your coach is if you can't see where the balls are landing it is a somewhat meaningless exercise.

So how does all of this translate into becoming an expert? There are three phases in acquiring a skill, the cognitive, the associative and the autonomous.

The cognitive phase is the initial learning stage where movements are slow inconsistent and inefficient, and although

there are large gains, performance is less predictable. In the associative phase the gains are less marked but the technique becomes more refined and and reproducible; however considerable concentration is still required. Finally the autonomous stage is reached where movements are accurate, consistent and efficient with little conscious effort being required.

The graph below shows that in an every day tasks such as driving the aim is to progress as rapidly as possible to the autonomous stage thus allowing you to use your mobile phone, change the CD and switch lanes on the motorway at all at once.



An expert uses the techniques described earlier, deliberate practice and feedback, to stay in the cognitive and associative phases as long as possible to ensure they reach the highest level of performance. If the embryonic expert loses the drive to excel, for whatever reason, they move into the autonomous phase and "peak early"!

Performance

It is well known that manual dexterity, strength and visulo-spatial ability decrease with age along with cognitive skills and the ability to sustain attention. The question has therefore been does this actually translate into a reduction in performance levels?



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Experience-Based Mitigation of Age-Related Performance Declines: Evidence From Air Traffic Control

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Abstract
 Previous research has found age-related deficits in a variety of cognitive processes. However, some studies have demonstrated age-related sparing on tasks where individuals have substantial experience, often attained over many decades. Here, the authors examined whether decades of experience in a fast-paced demanding profession, air traffic control (ATC), would enable older controllers to perform at high levels of proficiency. The authors also investigated whether older controllers would show diminished age-related decrements on domain-relevant cognitive abilities. Both young and old controllers and noncontrollers performed a battery of cognitive and ATC tasks. Results indicate that although high levels of experience can reduce the magnitude of age-related decline on the component processes that underlie complex task performance, this sparing is limited in scope. More important, however, the authors observed experience-based sparing on simulated ATC tasks, with the sparing being most evident on the more complex air traffic control tasks. These results suggest that given substantial experience, older adults may be quite capable of performing at high levels of proficiency on fast-paced demanding real-world tasks. The implications of these findings for global skilled labor shortages are discussed.

Studies of expert musicians and chess players have suggested that maintaining a high level of deliberate practice is the single most important factor in negating the age-related deterioration. Perhaps more relevant to us as surgeons is a study of Canadian Air Traffic controllers which demonstrated that experience can indeed mitigate against the age-related decline in performance.

You may not recognise this man, he is Chesley "Sully" Sullenberger III, he is 59 and has 19,000 hours of flying experience but why is this important?



Well he was the the pilot of this plane.



United Airlines Flight 1549. I think we can all agree he is an expert and there does not seem to be any age-related deterioration in his psychomotor skills or his ability to concentrate from takeoff to landing in the Hudson. If you want to listen to a masterclass in being cool under stress then you can listen to the cockpit recordings on YouTube.

Presidential Address: James Roxburgh *continued*

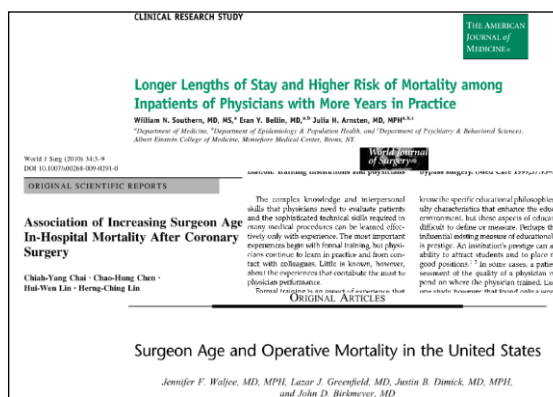
However there is a limit to this compensation. Airline pilots face mandatory retirement at 65 and I understand from BALPA, the British Airline Pilots Association, that pilots holding a Captain' rank who are over the age of 60 routinely sit in the co-pilot's seat or to use the correct jargon - the right hand seat.

A somewhat unlikely source of information on the decline of an expert comes from the Inland Revenue who have published tables listing the pensionable ages for a wide and diverse group of occupations. Downhill skiers can retire at 30, footballers at 35, money broker dealers at 50 and airline pilots at 55; and of course we all know that psychiatrists retire at 55!

So is any of this information relevant to the cardiothoracic community? I'm sure many of us will recognise the normal process of gradually increasing the complexity of training cases is a form of deliberate practice which is far more productive 'than see one do one'. Whilst simulator training is a routine part of an airline pilots life it is the exception rather than the rule in surgery. There is though some interesting research using laparoscopic simulators that suggests that the tipping point in terms of speed of recovery and outcome for treated patients is around 200 simulated procedures and interestingly this is the exact number of major cases that the SAC expects of aspiring consultants.

I trained in an era when Senior Registrars had considerable operative experience by the time they became consultants but even so I doubt any of us felt we had reached our personal plateau, whatever that turned out to be, until several years into our Consultant careers. Many would, I am sure, agree with me that this probably amounted to 10 years of intense exposure to cardiac or thoracic surgery. To day the newly appointed consultant is under even more pressure to perform for the Trust from day one than I was when I was appointed and so it needs to be understood by all concerned that the consultant appointment does not equate to becoming an expert. It is simply an important step.

In this article from last year's BMJ it was noted that serious complications, which often happened early in the surgeon's career, made the surgeon more



conservative or risk-averse. It could be argued that this is the 'event' that causes a surgeon to move into the autonomous phase and thus fail to reach their potential.

Studies have shown that doctors are poor at assessing their own weaknesses and level of performance even though they think they are good at it and thus feedback in all its forms is just as important to the surgeon as a coach, which is another form of feedback, is to the tennis player. As Lord Kelvin, the 19th Century scientist stated, 'If you cannot measure it, you cannot improve it.' and whether we like it or not quantitative feedback is necessary. I would though argue that this should be much more than mortality data and we should be focusing on what really matters to our patients, the vast majority of whom survive. Every single one of us involved in outcome measures knows we are forever scrabbling around to find the money to retain data managers and pay for software. The amount of time and effort from surgeons, both locally and nationally, that is provided FOC to the NHS is considerable. In my unit the cardiac surgery contract income is, according to the managers, around £14 million but there is no quality assurance budget I can assure you that British Airways know exactly how much they spend and why!

There is conflicting evidence on the performance of surgeons as they approach their late 50s and early 60's. In one large study of 461,000 Medicare patients age was not an important predictor of risk for the vast majority of procedures but when a deterioration in performance was noticed it was only for 2 specific procedures - pancreatectomy and CABG but not, interestingly, AVR It most marked in those undertaking

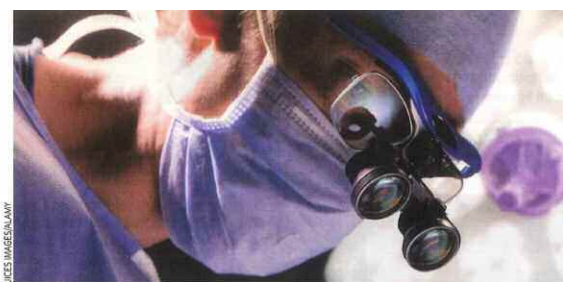
lower volumes. and lower volumes in this case refers to the US measure of volume i.e 50-75 cases. This, of course, chimes with the work on deliberate practice and the older musician. However we must accept that whilst many surgeons can continue into their late 60s some will find that they notice a deterioration in their performance before they reach the mandatory retirement age.

At that point we should accept that it is time to move into the co-pilots seat but Air NHS can only afford to fly with one pilot per plane!

The Politicians, the Press and the Public are demanding more and more outcome measures and surgeons are working in what seems like a more and more adversarial environment. The important question is? 'Does the outcome measure we currently use - death - really provide the best feedback' and as I have alluded to above I would argue that it does not.

The NHS must spend more time and money to provide better feedback which will benefit surgeons and patients. I believe the target driven NHS needs to understand much more about how to get the very best from its consultant surgeons and it can only do this if it understands that becoming an expert and staying one is both difficult and extraordinarily complex and that the needs and demands vary throughout what may be a career of over 25 years.

The hire and forget approach to a Consultant's career is not the way to get the very best from this fabulously expensive resource. You may think that appraisal and revalidation is the way forward. I couldn't possibly comment but it is certainly another rich source for the game of bullshit bingo!



Guilt, anger, and career concerns were among the reactions surgeons reported after major complications

Surgeons say they lack institutional support when things go wrong

Honorary Secretary's Report

Simon Kendall

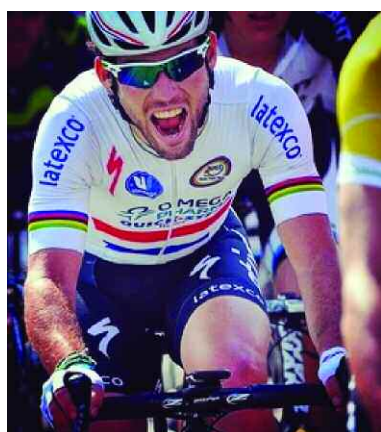


Individuals and Teams – Delivering Contemporary Surgery

Who are your heroes and heroines?

Johnny Wilkinson? Ellen MacArthur? Nelson Mandela? James Cook? Thanks to literature and modern media we can share the achievements of some absolutely amazing individuals.

I'd like to mention two of my heroes. As a Newcastle United and England supporter it hasn't been a particularly momentous lifetime of sport to put it bluntly. But then on holiday (July 2008) watching the Tour de France, a 23 year old Englishman emerged to win from the sprinting pack. Amazing. And he did it again in horrendous conditions the next day.



Mark Cavendish. Anyone who cycles 3000km over three weeks against the best of the world is a hero. But to keep up with the speed and emerge from the chaos of a 60 km/hr bunch sprint and win time and time again is phenomenal. He has now won the sprint points competition in the Tours of France, Spain and Italy as well the road race world champion in 2012.

The other hero I'd like to mention is more relevant to our specialty.

After 20 odd years of varying discomfort and more recently an undisguisable limp the time had come to get my hip replaced. Having assisted at such operations as a houseman and registrar I was not relishing the assault on my body. Over the years I picked up gossip about which orthopaedic surgeons were doing a good job – and there was one name that consistently stood out with the respect theatre staff had for him.

Apart from directly asking colleagues in the hospital who they would recommend there really was no other way to assess the competency or results of the orthopaedic surgeons. And the skills of the anaesthetists were based only on hearsay.

Meeting him in outpatients I hung on to his every word and I had little interest in hearing the full list of potential complications. As far as I was concerned he could put any implant in me that he felt was suitable! We discussed a provisional month for surgery and that was it. Nothing. No correspondence, no information.

So – hip replacement in December as a Day Case. Now this is mainly down to the anaesthetist – he wasn't a complete supporter of the enhanced pathway protocol but he recognised that consistency was important – he administered a cocktail of drugs along with an adept spinal that had me doing the stairs 6

hours later. The surgeon had seen me before the procedure (he didn't look like he'd had an extra glass the night before) and popped in before he went home – and very reassuring to hear his view how the procedure had gone.

And after a week the dressing came off and revealed a 10 cm scar. How can you do that operation through that size of incision? – and watching the You Tube clip of this approach it is even more amazing.

But the point of all this is..... a new hero: Andy Port – Orthopaedic Surgeon. He has transformed my life.

All of you reading this appreciate that this is what we do week in and week out. As surgical care practitioners, trainees et al we try to have that same empathy and compassion throughout our careers – but when multiple other distractions come into life it can be forgotten what a major part we can play in our patients' lives. They pick up on our every word, observe our body language and are placing a huge amount of trust and responsibility on our shoulders. And even when the NHS makes our job feel more and more difficult and less and less valued we shouldn't let it detract from how we present ourselves.

This experience stimulated some reflection on how cardiothoracic surgery compares to this limited experience of orthopaedics. On a patient level cardiothoracic surgery is at least trying to give patients some meaningful data on outcomes and performance – and many in our specialty are copying patients into the correspondence. At the same time reflection on how our specialty is innovating and evolving and finally how the individual is so dependent on their team.

Our patients can look up our performance – our SCTS site is public. It may not tell the whole story but it shows the sort of work we do, the numbers we achieve and our mortality figures. It must be reassuring for them that not only are we collecting the data but we are sharing it as well. More and more patients seem to be 'looking us up' before they have their surgery – and I certainly wasn't able to do that with my surgeon, just relying on the privilege of inside knowledge.

Is it possible to take this further? – the bottom line is to get a surgeon working in a safe team delivering great results, but would it be good to have some idea of their other professional skills – how their previous patients have rated them? What their team think of them? How effective their team is at covering problems? And the vital question whether the car parking is free? Whilst we have a monopoly on health care we don't have to compete for patients – but could this be the added value that patients could look up on a Health 'Trip Advisor' to help make their choice?

Honorary Secretary's Report *continued*

Progress

Many of us copy our patients into the correspondence about them. In other aspects of our lives we expect to be involved in the correspondence – with solicitors, builders, insurance policies etc. In our specialty we discuss the major issues of life and death / risks and benefits / freedom from cancer etc and it would be reasonable to share those odds / figures in writing – not only for the patient but also for those they want to share it with such as their their nearest and dearest. The letters have to be a little considered and 'patient friendly' but complaints are rare, and it is useful when the patient points out the occasional inaccuracies.

The 10cm incision was a reminder of innovation and progress. It can be easy to be cynical about the claimed benefits of small incisions – 'it doesn't make any difference' 'you can't do as good an operation' 'there are more risks'. However the innovators in the UK and around the world have helped to inspire the new generation of surgeons to try and make these minimal approaches the norm. Minimal access mitral surgery, performing AVR through a manubrial incision, VATS lobectomies as an expected standard of care, Endoscopic vein harvest becoming the norm. And it is extraordinary to watch a VATS thymectomy getting a better result than could ever be achieved through a sternotomy.

Day case cardiac surgery isn't with us – yet - but thoracic surgery has certainly moved to admission on the day of surgery and has the potential to reduce length of stay with enhanced pathways.

Teamwork

These innovations are only possible with a whole team approach – minimal mitral surgery requiring close anaesthetic and perfusion input; enhanced pathways requiring specialist nurses and anaesthetic expertise.

Teams – Johnny Wilkinson gave his interviews after his last games for Toulon and never missed an opportunity to praise and thank his team. Nelson Mandela regarded himself as a servant to all of his people. And Mark Cavendish will always acknowledge that he can't win on his own – he needs the 100% commitment and sacrifice of his team to get him in the right place. And in turn these remarkable and determined men feel / felt an enormous responsibility to give their utmost for the team and reward their colleagues with success.

But our surgical teams may not necessarily have the same unity behind the common goal that the England rugby team have. Our teams may have the diversity of the African National Congress where strong leadership is needed to keep all the factions on the same path. The the responsibility that comes with publication of our outcomes is almost completely borne by the consultant surgeons: for instance the anaesthetist covering ITU will certainly be caring for the patient but won't necessarily understand the impact of another death to the performance of the surgeon and the unit; and the trainee will want to avoid morbidity and mortality but doesn't comprehend the pressure their trainer is under to prevent a bad run in their figures. The problem for most of us is that the publication of our results tends

to isolate surgeons making them nervous about high risk cases and giving less cases to trainees. It would be so much better to share this pressure and this responsibility through the team so there is a common goal for better patient outcomes. The team of surgeons may be best placed to communicate and lead this sharing of responsibility, but as Mark Jones described in the last bulletin, this needs the surgeons to set an example and work constructively together.

On a patient level cardiothoracic surgery is at least trying to give patients some meaningful data on outcomes and performance

At the Board of Representatives meeting in December, Ralph Tomlinson (Head of the Invited Review Mechanism at the RCS London) told us how they have been called in to many different units and different surgical specialties where teams and / or individual surgeons are having problems. The trusts pay for this service and the resulting report belongs to the trust. With the experience they have accrued they have picked up on common themes that have caused these problems and often caused by a breakdown of effective team working due to a variety of issues. They have developed a questionnaire - a sort of self assessment - to help surgical teams gauge how they are functioning. Perhaps it is a test of your team if you can even contemplate completing this questionnaire – but it is a good start to see where you are and where you can develop. And on the same theme in Edinburgh at the AGM we had a presentation from a medical director who had turned around a unit with some difficulties and concluded that 'the Soft Stuff is the Hard Stuff'. Meaning that tackling the inter-personal problems, the behaviours, the trust and respect within in the team is the really difficult stuff to sort out.

So the hip replacement has been a blessing on a personal level, but has also given so much added value on a professional level: A reminder of what is important to patients through their surgical journey and also a reminder of what we've achieved in cardiothoracic surgery. We are in a new era in the delivery of surgery. Not just proving ourselves as competent professionals but also helping the team we are in to be effective and that we are a constructive part of that team. Still room for heroes and heroines – but not doing it alone and working hard on working together.

The Cardiothoracic Surgeon is Dead; Long Live the Cardiothoracic Surgeon

Mahmoud Loubani
Consultant Cardiothoracic Surgeon/Honorary Clinical Senior Lecturer



It is with a heavy heart and extreme sadness that I read the obituary of the Cardiothoracic Surgeon by Mr Simon Kendall in the December issue of the SCTS Bulletin.

However, as I read further it became apparent that this is maybe not an obituary of the brave Cardiothoracic Surgeon who has served his patients and this speciality with dedication and excellence but in actual fact is a do not resuscitate order. This was puzzling as it had not been obviously discussed with the Cardiothoracic Surgeon before it was issued and his opinions were not sought. Obviously that was in the good old days before the judgement of the court of appeal ruling on the 17 June stating that a do not resuscitate order with someone who has mental capacity without discussing it with him would constitute an infringement of their human rights.

Cardiac and thoracic surgeries are extremely complementary disciplines and this has been recognised on numerous occasions by the GMC who have refused to separate the two and declare thoracic surgery as a speciality of its own. However, faced with that decision a number of thoracic surgeons have still decided to carry on the struggle for independence of thoracic surgery believing that alone thoracic surgery will flourish. Their concerted efforts have been very successful so far and they are to be commended on their achievements in nearly acquiring self-determination and the right of independence for thoracic surgery from the overbearing cardiac neighbour.

Changing Practice

The fellowship exam in Cardiothoracic Surgery of the Royal Colleges of Surgeons since inception has been set at the level of first year of consultant in the speciality of cardiothoracic surgery and we expect all trainees at that level to be knowledgeable in all areas of both cardiac and thoracic surgery. This is likely to continue despite attempts at tweaking it as it is a prerequisite for the award of Certificate of Completion in Cardiothoracic Surgery. It is not unrealistic to expect fully qualified consultants to be able to maintain that level of knowledge. In fact, our speciality and field does not change so dramatically that we are unable to keep with the changes in both cardiac and thoracic surgery. We are all required to maintain our CPD and knowledge and this is easily achievable in the multitude of meetings and courses on offer that we can attend. Most have dedicated thoracic or cardiac sessions which we can attend and attain knowledge of the major developments and changes in the speciality. Anyone who has attended conferences recently would

notice that most of the topics are recurring topics, which have not changed significantly over the last 5 to 10 years with very little new material added. I therefore think keeping up with this level of knowledge in Cardiac and Thoracic Surgery would not be a problem.

The MDT's advent has been a great success and has streamlined the management of a lot of patients and improved their access to services and outcomes. The presence of both cardiac and thoracic MDTs is something to be applauded. However, most people would be able to attend a cardiac MDT lasting an hour to an hour and a half and a thoracic lung MDT lasting between an hour and an hour and a half in most job plans without undue stress or over stretching themselves. The two meetings would equate to 1PA which would easily fit into most job plans. The forming of friendships and good working relations with respiratory physicians and cardiologists would not be beyond the capabilities of most cardiothoracic surgeons obviously dependent on their sociability and conviviality.

Separating cardiac from thoracic surgery in such a small speciality would be detrimental to both

Direction of Travel

The direction of travel is set by people travelling. However, the cardiothoracic surgeons don't seem to be involved in this process although they are the ones asked and coerced to travel most. The most ardent leaders and institutions in the world have at some stage or another made direction changes, course redirection or plain U turns once it became apparent there was a need for it. It follows that the direction everybody seems to be asked to travel at present can certainly be changed or reversed.

Job plan approval is an issue that has to be taken seriously and the presence of a lung cancer MDT can be argued sincerely, however if a cardiac surgical job plan does not include a Cardiac MDT, is it also going to be rejected?

The Cardiothoracic Surgeon is Dead..... *continued*

Furthermore the SAC's direction of travel is to separate cardiac from thoracic surgery but this is a decision that was made to separate them without the need for it. The training programmes that have produced many cardiothoracic surgeons in the UK and across the world are capable of producing more fully trained surgeons. However if the decision is not to produce any more then there will be none produced and this becomes a self-fulfilling prophecy. If trainees are forced to choose cardiac or thoracic surgery very early in their career this might be a disadvantage to them rather than allowing them to decide later on in their training and also to give them the option of training as cardiothoracic surgeons if they wish to do so. With a training system becoming a competency based system if a trainee manages to satisfy all the competencies for both thoracic and cardiac surgery which may mean longer training time, they should be given the option to pursue that and be allowed to compete for cardiothoracic jobs if they become available. The Cardiothoracic exam has been an exam in the cardiac and thoracic fields and have been tested and tried and has produced good results with good validity and consistency. Changing the exam is not required or needed for the time being and separating it into cardiac and thoracic will not improve the depth or width of knowledge by trainees or their surgical skills, attitudes or behaviours.

Service Delivery

There are 63 cardiothoracic surgeons as listed on the SCTS website in the UK who provide thoracic surgery services to patients. It is difficult to know if all of these surgeons are being forced to choose which sub speciality; whether cardiac or thoracic will be their choice, however assuming the majority would go for cardiac surgery then that would leave quite a big gap in the country to fill with service provision and delivery for thoracic patients in general and lung cancer patients in particular. Currently we do not have sufficient trained thoracic surgeons to fill that gap even by 2018, which will mean having to import thoracic surgeons from outside the country with all the inherent problems of fitting into the NHS. Over the previous ten years training was nearly shut down as a result of poor manpower planning, this did not stop training but merely abdicated responsibility for it. Despite the banning of new appointments of substantive Cardiothoracic Surgeons there is a continuing demand for this role by various Trusts across the country, who are already seeking long term cardiothoracic locum posts, creating a new under class of consultants. Furthermore, a cardiothoracic surgeon is a more versatile individual who could both fulfil cardiac and thoracic surgery requirements within a department and if there is more demand on cardiac surgery then they could do that or extra thoracic cases if required. If no ITU beds are available then more thoracic cases can be performed. However, once you separate the two specialities it becomes more regimented and this flexibility is lost. Furthermore units that have satellite clinics and MDTs in the periphery would have

to send a cardiac and a thoracic surgeon to each of these clinics and MDTs rather than sending one person. This is certainly not cost effective; especially in the current climate of the NHS cuts, which will pose problems for a lot of the smaller departments who will not be able to automatically appoint two or three thoracic surgeons to fulfil the requirements for trauma and on calls.

In conclusion, the direction of travel is something we decide on and is not set in stone. There has been a concerted effort by a small number of thoracic surgeons to change the face of the speciality in the UK and they have been successful in their attempts in pushing that agenda a long way. However, separating cardiac from thoracic surgery in such a small speciality would be detrimental to both and would be the first step towards the formation of a new thoracic surgical entity, which will, in line with the ESTS competing with EACTS will compete with SCTS for membership and a voice. This will not serve either group as we will always be better and stronger together. It is up to the Cardiothoracic Surgeons to lead on the resistance to separatist movement and to probably develop a unified approach to this if there is appetite for it around the country.

Mr Mahmoud Loubani

Congratulations

Tara Bartley, OBE

*Simon Kendall
Tim Graham*

Last week Tara received her OBE from Prince Charles for her services to Cardiothoracic Surgery. She was put forward jointly by the Society, the College of Surgeons and the Royal College of Nursing.

Many of you will be aware of Tara's achievements - she has worked in cardiothoracic surgery in Papworth, Oxford, Walsgrave and now Birmingham where she leads a team of specialist nurses. However her award is mainly for the work she has done over and above that. From 2006 to 2012 she was the Nursing representative on the SCTS executive and delivered 6 superb nursing fora at 6 consecutive AGMs. She has been involved in several projects reviewing workforce in our specialty and extending the roles of the allied health professionals. Tara has also initiated and delivered the annual Advanced Cardiothoracic Surgery Practical Course and is a leading faculty member on the CALS course. In 2011 she received the prestigious Fellowship from the RCN and now has roles in Europe with EACTS in the Quality Improvement Programme, contributes to the American Association of Critical Care Nurses and in the UK is currently shaping the newly formatted exam for the SCPS.

During all these immense achievements she has somehow made room for plenty of family time with her husband Roger and their sons Miles and Lewis.

Many of the recipients the Queen's Honours are well deserved and this is one such example - Tara's achievements have been delivered in her own time over and above her 'day job' and our Specialty has significantly benefited from her endeavours.



94th American Association for Thoracic Surgery Annual Meeting

A UK trainee perspective

Keng Ang, Trainee, East Midlands Deanery
Attilio Lotto, Training Programme Director, East Midlands Deanery

I recently had the privilege to attend and present at the recent 94th American Association of Thoracic Surgery Annual Meeting at Toronto, Canada in April 2014. As a trainee, the meeting was a very unique and wonderful experience which I would highly recommend to all trainees.

The meeting was very well organised with a structured theme this year focusing becoming a master surgeon and educator. It started with a 2-day postgraduate course, delivered by leaders from respective fields. This year course highlights included a luncheon with presentation by Dr Delos Cosgrove, Drs. Alain Carpentier, Aldo Castaneda, and F. Griffith Pearson. This was followed a very intense scientific programmes covering various aspects and innovations in cardiothoracic surgery. In line with the theme of meeting, there were 2 guest lectures about effective coaching which can be applied for surgical training by Rick Pitino, Master coach of the 2013 national collegiate basketball champion, and Margaret Moore, CEO of Wellscoach Corporation; as well as an inspirational presidential address by Dr Sugarbaker about the concepts of "**Clarity of Purpose and Focused Attention, the Essence of Excellence**". There were also sessions by invited UK speakers: Professor Martin Elliott, and Professor Peter Goldstraw. The meeting concluded with video sessions on the Masters of Surgery by experts in the fields, sharing their techniques and tips of various procedures.

From a trainee perspective, I have benefited immensely from both from the educational experience as well as presenting in this meeting. It was also a great opportunity to meet the different experts in the field of Cardiothoracic Surgery. Furthermore, there was a special luncheon organised for trainees/residents during the meeting whereby you have can meet and interact with fellow trainees as well as the different training programme directors in North America over a formal lunch.

Overall this was a fantastic international experience for me, and as Dr Sugarbaker has described in his presidential message "*where your skills can be retooled and your outlook recharged for our specialty of cardiothoracic surgery.*" I would strongly recommend all trainees to attend this meeting if they have the opportunity.

Keng Ang, Trainee, East Midlands Deanery

Attilio Lotto, Training Programme Director, East Midlands Deanery



Guest Lecture; "Development of a Surgeon", by Dr Delos M Cosgrove, CEO and President of Cleveland Clinic – sharing his experience as a military surgeon



Presented on the use of novel dual lumen cannula for adult vvECMO, and was privileged to meet up with the co-inventor of the cannula, Dr J Zwischenberger after the presentation



Ionescu Scholarship 2013

Visit to Memorial Hermann Texas Medical Center, Houston

Deborah Harrington

As the recipient of the 2013 Ionescu scholarship I am extremely grateful to Mr and Mrs Ionescu and the Society for Cardiothoracic Surgery for this prestigious award.

I was appointed as the fourth consultant cardiac and aortic surgeon at the Liverpool Heart and Chest Hospital in March 2013. We have a dedicated thoracic aortic service and perform an increasing number of aortic cases, currently between 150 and 180 per year. Last year our unit performed 40 open thoracoabdominal aortic operations which is more than any other centre in the UK but still substantially fewer than major centres in the US. Thoracoabdominal aortic surgery is extremely challenging for the whole multidisciplinary team, requiring



surgical maturity and also interaction with many other team members. It requires complex anaesthetic and perfusion support including spinal drainage, left heart bypass, and specific neuromonitoring techniques. We have recently set up a neuromonitoring service using motor evoked potentials but this is in its infancy compared to similar services in the US. We also have an advanced aortic nurse practitioner, the first of its kind in the UK.

Professor Hazim Safi leads the cardiac and vascular programme at Memorial Hermann Texas Medical Centre. This is a world renowned institution for all aspects of complex aortic surgery including approximately 100 open thoracoabdominal aortic procedures per year. Our unit is fortunate to have an ongoing association with Professor Safi and his team and indeed he recently attended the fifth Liverpool Aortic symposium. He invited me and other members of our multidisciplinary team to visit him and his unit in order that we may continue to develop our aortic programme and improve outcomes for patients in the UK.

As well as me, our team comprised a senior clinical perfusionist, scrub nurse, neuromonitoring technician and advanced aortic nurse practitioner. We spent a week in January 2014 at the Heart and Vascular Institute at Memorial Hermann Hospital. During this time we saw the whole range of aortic operations including

redo arch surgery, descending aortic and thoracoabdominal aortic replacement.

As a surgeon I benefited hugely from observing multiple major aortic cases being performed by Professor Safi and his team. One of the major learning points was the flow of the operation which was seamless and the result of excellent teamwork and communication.

Our clinical perfusionist Sarah Shirley and senior scrub nurse Leny Varkey both found the experience extremely rewarding and an opportunity that they would otherwise not have had. Our neuromonitoring technician Fatemeh Jafardazeh gained a huge amount from working closely with Dr Huen a clinical neurophysiologist expert in spinal cord monitoring during thoracoabdominal aortic surgery. Michael Roberts, our aortic nurse practitioner had a fantastic time working on the ICU and 'floor' with his American counterparts who have much more autonomy than here in the UK. He hopes to be able to subsequently develop his role further back in Liverpool.

We also found time for a team visit to the Johnson Space Centre including historic 'Mission Control' and this provided us with our new motto, in the words of Gene Kranz, *'failure is not an option'*.

We are indebted to Professor Safi and his entire team, particularly Professor Tony Estrera who looked after us impeccably throughout our visit.

The award of the Ionescu scholarship meant that the entire multidisciplinary team could benefit from this exciting opportunity and allow a coordinated and cohesive approach to the development of complex aortic procedures here in the UK.



SCTS Education NCCG Course in Cardiothoracic Surgery

26 June 2014

Dear Colleague,

Re: SCTS Education NCCG Course in Cardiothoracic surgery

I write to you on behalf of the Education secretaries and the SCTS Education committee. I will be grateful if could circulate this to your clinical Fellows, Staff grades and Associate Specialists. SCTS Education's vision is to offer education and training courses to all the multi-professional staff of our wide speciality.

The Cardiothoracic medical workforce comprises of Consultants, trainees and non-consultant career grade doctors. There are various programmes which are aimed at Consultants and the Tutors have formalised a structured curriculum based courses for the trainees under the auspices of the SCTS education. The NCCG doctors do not get opportunities to attend meetings and the funding is limited, moreover they provide the service allowing the trainees to attend these educational events.

SCTS Education has addressed this gap in their training needs by constructing a course aimed specifically for NCCGs in CT Surgery which covers both clinical and professional aspects. The course covers general professional development topics in the morning and specialty specific current updates in the afternoon. The course will be free for NCCGs in Cardiothoracic surgery and will be offered by careful selection.

Venue: Clinical Sciences Building, University Hospitals of Coventry and Warwickshire, Coventry

Date: 8th September 2014

I have attached the draft agenda for your perusal and circulation. Please advise them to contact me regarding the course registration (srathinam@rcsed.ac.uk).

Kind Regards

Mr S Rathinam

Consultant Thoracic Surgeon & SCTS Thoracic Surgery Tutor
(on behalf of SCTS Education)

SCTS Education



SCTS Symposium for NCCGs • 8th September 2014 • University Hospitals, Coventry

REGISTRATION FORM

Refundable Deposit Fee £100

Name _____

Position _____

Number of years in specialty _____

Qualifications: MRCS / FRCS (CTh) / Other (please specify) _____

Main interest: Cardiac / Thoracic / Undecided _____

GMC Number _____

Institution _____

Address _____

Contact number _____

Email _____

Are you a member of SCTS? Yes No (Preference will be given to SCTS members)

I have herewith attached a cheque for £100 payable to the **Society for Cardiothoracic Surgery in Great Britain and Ireland** as a refundable deposit.

Signature _____

Date _____

Please send the cheque and form to: **Mr S Rathinam**, Consultant Thoracic Surgeon, Department of Thoracic Surgery, Glenfield Hospital, University Hospitals of Leicester, Groby Road, Leicester LE3 9QP

Cardiothoracic Forum

@ the SCTS Annual Meeting - Edinburgh

Christina Bannister
SCTS Nursing & Allied
Health Professional
Representative

The CT Forum at the Annual Meeting in the International Conference Centre in Edinburgh was a resounding success. Participation was good, we had over 60 nurses, doctors and allied health professionals attending during most of the sessions.

We had a large number of abstracts entered for the CT Forum this year and accepted 25 for presentation. My congratulations to all who submitted an abstract that was accepted, they were all exceptionally well presented. The audience selected the following papers as the 'SCTS Cardiothoracic Forum Best Paper' as the marks resulted in 1st and 2nd place winners;

1st Prize 'Should Recipients Choose their Donor? A National Survey of Patient Donor Choice Consent Forms'; Katie Morley and Stephen Clark, Freeman Hospital, Newcastle Upon Tyne.

2nd Prize 'Early insights from a Surgical Care Practitioner delivered EVH program'; Steven Power, V. Srivastava and Joe Zacharias, Victoria Hospital, Blackpool.

The winner for the 'SCTS Cardiothoracic Forum Best Poster' was Sarah Sherwood and Heyman Luckraz from New Cross Hospital, Wolverhampton with their presentation entitled 'Specialist Nurse Meetings - Communication is Key'.

The CT Forum had five sessions this year spread over the two days in Edinburgh. Our first session, planned for Tuesday 11th March was based on general cardiac issues, with some presentations looking at the principles of pre-assessment, nurse prescribing and transplant donor choice consent processes.

Following a joint plenary session with the main meeting, the CT Forum session, commenced with Andrea Spyropoulos, the President of the RCN, giving the opening remarks and a national perspective on nursing issues. The main plenary speeches were then followed by the general thoracic session with four presentations. To finish off the session we were able to listen to a fascinating plenary presentation by Scott Balderson, Lead Cardiovascular & Thoracic Surgical Physician Assistant, from Duke University Medical Centre who shared with the room an insight into the role of the physician's assistant in thoracic surgery.

The day was completed with a session updating the Cardiac Advanced Life Support Course (CALS). Three presentations were given, and an update from Joel Dunning with regards to current practices in cardiac advanced life support and changes in the protocols.

The sessions comprising Wednesday 12th CT Forum were based on Advanced Nurse Practitioner (ANP), Surgical Care Practitioner (SCP) and Physician Assistant (PA) working practices. Our first session had an international perspective with plenary talks from David Lizotte, the President of the Association of Physician Assistants in Cardiovascular Surgery (APACVS) in the USA; and Professor Marcus Hoffmann, programme director of the Physician Assistant programme at the DHBW University, Karlsruhe, Germany. These were followed by a presentation by Maureen Jersby, senior lecturer in adult nursing at the University



of Teesside, who gave an update in the future developments in relation to Surgical Care Practitioner education.

Once we had heard from our plenary speakers the floor was opened up for an extremely lively and stimulating discussion around the new updated SCP curriculum, training opportunities, the SCP exam and other issues pertinent to the SCP community. We had participation from senior members of the SCTS Executive and Sam Nashef, lead surgeon for the SCP Cardiothoracic exam, who had been in consultation with the Royal College of Surgeons. This proved to be an exciting session with plenty of opportunity for discussion from participants.

Our final session on Wednesday lunchtime looked in-depth at working practices in cardiothoracic theatres with a focus on surgical site infections and cardiothoracic wound management, with presentations examining all aspects of enhanced roles.

The CT forum in Edinburgh was a big success. We gained a new network of core nurses and allied health professionals across the country who have an interest in progressing training, development and service provision with cardiothoracic surgery, it was great to meet all the participants at the CT Forum who came from a wide range of backgrounds; from nurses, medical staff, surgical care practitioners, physiotherapists, physician assistants and other allied health professionals across the country. I would like to take this opportunity to thank all the plenary speakers, chairs, presenters and participants without whom the CT Forum could not exist. Not only do we all learn from others at the Forum but the networking and shared working practice information that we all get is invaluable. Thank you for your support, I am learning from your comments and suggestions and I urge you all to encourage your colleagues in nursing and allied health professional specialities to attend next year's forum in Manchester, where we are planning to run the first CT Forum stream at the SCTS University.

Surgical Care Practitioner Update

Consultations with the Surgical Care Practitioners remain ongoing, currently there are many streams of work progressing.

With regards to University courses and training, Steering Group meetings are being led by Maureen Jersby at Teesside University, and are working on curriculum development.

Cardiothoracic Forum

@ the SCTS Annual Meeting - Edinburgh

Consultations with the Royal College of Surgeons of Edinburgh have been held, which Tara Bartley attended in my absence. This discussion looked in-depth at the previously Royal College of Surgeons of England, London backed SCP exam. Funding issues still remain, and Mr Norman Briffa has agreed to chair the joint SCTS/ACSA exam board.

Scott Prenn have managed to secure funding with Ethicon for a SCP Master Class in Conduit Surgery for CABG. This is planned for later in the year, hopefully November, at the Manchester Surgical Simulation Centre. We will place information on the website once we have confirmation.

Discussions are continuing for increased involvement of ACSA with the SCTS, especially with regards to formal recognition of the Cardiothoracic Surgical Care Practitioners.

EACTS

The postgraduate nurses' day at EACTS will be run by nurses and allied health professionals from the UK and the Netherlands. Plans are in the final stages for this year's day which will be held in Milan on Sunday 12th October 2014. The SCTS CT Forum top marking presentations will be invited to present at this meeting. Please encourage attendance from all nurses and health care professionals as this is a great opportunity to link with nurses and allied health professionals across Europe.

The EACTS Quality Improvement Programme (QUIP) programme still continues - looking in-depth at quality standards across Europe with the concept to bring together common aspects and setting a benchmark for establishing quality improvement. This involves a review of current nursing quality outcomes; the implementation of a quality pathway for patients, and a review of outcome measures, examining established protocols and practice guidelines.

For any nurses and allied health professionals that would be prepared to share good practice with our colleagues around Europe and get involved with the QUIP programme please contact Tara Bartley, Lead Nurse for QUIP at Tara.Bartley@uhb.nhs.uk

Wider nursing issues

The RCN Congress was held this year in Liverpool in June. One of the main topics for discussions was around the proposed national pay increase. especially in the light of the recommendations of the pay review body, which the government have rejected. Dr Peter Carter highlighted this in his address and said that nurses and health care professionals should be united in strength for the fight for fair pay. He added that he was concerned that the lack of a pay increase would force more nurses out of their profession causing a crisis in the health care system.

In a key note address Sir Robert Francis QC told Congress while the technicalities of nursing are important, it's vital not to lose sight of the essential aspects of nursing care. He went on to say 'I fear that all of us have been taking nurses and nursing for granted. At its heart and soul it is a profession and vocation that is devoted to the care of patients. We need to cherish that central fact - or it becomes just another job.' This resounds soundly for advanced nurse specialists and surgical care practitioners amongst us who often find ourselves providing care for patients in a manner light years away from the basic, hands-on care we were trained to do. Although extended practice and advanced roles are important we must ensure that, as cardiothoracic nurses and allied health professionals we maintain a high standard of holistic care for our patients and their families.

Finally Andrea Spyropoulos, the RCN President, gave her farewell speech in which she praised the role that nurses provide in caring for patients. She said nursing staff were weary of constant demands to 'do more with less', and said it was time for a change. She went on to ask nurses to stop describing themselves as 'only a nurse'. 'There's no such thing as 'only a nurse'. You are a professional, you are well educated, you have a vast array of skills and you are truly great communicators.'

SCTS CT Forum Contacts

The SCTS CT Forum Facebook and Twitter page continue. The CT Forum is for all nurses and allied health professionals to belong to and I encourage you all to sign up to these pages and help us to communicate between all health care professionals working in the field of cardiothoracics, whether it be in outpatient departments, wards, intensive care, theatres or the community. We would like as many nurses and allied health professionals to join, to show that cardiothoracic health professionals have a voice and want to work together to improve the care provided for all patients.

The links for the pages are as follows, please pass these details on to as many nurses and allied health professionals that you all know and encourage everyone to participate.

Follow us at Twitter - [@SCTS_CTForum](https://twitter.com/SCTS_CTForum)

Join the Facebook Group - [SCTS CT Forum](https://www.facebook.com/SCTSCTForum)

If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward their name, address and title to me at Christina.Bannister@uhs.nhs.uk or chrisiebannister71@gmail.com or direct to Tilly Mitchell at tilly@scts.org

Chris Bannister

Nursing & Allied Health Professional Representative

Outcomes Data: A Letter from the Executive

16th June 2014

Dear Colleague

The Executive are aware that there is disquiet regarding the publication of surgeon specific data with its potential impact on risk averse behaviour and the working lives of members. We understand that cardiothoracic surgery is a team undertaking but cannot make an argument that outcomes data should be published at unit rather than individual surgeon level unless we can show that internal processes for, submitting and validating data, and responsibly acting on the outputs are robust. We write to remind you of the process behind the publication of data from the National Adult Cardiac Database and outline some developments for the future.

The publication of data from the National Adult Cardiac Database provides reassurance to patients and the public about the high quality of UK cardiac surgery. The data that you enter is uploaded to the National Adult Cardiac Database that is run by NICOR. NICOR is part of University College London and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) to run six cardiac national audits. NICOR is a partnership of clinicians, IT experts, analysts, academics and managers, which provides project, technical and analytical support for all of its audits and registries. The governance mechanisms for the adult cardiac audit are described at www.scts.org/professionals/audit_outcomes.aspx. Part of these arrangements is that five representatives from SCTS sit on the NICOR adult cardiac surgery audit steering group. The chair of this group reports to the Executive. The management of the audit and the methodology used are directed by HQIP. This methodology has also been subject to independent statistical review and can be seen at www.ucl.ac.uk/nicor/research/publications.

It is, of course, important that data are accurate. Part of your responsibility is to ensure that you enter data that are correct, match the definitions of the data points used in the National Adult Cardiac Database (available here www.ucl.ac.uk/nicor/audits/adultcardiac/datasets) and that you take an active part in validating the data when requested by NICOR.

In the light of potential discrepancies in data submitted from University Hospitals Birmingham, NICOR will shortly be recontacting you if your incidence of risk factors used to calculate predicted mortality, for the 2010 to 2013 data, is significantly higher or lower than the national average. You will be given the option of undertaking further validation of the data and resubmitting it to NICOR.

The concerns described in the first paragraph are not new, and have been the subject of considerable debate in the past. We continue to take them seriously. Specifically we will be taking the following steps:

- We will strengthen the SCTS Database Sub-Committee to cover the congenital and lung cancer audits as well as the adult cardiac audit to ensure a coherent approach across all three audits.

- We will provide updated, specific guidance about the steps individuals and Trusts should take to ensure accuracy of their data.
- We will provide advice about how units and Trusts should respond to the outputs from these audits and we will work with the Royal College of Surgeons of England to make it easier to provide external peer review to help this process when necessary.
- We will work with NICOR to develop the practice profiles and outcomes for individuals and units to better reflect the risk profile of the patients that they operate on.
- We will review the dataset and its definitions.
- We will evaluate the recently released governance toolkit, and the timing of the application of the recalibration factor, to ensure that individuals and units can undertake real-time monitoring of their outcomes.

We believe it is important that we are transparent about the issue with the public. At the end of last week SCTS and NICOR both put statements up on our respective websites explaining the situation and the action being taken. They can be found on the SCTS home page and at: www.ucl.ac.uk/nicor/nicor-newspublication/adultcardiacsurgerydatavalidation. We will write again after the Executive meeting on 4th July and have further discussion with the Board of Representatives and Audit Leads.

Yours Faithfully

Tim Graham
President

Graham Cooper
President Elect

Simon Kendall
Honorary Secretary

Malcolm Dalrymple-Hay
Honorary Treasurer

Ben Bridgewater
Chair Database Sub-Committee

The patient, GP and primary care team: Relationships on trial

Jo Cook

John Radcliffe Hospital,
Oxford

As a Research Nurse currently working on the Arterial Revascularisation Trial (ART), I have identified several interesting trends through the yearly telephone conversations, with patients, as part of their follow-up: patient's non-adherence to medication and treatment post discharge following CABG, the variation in GP's monitoring of cardiovascular risk and the implications for research. Professor DP Taggart is the principle investigator for ART and has been extremely supportive and encouraging with this work.

ART is a University of Oxford, multi-centre, international, RCT; funded by both the MRC and BHF. Its aim is to evaluate whether the use of both IMA's during CABG improves survival and reduces the need for further intervention (including surgery) compared to using a single IMA. 3102 patients were recruited in 28 centres across 7 countries. Once discharged, patients are followed up yearly for 10 years. The primary outcome is survival at 10 years; secondary endpoints include clinical events, reintervention and cost effectiveness. (Taggart et al, 2006)

I have used the data from our cohort of 427 patients, recruited at the John Radcliffe hospital in Oxford and have chosen to look at aspirin and statin medication and GP surgery visits.

It is important to note that although the figures presented show a high compliance, from a nursing perspective, I am focusing on the percentage of patients NOT adhering and examining the underlying reasons. This may have implications for both research and nursing practice.

Reports by NICE (2010) and the joint ESC/EACTS guidelines (2010) reinforce the importance of risk factor modification and pharmacotherapy; as despite the success of the CABG procedure, with in-hospital mortality at 1.5% (Bridgewater et al, 2009), patients are still at risk of CHD. Once discharged from hospital it is the responsibility of both the patient and primary care team to manage their health. However, it is here where there may be issues such as patient adherence to medication, risk factor modification and poor implementation of CHD guidelines amongst GP's.

This is reflected in several studies (Hobbs and Erhardt, 2002, Tolmie et al, 2006 and Gould and Mitty, 2010). Interestingly, this is despite the plethora of guidelines and the introduction, in the UK, of the Quality and Outcomes Framework (Health and Social Care Information Centre, 2012).

Both figures 1 and 2 demonstrate some interesting findings and opportunities which could be addressed, certainly from a nursing perspective. For example, how we approach patient education post CABG not only at discharge but also in the long term.

Interestingly, only 32% of patients (n=136) had attended cardiac rehabilitation more than 3 times despite all being referred to the service. Further analysis of the cohort could also identify any variations in sub group adherence.

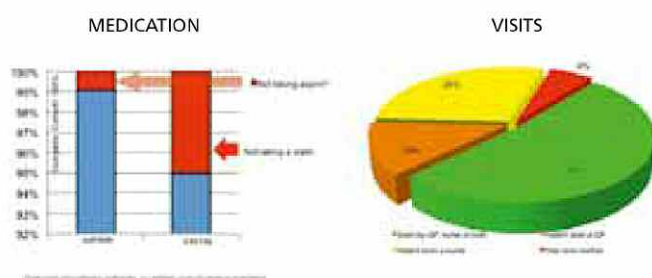
In the context of ART it would be interesting to see whether there are any demographic variations amongst the other UK centres in the study.

In conclusion, the patient needs to take responsibility for the self-management of their health and the GP with regular monitoring of cardiovascular risk. In terms of data analysis, these findings pose some interesting questions. Namely, what percentage of data is affected by the patient's non-adherence and GP's varying adherence to guidelines and how significant is this when analysing cardiac events, readmissions and reinterventions.

This creates an interesting dilemma when designing a research trial and is perhaps an area yet to be explored.

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CORESS

The Confidential Reporting System for Surgery

Stephen Clark

*Specialty Program Director for
Cardiothoracic Surgery, Consultant
Cardiothoracic & Transplant Surgeon
Freeman Hospital, Newcastle upon Tyne*

Use of this Confidential Incident Reporting System can Benefit Patients and Surgeons Alike

CORESS (the Confidential Reporting System for Surgery) is an independent charity with the goal of promoting safety in surgical practice across all disciplines in the NHS and the private sector. In essence CORESS receives confidential incident reports from surgeons and theatre staff which are then analysed by the CORESS Advisory Committee. This comprises representatives from each of the surgical specialty Societies, human factors experts, medico-legal representatives and Royal College and Armed Forces representatives who make comments and extract lessons to be learned.

Reports are then published in a variety of surgical journals alongside the Advisory Committees' safety lessons to educate fellow surgeons, raise standards and reduce the chances of a similar incident re-occurring in another centre. This compliments other mandatory reporting systems but CORESS aims to educate, rather than blame, is independent and serves all surgical disciplines. The remit of CORESS has recently widened to include hosting training courses on safer surgical practice and human factors.

CORESS was in fact developed to mirror CHIRP (Confidential Human Factors Incident Reporting Programme), the independent confidential reporting system for aviation where safety standards are rigorous. CHIRP has been in operation in aviation since 1982 and has made a very effective contribution to the resolution of important safety-related issues. CHIRP welcomes safety-related reports from flight crew, air traffic control officers, aircraft engineers, cabin crew and the general aviation community.

CORESS provides a means by which individuals are able to raise issues of concern without being identified to their peer group, management, or the Regulatory Authority. The analysis of safety-related reports by a truly multi-disciplinary expert panel would not otherwise be available while keeping the identity of the reporter and their hospital confidential. Even the Advisory Committee are unaware of the identity or location of the reporting individual.

However, reported events by cardiac and thoracic surgeons remains low in comparison to other specialties and although we may often think we are perfect we know in reality that we are fallible and vulnerable to unintended error. Reporting of incidents through this system will support cardiothoracic surgeons in bringing their experiences to light in an anonymised fashion for the benefit of colleagues across all of the other units in the UK who can learn from the recommendations of the Advisory Committee.

I would encourage all SCTS members to make use of this valuable resource for patient safety from which we can all learn. Submission of reports is easily done on line at www.coress.org.uk by completing a very simple form. Confidentiality is fundamental to the concept of the CORESS. On receipt of your report, all identifying data is removed and it is transferred to a standalone computer with no wired or wireless connections to any network. Identifying data is only ever available to the CORESS Chairman (Professor Frank Smith) and the System Manager. All identifying data is securely deleted before analysis, discussion by the Advisory Board and publication of reports.

The Freedom of Information Act does not apply to CORESS as it is an independent charity.

CORESS are interested in any safety-related incident involving you, your colleagues, your hospital or other organisations that you deal with. Incidents may be diagnostic or operative errors, technical or maintenance failures, regulatory or procedural aspects or unsafe practices/protocols. Useful lessons can also often be learned from incidents that do not result in adverse consequences and may only be known to the reporter.

Reporting to CORESS means that your peers will learn valuable safety lessons from your incident, and will ultimately help to ensure these errors are not repeated. Reporters also receive a certificate for their contribution, which can be in appraisals and to demonstrate your commitment to safety in the profession.

In future CORESS reports relating to cardiothoracic surgery will be published in the Bulletin.

Stephen Clark

I would encourage all SCTS members to make use of this valuable resource for patient safety from which we can all learn.

Developing a True Cardiothoracic Surgeon: Professionalism, Regulation and the Normalization of Deviance

*Hisham M.F. Sherif,
Cardiac Surgery,
Christiana Hospital
Newark, Delaware,
USA*

*For the secret of the care of
the patient is in caring for
the patient.*

Francis W. Peabody, MD (1881-1927)

*This above all:
To thine own self be true*

Hamlet: Act I, Scene III

The status of physicians as professionals has changed significantly since ancient times. Due to their possession of a unique set of knowledge and skills that the rest of the society does not have (also known as Asymmetry of Information) they have enjoyed an exceptionally elite status in ancient cultures. Generally regarded as the high priests of the gods with exclusive access to divine knowledge, sometimes -as in the case of Imhotep in ancient Egypt- they were elevated to the status of a god. Because they were capable of influencing unexpected and dramatic results in the lives of the sick and injured, they were also labeled 'magicians'. These practitioners and their decisions were regarded as infallible, unquestionable, beyond reproach or accountability.

The Middle Ages, thanks largely to the efforts of scholars such as Avicenna, saw the beginnings of implementation of the Scientific Method in the education, training and credentialing of physicians. With the establishment of the first medical schools and publication of textbooks, the wall of exclusivity was being progressively removed. Access to medical education, although still limited, became easier to members of the general public. The first tests of competency were conducted at the end of training. Medical practitioners were being increasingly seen as the professionals they are to become, with specific and unique education and skills setting them apart from the general public. However, the practice largely remained a 'master-apprentice' model. In the following centuries, the first professional organizations (mostly guilds and fellowships) emerged to better define and regulate the practice of medicine. These primitive organizations later evolved into the professional societies, specialty boards and colleges we have today.

The objective of the practice of medicine, however, has hardly changed over the millennia. At least until the recent decades, it has remained to prevent harm and to alleviate the pain and suffering of people due to disease or injury; hence the focus on safe practices and reduction or eliminations of errors.

Since a profession -by definition- is an area of practice requiring a specific, specialized set of skills that are partially or entirely acquired by intellectual training and applies to a specific field of human endeavor, the inherent Asymmetry of Information renders simple market dynamics ineffective in regulating this practice and to protect the 'customers'. Given the benevolent objectives of the practice, the role of the public interest and overall regulatory bodies of society (i.e., the State) become necessary for protection of the citizenry. However, this is still based on the self-regulatory functions and properties of the organizational bodies themselves, namely professional Societies, Boards and Colleges. Since these organizations possess the necessary knowledgebase to determine (a) the minimum requirements for a safe, scientifically-based competent practice of medicine, (b) to ensure that only the properly educated, trained and skilled persons be allowed to practice, and (c) that accountability for errors in judgment and practice be maintained.

These principles have led to the development of specific, rigorous procedures for the credentialing and licensure of medical professionals as pre-requisites to join the workforce. Governments, on local and national levels, have relied on these standards for ensuring the safety of medical practice to prevent harm to individuals as well as the society at large, and for establishing mechanisms for accountability for adverse outcomes.

This crucial fact that the physician possesses a unique set of education, training, skills and judgment unmatched by other members of the healthcare team remains the foundation for the physician -as the leader of a multi-disciplinary team of professionals and the primary decision-maker - bearing the ultimate responsibility for the patient: in clinical, ethical, moral and legal terms.

Cardiothoracic surgery as a scientific discipline adheres to these principles through the oversight of our organizational bodies such as the American Board of Thoracic Surgery and the European Association of Cardiothoracic Surgery. These governing bodies have established rigorous, specific and detailed guidelines for the education, training, proof of competency examinations and practice of clearly-defined areas of practice in the specialty: including preoperative, operative, postoperative and critical care management. As such, truly complete cardiothoracic surgeons must be demonstrated to have the necessary didactic knowledge, training and skills to

Professionalism, Regulation and the Normalization of Deviance *continued*

safely and effectively manage patients with diseases of the cardiopulmonary unit throughout the entire time they under their care. In clearer terms, a clinician whose sole expertise and competence are technical operating room skills does not qualify as a true or complete cardiothoracic surgeon.

Measures such as examinations, continuing medical education, licensure and the requirement for maintenance of certifications are well-established mechanisms to ensure the consistency of the safe practice and to prevent harmful medical errors.

Patient Safety

Unfortunately, the advent of Managed Care Organizations (MCO) and Healthcare Management Organizations (HMO) has been associated with a much decreased focus on patient safety. Instead, the main focus of these organizations has been cost-effectiveness, usually expressed in pay-for-performance measures and reimbursement regulations, since virtually all these organizations share the same structure and corporate mentality of insurance companies, with a skewed version of risk assessment: Financial risk as opposed to mortality and morbidity risk. This is degenerating into a deplorable situation when hospitals, institutions and surgical units are increasingly preoccupied with saving money, as opposed to saving (or improving) lives, which is anathema to the very core of medical ethics

By a process of Normalization of Deviance, this increased commitment to the 'financial safety of the institution' at the expense of patient safety is being reinforced by the following factors:

- Lack of a fundamental commitment to patient safety and patient-centered care. Unlike medical professionals, such business entities have a very weak interest, if any, in 'doing the best for the patient'; while their main focus remains profitability.
- Rationalization of financially-appealing but scientifically unproven (and therefore deviant) practice as 'legitimate' and even necessary. The recent paper by Skinner et al about staffing cardiothoracic intensive care units by non-surgeons is a classic example.
- Institutionalization of these practices, thus exposing newcomers (new graduates and students) to a new 'norm' of practice. A new graduate or a trainee surgeon will be readily dissuaded from a career in this specialty upon realizing that a nurse practitioner is seen by the institution as 'better' in managing critical care patients.
- 'Adverse socialization' in which these newcomers will not be accepted into the 'new normal' environment unless they comply with this behavior. The fact that trainees are expected or even encouraged to give up an essential part of their professional identity is creating a dangerous precedent where licensed surgeons are in reality incompletely trained and thus more liable to commit significant errors in management.

- Irrational optimism: Tolerance and underestimation of the significance of errors and their sequelae, which leads to ignoring subtle and often weak warning signs ('threats') as 'normal' or no cause for alarm.

In conclusion, the governing organizations in our specialty should exercise a more active role in better defining and developing a truly complete cardiothoracic surgeon -through recruitment and candidate selection, comprehensive and intensive education and training, supported by rigorous evaluation and credentialing. By closely or even jealously guarding our professional identity, we should be in a better position to influence regulatory decisions that are currently being made by non-professionals. Education and training should always be based on sound science, not on the whims and erroneous perceptions of candidates, nor to satisfy short-sighted or under-informed administrative or political demands. This is the only responsible and ethical way to ensure a thriving specialty.

Paraphrasing Shakespeare:

Let us get rid of all the lawyers

(King Henry VI, Part II: Act IV, Scene II)

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Professionalism, Regulation and the Normalization of Deviance *continued*

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Cardiothoracic Surgery Career Workshop

*Kareem Salhiyyah, Sunil
Ohri, Aiman Alzetani*

The department of cardiothoracic surgery at University Hospitals Southampton has organized a unique one-day workshop covering career advice in cardiothoracic surgery and a surgical skills practice.

The course was targeted for junior doctors and medical student interested in a career in cardiothoracic surgery. It aims at making candidates familiar with cardiothoracic surgery and its subspecialties including the scope of work, life style, future directions and career satisfaction.

The first half-day was in form of lectures that covered topics related to both cardiac and thoracic surgery and their history, scope, challenges& future directions. The candidates were also introduced to the training pathway in cardiothoracic surgery, and national selection process, and career progression in cardiothoracic surgery. Some of the national trainees gave an interactive session on the best advice to improve training portfolio, prepare for specialty applications and interviews. There was a talk on research in cardiothoracics, its importance, role in training, options and requirements.

In the afternoon, there was a practical session of surgical skills, which was generously sponsored by Ethicon represented by the cardiothoracic sales specialist Kirsty Reid. The skill stations covered a wide range of skills in both cardiac and thoracic surgery at different levels. They included knot tying, suturing, coronary anastomosis, chest drain insertion, VATS simulator and stapling devices.

The workshop received and excellent feedback from the candidates. They thought it was a unique learning and practical experience. Those who were interested in cardiothoracic felt more oriented for the specialty and some, who did not have enough exposure, thought it was an eye-opener for them. The practical stations were thoroughly enjoyed, and gave candidate to experience and practice very essential surgical skills and techniques.

There was also a successful experience from running a small course by the Southampton trainees to help preparing for the national selection interviews.

We are planning to run another workshops early next year. For more information on participating or attending please contact kareemsal@doctors.org.uk

SCTS Tutors' Report

*Narain Moorjani,
SCTS Cardiac
Surgery Tutor*



*Sridhar Rathinam,
SCTS Thoracic
Surgery Tutor*



Since our appointments as Cardiac and Thoracic Surgical Tutors in September 2013, our main responsibility has been the development and delivery of training courses for Cardiothoracic Surgery Specialty Trainees. The Cardiothoracic Surgery Tutor post, which had previously been run by the Royal College of Surgeons of England as a single post, has now been split into separate Cardiac and Thoracic posts and moved under the auspices of the SCTS within the domain of SCTS Education.

Our vision is to change the way cardiothoracic surgery training course are delivered, from the current status quo of a few courses that scattered throughout the 6 years of training, to a programme of continuous learning with a structured portfolio of courses that is mapped to the ISCP curriculum. This would include a revamp of the existing courses, the introduction of some new courses and incorporation of some of the well-established national courses that have a proven track record of delivering excellent educational content.

The primary objective of these courses is to cover the important aspects of Cardiothoracic Surgery described in the curriculum, especially with regards to patient management, practical skills, data interpretation and operative management. This would



Cardiothoracic Intensive Care and Surgical Access Course (European Surgical Institute, Hamburg, Germany, May 2014)

augment the knowledge gained from reading textbooks and journals, as well as the clinical and operative experience gained during their 6 year programme.

Each course will be formally accredited by the SCTS and be delivered using a broad range of simulation techniques, including wetlabs and simulated live operating. The plan is to deliver the programme of courses free of charge to all nationally appointed Cardiothoracic Surgical Specialty Trainees, through an educational grant from industry that has been secured in principle.

The portfolio of courses has been presented to the SCTS Education Committee, Speciality Advisory Committee (SAC) and Training Programme Directors for their approval and will consist of 12 courses, with 2 courses per year for each of the ST3 to ST8 years.

In addition, the 'Essential Skills in Cardiothoracic Surgery' course will continue to be run between the Royal College of Surgeons in London and Edinburgh. This course will be aimed at those in the ST2 year of their run-through training programme or those wishing to apply for entry at ST3 level.

In the first of the new courses, we designed a programme that amalgamated the important aspects of cardiothoracic intensive therapy and surgical access. It delivered registrar level components of the Cardiothoracic Advanced Life Support (CALS) course, which had been developed by Joel Dunning and Adrian Levine, through scenario based teaching.

ST 3	Introduction to Specialty Training in Cardiothoracic Surgery Course	Cardiothoracic Intensive Therapy and Surgical Access Course
ST 4	Core Cardiac Surgery Course	Core Thoracic Surgery Course
ST 5	Intermediate Viva Course	Non-Technical Skills for Surgeons (NOTSS)
ST 6	Cardiac Surgery Sub-specialty Course	Thoracic Surgery Sub-specialty Course
ST 7	FRCS (C-Th) Revision / Viva Course	Cardiothoracic Surgery Review Course (Non SCTS)
ST 8	Cardiac Surgery or Thoracic Surgery Pre-consultant Course	Professional Development Course

SCTS Tutors' Report *continued*

In addition, the trainees had an opportunity to develop cardiac and thoracic operative skills on live simulated models, including sternal opening and closure, internal mammary artery harvesting, arterial and venous cannulation, thoracotomy, pleurectomy and wedge resection, as well as developing strategies on how to manage a number of emergency operative scenarios. The course, including travel and accommodation, was provided free of charge to the trainees through industry support from Ethicon.

In addition, the Introduction to Specialty Training in Cardiothoracic Surgery Course, Cardiothoracic Surgery Specialty Skills Course and Intermediate Cardiac Surgery Courses have been run at the National Wet lab Centre, Royal College of Surgeons of England and Royal College of Surgeons of Edinburgh, respectively.

We would like to take this opportunity to thank all the course directors and faculty members, who have provided their time, wisdom and enthusiasm. It has been much appreciated by the trainees and without which it would have been impossible to deliver these courses. If anyone else is interested in teaching on the portfolio of courses in the future, we would be grateful if you could contact us (narainmoorjani@hotmail.com or sridhar_rathinam@yahoo.co.uk), as we would value your support.

In addition, we would like to thank the SCTS Executive, SCTS Education secretaries, SAC Chair, Training Programme Directors and many others for their advice, guidance and support in allowing us to develop our vision, which we believe will provide a unique opportunity for Cardiothoracic Surgical Specialty Trainees. We are also greatly indebted to our industry partners, especially Ethicon and Sorin, for their organisational and financial support.

Narain Moorjani, SCTS Cardiac Surgery Tutor

Sridhar Rathinam, SCTS Thoracic Surgery Tutor

Royal Society of Medicine Cardiothoracic Section

Aman S Coonar

Over the last few years, the Cardiothoracic Section at the RSM has grown with themed meetings 2-3 times/year exploring a range of topics relevant to Cardiothoracic Surgeons, such as trauma, new technologies and service improvement.

The RSM encourages interaction with other specialties, public engagement and fostering interest in the speciality and medicine. We are particularly interested in encouraging young people into the speciality, and have a programme of subsidised places for 6th formers and medical students. Most of the 6th formers have been from state schools.

Trainee numbers at our meetings are high and we are delighted that an increasing number of consultants attend meetings.

Once criticised as being too London-centric we actively seek members from around the UK and abroad. People interested in Cardiothoracic surgery but not necessarily doctors are also very welcome. We now have representation from several UK centres and recently the armed forces.

Our most recent meeting in June 2014 was on Cardiothoracic Trauma and was organised by Kandadai Rammohan from Manchester. The day featured senior military doctors, including the Professor of Armed Forces Surgery. We were delighted also to welcome Tim Graham, President of SCTS, and Richard Steyn amongst the faculty. Excellent case reports from trainees were also presented, with RSM champagne prizes for the winners.

Our next meeting is on Friday 14 November 2014, in London, and will be on the topic of higher risk surgery and risk avoidance! It's an important topic and is likely to be controversial so please join the discussion and save the date!

If you are interested in the cardiothoracic section of the RSM (which includes on-line journals, library facilities and a decent place to stay in London) or could even help with the section activities please do get in touch (cardiothoracic@rsm.ac.uk).

Aman S Coonar

aman.coonar@nhs.net

President, Cardiothoracic Section,
Royal Society of Medicine, London UK



SCTS Annual Meeting 2014: Prizewinners

Ronald Edwards Medal - best scientific oral presentation

Aiman Alassar

Incidence and mechanisms of cerebral ischemia following transcatheter aortic valve implantation compared with surgical aortic valve replacement

John Parker Medal - best clinical presentation

Saqib Qureshi

Improving transfusion related adverse outcomes in cardiac surgery. The role of RBC rejuvenation

Bob Bonser Aortic Surgery Prize

Mo Bashir

Development of A Risk Prediction Model for Aortic Surgery Using the National Institute for Cardiovascular Outcomes Research (NICOR) Database

Society Thoracic Medal - best thoracic presentation

Malcolm Will

VATS Segmentectomy - The future of pulmonary resection?

Best Cardiothoracic Forum Presentation - 1st and 2nd prize

1st Place: Katie Morley

Should Recipients Choose their Donor? A National Survey of Patient Donor Choice Consent Forms

2nd Place: Steven Power

Early Insights from a Surgical Care Practitioner Delivered EVH Program

Best Cardiothoracic Forum Poster

TBC

Patrick G. Magee Student Prize - best student poster presentation

1st Place: Oliver Brown

Coffee reduces death risk after acute myocardial infarction: a meta-analysis

Joint 2nd Place: Leila Fananapazir

A study to compare the diagnostic accuracy of three Enzyme Linked Immunoabsorbent Assays to detect Neutrophil Gelatinase-Associated Lipocalin, A candidate biomarker for acute kidney injury in cardiac surgery

Joint 2nd Place: May Hu

A comparison of the efficacy and adverse effects of double-lumen endobronchial tubes and bronchial blockers for lung isolation: a systematic review and meta-analysis



**GENEVA –
Switzerland**

**6 – 10
September
2014**

www.wscts2014.ch

**IMPORTANT DATES
AND DEADLINES:**

Online Registration
and Abstract Submission
opening:
17 January 2014

Abstract Submission
Deadline:
30 April 2014

Early Pre-registration
Deadline:
28 May 2014



**24th Annual World Congress
of the WSCTS**

6 - 10 September 2014
Geneva / Switzerland



**Welcome
to Geneva**

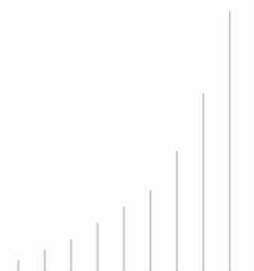
**Welcome
to the World
Society of
Cardiothoracic
Surgeons
(WSCTS)**

Professor Afksendiyos Kalangos

President of the Organizing Committee



Scan the code for more information.



New Appointments

Name	Hospital	Specialty	Starting Date
Mr Yasir Abu-Omar	Papworth Hospital, Cambridge	Adult Cardiac & Transplantation	May 2013
Mr Ishtiaq Ahmed	Royal Sussex County Hospital, Brighton	Adult Cardiac	Jan 2014
Mr Adam Szafranek	Nottingham University Hospital	Adult Cardiac	Jan 2014
Mr Aron-Frederick Popov	Harefield Hospital, London	Cardiothoracic & Transplantation	February 2014
Mr Kelvin Lim	Royal Infirmary of Edinburgh	Cardiac	April 2014
Mr Ayyaz Ali	Papworth Hospital, Cambridge	Adult Cardiac & Transplantation	May 2014
Mr Vassilios Avolonitis	Guy's & St Thomas' Hospital, London	Cardiac	May 2014
Mr Ravi De Silva	Papworth Hospital, Cambridge	Adult Cardiac	May 2014
Ms Donna Eaton	Mater Misericordiae Hospital, Dublin	Thoracic & Lung Transplantation	May 2014
Mr Arvind Singh	Essex Cardiothoracic Centre	Adult Cardiac	July 2014
Mr Paul Whitelock	Castle Hill Hospital, Hull		

Other Appointments

Mr Sudhir Bousari	Essex Cardiothoracic Centre	Cardiothoracic Surgery Locum	April 2014
Ms Ragini Pandey	Bristol Royal Hospital for Sick Children	Congenital	
Mr Zahid Mahmoud	Aberdeen Royal Infirmary	Locum	April 2014
Mr Claudio Pragliola	Derriford Hospital, Plymouth	Locum Cardiac	May 2014

Announcements

- **Doug West** has taken over from Richard Page as the SCTS Thoracic Audit Lead.
- **Clifford Barlow** and **Enoch Akowuah** have been appointed as Deputy Meeting Secretaries. Clifford will take on as the Meeting Secretary from Ian Wilson in April 2015, and Enoch will continue as Deputy Meeting Secretary until he steps into the Meeting Secretary post at the end of next term.

ACCEA 2014 Round

Today we have been informed by ACCEA that the process for applications is open from today with a closing date of 14 August 2014 at 5pm, there is only an 8 week period from start to finish. We will be informing all RCS Members and Fellows later today. We will be sending out an email later this week with a timetable.

If you wish to speak to anyone in ACCEA, please use <https://www.gov.uk/government/organisations/advisory-committee-on-clinical-excellence-awards>

Laura Gray, PA to Chief Executive & Director of Internal Services, The Royal College of Surgeons of England

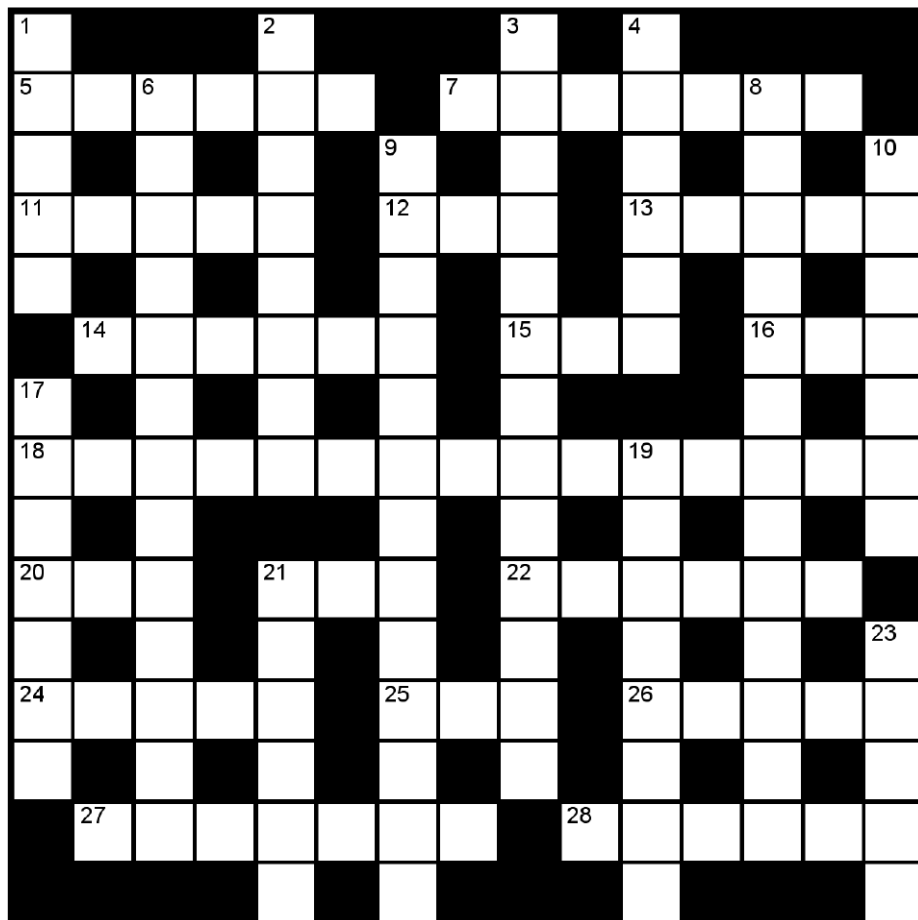
Birmingham Review Course

Date: 25th – 28th September 2014
 Meeting: **Birmingham Review Course in Cardiothoracic Surgery**
 Venue: Education Centre, Birminham Heartlands Hospital, Bordesley East, Birmingham
 Contact: L.R. Associates – Ms. L. Richardson, 58, Kiln Close, Calvert Green, Buckingham, MK18 2FD.
 Email: lorrainerichardson1@btinternet.com
 Tel & Fax: 01296 733 823
 Mobile: 077 111 32946
 Website: www.birminghamreviewcourse.co.uk

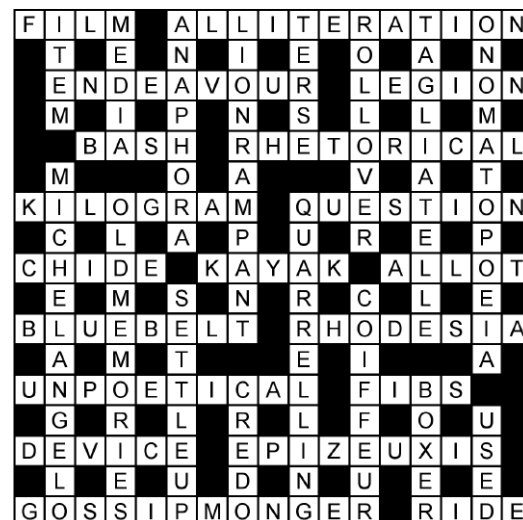
the crossword



by Sam Nashef



Last issue's solution



Send your solution by 30 December 2014 to:

Sam Nashef, Papworth Hospital, Cambridge
CB23 3RE or fax to 01480 364744

Solutions from areas over 10 miles from
Cambridge will be given priority.

Across

- 5 Nursery crew and chef without tails (6)
- 7 Secretary wearing shred is a model (7)
- 11 Cleric beheaded for crime (5)
- 12 Answering back, full of indignation (3)
- 13 Starts off text with "LOL" to get praise (5)
- 14/15 Bottom solver's villain here (6,3)
- 16 The Titanic encountered some (3)
- 18 Ten games played in Snaefell may be full of buzzwords (10,5)
- 20 See 19 Down
- 21/21D Spooner's girl trades these on the beach (3,6)
- 22 In touch on choosing a manager (6)
- 24 Rubbish organs (5)
- 25 Poem sounds outstanding (3)
- 26 Story leads from a biographical literary editor (5)
- 27 Sternal disruption for horny ones (7)
- 28 Fools house with a sex change (6)

Down

- 1 Rock beat one stripped for big 21 (5)
- 2/8 Slim monarch unpacked creativity in 18 (8,7,3,3)
- 3 See 19
- 4 Sweet exit with gold (6)
- 6 Where Papworth, Norwich and Basildon organise and enter treatment (7,6)
- 8 See 2
- 9 Naughty nurse and maid with some naughty acts (13)
- 10 Nice weather (18 for the type of 2, 8) (4,3)
- 17 Compiler's one gallery copy (7)
- 19/20/3 Choir should be consistent in 18 (4,4,3,4,4,5)
- 21 See 21 Across
- 23 First to cover a beauty counter in 26 (5)

Enjoy the crossword in this issue of the Bulletin. To encourage more participation, there will be three prizes for the first three correct entries received before 31 October 2014. (Hint: Three of the answers can be found in James Roxburgh's Presidential Address on Pages 2-4)

Congratulations to the Crossword Winners

- Susan Elkington (secretary to Alan Bryan, John Hutter and George Azimopoulos in Bristol)
- Rana Sayeed