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SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

"Type B" cardiology

SIR,—I would seriously question the estimate by Professor J R Hampton (18 September, p 759) of the requirement for open heart operations for the Trent region and his agreement with the figures of Dr M Joy and Dr I Huggett (18 September, p 790) of about the same rate for a district general hospital in south-east London.

The figures for any region are seriously biased by the reality of whether a demand can be met locally. The recent article by Kennedy *et al*[1] gives a conservative estimate for the necessity for cardiac surgery in Olmsted County, Minnesota, during the years 1973-80. Their figures suggest a rate over the last four years (when they feel demand has reached a plateau) of 480 cases per million population, almost double the figure cited by Professor Hampton. A report by an expert committee of the Scottish Home and Health Department[2] gave a rate of 300 cases for each million of the population in Edinburgh in 1975. It is important for the planning of future cardiac surgical facilities in this country that figures for demand are not misinterpreted.

When local cardiologists and, more importantly, local general practitioners know that their patients' demands cannot be satisfied they simply do not refer patients for investigation, and hence demand is seriously underestimated. This might be nice for health authorities whose budgets are severely strained but it is not particularly nice for patients.

I would also disagree with Professor Hampton's conclusions about the distinction between type A and type B cardiology. We believe that we train both types of cardiologists here, and most of our trainees, in fact, go on to type A cardiology. They have all participated in general medical acute admissions, and I head one of the four firms handling medical acute admissions to the John Radcliffe Hospital. We spread ourselves over three of the four admitting firms by attachments of consultants or senior lecturers. The so called type A cardiologists certainly spend 80% of their time doing cardiology, but an important element of acute general medical admission is still included. We feel that it is particularly important both for service and for training that cardiologists do not see cardiological problems in a district general hospital only as a result of referral from another physician. We also feel that type B cardiologists need to be as well trained as type A cardiologists.

In my experience most district general hospitals (or at least the physicians on the appointing committees) want a fully trained cardiologist when they appoint one so that they have access to the best specialist opinion in their hospital. I believe that it is relatively simple to distinguish between type A and type B cardiology at consultant level. I do not think it is useful to make this distinction below consultant level. When consultants are appointed to type B posts it is very important that they liaise closely and share the same philosophy for investigation and treatment as their colleagues in type A posts. I believe the distinction between type A and type B has been overemphasised both in training and in consultant practice.

As Professor Hampton himself states, a very large proportion of any district general hospital emergency work is cardiology. I do not believe that such patients are best handled by general physicians who have had a smattering of cardiology of the noninvasive kind which Professor Hampton advocates. Such philosophy is a recipe for continuing unmet need in the general population. I think that it is completely unrealistic to expect all physicians in a district general hospital whatever their special interest to be competent cardiologists. The very training of most physicians in district general hospitals (posts which are highly competed for) includes considerable specialisation in gastroenterology or whatever. It is unrealistic to expect them to be competent cardiologists as well. District general hospitals need specialised competent cardiologists, and by and large this is what they get. The improvement in general practice means that all of us need run fewer and fewer follow up clinics if there is trust between the hospital and the practice. My final disagreement is with the statement that noninvasive cardiological techniques are easy to learn. My estimate is that they are considerably harder than cardiac catheterisation.

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[1] Kennedy RH, Kennedy MA, Frye RL, *et al. N Engl J Med* 1982;**307**:986-93.
[2] Programme Planning Group of the Scottish Health Service Planning Council. *Cardiac Surgery*. Edinburgh: Scottish Home and Health Department, 1977 (Kay Report).