BRITISH CARDIAC SOCIETY NEWSLETTER

Registrar training

Implementation of the new pattern of training for registrars has been predictably slow. Cardiology is not the only specialty that is changing. All the major specialties are following our initiative in introducing three year blocks to replace the two year registrar and four year senior registrar posts. Many regional health authorities had only recently reorganised rotations on the old template when the new requirements became known, and the dismay was understandable from all who had worked hard to piece together a complex jigsaw. Now the process has had to start again. Problems are compounded by the necessary differences in training requirements. Cardiology has considerably more need for technical skills than most medical specialties, and only gastroenterology runs it close in this respect. Of our six year programme, we therefore require five to be centred on cardiology with only one in general internal medicine (that may, of course, be based principally on another subspecialty). Others require totals within their disciplines ranging from two to four. All require rotations between specialist centres and district general hospitals. Research has to be fitted into the formula with rules that have not yet been defined fully. The very large reduction in the number of career registrar posts imposed by the Joint Planning Advisory Committee (JPAC) could generate competition, claims, and counter claims between consultants who see a threat to their ability to provide a safe service—though all the meetings we have attended have been notable for the spirit of cooperation that has emerged. The difficulties that beset authorities struggling to satisfy as many as possible of the requirements and competing claims could very readily induce inertia born of helplessness. In this setting a sensible tactic encouraged by the Manpower Committee of the Royal College of Physicians is for a few regions to take a lead, with all the support that is necessary from both local and national representatives of the specialties. The North West Thames Region is amongst those furthest along the difficult path, and it now has draft proposals that have been under discussion since February. The North East Thames and Trent regions are close behind. Other regions have arranged many meetings and are likely to adopt some of the principles already worked out elsewhere.

General medical component in cardiology training

In addition to doubts about numbers of available posts, the criteria needed for district hospitals to take part in rotations, the arrangements to accommodate the different types of research, and the special requirements of high flying academics, cardiology faces one more issue that has not yet been settled—though a decision is needed urgently. The Specialty Advisory Committee in General Internal Medicine requires at present that our trainees spend one year in

Internal Medicine at senior registrar level if dual accreditation is to be granted. This has been assumed to translate into one year of the new final three year block. But this is disruptive for major centres and unsettling for trainees particularly for those with interventional skills that have to be maintained and fine tuned. It also adds to the difficulty of establishing rotations within the first three years: inclusion of general medicine here makes the jigsaw appreciably easier. The proposal has been made recently that the general medical year could be the last of the first three year block—still within four years of the end of the training programme, as now. We hope this compromise will be acceptable, for without it we may have to revert to single accreditation for at least some of our trainees. We would regard this as a retrograde step, especially with the increasing emphasis on cardiology in the district hospitals.

Cardiology in the district hospital

A Working Party of the British Cardiac Society on Cardiology in the District Hospital reported in 1987. We intended that the report should be updated from time to time. This is now opportune because of the major changes that are occurring both in the practice of the specialty and in the organisation of health services generally. Council believe that an entirely new team will find it easier to take a fresh look at an evolving scene. They emphasised that this decision implied no dissatisfaction with the previous group: at least one of the authors of your Newsletter (who was Chairman of the previous Working Party) hopes that this sentiment is sincere . . . The chairman of the new group will be Andrew McLeod: membership will be announced in due course.

Coronary prevention working party

As a result of helpful advice from Michael Oliver, Council has decided to postpone plans for an update of the British Cardiac Society report on coronary disease prevention. One meeting of the group has already taken place, so the change of plan was not made lightly. But two factors led us to this decision. First, a number of doubts about the long-term value of some measures of primary prevention will not be fully resolved for at least a couple of years. Secondly, several other reports will be published in the next 12 months, and it may be unwise to confuse the public with a plethora of advice that may seem to differ in emphasis. Plans for a new report have not been abandoned. It is only the timing that has changed.

Campaign for legislation on smoking

Andrew McLeod has another special responsibility on Council. He maintains an interest on our behalf in the campaign against smoking. He has sent the following note for the newsletter.

"Thoracic physicians have taken the initiative in forming Doctors for Tobacco Law. As cardiologists, we have been urged to support them in achieving a higher profile for clinicians who seek to influence politicians in the battle to reduce smoking prevalence. As part of this campaign, each of us should consider writing to our local Member of Parliament to request support for the initiative of the European Community directive aimed at banning tobacco advertising and sponsorship. Our Government are at present taking a weak line on this issue. Yet advertising bans in New Zealand and Canada have been followed by a reduction in cigarette

consumption. Informed advice suggests that the Government is nonetheless sensitive to consumer and constituency opinion on this issue. Do not delay. Write to your Member of Parliament at the House of Commons now." Council warmly endorses this advice.

Survivors of myocardial infarction and patients with stable angina: research initiatives

David de Bono, John Hampton, and Bob Wilcox have also written to the newsletter regarding two possible new trials that will interest members of the society. They pose important questions and suggest how we could find answers. "When should we advise coronary angiography for patients with 'stable' angina or for the survivors of recent myocardial infarction, whether or not they have had thrombolysis? While we may accept that left ventricular function and the distribution of coronary lesions helps us to stratify patients by risk, how certain are we that intervention (CABG, PTCA) based on angiographic findings is beneficial in such patients? Current medical opinion is divided on the best way to investigate and manage patients with stable angina pectoris whose symptoms are controlled on medical therapy. Is knowledge of the specific coronary anatomy in an individual patient essential for optimal planning or can angiography be deferred until required on symptomatic grounds? We may accept that most survivors of acute infarction should be given the opportunity of tolerating β blockers and/or aspirin, but the place of angiography is by no means established from good prospective trials. Further, the policy of post-infarct exercise testing is widespread, yet we have no clear guidelines of when, how much, or what precisely to do with those who have a "positive" result. These questions have enormous implications for resource planning and training. In some areas the waiting time for diagnostic angiography and surgery for symptomatic patients may exceed twelve months, even without the added workload imposed by a policy of "exposing ischaemia" in those who are symptomatically well. We are therefore proposing two prospective randomised trials. We plan to call them CAMI (Coronary Angiography after Myocardial Infarction) and CASA (Coronary Angiography in Stable Angina). In brief, patients with positive exercise tests (still to be defined) will be randomised to be offered angiography or not. The former will be advised to proceed to intervention according to predetermined anatomical distributions of their coronary lesion(s) whereas the latter will be offered angiography according to subsequent symptoms. Patients who have negative stress tests (and therefore would not qualify anyway for randomisation) and those randomised to angiography who decline to have it will also be followed up. We wish to determine whether a policy of symptomatic treatment, with angiography as necessary, is less, the same, or more 'advantageous' than a policy of early investigation and intervention. We will be interested in comparing the demand for intervention of an early versus a deferred investigational policy, the subsequent clinical course of the different patient groups (symptoms, quality of life, medical therapy, readmissions, re-infarctions), and survival. If you, too, feel that the answers to these questions are important why not join us?" Those interested should write to Bob Wilcox at the Department of Cardiovascular Medicine, University Hospital, Nottingham NG7 2UH.

The Harrogate meeting

We have a last report on plans for our spring meeting (26 May–29 May). Preparations are now well under way. The format of the meeting will be that adopted in previous years with the main meeting running between 27 May and 29 May, with the preceding day (26 May) allocated to the working groups of the society. There are now five active working groups of the society (pacing and electrophysiology, intervention, echocardiography, nuclear medicine, and paediatrics). Each group produces its own programme for the Tuesday afternoon which members of the Society may wish to attend. It has been suggested that the programmes of the working groups might be more closely integrated with the main meeting in future years: the newly formed Programme Committee are looking at this option. If you have any views we would like to hear from you. As before there are three plenary sessions in the main programme. The plenary session on 27 May is on epidemiology, chaired by David Wood. The plenary session on 28 May is an update on transplantation, chaired by John Dark. The plenary session on 29 May is an update on thrombolytic and angioplasty trials co-chaired by David de Bono and Anthony Rickards. In each of these sessions there will be presentations from American and continental European speakers. We have been impressed by the number and quality of abstracts submitted this year for the scientific meeting and numbers again have topped previous records. The total of 685 submissions represents a 15% increase on last year: of these a total of 270 (39%) have been accepted for presentation. We have increased

the number of posters presented this year, with two separate poster sessions on the Wednesday. The main lectures this year are the Thomas Lewis Lecture to be given by Professor Eugene Braunwald from Harvard and the St Cyres Lecture to be given by Raphael Balcon. As a follow up to the successful meeting held in December we will be discussing the developing internal market in cardiology and cardiac surgery. The other innovation this year is a session primarily aimed at the district general hospital cardiologists. This session is to be chaired by Andrew McLeod. Speakers will discuss some of the controversies in contemporary cardiological practice. We would like to hear your views about this experiment. As can be seen from the changes outlined above, the society is slowly modifying the format of the Annual Scientific Meeting in response to members requests and needs. To facilitate this process we have organised a Programme Committee that is chaired by Andrew Henderson. The committee comprises Ronnie Campbell, Andrew McLeod, Duncan Dymond, and Paul Oldershaw. It met formally for the first time recently to formulate the programme for Harrogate, and will be meeting again during the course of the meeting to make modifications that can be adopted subsequently at Wembley and Torquay. If you wish to make suggestions to this committee please write to Andrew Henderson. Ideally new ideas should be passed on before the Harrogate meeting because changes take a long time to implement. Areas for debate already include the inter-relation between posters and oral presentations, methods by which poster sessions can be improved, and

the balance between presentation of original work and update sessions. You will hear more in future newsletters.

Honours

Members of our society featured in the new year honours. Magdi Yacoub will receive a knighthood on 19 May and Michael Webb-Peploe an OBE on 17 March. We apologise for being late in offering our congratulations. We have more good news. John Camm and Tom Evans have both been made Queen's Honorary Physicians (civilian).

Our newsletters have been getting longer, a trend we may not be able to reverse . . . We have decided to try subheadings. We hope this will not encourage colleagues to be selective in their reading: that would be at the peril of missing vital information, and assuredly cannot be recommended.

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NOTICE

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The Annual Meeting of the **British Cardiac Society** will take place at the Harrogate International Centre on 26 to 29 May. The closing date for receipt of abstracts was 3 January.