

# National survey gives unique picture of trainee cardiologists



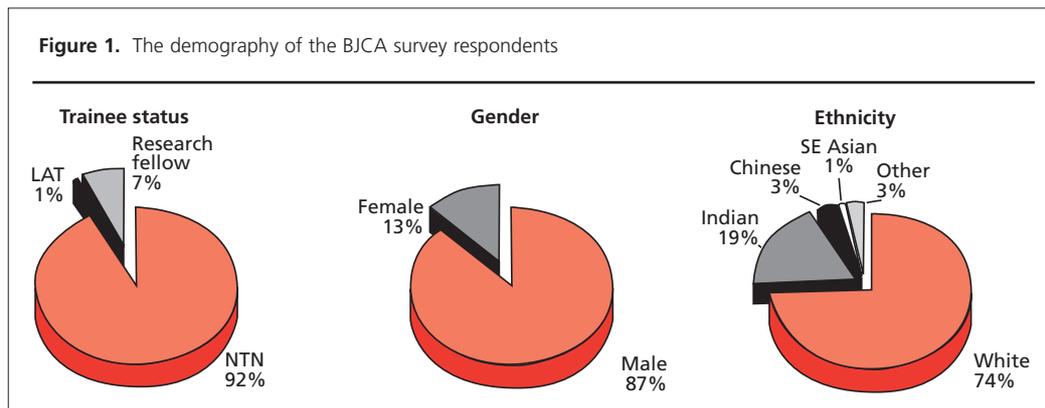
An annual survey by the British Junior Cardiologists' Association has given an interesting insight into the career intentions, working patterns and views of UK cardiology trainees.

## Introduction

The British Junior Cardiologists' Association (BJCA) represents cardiologists in training on national training committees and provides its members with up-to-date information relating to training and education. Over the last three years we have developed a national trainee survey which we hope to continue on an annual basis. This provides information to the cardiology specialist advisory committee (SAC) on training in the different deaneries to help ensure equity and highlight any deficiencies. More recently, the survey has also sought to canvass the views of the trainees on more controversial issues and establish trainees' career intentions. This information should be of interest to the British Cardiac Society (BCS) manpower committee but also, more importantly, to trainees themselves regarding the career intentions of their peers. With the response rate to the survey increasing each year, the results are now more representative, robust and appropriate for widespread dissemination.

## Methods

The BJCA holds an electronic database of over 500 cardiology trainees in the UK. This includes the grades of SpR, VTN, LAT, LAS, research fellows and non-consultant career grades specialising in cardiology. The survey was conducted in January 2004 and distributed electronically



via the BJCA deanery representatives to all juniors in their respective regions. Responses to the survey were anonymous and could be returned either electronically or as a hard copy to either the deanery representative or directly to the BCS head office, where they were collated into a database.

## Results

There were 149 responses overall, representing approximately one third of UK cardiology trainees, a good response rate for an unsolicited questionnaire. There were marked differences in the response rates by region, with Oxford, South West, Wessex and Yorkshire regions achieving almost 100% returns. More disappointing were East Anglia, Northern, Trent and Wales, who didn't provide a single return between them. The results are nevertheless considered valid, as it is not anticipated that trainees in non-responding regions differ significantly in their views from those in the rest of the country. We aim to improve the response

rate next year, aiming for at least 50% response and including every region.

## Who are we?

The demographic breakdown of the respondents is shown in figure 1. While the proportion of women training in cardiology is higher than the proportion who are consultant cardiologists, clearly there is a long way to go to attract more women to the speciality. The majority of trainee cardiologists are white and male, though there are proportionately large numbers of trainees from the Indian sub-continent (India, Pakistan, Bangladesh, Sri Lanka; UK population 3% in 2001 Census) and of Chinese origin (UK population 0.4%). The black population is under-represented, with no respondents from this ethnic group. It is also apparent that the numbers of non-NTN holding clinical trainees and research fellows are underestimated in this data set.

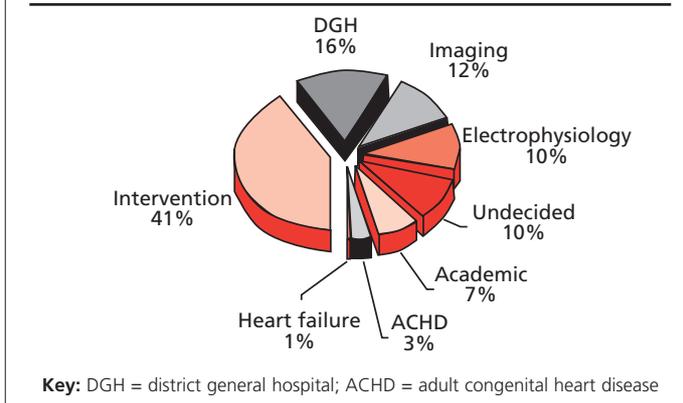
## Where are we going?

Figure 2 shows the intended

sub-speciality interest of the respondents. Interventional cardiology is still the largest single sub-speciality interest, although it is not in the majority except in London, Yorkshire and the South West deaneries, where the rates of would-be interventionists are highest (50–55%). London had fewer trainees interested in imaging (6%), although more with an academic interest (11%). Oxford had the highest interest in academia, at 23% of respondents.

These data could be extremely useful not only for manpower planning, but also for informing SpRs of the 'competition' in their (sub) speciality for consultant posts, both locally and nationally. Higher response rates in future surveys could allow a much more detailed analysis, for example, presenting the career intentions of trainees by CCST year or even by deanery. This could be invaluable for those trainees undecided as to whether to pursue a particular sub-speciality interest.

**Figure 2.** Sub-speciality interest of BJCA survey respondents



In a preliminary attempt to show this we have calculated (using a 3x multiplication factor on the basis of a one third response rate) the 'anticipated' numbers of trainees in the three largest sub-specialities likely to be eligible for consultant appointment in each year from this data (figure 3). These figures are very approximate as they assume a similar distribution of CCST dates and sub-speciality interests in the non-responders to the survey.

**Accreditation**

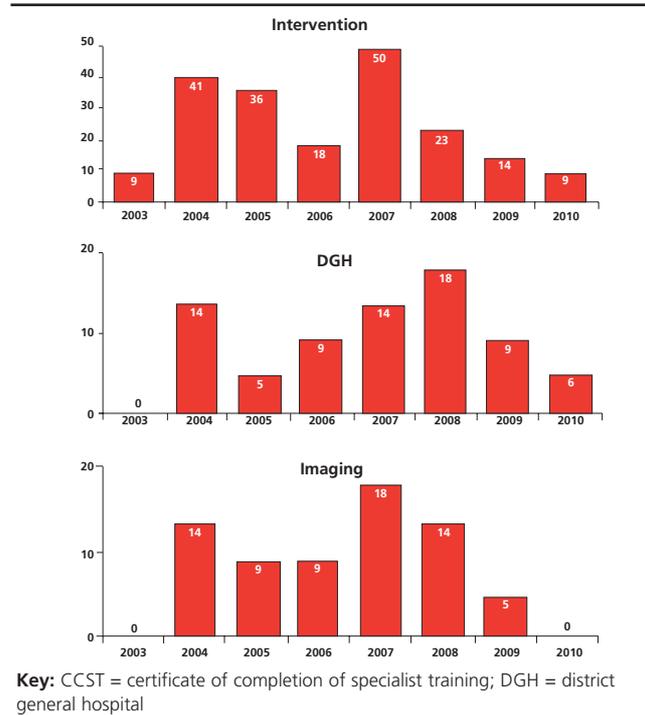
The issue of accreditation is always controversial. Whilst the SAC clearly advise dual accreditation, it is known that approximately 50% of UK consultant cardiologists no longer have a commitment to general internal medicine (GIM). As this figure is likely to increase, we were interested not only in whether trainees were aiming for single (cardiology) or dual (cardiology + general internal medicine) accreditation, (figure 4a) but what their preference would be if they had the freedom to choose (figure 4b). There is a perception that some trainees would like to drop GIM and concentrate purely on cardiology, but are afraid to do so,

perhaps because of disapproval locally (due to service commitments for GIM) and fears about future job prospects or SAC/JCHMT approval. This was borne out by this survey, in which nearly 60% of those planning dual accreditation would opt out of GIM given the opportunity. This figure was even higher for those wanting to sub-specialise in intervention (70%), electrophysiology (75%) and adult congenital heart disease (100%).

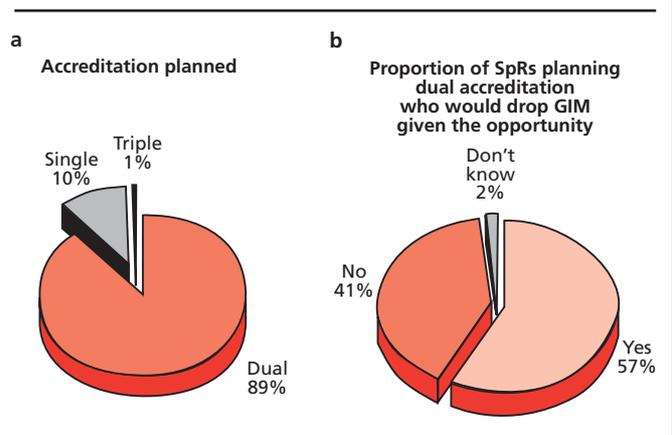
**Working patterns**

At the time of the survey most trainees (75% of respondents) were on an on-call rota for out of hours work and, irrespective of working pattern, a slight majority (57%) were resident in the hospital out of hours. All trainees on full shift systems and all but one on partial shifts were resident on call, while 50% of those on on-call rotas or hybrid systems were resident. There were some significant regional differences: 75% of London trainees were resident (85% in south London) while 33% of non-London trainees were resident out of hours, with the notable exception of Wessex, where 100% of

**Figure 3.** Number of trainees acquiring CCST by year and sub-speciality interest (extrapolated data)



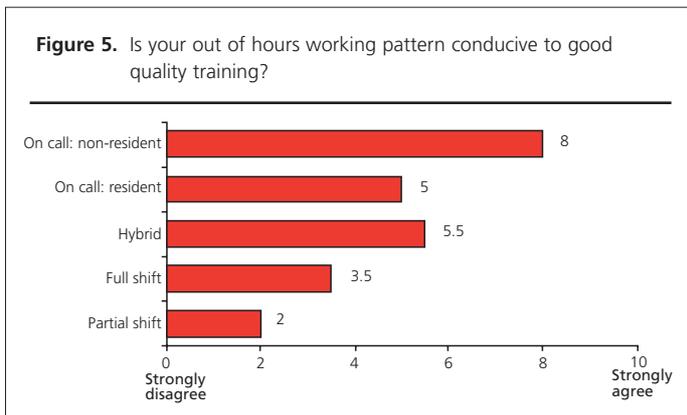
**Figure 4.** Accreditation of BJCA survey respondents



trainees were resident on call.

The out of hours working arrangements are of major importance with the European Working Time Directive (EWTD) effective from 1st August 2004, as any time spent resident on call counts in its entirety towards the total

weekly hours. There are likely to be significant differences in required middle grade cover according to the type of hospital worked in (which was not asked in the survey), and in the available staffing. It seems likely that many hospitals will review their arrange-



ments this year, with particular attention on the need for residency. Given that in general non-London trainees have a much lower rate of residency on call (even allowing for the differing proportions of teaching hospitals), we may expect to see some London hospitals changing their on-call arrangements.

Perhaps the most important issue regarding the out of hours working pattern is whether good quality training can be achieved alongside the service provision. Figure 5 demonstrates the difference between working patterns in the trainees' assessment of the effect of out of hours work on their overall training. The respondents were asked to rate their agreement with the statement "Your pattern of out of hours work is conducive to good quality training" on a 10 point scale from 1 (strongly disagree) to 10 (strongly agree). The median scores are shown and it is evident that non-resident on-call rotas were considered the best for training. These are important issues when attempting to balance the service and training commitments of a department, together with the New Deal and EWTD requirements. It is important, however, that

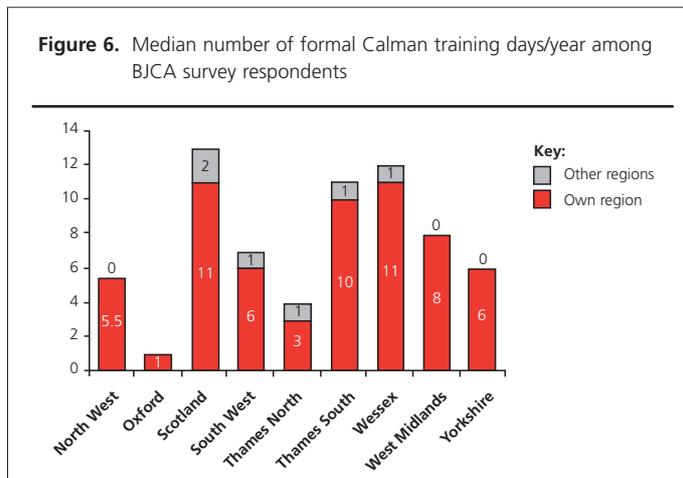
the effect on training is not overlooked in the drive for good service provision, and it will be the responsibility of the SAC to ensure that this is not the case.

#### Study leave/formal training

It is encouraging that the majority (78%) of trainees were allowed study leave to attend the British Cardiac Society annual scientific session in 2003, in line with the JCHMT recommendation that trainees should be allowed to attend at least two thirds of annual BCS meetings throughout their training programme. The proportion ranged from 63 to 100% by region and although these differences do not appear to be major in a single 'snapshot' view, we aim to monitor this annually to see if there are persistent trends.

It is also encouraging that the majority of trainees (90%) felt they had ample opportunity to attend training courses, although only 66% felt they had adequate funding for this, ranging from 38% (Oxford) to 100% (Wessex and West Midlands).

There were significant differences by deanery in the number of regional (Calman) training days provided per



year, with Scotland, South Thames and Wessex being better provided for and Oxford having none of its own (figure 6).

#### Conclusion

The BJCA survey for 2004 provides unique information on career intentions, working patterns and the views of trainees regarding quality and availability of cardiology training in the UK. This information is particularly useful for highlighting regional differences and could be used to effect change in those regions where either working patterns or access to training is having a negative impact. In particular, out of hours working patterns are clearly felt to have an impact on the quality of training and this will have to be monitored and highlighted to the SAC in those regions most affected.

The responses to single/dual accreditation and subspecialty interests could be used to guide future training policy and manpower planning. Of particular interest is that despite official SAC and JCHMT advice that accreditation should include GIM, 57% of trainees who have not yet

opted for single accreditation would like to do so.

The BJCA is grateful to all those who took part this year and, in particular, to the regional representatives who co-ordinated the survey locally. The most important outcome from the annual survey is the information that it provides to the individual trainee. It is paramount that next year we get a higher response rate, including data from all regions. With more robust data we could, for example, provide a breakdown of career intentions by CCST date and by region, so that individuals know exactly the level of local and national competition for their CCST year. A higher response rate should be possible as the survey takes approximately one minute to complete and is anonymous. It is hoped that the potential of this type of survey and the advantages that can be gained from it will be apparent to all trainees and so encourage them to participate in the future.

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