So you want to be a cardiologist? 2012 update: part 1

Commentary speaks to the people at the forefront of the cardiology specialty training year 3 (ST3) application process in the UK in a series of three articles: Drs Liz Berkin, Sarah Clarke, Grant Heatlie, Andre Ng, Raphael Perry and Ian Wilson

Nationally, we are still under provisioned in cardiology at consultant level, so job prospects remain favourable at present … The lucky few who go on to secure an NTN in cardiology will embark upon a hugely rewarding, ever expanding and truly kaleidoscopic specialty training experience.

The disappointment caused by the failings of MMC upon its introduction in 2007 has now abated to some degree. Several high-profile groups, each with a vested interest in constructing a fair, robust and transparent selection process for specialty training through MMC, namely the British Medical Association (BMA), the Royal Colleges of Physicians Training Board (RCPPTB), specialist advisory committees (SACs), the British Medical Association (BMA) and its Junior Doctors Committee (JDC), and the Department of Health (DH), all deserve praise for their combined efforts. However, throughout this evolutionary period the highly competitive nature of attaining a national training number (NTN) in cardiology has remained consistent.

Commentary speaks to the people at the forefront of the UK cardiology ST3 application process to discover everything prospective candidates need to know to make an informed career choice and to have the best possible chance of success. Dr Liz Berkin, consultant cardiologist at Leeds General Infirmary and deputy medical director at the JRCPTB, is responsible for ensuring that ST3 recruitment for cardiology is fit for purpose. Dr Ian Wilson, vice-chair and secretary of the SAC for cardiology, is integral to setting the core curriculum. Dr Sarah Clarke, vice-president of education and research at the British Cardiovascular Society (BCS), is involved intimately in the ST process, with a particular focus on the knowledge-based assessment (KBA) – an exit exam that all cardiology trainees must pass prior to achieving their certificate of completion of training (CCT). Drs Grant Heatlie, Andre Ng and Raphael Perry, training programme directors (TPDs) of the West Midlands, East Midlands Healthcare Workforce (South Centre) and Mersey deaneries respectively, also offer their insights.

Do you think cardiology remains an attractive career proposition?

Liz and Ian: Definitely, but cardiology trainees now need to make choices [that is, whether or not to incorporate general internal medicine (GIM) and which modular training to undertake] at an earlier stage. These choices inevitably limit the consultant posts for which they are suitable at completion of training, but many of the larger district general hospitals are already beginning to subspecialise to accommodate these changes.

Grant: Yes, cardiology has a wide variety of subspecialty options, some of which are still expanding. Nationally, we are still under provisioned in cardiology, so job prospects remain favourable at present.

What did you do to get yourself a recognised training post in cardiology?

Grant: I tried and tried and tried. I went through a cycle of not being good enough to be shortlisted, getting shortlisted, coming last, doing better and eventually I got a job. I identified the strengths and features that made me stand out as good or different and played heavily to these. I avoided spending multiple years in non-career grade posts.

Raphael: I worked as a cardiology clinical registrar as part of a GIM rotation and then in a research post, where I produced publications. I developed technical skills and attended courses in echocardiography and pacing, and so on.

Can you draw parallels between what you did and what is required of junior trainees today?

Liz and Ian: Trainees these days need to be more calculating and to plan more than we did. It is not enough to be a good clinician who has passed the member of the Royal College of Physicians UK (MRCP(UK)) examination. The specialty is so competitive that you have to rise to the top 30–50% at the shortlist stage even to get an interview. Look carefully at the person specification, talk to the cardiology TPDs and try to ‘tick every box’. You will need to get good scores in most domains in order to get an interview. Calculate your probable shortlist score and compare it with those on the RCP’s ST3 recruitment website. Work out how competitive you are and consider choosing a less-competitive deanery (or even specialty) if you are not in the top quartile. If you are lucky enough to be invited to interview, plan the interview very
carefully – the interview stage remains very competitive, with almost one third of interviewees deemed unsuitable for an offer of a post.

Andre: It is now more difficult to show commitment to a specialty as many core medical trainees look alike. It is therefore important to take every opportunity to publish (for example, case reports and reviews), and it would be sensible to take a higher degree early in order to be competitive for the popular specialty training posts – this aspect is very similar to the good old days.

How fair and robust is the current ST3 selection process?

Liz: The process is much more robust than it was, but I would say that having played a large part in designing it! In the days before applications were anonymised and standardised, candidates may have been invited to interview (or not) according to where they worked, who they worked for, their name or their sex. Even the appearance of their curriculum vitae (CV) may have influenced selectors, who were often faced with more than 100 eligible applications for each post but could interview fewer than 10 candidates. It is fairer for all to base the shortlist score only on achievements.

The current interview process, by which candidates can gain marks in multiple stations from multiple interviewers, is also fairer than the old ‘panel’ interview, during which a poor answer to one question was heard by all interviewers, who marked it accordingly. With separate stations, the candidate gets a fresh start each time. Each interview is more structured and standardised than they were before MTAS was introduced. In years gone by, consultants rarely had any training in interview techniques and objective scoring; now, all interviewers are trained, receive an on-the-day briefing and can shadow an experienced interviewer if they are new to the job. In addition, all interviewers have to undergo regular equality and diversity training.

A few years ago, we didn’t know how many candidates applied to each specialty and didn’t have any consistent information about shortlists or interviews, but we did know that practice was very variable. Coordinated recruitment means that we now collect data and undertake analysis and research to improve the process. We can also provide much more information to prospective applicants to maximise their chances of success.

Grant: The process is designed to be both fair and robust, but I’m not sure if it achieves either. In attempting to be fair, the process has become dehumanised.

Can the selection process be improved?

Liz: For me, the current best selection methods are within the interview, so I would like to see all applicants offered an interview – not that the interview itself is perfect, but you get nowhere without it. For core medical training (CMT), we undertook to offer all eligible candidates a single interview, so that candidates could ‘sell themselves’ verbally in addition to their written application. However, we first had to prove that interviews were fair and repeatable and also had to commit to a potential large increase in interview capacity. We have not yet been able to take these steps for the medium to large medical ST3 specialties, some of which remain very oversubscribed. If we committed to providing an interview for every applicant to cardiology, I have a feeling that we would be even more swamped with applications than is already the case.

Currently, at least half of applicants get two interviews, which denies an interview to those with lower rankings. We could increase our ability to interview more candidates by limiting applicants to one application per specialty, but candidates might not accept that. We know that there is enough interview capacity for all candidates to gain a single interview for the other specialties, but, unfortunately, this is not the case for cardiology because of the huge number of applications. Some sort of ranking process thus has to be implemented at the application stage, so that the limited number of interview slots can be offered according to application score. The only areas that can be scored from the application form tend to be academic- and energy-related achievements, as we don’t yet know how to measure a good clinician on paper. You cannot (and should not) judge a good clinician from references or the learning ePortfolio, as the former is subjective and not referenced to criteria and the latter is a personal learning tool and not an assessment tool for interviewers. Although the interview is the current ‘gold standard’, it’s a bit like taking a history from a patient without examination or diagnostic tests. It would be good to have some more objective measures. It will be interesting to see the results of the foundation recruitment pilot, which is assessing the value of knowledge-based and situational judgement tests alongside the usual ‘white-space’ text answers.

Andre: It is shocking and surely not right that references are not allowed to be considered for the selection process. If references were incorporated, this would help recruiters make a correct final decision on selection.

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