BRITISH CARDIAC SOCIETY NEWSLETTER

Staffing cardiac units into the twenty first century

The Society held a meeting on staffing for members on 29 November at the Royal Society of Medicine. Shortly afterwards the Government's response to the Calman Report brought the disappointing news that changes will be implemented over several years and within existing resources.

The morning session opened with a review by Brian Pentecost of the Calman Report that emphasised the structure of training in relation to general internal medicine and the common trunk training. Michael Petch reported on the first draft recommendations from the executive of the newly formed European Cardiology Board (made up of representatives of the Union Européenne des Medecins Specialistes (UEMS) and the European Society of Cardiology). The requirement to achieve compatibility with Europe was a major reason behind the Calman Report.

The recommendations mean that in future there will be a single training grade amalgamating the registrar and senior registrar grades. Training in cardiology will start after two or three years post-registration common trunk general training and after the trainee has obtained the MRCP.

Dr Robin Cairncross gave a view from the National Health Service Management Executive. He emphasised the need to shorten training and balance staffing. There seemed to be little pressure to reduce staffing at senior house officer level and this created the risk of a manpower obstruction at this level. Members remained sceptical, and rightly so, about whether the Government will fund the appropriate number of consultant posts to achieve these changes.

John Camm reviewed the challenges that academic medicine and research face under the Calman proposals. The earlier report, "Achieving a balance", apparently reduced the number of United Kingdom graduates doing research in cardiology and some of the manpower has been replaced by the incorporation of nurses, technicians, non-medical scientists, and overseas doctors into research programmes. The Calman Report had raised serious concerns about the future of research training, and a further review is under way. John Camm reported that there seemed to be a consensus in the United Kingdom and Western Europe that a two year period of research will be needed to achieve the necessary standards of research for an MD degree, with a PhD degree taking three years or longer. John Camm recommended that:

(*a*) A specific research appointment although not mandatory should be strongly recommended to all cardiology trainees.

(*b*) A higher degree is not essential but does provide an important supervised structure in which research can take place. Trainees should therefore be encouraged to obtain an MD or PhD.

(*c*) Research opportunities should be provided throughout the training period without requiring trainees to abandon their training number and slot.

(*d*) The training scheme should be sufficiently flexible to allow easy movement between academic and service career tracks.

(*e*) The training scheme should be comprehensive and flexible enough to ensure that academic clinicians are fully trained clinically and that the academic background of service cardiologists is sufficient for them to be able to interpret, apply, and appreciate the results of research into cardiovascular disease.

The afternoon session dealt with the changes that would be required for training cardiologists in the future. Even without the impetus of Calman and the European Cardiology Board there was broad support for the initiatives being developed by the Specialist Advisory Committee in Cardiovascular Medicine and the Joint Committee on Higher Medical Training. Michael Webb-Peploe outlined the new training programme structure while Roger Hall developed the theme of training guidelines. Roger Boyle detailed the likely form of assessment that would be integrated into the training. Several components were held to be important in the assessment process, which will take place annually. These include clinical skills, technical ability in investigations, ability to relate to patients and colleagues, and knowledge of audit and management processes. To set or refine targets for future years the trainee will participate fully in identifying the strengths and weaknesses of his or her programme and of the training programme and trainers. The role of the log book will be extended. This process is likely to lead to some trainees leaving the programme at an early stage to find more suitable careers elsewhere in medicine.

Participants at the meeting supported the view of the Royal College of Physicians that a formal exit examination is unnecessary if a programme of progressive assessments continues throughout the training period. Though most of the recommendations from the Specialist Advisory Committee and Training and Manpower Committee were accepted, those members present took the view that a minimum number of procedures for adequate training would have to be specified but that flexibility was important too.

These changes lead on to a discussion on the increasing burden on cardiologists. The pressures are already considerable and demands will increase with advances in investigation and treatment. In addition, as training posts are reduced and the working hours for trainees become shorter, the work load will fall increasingly on consultants. In addition more consultant time will be demanded by more structured supervised training, including assessment, by audit management, and by the purchaser provider negotiations. The meeting also discussed the way in which the burden might be eased. Miss Anne Townsend, a senior nurse from the Freeman Hospital, Newcastle upon Tyne, talked about extending the role of the cardiac nurse and developing the role in cardiology of the clinical nurse specialist with specific training skills, responsibilities, and autonomy. Such specialist nurses could take over some of the tasks currently undertaken by junior doctors but the potential conflict with the training of doctors was recognised. There seemed to be little support for the introduction in the United Kingdom of a new group of professionals like physicians' assistants in the United States.

At present there are few Staff Grade appointments in cardiac units. In a general discussion there was little enthusiasm for increasing them significantly and the potential long-term difficulties associated with these posts were emphasised.

Douglas Chamberlain presented possible templates for the new training programme incorporating district general hospitals and tertiary centres, including time for research training but emphasising the need to keep flexibility. He also looked at the manpower implications, which imply a significant reduction in the number of career trainees—that is, trainees from within the European Union (EU) at registrar level. There need be no overall reduction but the shortfall will need to be made up from trainees from outside the EU and there was concern about how many suitable trainees could be recruited in the long term. These visitors will participate in the same training programmes as the career trainee but not usually for as long.

Douglas Chamberlain went on to emphasise that in response to the Calman Report the Royal College of Physicians had said that 45% more consultants were needed over the period of implementing the new shorter training programmes. This is new expansion in addition to the existing need for expansion in cardiology. This implies an annual increase in consultants of about 12% over the next 5 years. If this is not achieved there is a risk that standards of patient care will fall. The future seems threatening and the challenges of the twenty first century for staffing cardiac units cannot be ignored or avoided.

Current rules for accreditation by the Joint Committee for Higher Medical Training

Many consultants and senior registrars may not be fully aware of the requirements for obtaining accreditation in "cardiovascular medicine including general internal medicine". At present accreditation cannot be obtained in cardiovascular medicine alone. To obtain this combined accreditation (which is not dual accreditation) a senior registrar must undertake a minimum of 2 years in cardiology and 1 year in general internal medicine *within the last 4 years of training*. The post in general internal medicine must be approved by the Joint Colleges Higher Medical Training Committee (JCHMT) and should involve unselected "take" with continuing general medical care of patients. Some existing senior registrar training posts include a rotation into general internal medicine or a qualifying component of general internal medicine. Unfortunately, the remainder do not. Senior registrars who have completed their cardiological training in programmes that did not include general internal medicine are therefore encountering difficulties in obtaining accreditation. The Specialist Advisory Committee (SAC) intend to negotiate with the JCHMT with a view to making it possible to obtain accreditation in cardiovascular medicine alone. The outcome of these negotiations cannot be anticipated but any changes will be announced. Senior regis-

trars who foresee difficulties in obtaining accreditation should contact Michael Webb-Peploe (chairman of the SAC in Cardiovascular Medicine) via the JCHMT office, Royal College of Physicians, 11 St Andrew's Place, Regents Park, London, NW1 4LE (tel: 071 935 1174).

British Cardiovascular Intervention Society

Martin Rothman writes: "The Winter Scientific Meeting of BCIS was held in Manchester and hosted by Bernard Clarke and his colleagues from the Manchester Royal Infirmary and Wythenshawe Hospital. As usual the meeting was well attended and apart from the time-honoured sessions for reviewing angiograms there were important presentations on intracoronary stenting and the results of the recent Benestent trial, the function of the Department of Health's new Devices Directorate, and an update on the advances made in our understanding of the function of the endothelium and the mechanisms underlying restenosis."

"The next BCIS meeting will be the international 2 day Angioplasty '94 Meeting, to be held in London on 20 and 21 January, 1994 for which generous sponsorship has been received from industry. The programme covers a wide range of topics, with presentations given by various speakers from the United Kingdom and elsewhere. Enquiries about this meeting should be made to Beverley Charters of BCOS Ltd, the course organiser (tel: 071 637 0016)."

"There will be a BCIS meeting at the British Cardiac Society Annual Meeting in Torquay on 18-20 May 1994 and the provisional date of the Winter Meeting, to be held in Cardiff, is Friday 30 September 1994."

"The final returns of data on interventional procedures undertaken in the United Kingdom in 1992 are being analysed and should appear in the *British Heart Journal* in the first half of 1994. A subcommittee of BCIS Council has been set up to look at the best ways of collecting data in the future and at how some additional information on risk stratification of cases can be included. It is likely that the collection of data will move to a more computer oriented system and away from the present paper forms; the feasibility and cost of such a system are being assessed. Unfortunately, for our contacts in interventional units, requests for the 1993 returns will be sent out early in the New Year. Prompt returns of complete data would be greatly appreciated."

"The membership of BCIS now stands at 275, with 180 medical, 15 radiological, 29 nursing and technicians, and 51 industry members."

"Finally, Peter Hubner and Alan Mackintosh will be standing down as council members of BCIS in February, having served on council since the inaugural meeting of BCIS in 1987, for much of this time as Honorary Secretary and Honorary Treasurer respectively. The present activity of BCIS owes a lot of their enthusiasm and hard work in the past, for which we owe them many thanks. Any BCIS member wishing to nominate their replacements should write to Huon Gray, Wessex Cardiac Unit, Southampton General Hospital, Southampton."

European Society of Cardiology

Philip Poole-Wilson writes: "At the Autumn meeting of the Board of the European Society of Cardiology the responses, both favourable and critical, to the Nice Congress were discussed. Many letters of appreciation had been received. One complaint concerned the fact that smoking took place on the Congress premises and a second pointed out how few women chaired sessions or were speakers during the Congress. I was surprised that there were so few adverse comments about the problem of transport in Nice. Perhaps that was because on balance any difficulties with travel arrangements were offset by the pleasant environment. Because of the large number of problems encountered with double projection the Board decided that in future double projection will not be available during the Congress, except in the largest auditorium which is usually reserved for plenary sessions. The Board was also concerned about the number of "no shows" for the oral and poster sessions, estimated to be 1%. In future firm action will be taken. Anyone who has an abstract accepted, either for oral presentation or for a poster, must ensure that it is presented."

Other news

Abstracts for the Torquay meeting have poured in and the total number received was 868—this is an increase of 22% on the number received last year. Abstracts have now been sent out for blind marking and the Programme Committee meets early in January to put together an exciting programme. In Torquay the St Cyres Lecture (the other formal lecture with the Thomas Lewis Lecture) will be given by Professor Gunter Breithardt. It is entitled "Management of patients with sustained ventricular tachycardia or previous cardiac arrest—the changing scenario in the 1990s.

It is sad to record the death of Leon Resnekov, a member of the Society since 1963. He spent 10 years in London at the Cardiothoracic Institute and National Heart Hospital before moving to the United States in 1967 where he followed a distinguished career in Chicago. He gave the St Cyres Lecture to the British Cardiac Society Annual Meeting in 1979.

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CORRECTION

Postoperative cardiac surgical care: an alternative approach *A Jindani, C Alps, E Neville, B Sonmez, K Tung, B T Williams* (1993;**69**:59–64). We regret that the name K Tung, an author of this paper, was misspelt.

CLINICAL GUIDELINES

Mobile cardiac catheterisation laboratory: Recommendations of the Medical Practice Committee and Council of the British Cardiac Society

The increasing demand for diagnostic and therapeutic catheterisation has encouraged significant changes in service provision. One such development is catheterisation in district general hospitals, which was the subject of an earlier report from the British Cardiac Society (*Br Heart J* 1994;71: 110–2). Another linked development is the use of mobile catheter laboratories, which is the subject of these guidelines. Mobile catheter laboratories are a valuable addition to the currently available facilities.

Mobile catheter laboratories may be used in two different circumstances:

(*a*) In centres that also have fixed catheter laboratories, either to provide additional facilities or to substitute for the fixed laboratory in case of breakdown, methicillin-resistant *Staphylococcus aureus* contamination, etc (mainly regional centres).

(*b*) In centres that have no fixed catheter facilities, usually because the workload of that centre is not sufficient to justify the purchase of a fixed laboratory (mainly district general hospitals).

Mobile catheter laboratories can be used by host hospitals in various formats. They may require only the *x* ray facility (with medical, nursing and technical staff being provided by the host hospital) or, at the other extreme, they may require both the *x* ray facility and the staff to use it, including the cardiologist, in which case the host hospital needs only to organise the patients and monitor them after the procedure.

Because of this variety of practice all clinical and managerial responsibilities must be agreed before the laboratory becomes operational and responsibility for patient and staff indemnity must be clearly defined. All companies that own mobile laboratories should have their own procedure manuals to which the host hospital must agree before any procedures are carried out. The following items should be addressed in any such manual.

REQUIREMENTS FOR USE OF MOBILE CATHETERISATION LABORATORY

The mobile catheter laboratory should be sited on level ground in an accessible position—ideally, near to appropriate day care facilities. Before operating in the laboratory the cardiologist responsible for the procedures should agree:

(*a*) The stock and range of catheters, introducers, and other disposable equipment that are on the mobile laboratory

(*b*) The re-usable equipment, particularly for brachial arteriotomy

(*c*) The emergency drugs, contrast agents, and equipment (defibrillation, portable monitors, temporary pacing equipment)

(*d*) Who is to have access to the unit and under what circumstances?