

other than the entrance exam, I wonder how many are discouraged by the quaint customs which, although fascinating when one understands them, may not be absolutely necessary to get the work done. My lengthy struggles with classical languages seemed finally justified when confronted by the agenda heading for the Censors' board on which I had the honour of sitting as a Members' representative—it was all in Latin!

I would also draw your attention to the plight of physicians faced with contracts for work requiring a year on year increase in numbers of patients seen, with financial penalties for missed clinics and the like. Can any jobbing physician escape often enough to the peaceful splendour of the College to be useful unless there is a generous supply of research fellows and registrars to do the work that generates the funds? Even the most open minded manager might not feel like squaring the kudos of having a physician working in the College with a failure to meet contract specifications.

I have thought very hard about possible solutions to this crucial time element—it is not easy. Should the College pay locum fees for Members of some of its committees? Should it invest heavily in information technology so that each district has a communications centre where Members and Fellows can go to participate in televisual conferences? A certain recipe for shorter meetings!

In summary, I do not believe that there is real antipathy or apathy towards the College, just unawareness of the potential contribution one could make, compounded by the problems created by the internal market. There is plainly a gulf of expectations here; I hope that the College will lower its drawbridge enough to allow the Membership to put its best foot forward.

GILLIAN F TURNER

Member, Standing Committee of Members 1989–93

Investigation and management of stable angina

Sir—The summary by de Bono and Hopkins of a forthcoming report on angina (July 1993, pages 267–3) comprehensively covers the practical issues in the investigation and management of stable angina, but fails adequately to identify the role of radionuclide myocardial perfusion imaging in screening patients for coronary artery disease and determining the prognosis of patients with proven coronary artery disease. This is particularly unfortunate because nuclear medicine facilities are available in most district general hospitals and the report will undoubtedly be used to draw up local guidelines for the investigation and management of coronary artery disease.

The underutilisation of myocardial perfusion imaging in the UK compared with the rest of Europe and North America is well established. The reasons for this are complex but include the absence of adequate training in nuclear medicine techniques at undergrad-

uate and postgraduate level. In a cost conscious environment, sensitive diagnostic tools with a low morbidity and moderate cost cannot be ignored.

The British Nuclear Medicine Society has begun a cost benefit study in conjunction with the King's Fund and Brunel University, to clarify the issue of cost benefit for myocardial perfusion imaging.

S E M CLARKE

President, British Nuclear Medicine Society, London

Sir—A review of practice in any area of medicine, especially when guidelines are implied, is guaranteed to provoke comment from practitioners with alternative views. Your report on the investigation and management of stable angina is no exception (July 1993, 267–73).

Nuclear cardiology is not used as widely in the UK as elsewhere [1]. It is perhaps understandable that cardiologists who have been trained without access to adequate facilities use techniques such as myocardial perfusion imaging only when all else fails, rather than as an integral part of their management of stable angina. Where good quality nuclear cardiology is available, however, it can be used in this way. This idiosyncratic use of nuclear cardiology in the UK is no excuse not to cover its proper role.

Nuclear cardiology is mentioned appropriately as a useful adjunct to exercise electrocardiography for the diagnosis of coronary artery disease, but it is not mentioned at all as a method of assessing the risk of future cardiac events. There is abundant evidence that the presence, extent and severity of perfusion abnormalities in patients with stable angina are powerful and independent indicators of risk. As a prognostic indicator, perfusion is more powerful than symptoms, the electrocardiogram and coronary anatomy, and it is at least equal to exercise left ventricular function [2]. The only uncertainty that remains is whether myocardial perfusion and stress left ventricular function are independent predictors, or whether one alone holds most of the information. Since both of these assessments are best made by nuclear techniques, to omit mention of nuclear cardiology for the assessment of prognosis is unwarranted.

The review rightly indicates that facilities for nuclear cardiology should be available in secondary care centres, but suggests that the results of the perfusion scan are part of the basic data set only 'if available'. Does this mean available in the centre or available for the individual patient? In the light of our comments on prognosis, we suggest that firmer guidelines are required and believe that it is justified to include myocardial perfusion scintigraphy in the basic data set. Not only does this aid the selection of patients for intervention, but it also provides an objective assessment of ischaemia against which future symptoms and intervention can be assessed.

We are forced to ask therefore whether the joint

working party had access to nuclear cardiology expertise when preparing their paper. As a group affiliated to the British Cardiac Society and British Nuclear Medicine Society, we would have been pleased to contribute. We hope that it is not now too late to ask for clarification of the role of nuclear cardiology in the management of stable angina.

References

- 1 Underwood SR, Gibson C, Tweddel A, Flint J. A survey of nuclear cardiological practice in Britain. *Br Heart J* 1992;67:273-7.
- 2 Brown KA. Prognostic value of thallium-201 myocardial perfusion imaging. A diagnostic tool comes of age. *Circulation* 1991;83:363-81.

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If I were a patient

Sir—If I were a lay but reasonably informed member of the public who suffered stable angina I would seek advice from a specialised doctor, in this case, a cardiologist.

I would expect this expert to be fully conversant with the diagnostic and therapeutic possibilities of angina based on personal experience of the many options available for the investigation and management of my condition.

I would also expect advice on the steps to be taken towards clarifying my medical problem, explanation of the extent and severity of my disease, the alternative forms of treatment and the possible ways whereby my progress could and should be monitored. I would expect the cardiologist to inform me of the risks, benefits and costs of the steps I would be taking. I would finally expect a logical approach to the investigation of my disease, starting from 'easy' tests and progressing to more complex investigations, if deemed necessary.

Your article on this subject (July 1993, 267-73) disappoints me, 'as the patient in question'. Many of my basic requirements as described above, are found wanting. I find only a superficial discussion of relative merits or costs, of relative risks and benefits. No mention is made of the importance of defining the extent and severity of my condition and no mention of the fact that angina, perceived by me as pain, holds few clues to the severity of my condition; that the extent of abnormalities on the ECG only poorly correlates with

either outcome or severity of my present problem; that little attention is paid to those tests which uniquely and directly demonstrate the state of the perfusion of my myocardium—tests which I know from the literature can classify me at low, intermediate or high risk of future infarction or death, tests which correlate best with long term outcome and which will warn me and my family of the need to make personal decisions concerning my job and/or my future.

May I ask you then: how many cardiologists have expertise in all of these available techniques in the UK? How does this compare with the rest of Europe and the USA? What is your audit group proposing to do about it? Has the working party a group of experts in these new tests which should be contributing to the discussion? If so, why were these experts not given an opportunity to be heard?

PETER JOSEF ELL

Director, Institute of Nuclear Medicine, London

Editor's note: The article in the *Journal* clearly states that it is a summary of the discussions of a working party. The full papers will be published later this year and will give the answers to many of these questions.

Clinical and public health ethics

Sir—Professor Leck (April 1993, pages 161-8) well describes the ethical dilemma between considering efficacy of treatment in quality-adjusted life years (QALYs) which reflect the total potential benefit to the patient, and the immediate benefits which are of particular concern to the elderly.

Not only the physician and patient, but also the patient's family and society as a whole have an interest in the health of an individual. I am now old enough to accept that my most useful years as the father of a family and as a productive member of society are now largely expended, and I would have no objection for this to be taken into account in the cost-benefit analysis of my own care.

Improvement may be measured in two ways: first, the difference between the treated and untreated state and second, the absolute level of health achieved. Over a lifetime, few measures might be regarded as of equal importance. To the elderly patient who accepts the concept of having had a good innings and who is now bed-bound and knows he is dying, good pain control might give almost complete satisfaction despite the poor level of absolute health achieved. On the contrary, the value to family and society of an individual's good health might best be expressed in absolute terms.

I accept the measurement of quality of life is difficult but that does not mean we should not attempt it. I suggest a new concept of the value adjusted life quotient which would take into account the legitimate interests of the individual, the physician, and the immediate and wider family in the context of the