BRITISH CARDIAC SOCIETY NEWSLETTER

Changes in cardiological services

Recent newsletters have been dominated by news of changes in cardiological services. This is likely to be the trend for the future, because events in many areas are moving with breathtaking speed. We are concerned that inadequate time is being given to consider the implications of new strategies in the National Health Service. Planning suffers, as does morale. The delivery of health care is compromised. We have no doubt that this period of turbulence will pass. Afterwards some of our practices will be better for the changes, some may be worse, and others will have reverted to the status quo. We may not like the developments that are taking place, and we may even be certain that some of the new strategies will be detrimental to the service. But if changes are reasonable—or in any case inevitable—we have an obligation to work with them as best we can. At the time of writing, the specialty reviews (under the aegis of the London Implementation Group) are working to a tight schedule to have recommendations available to the Secretary of State by the end of May. Our own committee under the chairmanship of Professor Richard Alderslade is helping to mould a consensus view from within the Society that can be submitted in oral and written evidence to the specialty review within the next few weeks. Our committee is working to the following brief: "To facilitate the discussion amongst provider units at District and Regional centres of the rationalisation of cardiac services in the Thames Regions in response to the review of cardiac services by the London Implementation Group, and to advise." We do not underestimate the difficulty of their task.

Inevitably the Tomlinson report will lead to changes for many of our tertiary centres. But other changes are occurring in response to the new philosophy of the internal market. One of these has been the development of cardiac catheterisation facilities within district general hospitals. The British Cardiac Society approves of this development in principle, but believes that laboratories should operate remote from full tertiary centres only where a number of criteria can be met. These criteria have been set out in a document that has been approved by Council: it will be published in full in due course, but in the meantime copies can be made available on request. In brief, facilities should be developed only in the context of an overall strategic plan for cardiology services determined by purchasers in consultation with provider units; they should serve a population of at least 500 000 (implying that two or more districts should share the facility); at least two operators should be available, each maintaining experience by undertaking a minimum of four cases per week; the operators should be fully trained in cardiac catheterisation and should have had adequate recent experience; the patients and the cardiac procedures should be under the

direction of a cardiologist, though radiologists with appropriate training in cardiac catheterisation and coronary angiography may be able to share the workload; the laboratory should be staffed by appropriately trained nurses, technicians, and radiographers; the equipment should be such that the image quality is at least as good as one would expect at regional centres and should conform to the latest recommendations on radiation exposure; close links should be established and maintained with cardiac surgeons and interventional cardiologists in order to review all potential cases for intervention, establish methods of referral and waiting list priorities, and agree protocols for postoperative care and follow up; district hospital laboratories must be audited and should enrol in the confidential enquiry of catheter laboratory complications being run by the audit committee; finally junior doctors may be trained to undertake coronary angiography in district hospitals only if they are holders of posts recognised by the Joint Colleges Higher Medical Training Committee.

Funding problems of the internal market

Everyone is aware that the first year of the full implementation of the internal market in most of the United Kingdom (Scotland has had a year's grace) has been beset with considerable funding difficulties. The causes are manifold: they include inexperience in contracting, misunderstanding of the implications of the government's insistence that money would follow the patient, conflict between need to shorten waiting lists and need to "pace" the work throughout the year (called over-performance), and of course mismatch between funding and perceived clinical need. For whatever reasons, between late January and early April we have had the paradox that most of our cardiac centres were working below capacity while many patients designated as having urgent clinical problems were waiting for interventional procedures. We conducted a survey in response to a request for information on the performance of units. Of 21 major centres answering our questionnaire (not including special health authorities), 16 had completed contracts for some or all of their districts, 10 had not been able to negotiate adequate supplementary contracts, 13 were working below capacity, and eight were having difficulties providing services for emergency cases. We are pleased that the NHS Management Executive wrote a letter to Managers and Chief Executives in February "to ensure that patients who need investigation or treatment as a matter of clinical urgency are dealt with promptly within usual local timescales". We hope that greater experience with the new system of funding will ease a situation that seems at present to be highly vulnerable.

Screening for hypertrophic cardiomyopathy

John Goodwin writes: "The Hypertrophic Cardiomyopathy Association (HCA) has formed a joint committee with the National Institute of Sports Medicine to investigate the practicalities of screening young athletes for the presence of heart disease that might endanger them in the pursuit of extreme physical effort. A pilot programme has been set up in Glasgow and is due to start shortly: 1000 athletes will be screened by

questionnaire, by clinical examination, by electrocardiography, by echocardiography, and when practicable by genetic studies for hypertrophic cardiomyopathy. The officers of the new committee are Professor Greg McClatchie (chairman of the National Institute of Sports Medicine), chairman; Bill McKenna (reader in cardiological sciences, St George's Hospital and Vice President HCA), vice chairman; and Stuart Hillis (consultant cardiologist and sports medicine expert, Glasgow) secretary. Other members are John Goodwin (emeritus professor of clinical cardiology, Royal Postgraduate Medical School, and President HCA), Michael Davies (professor of cardiac pathology St George's Hospital and Editor, *British Heart Journal*), Graham Davies (consultant cardiologist, Hammersmith Hospital and Royal Postgraduate Medical School), Dr Chris Butler (general practitioner and sports medicine expert), Dan Tunstall Pedoe (consultant cardiologist St Bartholomew's Hospital and medical director London Marathon), and Mr Terry Yorath (professional footballer and coach). The pilot study aims to establish data on several aspects of the initiative: on likely yield of cases; on obtaining the understanding and cooperation of subjects, families, and sports institutes; on establishing ways of advising and counselling; and on financial considerations. Many unknown variables have to be established before any larger scale screening programmes can be contemplated. Of particular importance, as far as HCA is concerned, will be the differentiation between the normal athletic heart and the cardiomyopathy heart. When doubt exists after the basic screening procedures have been carried out, effort testing and more sophisticated investigations are envisaged. Attention has rightly been drawn recently (in an editorial in the *British Medical Journal* 1993;306:409) to the problems of mass screening for conditions for which little treatment is available. I agree in general with this view, but it does not apply in hypertrophic cardiomyopathy for which—fortunately—much can now be done to treat the condition, to improve prognosis, and to relieve anxiety. The committee is particularly sensitive to the issues of morale, anxiety, and uncertainty on the part of those taking part in the screening process. The reasons for the study will be carefully explained to all involved and the advantages to the individual and the sporting institutions concerned will be made clear. As President of the HCA, I am well aware of the high level of anxiety that the sudden death of the young active people engenders, and of the need to counsel hypertrophic cardiomyopathy families. The members are desperate that more should be done to detect significant cardiac disease and to avoid such tragedies."

Grown-up congenital heart disease

We have received the following contribution. "Over the last 10 years Jane Somerville has made the British Cardiac Society aware of the problems faced by patients with congenital heart disease after childhood. "Who knows, who cares?" about those with grown-up congenital heart disease (GUCH) has been a repeated rallying cry. The British Cardiac Society has set up a working party on GUCH to examine the problems of management of adolescent and adult

patients with congenital heart disease in the country. The Department of Health does not recognise adolescence (12–19 years), so we define adult GUCH as 16 years and over. The working party is to make recommendations on the ideal organisation within the country for this increasing population of patients who, for many different reasons, are not receiving optimal specialist care. The working party has wide geographical representation from both paediatric and adult cardiology and from cardiac surgery, which is needed in 20% of admissions. The working party is to be chaired by Jane Somerville with Stuart Hillis as secretary. Other members are Roger Hall, Paul Oldershaw, Stewart Hunter, John Deanfield, and Darryl Shore. The first meeting to establish the aims of the working party took place in February and the next meeting will be at the Wembley conference. The working party will try to identify current provisions for GUCH throughout the nation, identify the size of the problem, stress the importance of the training of a GUCH cardiologist, and set out ideals for surgical management of this special group. Jane Somerville would like to know of any problems that members have encountered with the care and management of GUCH patients. A standard questionnaire will be circulated through the BCS office about clinical practice. Despite recommendation, in the Fourth Report of the Joint Cardiology Committee of the Royal Colleges and by the Working Party on the Future of Paediatric Cardiology, that care for the GUCH should be provided by supraregional centres, the Supraregional Services Advisory Group of the NHS Executive has rejected an application for supraregional designation (and funding) for this purpose on the grounds that the service is "fairly widely available". We find this remarkable. It is timely and appropriate that the British Cardiac Society has taken responsibility for the solution of GUCH problems."

The Wembley meeting

This is almost upon us. The Society will decide in due course whether it wishes to use a London venue again or not. The plans for Torquay in 1994 are already under way. Each year sees some changes in the organisation of the meetings: some are successful and retained, while others are tried once and dropped. One change this year is the adoption of camera ready abstracts. These will have come to members as a supplement to this copy of the *British Heart Journal*. Remember to bring the supplement to Wembley with you. . .

News from Europe

Philip Poole-Wilson writes as follows. "Arrangements are proceeding well for the XV Congress of the European Society of Cardiology which will take place from 29 August to 2 September 1993 in Nice. Over 6000 abstracts have been received. The largest number are from Germany (17%), followed by Italy (13%) and the United Kingdom (12%). The number sent from the United Kingdom has continued to increase each year. The largest clinical areas are arrhythmias, echocardiography, interventional cardiology, and myocardial infarction. Basic science including molecular biology, cardiovascular physiology, cellular biology, and the biology of the vessel wall

are well represented. Plans for the Congress in 1994 are developing. As most readers will already know, this will be a joint meeting. It will be the XII World Congress of Cardiology and the XVI Congress of the European Society of Cardiology. That meeting is expected to be larger than usual. The dates are 10 to 14 September 1994. One major change is that the last date for the receipt of abstracts will be 1 December 1993. Please do make a note of that date.

News of colleagues

We have been saddened to learn of the death of John McMichael. John Goodwin has written a tribute. "Sir John McMichael died on 3 March 1993 after a long illness most bravely borne. He was born in Gatehouse of Fleet, Kirkcudbrightshire in 1904. He studied medicine in Edinburgh and soon emerged as one of the brightest students of his era. At the age of 29 he won the Gold Medal for his MD thesis during his tenure of a Beit Memorial Fellowship. His early researches were into respiratory disease and diseases of the spleen and liver. But he soon became interested in the cardiovascular system, and was quick to appreciate the great possibilities for research offered by cardiac catheterisation. He joined the staff of the Royal Postgraduate Medical School (then the British Postgraduate Medical School) as reader in medicine and succeeded Sir Francis Fraser as Director of the Department of Medicine in 1946. He pioneered cardiac catheterisation with colleagues Peter Sharpey Schafer and Sheila Howarth. Despite dire warnings of disaster, he pressed on courageously and established catheterisation firmly in Britain. He went on to establish the Royal Postgraduate Medical School at Hammersmith Hospital as a centre of excellence for training talented young people in research, emphasising always the importance of departmental cooperation and of considering the whole of the patient, not only individual organs. As a result of his inspired leadership, advances were made during the second world war by distinguished younger colleagues in liver disease, the crush syndrome, and renal failure. But McMichael's enduring love was for the cardiovascular system. He pointed out the limitations of digitalis in the treatment of heart failure, and the importance of "high output failure". His monograph "The Pharmacology of the Failing Human Heart" was a classic of its kind. He was closely involved in the development of the coronary care unit at Hammersmith Hospital by John Shillingford. Later, he became interested in hypertension and pioneered the use of ganglion blocking agents in the early days of effective pharmacological treatment of high blood pressure. McMichael was instrumental in enlarging the buildings and facilities of the Royal Postgraduate Medical School in an extensive way, but his work was not confined to the school. He played a leading part in the development of the British Heart Foundation, was President of the British Cardiac Society from 1968 to 1972, and was President of the Fifth World Congress of Cardiology in London in 1970. He was a member of the Medical Research Council, a Wellcome Trustee, and Vice President of the Royal Society. He succeeded Sir James Patterson Ross as Director of the British Postgraduate Medical Federation. Many honours came to him. He was knighted in 1965 and elected as fellow of many colleges and medical societies, but the honour that he valued most was his Fellowship of the Royal Society. He lived to

see the same honour bestowed on his son Andrew. When I saw John McMichael shortly before his death, he was delighted when I pointed out the unique (probably) distinction of two Fellows of the Royal Society in the same family! John McMichael was a great man in many ways; great in caring for patients and colleagues interests, great in courage and imagination, great in determination, great in maintaining the best interests of medicine. The sight of his tall figure striding down the main corridor at Hammersmith was always reassuring, as was his talent for inspiring loyalty and affection in his colleagues. He will be sadly missed, but his memory and his message will never die."

We have news of new appointments. Alastair McCance has been appointed cardiologist at Derby City Hospital. Nilesh Samani has become senior lecturer/honorary consultant cardiologist and Cliff Garratt has become senior lecturer in cardiology—both in Leicester.

And finally

This is the final signing off for the present partnership in the production of the newsletter. By the time the next one appears the Society will have a new president and the other new signatory will be that of the assistant secretary. One of us has been involved with the newsletter since its inception in August 1990. We believe it has proved a useful way of keeping members informed about developments related to the Society. The *British Heart Journal* is not a newspaper and is not geared to rapid dissemination of hot news. But the technical editor and the printers have been tolerant beyond any reasonable expectation by giving us last minute copy dates. We are grateful to them and to two Editors for their cooperation over the past three years. Our very last message is to remind our members that news or views for possible inclusion in the newsletter are always welcome.

DOUGLAS CHAMBERLAIN
President, British Cardiac Society
DUNCAN DYMOND
Secretary, British Cardiac Society
9 Fitzroy Square
London W1P 5AH

CORRECTION

The details given in the review of *Percutaneous balloon valvuloplasty* that appeared in the January 1993 issue (1993;69:94–5) are incorrect. This book was published by Igaku-Shoin Medical Publishers, New York and Tokyo.

NOTICE

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