BRITISH CARDIAC SOCIETY NEWSLETTER

Many members will have received the letter from Dr Kenneth Calman, the Chief Medical Officer to the Department of Health, on the implementation of the report *Hospital doctors: training for the future.*

Dr Calman wrote that Ministers had agreed to the full implementation of the report, which encourages the development of a consultant based service. This will shorten training from an average of 12 years to an average of 7 years with more structured and intensive training. The registrar and senior registrar grades will be unified and the finishing point of specialist training will be defined by the Certificate of Completion of Specialist Training (CCST).

Dr Calman recognised that the present rate of expansion of consultant posts (2%) needs to be increased. Some existing senior registrar appointments will be upgraded to consultant posts. He emphasised two important conditions: firstly, that there will be no overall increase in NHS resources to fund the changes and, secondly, the need to move away from existing medical staffing policies towards more flexible measures that emphasise "local decision making and priorities".

The NHS Management Executive will be issuing an implementation plan for consultation, but the responsibility for deciding content, direction, and criteria for specialist training rests with individual specialist Royal Colleges and hence through to the SAC in Cardiovascular Medicine and our Training and Manpower Committee. It is important to recognise that the minimum length of training programmes is being reduced but it remains to be seen how much flexibility there will be, especially in terms of funding of the training programmes through the postgraduate deans. During 1994 the General Medical Council will be consulting on the content of general professional training before specialist training.

The letter recognises many difficulties in achieving the change, including the period immediately after the award of a CCST and the introduction of a national numbering system of trainees. These issues are being taken forward by a working group and an implementation steering group. Furthermore, three expert groups are looking at the training of doctors in academic and research medicine, the training of overseas doctors, and the training of general practitioners. Dr Calman envisages that the change to the new structure will be completed within six years. There are many important changes ahead and the Training and Manpower Committee will be working with the British Cardiac Society Council to ensure that six years from now we have excellent training programmes with appropriate numbers of trainees and adequate numbers of consultants to provide the level of specialist care that patients with cardiac disease have a right to expect. Please send any views you have to the British Cardiac Society.

The following two reports from the Joint Audit Committee and the European Society of Cardiology make it clear that clinical guidelines will play an increasingly important part in everyday practice—we must all be involved.

Joint Audit Committee BCS/RCP London

David de Bono writes in defence of clinical standards: but not of cookbooks:

"The NHS Management Executive has recently (and some would say belatedly) become interested in the concept of writing clinical standards into purchaser-provider contracts. Among documents recently circulated to purchasers as possible source material on which to base such standards was a paper on audit guidelines and clinical standards in stable angina prepared as a summary of a workshop held under the auspices of the Joint Audit Committee of the British Cardiac Society and the Royal College of Physicians of London. The Joint Audit Committee has since held a further workshop on acute myocardial infarction and intends shortly to hold workshops on heart failure, arrhythmias, and valvar heart disease. Is this an attempt to curb the rich diversity of British cardiological practice by imposing rigid guidelines or cookbook protocols? Emphatically not! There is increasing recognition by all parties, not least by purchasers, that the only guidelines likely to be followed—and therefore effective—are those drawn up locally with the involvement of all interested parties including general practitioners with a full understanding of local problems and resources. The two main objectives of the Joint Audit Committee summaries are firstly to provide a brief but accurate description of the clinical condition and a synopsis of recent clinical trial data and second to identify essential features that need to be recorded so that clinical practice can be audited. If clinicians can use this material to help them draw up local guidelines, then our aim will have been fulfilled. In practice, no one can or should expect absolute compliance even with local guidelines: this would be robotics not medicine. On the other hand, clinicians who depart from locally agreed guidelines should be prepared to justify their action and, even more important, to record their results. When I started in cardiology I was taught to use 8 gauge catheters, always to do a left ventricular angiogram, always to heparinise the patient, and to keep catheter patients in hospital overnight (if not for three or four days). I now do none of these. Changes in management of myocardial infarction, arrhythmias and heart failure have been even more spectacular. But there is no point in being an innovator unless process and outcome are properly recorded so that they can be independently checked, compared with conventional wisdom and, if better, communicated efficiently to others. Purchasers will increasingly seek to write audit funding into individual contracts rather than to deliver it as a lump sum; they can be educated to see properly audited innovation as being essential to their own interests as well as those of the provider."

European Society of Cardiology

Philip Poole-Wilson writes: "Some of you are involved in working groups that prepare guidelines, academic comments or policy statements on areas of interest in cardiology. The Board of the European Society of Cardiology has clarified how these activities should be classified. A task force is established by the board to prepare recommendations or guidelines. Task forces can be proposed to the board by working groups, national societies, or others. The final document needs endorsement by the Board of the European Society of Cardiology and will be published in the *European Heart Journal.* Study groups can be established by working groups of the European Society of Cardiology to look into specific topics and to prepare opinions and recommendations. These reports reflect the opinions of the study groups and working group. Ideally reports from study groups should be submitted to the *European Heart Journal* and they almost certainly will be subjected to the normal reviewing process. I do hope that many of you will join task forces or study groups. If there are topics that you think should be evaluated in the context of a working group of the European Society of Cardiology do suggest that to the chairmen of those working groups.

Forthcoming meetings

Jarda Stark is due to give his Tudor Edwards Lecture entitled "Quo vadis paediatric cardiac surgery" on 2 June 1994 at 5.00 pm at the Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London. For further information telephone 071 405 3474.

A second meeting on *Cardiovascular Disease Prevention* will be held on the 19–22 July 1994 at the Conference Centre, Kensington Town Hall, London. Please contact Hampton Medical Conferences Limited, Hofer House, 185 Uxbridge Road, Hampton, Middlesex (tel: 081 783 0810) for further information.

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NOTICE

The 1995 Annual Meeting of the **British Cardiac Society** will take place at the Conference Centre, Harrogate, West Yorkshire from 23 to 25 May.

CORRECTION

Increase in plasma β endorphins precedes vasodepressor syncope *D R Wallbridge, H E MacIntyre, C E Gray, M A Denvir, K G Oldroyd, A P Rae, S M Cobbe.*
We regret that owing to a printers' error all four figures in this article in the May issue (*Br Heart J* 1994;71:446–8) appeared in the wrong order and with wrong legends. The corrected version of the article is reprinted on pages 597–599 of this issue.