You want to be a cardiologist?

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Aung Myat gives a guide to maximising your chances of success in one of the most competitive specialties

Cardiology embodies that unique mix of hands-on practical application allied to sound physiological principles, supported by a rich and continually evolving evidence base. Patient care is approached holistically through primary and secondary prevention with tailored treatments employing medical, percutaneous, and surgical interventions. It is a highly competitive specialty. Modernising Medical Careers (MMC) and run-through training have turned what was already a difficult proposition into a much harder one.

Cardiology recruitment post-MMC and the Tooke report

Professor William Burr, associate director of medical education at the Joint Royal Colleges Postgraduate Training Board, and Professor Stuart Cobbe, chairman of the specialist advisory committee, provide the following insight into the current recruitment situation:

- In 2008 there were 80 specialty trainee 3 (ST3) cardiology posts available in England. Of these, 29 were offered to open competition via a national recruitment scheme. The remainder were internally matched to ST2 core medical training doctors as part of run through training.

- The MMC England Board has now agreed to uncouple core medical training from specialty training. This will mean doctors appointed to core medical trainee 1 posts in 2008 will be given 2-3 year contracts and not run-through contracts. The same situation does not apply in Scotland.

- In 2009 ST2 doctors in medical specialties will continue to be appointed in closed competition to around 45 “golden ticket” ST3 posts divided among each deanery. There will be 20 to 25 “headroom” posts available for open competition. It remains to be seen whether these posts will be advertised nationally or through individual deaneries.

- In 2010 it is estimated that there will be 75 ST3 cardiology posts in England. Again whether these posts will be advertised nationally or through individual deaneries remains undecided.

The experts say

Entry into cardiology specialty training remains in a high degree of flux, and the next 18 months will be particularly difficult for those not in run-through training. So how do you get yourself over that career hurdle? Tony Gershlick, professor of interventional cardiology and programme director for the Leicester, Northampton, and Rutland Deanery, and Martyn Thomas, consultant interventionalist and clinical director of cardiothoracic services at Guy’s, King’s College, and St Thomas’ Hospitals NHS Foundation Trust, give us their views.

What strategies did you adopt to become a cardiologist?

TG: An understanding of what was required. What was required then was foresight and getting the most out of the opportunities offered. That also applies now. You should be enthusiastic and keen to do things that others will not have done and that includes making contact with the training programme director or lead consultant to see how that’s best done.

MT: I was old school before specialty training existed. My principal strategy was to get the basic postgraduate exams and then I got a registrar rotation in clinical pharmacology. From this I attained a cardiology rotation, did an MD, and then specialised in
interventional cardiology.

What makes a good cardiologist?
TG: A good cardiologist is first and foremost a good doctor. You have to read up and be abreast of the data and practise medicine that is evidence based and guideline based. Good doctors should know their area inside out and get up each day to do something useful.

MT: Cardiology is a specialty that sits on the cusp between medicine and surgery. There are a lot of practical aspects to the specialty. I have always said that you need to be a golfer with a good memory. This means a degree of hand-eye coordination, a memory to pass exams, and good decision making to guide you through what are often life threatening situations.

What should potential trainees be doing after passing the MRCP?
TG: Touch base with specialist registrars and ask them what they did and what you should be doing to improve your chances of getting a training post. Seek advice from your educational supervisor. Become involved in audit. Go to the cath (abbrev OK?) lab and see echocardiography being done. Find out what is required and make yourself better than everybody else.

MT: I think you should do an MD or a PhD. This will distinguish you from others when trying to get a specialty training post.

What is the best way of obtaining a post as a clinical research fellow?
TG: Through contacts and adverts. There are two forms of research and both are good. One is where you ride shotgun on a research project and that usually guarantees an MD and papers. The other is a bit more speculative but often has better ownership. Here the fellow answers a specific question by formulating hypotheses, constructing a protocol, and organising funding.

MT: Do a locum appointment for training post in an institute with a good research record. This will allow you to meet influential people who can then advise and support you.

Is there such a thing as “good” and “bad” research?
TG: While no research is bad, poor research is where you presume there is going to be an answer and the wrong hypothesis is set up. Research is a process that teaches you about analysing original data, organising your mind, getting from A to Z, and overcoming the many obstacles that can arise. Negative research may be as important as positive research and can often be more so.

MT: Definitely, and more specifically, good and bad centres. Try and choose a centre that has a record of delivering MDs or PhDs. Many centres seem to offer a lot but you will become a dogsbody running poor clinical trials. These centres should be avoided.

Apart from novel research and review and case report articles what other types of publication score well?
TG: Proper audit of clinical issues. Observational research that is statistically valid. Meta-analyses are very good provided you understand their limitations. Studies involving registry data can also prove fruitful. It is the process that is important.

MT: I am most impressed by enthusiasm and good writing ability. Publish whatever you can, present whenever you can—but maintain your enthusiasm.

How many angiography, pacing, and echocardiography procedures should candidates aim to complete?
TG: You are expected to have become competent in these procedures at the end of your training so theoretically you don’t need any. If, however, someone had seen or conducted 25-50 echos, had been to the cath (?) lab, or put some temporary wires in then that will be looked upon favourably. Ultimately it is about demonstrating enthusiasm.

MT: I’m less convinced that absolute numbers are important any more. Competency is the crucial factor. Have you been trained in a procedure and are you competent—not how many you have done. Keep a logbook to validate your claims.

What types of course or conference should candidates attend?
TG: Attendance of any medical course will count. A Royal College of Physicians course on heart failure or a teaching skills
course for instance. Anything that shows commitment and initiative is regarded as useful.

MT: For core training, general conferences such as the British Cardiovascular Society conference is good. Once you have been approved for subspecialty training then more specialised meetings such as ACI and EuroPCR (for interventional trainees). In addition management training is essential. A business degree (MBA) could also be a very astute thing to do at some stage in your training.

How should a candidate prepare for a cardiology interview?

TG: Visit the department. Know the workings of the department—ie, who refers patients, what are the protocols etc. Know about the post. You need to be clear and concise. You should listen to the question and answer it efficiently. The people who do worst are those who just ramble on excessively.

MT: Be aware of recent major trials and national cardiology policies. Also learn management buzz words—governance, audit, etc.

Once in the interview do all candidates start on a level playing field?

TG: Scoring of the application form gives you a shortlist and then at that point you are all appointable. If two people interview well and one of them has more publications or has completed an MD then clearly that person will have the advantage. Aaptitudes (experience, research, interview performance) are weighted (normally 1 to 3) for each candidate and then scored a mark of 1 to 4. The numbers are then multiplied to give an overall score.

MT: Yes; there may, however, be a favoured candidate but anything is possible on the day.

What key points are you looking for when interviewing candidates?

TG: Enthusiasm, aptitude, clarity of thinking, ambition, assertiveness, and somebody who I can say is going to be a good cardiologist at the end of their training.

MT: Enthusiasm and dedication. I also like individuality. If someone has taken the trouble to travel abroad to gain more experience then I give this a big plus.

What advice can you give to those doctors who have been unsuccessful thus far?

TG: If you have scored well in the application process then apply again next year but fill up the time usefully. Do some research, attend more courses, and attain locum appointment for service posts or locum appointment for training posts. Don’t just hang around, but also be realistic; if you didn’t score particularly well or got poor feedback then choose something else—better now than in the future.

MT: Be tenacious but realistic. Don’t give in too early but at some stage you need to realise that cardiology is a very competitive area and some will fail. Life is too short and there is more to life than cardiology—but not much.

Pros and cons

Obtaining a training number in cardiology is by no means easy. Having ticked the boxes and jumped the hurdles the actual paucity of training posts means that many are still left disappointed. If you are lucky enough to attain that number then there is the prospect of a possible eight years of training ahead: a five year training programme, a two year research MD, and a further year spent out of programme completing a fellowship in the subspecialty you ultimately select. Once training is completed then the quest to find a consultant post begins and that too is hugely competitive.

If you aspire to a career in cardiology despite these obstacles you can look forward to a wonderfully expansive specialty with ample opportunity to do meaningful research, enter academia, or remain in the clinical forum. You will be instigating interventions largely borne out of landmark clinical trials, and the therapies you administer often produce immediate results. There is a huge diversity of subspecialties available to you ranging from heart failure and congenital heart disease through to intervention, imaging, transplant medicine, and electrophysiology. Or you can remain a general cardiologist and have dual accreditation in internal medicine. The possibilities are endless.

To optimise your chances of success be aware of the current recruitment position. Secondly, aim to tick as many curriculum vitae boxes as possible to stand any chance of being shortlisted for interview. And perhaps, most importantly, make yourself
visible and impress those who matter. Good luck.

**Further information**

- Joint Royal Colleges of Physicians Training Board— [www.jrcptb.org.uk/Specialty/Pages/Cardiology.aspx](http://www.jrcptb.org.uk/Specialty/Pages/Cardiology.aspx)
- Royal College of Physicians— [www.rcplondon.ac.uk/specialties/Cardiology/Pages/Cardiology.aspx](http://www.rcplondon.ac.uk/specialties/Cardiology/Pages/Cardiology.aspx)
- British Cardiovascular Society— [www.bcs.com/pages/default.asp](http://www.bcs.com/pages/default.asp)
- British Heart Foundation— [www.bhf.org.uk/default.aspx](http://www.bhf.org.uk/default.aspx)

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