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Second report of a Joint Cardiology Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England on combined cardiac centres for investigation and treatment with a note on the requirements of cardiology in hospitals outside such a centre

'In issuing this report of the Joint Working Party, and in welcoming its general recommendations, the two Colleges emphasise that these plans, if they are to be fulfilled, will require time for further discussion on such important aspects as access to training for those in medicine and surgery who require experience in cardiac work, and the implications for specialties such as radiology and anaesthesia. The two Colleges also regard it as essential that adequate additional funding is provided in such a way as to impose no detriment on the existing services.'

SUMMARY (1) This, the second report of a Joint Cardiology Committee of the Royal College of Physicians of London, and the Royal College of Surgeons of England, on combined cardiac centres for investigation and treatment updates the original report of 1967. (2) The following recommendations should be considered as a design for a modern cardiac centre and are based on current demands and developing trends. (3) The past decade has seen the establishment of a number of new investigation techniques such as coronary arteriography, left ventriculography, echocardiography, the use of radio-nuclides, and the development of sophisticated electrophysiological techniques. In addition, there has been a change of emphasis in cardiac surgery. (4) Coronary artery bypass grafting has become established internationally as a low-risk procedure for relieving cardiac pain. In certain cases there may also be benefit in terms of life expectancy. (5) The demand for surgical treatment of valve disease and congenital heart disease continues. (6) Recommendations are made regarding: (a) workload, (b) siting, (c) staffing, and (d) size of a modern cardiac centre: (6a) Centres should be capable of undertaking a minimum of 200 open-heart operations a year. (b) They should be sited in relation to a general or university teaching hospital. (c) Staffing should be calculated on the basis of providing a 24-hour service as well as taking into account the needs for teaching and research. To achieve maximum efficiency and economy each centre will require three consultant cardiac surgeons and supporting staff. It is estimated that they and their teams could achieve approximately 600 open-heart operations per year. (d) The size of a centre will ultimately depend on the size of the population served. Data available from South Australia and Scotland suggest that 600 open-heart operations a year might be expected from a community of approximately two million. (7) Cardiac centres must be a regional or, preferably supraregional responsibility. They should receive directly earmarked funds allocated on a national basis. Competition for funds at district level must be avoided. (8) It is envisaged there will be a limited number of special paediatric centres. These will be associated with a major cardiac centre and wherever possible with a paediatric department of a university hospital. At these centres there will be special expertise for neonatal and infant cardiac surgery. Much of the routine paediatric work, especially for older children, will be done in the ordinary cardiac centres and in the paediatric departments of general and university teaching hospitals. (9) Requirements for a cardiac department in regional hospitals and hospitals not directly associated with a major cardiac centre are outlined. (10) In view of the rapid developments and changes in cardiovascular medicine and surgery, this report should be reviewed in not more than five years by a joint committee of the Royal College of Physicians and Royal College of Surgeons, and thereafter as recommended.