LETTERS TO THE EDITOR

The British Heart Journal welcomes letters commenting on papers that it has published within the past six months.

All letters must be typed with double spacing and signed by all authors.

No letter should be more than 600 words.

In general, no letter should contain more than six references (also typed with double spacing).

Answers to complex questions cannot be derived from "simple" trials

SIR—Much can be learnt from the comparison drawn by Topol and Califf between mega-trials and mini-trials (British Heart Journal 1992;68:548-51). The ideal mega-trial should have the capacity to address simple questions prospectively and unequivocally, as well as the ability to provide tentative answers to complex problems by retrospective analysis. For instance, the unequivocally beneficial effects on survival emerging from the CONSENSUS trial initially obscured the fact that the dose regimens employed could have adverse effects on diuretic requirements. Almost by default, this led to the belief that co-prescription of angiotensin-converting enzyme inhibitors generally resulted in an increase in diuretic requirements, despite evidence to the contrary emerging from at least one "mini" study.1 It only emerged from retrospective analysis that dose-dependent hypertension was an important factor in determining the renal response (and hence the diuretic response) to co-prescription of enalapril during the maintenance phase of treatment.2 We now know that in other states of fluid overload, such as cirrhosis with ascites, co-prescription of a mean daily dose of 20-64 mg captopril has a diuretic-sparing effect that is not evident at higher doses.3 This paradoxical relation between natruresis and captopril dosing has been demonstrated in chronic heart failure as well.7 These examples justify the conclusion that, despite the increasing popularity of the mega-trial, the mini-trial (or even the mini-study) remains an "excellent means of establishing drug dosing".4

G KOLBEBE
Department of Medicine for the Elderly, Tameside General Hospital, Fountain Street, Ashton under Lyne OL6 9RW


Cardiac surgery: moving away from intensive care

SIR—The Oxford group have reported their efforts to minimise the costs of cardiac surgery by reducing the need for postoperative intensive care (British Heart Journal 1992;68:430-33).

Early extubation and postoperative management of cardiac surgical patients in a general recovery area as opposed to an intensive care unit has been mooted before and there is little doubt that certain patients do not require intensive care facilities. On the basis of 245 patients treated over a four month period the Oxford group conclude that "over 90% of patients undergoing cardiac surgery would recover safely and be treated effectively in a more economical area than intensive care".

This conclusion raises two important questions: (a) can it be extrapolated to all cardiac surgical units in the UK and (b) should it be the basis of future planning of postoperative care facilities for cardiac surgical patients? The answer to both questions lies in the tacit understanding that the demographic features of the Oxford surgical population are representative of those of the UK as a whole and that these features are unlikely to change in the future. Is this valid?

To enable comparison between cardiac surgical populations Parsonnet and colleagues have described a simple method of categorising patients into various risk groups that is highly predictive of operative mortality, postoperative complications, and duration of hospital admission.1 Of particular importance are patients requiring emergency surgery, aged more than 70 years, ejection fraction less than 30%, redo operations, pulmonary artery pressure greater than 60 mm Hg for mitral valve surgery, aortic gradient greater than 120 mm Hg for aortic valve surgery, morbid obesity, diabetes, and hypertension. Little of this information is present in the Oxford results, making comparisons with other units difficult. The fact that only 55% of the Oxford patients received coronary artery bypass grafting: Is the operation different today? J Thorac Cardiovasc Surg 1991;101:1080-15.


NOTICE

The 1993 Annual Meeting of the British Cardiac Society will take place at the Wembley Conference Centre from 18 to 21 May.

BRITISH CARDIAC SOCIETY NEWSLETTER

Cardiological technicians and NVQs

We hope that members of the Society will read this section with care because it has considerable relevance to the organisation of our departments. Cardiologists rely increasingly on the expertise of technicians, as diagnostic methods and treatments in cardiology become ever more complex. The Society of Cardiological Technicians has played a leading part in planning training
programmes for its members, and the British Cardiac Society has always been willing to cooperate in this important area. It is symbolic of the close association of the two societies that the technicians have traditionally been considered cardiological to their President, and Michael Martin has recently taken over this role from Eric Coleman who has given long and caring service. The chairman is Christopher Darby, Technical Manager in the Department of Cardiology at St Bartholomew's Hospital.

Training of technicians has been based in recent years on courses provided by the British Cardiovascular Technicians Education Council (BTEC) or the Scottish Vocational Education Council (SCOTVEC), taken in many regional colleges or polytechnics (as they then were). This training provided a broad base of scientific knowledge that we believe to be essential for the pluripotential skill of modern cardiological technicians.

But arrangements for training are now entering a period of flux with the introduction of National Vocational Qualifications (NVQs) and Scottish Vocational Qualifications (SVQs), which could influence substantially the levels of competence expected of many of our technicians. Technicians must be involved fully in the new process to ensure that changes can improve or at least maintain standards that are so important to good patient care. To this end a meeting was held at the request of the representatives of the British Cardiac Society, the Society of Cardiological Technicians, the National Health Service Training Directorate, and their training consultants. Our visitors, led by the author, Michael Martin, had travelled from Bristol for the meeting, which may have done much to improve the prospects for a successful transition to the new arrangements.

Cardiologists need to know something of the principles underlying NVQs. NVQs are nationally developed and recognised qualifications that are based on defined standards of competent performance required in employment in the past seven years. NVQs have been developed by industry, commerce, local government, and health sectors of the economy. These NVQs are called Educational Qualifications (EQA). The latter is made up of educational, employment, and government interests. The work of developing NVQs has been devolved by NCVQ to some 190 “Lead Bodies”. The Lead Body covering the NHS is called the Care Sector Consortium.

NVQs developed by the Lead Bodies are allocated levels within a national framework of vocational qualifications, depending on the level of competences required. This national framework has been designed to embrace all types of work within the UK and is divided into five levels. The first level relates to “varied work” that requires activities that may be routine and predictable”, while at the other end of the scale the fifth level relates “to the application of a significant range of fundamental principles and complex techniques across a wide and often unpredictable variety of contexts...” (Excerpts only, not quoted in full). By the end of 1992, NVQs had been developed to cover 80% of the UK workforce, so that most people can now register at a level NVQ that is commensurate with the job they do. Within the last few months detailed standards have been defined and published for three groups of physiological measurement technicns, namely audiological, neurophysiological, and respiratory physiological. Progress has been much slower for cardiological technicians.

Several factors have contributed to the slow progress for definitions of competence and ability needed by cardiological technicns, and some influences are mentioned below. First, the original planning was based on the premise of a large common core of skills between different types of physiological technicians. This concept was always simplistic and has become unsustainable with increasing specialisation. Secondly, authoriites within the Department of Health have resisted the notion that knowledge of permanent pacing, cardiac catheterisation, and echocardiography are all parts of the skill of a basic grade technician—a view that has considerable implications for the NVQ level that would be appropriate, and for the educational standard that may eventually be needed for entry. Thirdly, the British Cardiac Society has not been formally invited to participate in discussions and has had no influence on the draft definitions of skills that already exist. Fourthly, the technicians themselves believe that NVQs do not embrace employment-led standards that relate to work performed rather than academic “underpinning knowledge.” Employers in the future may fail to understand the imporance and value of that part of this house now often reluctantly for pay for this training which we believe to be essential if standards are to be maintained. The BTEC and SCOTVEC courses currently available do provide this background and therefore the acquisition of this knowledge is generally funded.

Both the British Cardiac Society and the Society of Cardiological Technicians are adamant that the role of the cardiological technician must not be fragmented as current proposals imply. An Authority could well be misled into employing basic technicians worked up as having adequate skills for a specific limited role relating, for example, to exercise testing and assisting in temporary pacing. This seems to have been the concept underlying current training. It is draft proposals that dictate the reality of echocardiography in most district hospitals and permanent pacing in many of them.

The representatives of the Training Directorate were sympathetic to our concerns and agreed to consider a reappraisal of the role of cardiological technicians. We were appreciative of the flexibility they showed during our negotiation. We will shortly be setting up a small group with representatives from both societies to open fresh discussions with the Training Directorate on the role of the Cardiological Technician. The new group should also participate in discussions already under way to help cardiological technicians obtain recognition as a profession supplementary to medicine. Such a classification would require high educational standards for entry and strict monitoring of the attainment of professional competence.

Hart-Line
This is not a spelling error: our word processor does not permit them. Anthony Nathan has written to us about a new service that many will find of interest. “It has been apparent for some while that there are many problems in the United Kingdom, and elsewhere, concerning accurate arrhythmia diagnosis and appropriate management. The British Pacing and Electrophysiology Group has set up a fax based arrhythmia advice service called Hart-Line, which will be running early in 1993. Six institutions will have a fax machine dedicated to receive electrocardiograms as part of this service, which initially will be running during normal working hours. Electrocardiograms can be transmitted to these centres together with a short standardised request form, and the centres will endeavour to respond within 2-4 hours with either an arrhythmia diagnosis or suggestions for management. The six participating centres are: Anthony Nathan at St Bartholomew's Hospital.”

Fax machines again
The news of Hart-Line reminds us that we have been strong advocates of personal fax machines as a routine work tool for consultants cardiological (Newsletter: May 1991). Many night-time errors could be avoided if junior staff could contact those on call an electrocardiogram from a patient with suspected infarction or a serious arrhythmia. But we raise the matter again for another reason, prompted by an item in the News Notes of the General Medical Council of December 1992. This refers to a revision of its advice on professional confidence that takes account of increasing use of fax machines to transmit clinical information about patients to other colleagues. We believe that fax machines offer a more secure substitute has usually been rejected. There are occasions when a referral is required urgently for good reasons, but we feel that increasing carelessness about the dissemination of such confidential matters should be resisted. At the very least we suggest that those forced to adopt this procedure should insist that a secretary is waiting to receive the fax, and will agree to phone immediately if “it has been received”. There is evidence that it has not been left to await collection later on.

News from Europe
Philip Poole-Wilson writes as follows. “Preparations for the Congress in Nice from 29 August to 2 September are well in hand. May I remind all members that the final day for the receipt of abstracts is 14 February 1993. We expect the acceptance rate for abstracts to be similar this year to that of previous years at about 30-35%. In addition to oral and poster abstract presentations, there will be 50 sessions organised by the working groups, symposia
organised by the Executive Scientific Committee and 17 "how-to" sessions, as well as state of the art lectures. The work of the Executive Scientific Committee has increased greatly with regard to organising the programme and making the final selection of abstracts. The Board has agreed that five additional persons should be co-opted as ad hoc consultants for the meeting on 1 and 2 April to help the Executive Scientific Committee with this work.

The working groups of the European Society of Cardiology are very active. Several are putting forward guidelines for investigation, management, and treatment of cardiac conditions. At present the Board is considering guidelines on percutaneous balloon valvuloplasty for valvular stenosis, prevention of thromboembolic events in valvular heart disease, and for exercise testing. These documents may have implications for cardiology in Britain. A task force is being set up on the measurement of clinical aspects of heart rate variability by the Working Groups on Computers in Cardiology and Arrhythmias. The Working Groups on Arrhythmias and Cardiac Pacing are setting up a European Registry for Implantable Cardioverter/Defibrillators (EURID). Further information on any of these matters should be obtained from the chairman of the working groups whose names and addresses can be obtained from the pink pages at the back of the European Heart Journal.

News of the Society
We have further details of the third British Cardiac Society teach-in which is to take place on Tuesday 23 March on the subject of Endothelium for Cardiologists. The meeting will be organised and chaired by Andrew Henderson. It will concentrate on the role of endothelium derived relaxing factor (EDRF). The first section will be devoted to the normal physiology and cell biology (speakers to include Malcolm Lewis, Tudor Griffith, and Ajay Shah) together with an overview of endothelin (Michael Randall). The second session will address pathophysiological and clinical aspects (speakers to include Patrick Vallance, Jim McLenachan, Jerry Smith, Andrew Newby, and Robin Wilson). This will be as popular as our previous teach-ins. It will now be too late to remind members that they have priority for the 40 places, because four weeks before the meetings we throw them open. As previously we will have a waiting list, and some of those booking late may be lucky. Please do not book and fail to turn up without letting us know—others will want your place. The time, as usual, will be 10 am to 4 pm, and lunch will be provided.

News of members
Anthony Scriven, who has been a senior registrar in Glasgow, has been appointed to a new post at Leicester General Hospital as consultant physician with an interest in cardiology. Mark Papouchado has been appointed as physician and cardiologist to Frenchay Hospital. He has been senior registrar in Bristol.

DOUGLAS CHAMBERLAIN
President, British Cardiac Society
DUNCAN DYMOND
Secretary, British Cardiac Society, 9 Fitzroy Square, London W1P 9AH