and reinforces selected cognitive tendencies. Both for scientific and practical usage when do we think 'tachycardia' and think 'bradycardia'? One is reminded of the early limits for sinus bradycardia induced by β adrenochrome blockers. As late as 1980 the rate target was set (by British Commonwealth authorities) at "under 70 beats per minute", and until recently 60 beats per minute was the lower limit used by many physicians.

We studied people at rest in a familiar environment in the afternoon, typically when most physicians in the United States see most of their non-urgent office patients. Whatever the epidemiological data and statistical manipulations a rate in the 90's in resting adult patients intuitively should be considered "fast" and I am certain that few physicians would be satisfied at any age when their own resting (not so basal) daytime heart rates above 90.

David H Spodick, Cardiology Division, Saint Vincent Hospital, Worcester MA 01604, USA
1 Meijler FL. Is there such a thing as a normal sinus rate? Br Heart J 1993;69:376.

This letter was shown to the author, who replies as follows:

Sir,—The style and content of Dr Spodick's reaction to my Viewpoint show that he feels somewhat aggrieved that in the first place my opinion was asked and in the second that I tend to disagree with him on the importance of finding another operational definition of "normal" sinus rhythm. I regret this because in science a difference of opinion should be fun.

I remain unconvinced of the need for a change. This does not imply that I like a "normal" sinus rate of 60 to 100 beats per minute better than 50-90. I do not care unless it has been shown that one rate has more clinical relevance than the other or would improve our understanding of sinus node function in health and disease. Also no group of people—male or female; small or large; white or black; tall, small, or mixed—can represent all of mankind. Normality in Massachusetts, Halifax, or Framingham may not be the same in Holland, Nigeria, or Japan.

Finally I am not convinced by my peers in the American College of Cardiology that a change in the "normality" of sinus rate is important. In science two do not necessarily know more than one.
is hoped that no registration charge will be necessary.

The meeting will run from 11 am to 4.30 pm and lunch will be provided. Further details can be obtained from Dudley Pennell, Magnetic Resonance Unit, Royal Brompton Hospital, Sydney Street, London SW3 6NP. Telephone: 071 351 8819; fax: 071 351 8816.

JPAC quotas for senior registrars in cardiology

Many of you will have seen Executive Letter (93) 52 issued by the NHS Management Executive. The table below shows the existing and new quotas for senior registrars in cardiology with the bracketed figures referring to paediatric cardiology posts which are additional to the main quota.

<table>
<thead>
<tr>
<th>Region</th>
<th>Previous quota</th>
<th>New quota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>1 (1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>2 (1)</td>
<td>4 (1)</td>
</tr>
<tr>
<td>Trent</td>
<td>4</td>
<td>6 (1)</td>
</tr>
<tr>
<td>East Anglian</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>North West Thames</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>North East Thames</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>South East Thames</td>
<td>3 (1)</td>
<td>4 (1)</td>
</tr>
<tr>
<td>South West Thames</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Wessex</td>
<td>2 (1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Oxford</td>
<td>2 (1)</td>
<td>3</td>
</tr>
<tr>
<td>South Western Region</td>
<td>2 (1)</td>
<td>3</td>
</tr>
<tr>
<td>West Midlands</td>
<td>3 (1)</td>
<td>4 (1)</td>
</tr>
<tr>
<td>Mersey</td>
<td>2</td>
<td>3 (1)</td>
</tr>
<tr>
<td>North Western</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Wales</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>The Hospitals for Sick Children</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Royal Brompton National Heart &amp; Lung Hospitals</td>
<td>3 (1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Hammersmith &amp; Queen</td>
<td>Charlotte’s Hospital</td>
<td>2</td>
</tr>
</tbody>
</table>

This table has been published by the NHS Management Executive with an indication that where a region stands to gain one new post—that should be achieved by the 31 March 1995 and if it is more than one—the quota should be achieved by no later than the 31 March 1996. It is important to recognise that these are notional quotas proposed by JPAC and based on a series of planning assumptions. It is also important to recognise that educational approval is required before the posts can be implemented and funding has to be approved. Further discussions are continuing between the Management & Training Committee of the Society, the SAC and the NHS Management Executive about final distribution of these posts. The total allocation for trainees in England and Wales is now 71 with 10 being protected specifically for paediatric cardiology. In addition to these 71 posts, 3-5 whole time equivalents were top sliced for part-time training posts and a further six posts have been allocated for research. Thus the national target for England and Wales is a total of 80-5 whole time equivalent posts.

News of colleagues

John Gammill has been appointed as physician with an interest in cardiology in Ayr and Laura Anne Corr has been appointed as consultant cardiologist at the Brook General Hospital, London.

D JOHN PARKER
President, British Cardiac Society

JOHN G P CLELAND
Assistant Secretary, British Cardiac Society

9 Finney Square
London WIP 5AH

CLINICAL GUIDELINES

Exercise testing when there is not a doctor present: Recommendations of the Medical Practice Committee and Council of the British Cardiac Society

1 LOCATION OF THE EXERCISE ROOM
The exercise room should be in or close to the outpatient department or cardiac ward. It is essential that medical and nursing staff are close by and are able to reach the exercise room within one minute of the cardiac arrest alarm being raised.

The room should be large enough to allow resuscitation procedures to be carried out and for a stretcher trolley to be brought in.

Ideally the room should be air-conditioned and have a piped oxygen supply and piped or portable suction.

2 CARDIAC ARREST ALARM
A suitable alarm system should be installed so that help can be summoned immediately should an arrest occur. The alarm should be tested regularly and there should be cardiac arrest drills so that all involved understand the procedure in the event of an arrest.

3 RESUSCITATION EQUIPMENT
The exercise room should have full resuscitation equipment including a defibrillator, cardiac arrest trolley, intravenous infusion equipment, etc., which should be checked at regular intervals.

4 TECHNICIANS
Only technicians who are fully trained and of a senior grade should be expected to perform medically unsupervised tests. The technicians should be fully conversant with the reasons for stopping an exercise test, capable of taking blood pressures, and able to read the electrocardiogram.

The technicians should have appropriate training and understanding of exercise testing and resuscitation. The head of department must satisfy himself/herself that the technician is competent in all relevant areas of resuscitation.

There should be two technicians in the exercise room or one technician in the room and at least one other technician/nurse absolutely immediately available.

5 PHYSICIAN COVER
A named physician should be responsible for each exercise test. This physician should be someone who will be close by, either in outpatients or on the ward, while exercise testing is taking place. The technician should be able to contact the physician should any problems arise or if there are any queries.

6 BOOKINGS FOR EXERCISE TESTING
Shortly before an exercise test is performed the patient should be examined by the physician who is requesting the test and who has seen the resting electrocardiogram.

7 REQUEST FORMS
Request forms should be completed and the forms should be signed only by a physician. The technician should not perform the test if the medical details on the forms are not completed correctly or the forms are not signed by the responsible physician. The request form should include a statement, to be signed by the physician, that the patient has been examined and that it is safe to proceed with a medically unsupervised test.

8 HIGH RISK TESTS
All high risk exercise tests should be supervised. Exercise tests on any patient with aortic stenosis, hypertrophic cardiomyopathy, unstable angina, recent myocardial infarction, and on all others with a recognised potential for developing malignant arrhythmias should be supervised by a doctor. If there are any doubts over the suitability of a patient for a medically unsupervised test the test should be supervised.

NOTICES

The 1994 Annual Meeting of the British Cardiac Society will take place at the Riviera Centre, Torquay, from 17 to 20 May.

Fifteenth Interamerican Congress of Cardiology and Fourth Meeting of the International Society for Heart Research (Latin American Section).

The Congress and meeting will be hosted by the Chilean Society of Cardiology and Cardiovascular Surgery in Santiago, Chile, from 6 December to 9 December 1995. Dr Edgardo Escobar is president of the organising committee and enquiries should be addressed to the Secretariat, Los Conquistadores 2251, Dept 4, PO Box 16854, Providencia, Santiago, Chile. Fax: 56-2-2334715.

The British Society for Cardiovascular Research will be holding a workshop entitled "The Enigma of Atrial Fibrillation" at University College Hospital, London, on 26 January 1994. Further details and application forms are obtainable from Dr Suzanna Hardman, Department of Cardiology, University College Hospital, Gower Street, London WC1E 6AU. (Tel: 071 380 9888. Fax: 071 388 5095).

Under the auspices of the European Society of Cardiology working groups on coronary circulation, myocardial function, and pathogenesis of atherosclerosis, there will be a Meeting on Current Concepts in the Therapy of Coronary Artery Disease at Garmsih-Partenkirchen, Germany, January 26–29 1994. Details from the Congress and Conventions, PO Box 100619, Frankfurtur Str. 56-60, D-63006 Offenbach a.M. Germany.