



26 November, 2013

Introduction.

We write in response to the Shape of Training “Securing the Future of Excellent Patient Care” report, published 29 October 2013¹. We acknowledge the 5 general themes upon which the review based its terms of reference. We aim to respond to the final report recommendations from our perspective as physicians and trainee cardiologists. We wish to address, in particular, the proposals that postgraduate training would be shortened from 7-10 years to 6-8 years and that more generalists and fewer specialists would be trained.

Current postgraduate training in cardiology (not including research and fellowships) to achieve a certificate of completion of training (CCT) takes at least 9 years. The report’s proposal is for a reduction from 7-10 down to 6-8 years to achieve a certificate of specialty training (CST). A CST holder would be the ‘broad-based worker’, whose role is not precisely defined. In cardiology, subspecialty training takes 2 years so it is difficult not to see the CST as an *inferior* qualification, a sub-consultant grade in all but name, which would produce a ‘consultant’ with the reduced experience, skills and competence equivalent to those of today’s registrars at completion of core cardiology training at the end of ST5. This will impact negatively on patient care.

We do recognise that there is decreased competition for and under-recruitment in, emergency medicine, acute medicine and all medical specialties in which there is work on the acute medical take. We believe that an improvement in the patient’s experience of the acute hospital trust through appropriate valuation of acute and emergency medicine and the appropriate resource allocation to the hard-pressed acute medical admissions units and general medical and surgical wards is a more effective way of improving patient care than simply directing a higher proportion of secondary care doctors to engage in these struggling and unsustainable areas^{2,3} of the hospital without the much-needed service reforms that they require.

Good clinical care for patients is the principal concern.

We recognise that there is a problem with service provision in both emergency admissions to acute hospitals and in the care of patients on general medical and surgical wards. The average age of our patients is rising, and their clinical needs are increasingly complex. We wish to take our share of responsibility as cardiologists to address these problems and contribute to a whole-NHS solution that improves both patients’ clinical outcomes but also their overall experience of the health service.

Cardiology is a broad and general specialty.

Cardiology is a ‘general’ specialty in and of itself. There has been huge expansion in the breadth and complexity of cardiology services over the last 20 years. During this time primary percutaneous coronary intervention (PCI) has been transformed from a pioneering technique to a national service; complex biventricular pacemakers and defibrillators are implanted routinely in district general hospitals and ever more complex electrophysiology techniques are deployed in the diagnosis and permanent cure of arrhythmias. Chronic and acute heart failure care has become increasingly specialised and has had notable success with early intervention in the acute setting⁴. Structural intervention services develop in scope and

sophistication, just as grown-up congenital heart disease expands to manage the increasing number of children with heart disease surviving to adulthood. The diagnostic imaging available to cardiologists has increased in variety, and advanced across the domains of ultrasound, CT, MRI and nuclear imaging. New drugs are regularly added to the wide cardiac pharmacopoeia and the huge evidence base of cardiovascular medicine continues to grow at pace. At a time when our specialty is continuing to super-specialise, placing increasing demands on cardiologists in terms of knowledge and the acquisition and maintenance of 'craft' skills, we believe that 'generalism' for a cardiologist already exists as 'general cardiology'.

Cardiology training is already compressed.

There is abundant evidence from recent UK cardiology practice that specialist care improves patient outcome^{4,5,6,7}. It is for this reason that we are concerned about proposals to shorten training at the expense of specialist skills. Cardiology registrars report that it is *already* not possible to satisfactorily and safely complete cardiology and general medicine training within a 5-year registrar training programme. The training programme was shortened by a year in 2007 and weekly hours for service provision and training are now officially restricted to 48. In this year's British Junior Cardiologists' Association (BJCA) survey 74% of trainees indicated that they wish to return to a 6 year training programme, 92% of trainees routinely or frequently train outside of their permitted maximum hours in order to achieve clinical training to their own satisfaction. We also know that our colleagues in less than full-time training who have an extended training period, are predominantly women (81%). Over the last 10 years, the number of female trainees in cardiology has increased modestly from 13% to 21%. We are concerned that further limitations to training time, or barriers to specialist training, may disadvantage female trainees. It has also become routine to complete a higher research degree (83% of trainees report that they have or will undertake higher degree research), and usually a fellowship, extending training as a registrar by 3 to 5 years. This places cardiology trainees in a very different, and disadvantageous, position in relation to other secondary care colleagues when faced with a significant further restriction of their training time. This is important because we believe that it will increase the risk to cardiology patients in the future and compromise their care.

Radical restructuring of training is not a solution to a service problem.

'General' training, general internal medicine [G(IM)] in the case of physicians, is important and all cardiology registrars contribute to the acute medical take during their core cardiology training. We know that acute physicians are working extremely hard across the NHS. At the same time it is recognised that the experience of patients, but also doctors in many acute medical admissions units (AMUs), is not of an acceptable standard and is unsustainable^{2,3}. The solution to this unacceptable situation is not, in our opinion, to bypass the structural service-provision problem and to direct more staff, reluctantly, into the acute and general medicine environment. Rather, we assert that the environment must be adequately resourced and acute medical care rewarded in terms of both the tariffs payable to trusts for acute admissions and the pay of nursing and medical staff in acute admission and general wards. Specialist problems should either lead to early specialist attention to patients in acute/general areas or rapid, direct admission to the specialist ward/centre. As a result the AMU may once again become a place to learn, to train and, most-importantly, to take pride in good clinical care. We believe this would 'pull' trainees and consultants back to this varied and stimulating area of hospital medicine rather than 'pushing' everyone to take on their 'share of the burden' in a dysfunctional environment.

A model for acute cardiac care.

We propose that the most efficient and effective model for cardiologists' work is in addressing that significant (30%) proportion of the unselected take⁸. We support the model for acute cardiac care laid out in the British Cardiovascular Society's (BCS) report of 2011⁷. Acute cardiology patients should be admitted to acute cardiac care units directly. This model exists already in the primary PCI network, and is being extended in some regions to patients with non-ST elevation acute coronary syndromes and with acute heart failure or rhythm

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disturbances. For inpatients outside cardiac centres cardiology cover can be provided by a 7-day consultant led service, as 'inreach'. This would allow these patients to access specialist cardiac investigations and interventions at the earliest opportunity.

We share the Shape of Training report's aspirations to focus on our patients' individual needs and so to improve their care. We respectfully submit that another radical shake-up of training will not directly solve the recognised problems in service provision, resulting from an aging population with increasingly complex needs, particularly with emergency and acute admissions and on general wards. We believe that shortening the duration of training; at the expense of the specialist care that improves patient outcomes would be counterproductive. We also feel that directing all doctors to work with unselected acute admissions and on general wards, without addressing the problems in these areas, will not lead to the improved patient outcome that is our shared goal. We look forward to continuing work with BCS, Royal College of Physicians and the Shape of Training review to ensure cardiology training supports excellent patient care.

British Junior Cardiologists' Association Council

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2. RCP *Hospitals on the edge? The time for action*; Royal College of Physicians: 2012.
3. RCP *The medical registrar: Empowering the unsung heroes of patient care*; Royal College of Physicians: 2013.

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