pathology by Becker and Anderson. It is beautifully and intelligently illustrated and drives home the message that a full appreciation of the varied pathological processes of heart valves is crucial to the success and otherwise of balloon dilatation. Because clinicians cannot get as close a look at these valves as pathologists, we need to listen to their warnings and their often relentless logic. If we had done so in the past we might more quickly have learned our lesson with balloon dilatation of the aortic valve.

The chapter on echo-Doppler assessment is outstanding. It establishes the argument that cardiac catheterisation has long outlived its usefulness. Patients should no longer be subjected to the discomfort, risk, and expense of an invasive study unless there is a separate need for coronary angiography. Also it is probably not justifiable for any unit to perform balloon dilatation of heart valves without a full echo-Doppler service. Indeed, given the widespread availability of echo-Doppler the long chapter on the electrocardiographic assessment of valve disease stands forlorn and redundant.

Finally, at a tenth of the cost of a balloon catheter for mitral valve dilatation this book is clearly a sound investment for all units that do balloon dilatations. I recommend it to interventionists and aspiring trainees, to nurses and technicians, and especially to surgeons.

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Registrar training programmes
Our previous note about registrar training programmes was in September 1992. We mentioned then that we would report in due course the results of discussions on the general medical component of the specialist cardiology programme. This component is a requirement for completion of dual training for cardiovascular medicine and for general internal medicine (GIM). Until recently a year had to be spent in general internal medicine during one of the four senior registrar years. The introduction of the new split six year training programme— with only three years at registrar grade - made it desirable to have greater flexibility in the timing of the year in general internal medicine. For most people this could best be spent during the first three years at registrar grade. Although this would be more remote from the time of promotion to consultant grade (often with responsibility for a general medical emergency "take") the proposed new arrangement would have the clear advantage of ensuring that the general medical training was neither omitted nor curtailed. Some Regions have already made arrangements assuming that agreement would be reached on flexibility, but there was a risk that without it the new programmes would not be acceptable. The meeting with the Specialist Advisory Committee in GIM took place in late November, with cardiology represented by Michael Webb-Peploe who writes as follows: "At our recent meeting the following points were provisionally agreed in relation to the general medicine component of the training programme in cardiovascular medicine. First, that of the total six year training programme (three years at registrar grade, and three years at senior registrar grade) one year should be spent in general internal medicine.

Secondly, that the year in general internal medicine could occur at any time during the first three years of the total six year training period. Thirdly, that this training could occur while working for a cardiologist in a District General Hospital, but that the trainee would also have to be working and be trained by another consultant whose special interest was not cardiology. Fourthly, that the general internal medicine must include 100 "take days" for which the registrar would be expected to be resident in the hospital, to handle all the emergency admissions which must be unselected, and to have continued responsibility for the emergency admissions which should therefore not fall to other firms once they had entered the hospital. Fifthly, that at least one of the outpatient sessions attended by the registrar should not be a cardiology consultation. Finally, that proposed training programmes in cardiovascular medicine should provide information about the whole first three year timetable and duties, and should be approved by the Specialist Advisory Committees in both general internal medicine and cardiovascular medicine. In order to fulfil these requirements within legal on call rotas it follows that most trainees must take part in "on call" duties for 18 months and possibly two years of the first three years. Care will be needed in planning their programmes to ensure that they have adequate training in cardiovascular medicine (particularly in invasive cardiology) as well as in general internal medicine."

Regions that have not yet implemented the new style programmes should consider doing so soon and stress the importance of submitting the whole of the three year programme to the JCHMT office. Individual years cannot be considered in isolation. Most registrars in cardiology have already had extensive experience in general medicine. We will seek clarification on how much credit can be given for previous "take day" commitments.

Senior registrar training programme: JPAC review
The Society, through its Training and Manpower Committee, requested an early review of the number of senior registrar posts available to the specialty because the current shortage of trained individuals is expected to continue. The meeting with the general purposes sub-committee of the Joint Planning Advisory Committee (JPAC) took place on 18 November. From the previous review we have 30 new posts in England and 26 in the JPAC formula. Of these, two were top sliced for a part time quota, 10 for research posts, and eight for paediatric cardiology. This left 42 posts for numbered senior registrar posts in full time adult cardiology for England and Wales. Our surveys suggest that we have 44, an anomaly that is unexplained at present. During the 1989 JPAC review we predicted a continuing growth rate of 5% in consultant vacancies. This prediction was not accepted, though it has proved to be accurate. Retirements are occurring at a faster rate than previously, partly because of the expansion of cardiology into the district hospitals 25 years ago, and partly because of the trend towards retirement at a younger age. Although the change from a four year training programme to a three year programme will reduce the present shortfall, the JPAC formula—based on predicted consultant opportunities and years in the senior registrar posts—supports our contention that more posts are needed. As a result of the meeting the committee agreed to recommend an increase of 20-5 senior registrar posts. No decision has yet been made on allocation to Regions, and, in any case, new posts require local approval, educational approval, and funding. On average two years elapses between JPAC approval for a newly set up appointment and it being fed into the system. Therefore no rapid changes can be expected, but any centres that feel they can provide appropriate training facilities should make this known to the Training and Manpower Committee (British Cardiac Society) for advice on how best to proceed. We will give more details in the next newsletter.

News from the British Heart Foundation
The British Heart Foundation has recently made £450 000 available to start 20 new rehabilitation schemes throughout the country. Evidence for an impact of rehabilita- tion on prognosis is far from conclusive, but those of us in hospitals that have well organised programmes need no convincing of their value in restoring confidence in patients, in reducing anxiety levels in both patients and spouses, and in making a major impact on quality of life. The 20 new programmes are in addition to the 38 already started in 1992 by the 32 district general hospitals in the United Kingdom so much remains to be done.

News from Europe
Philip Poole-Wilson writes: "A new board of the European Society of Cardiology was elected during the Congress in Barcelona in September. The first meeting of the Board took place in October. Because of the untimely death of Professor Attilio Reale there is now no past President. The statutes state that the Board may appoint any previous Board member to this post for a period of two years. Professor Kalevi Pyorala from Finland is the new President elect, having already been President from 1991 to 1993. Professor A. J. N. W. Newby from Rotterdam was appointed as the first President acting Past-President. He will be chairman of the Nominating Committee for the next Board which will be elected in 1994. Professor Maarten Simonis from the Netherlands was elected Vice-President in charge of Working Groups. Numerous committees were established to undertake the many tasks of the Society. These
include the credential committee which is responsible for awarding the title of FESC (Fellow of the European Society of Cardiology), a committee for awarding research grants and scholarship, a research committee, an ethics committee, a European Heart House Committee, an audio-visual Committee, and also representatives for various task forces and for the European Board for the specialty of Cardiology and an Executive Committee which has ten members. This will be an important Committee. The representatives appointed by the European Society of Cardiology are Michael Camm, Richard Levy to a new post as consultant cardiologist with an interest in heart transplantation at Wythenshawe Hospital, and Walter Rothen to replace Gerald Sandler as physician with an interest in cardiology at Barnsley District General Hospital. A committee set up to make an appointment to a new post in another district general hospital was unable to make any recommendation and a new advertisement will appear in due course. These four posts attracted a total of 35 applications. We apologise for being slow to mention the appointments from October 1991 of Gianni Angeli to a British Heart Foundation Personal Chair of Cardiac Surgery at the University of Bristol and Lindsey Allan as Professor of Petal Cardiology at Guy’s Hospital (United Medical and Dental Schools of Guy’s and St Thomas’ Hospitals).

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NOTICE

The First International Congress of Nuclear Cardiology will be held in Cannes, France, from 25 to 28 April 1993. Topics covered are—myocardial viability, prognosis, cardiac function, image display, analysis, detection of coronary artery disease, thrombolysis and acute myocardial infarction, multicentre trials, monoclonal antibodies, cardiomyopathy, echo, nuclear techniques, modes of stress testing, and choice of perfusion agents. Further information from Mr Marry Parry, Secretariat, Adelphi Communications Ltd, Adelphi Mill, Bollington, Cheshire SK10 5JB, United Kingdom (Tel: 44 625 575500; Fax: 44 625 575853).