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.

Region	*Previous quota*	*New quota*
Northern	1 (1)	3 (1)
Yorkshire	2 (1)	4 (1)
Trent	4	6 (1)
East Anglian	1	3
North West Thames	4	4
North East Thames	4	4
South East Thames	3 (1)	4 (1)
South West Thames	2	3
Wessex	2 (1)	3 (1)
Oxford	2	3
South Western Region	2	4
West Midlands	3 (1)	4 (1)
Mersey	2 (1)	3 (1)
North Western	4	4
Wales	2	4
The Hospitals for Sick Children	0 (1)	0 (1)
Royal Brompton National Heart & Lung Hospitals	3 (1)	3 (1)
Hammersmith & Queen Charlotte's Hospital	2	2

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 Manpower & 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 F CLELAND
Assistant Secretary, British Cardiac Society
9 Fitzroy Square
London W1P 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 Rivieria 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 Enigmas 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 Garmisch-Partenkirchen, Germany, January 26–29 1994. Details from the Congress and Conventions, PO Box 100619, Frankfurter Str. 56-60, D-63006 Offenbach a.M. Germany.