Back to the future? Developments in postgraduate cardiology training

Postgraduate medical training has undergone extensive reform in recent times. This article outlines the current state of affairs and possible future developments in cardiology specialist training.

Introduction

Over the last two years postgraduate medical training in the UK has undergone radical and controversial reform with the implementation of Modernising Medical Careers (MMC). A product of the 2002 report into reform of the Senior House Officer grade, *Unfinished Business,* by the chief medical officer Sir Liam Donaldson, the stated aim of MMC is to "drive up the quality of care for patients through reform and improvement in postgraduate medical education and training". The broadly successful implementation of a foundation programme for newly qualified doctors in 2005 was followed by the launch of higher specialist training as 'Specialty Training' in 2007.[1] The abandonment in Spring 2007 of the failed online Medical Training Application Service (MTAS) was precipitated by a serious breach of data security, an event that catapulted a hitherto parochial medical issue upon Fleet Street with widespread media criticism of the implementation of MMC.[2,3] During the resulting acrimony, the MTAS debacle and the wider issues around MMC were rarely considered as separate ventures, an admittedly subtle distinction subsequently exploited by the architects of training reform.

Cardiologists, along with many of their colleagues, expressed concern about several aspects of change including the principle of 'run-through training' and the creation of a politically motivated sub-consultant 'specialist' grade. In response to these and other concerns, an independent inquiry headed by Professor Sir John Tooke was established by the Secretary of State for Health in April 2007.[4] Reporting in October 2008, Tooke made wide-reaching recommendations in eight key areas, including a fundamental reversal of the central tenet of 'run-through' training by 'uncoupling' training in popular specialties from core medical training. Even more radical is extensive re-organisation of training infrastructures with responsibility for oversight of medical education ceding from the Post-graduate Medical Education and Training Board (PMETB) to the General Medical Council (GMC), a remarkable reversal in fortune for the recently embattled GMC. In a move interpreted by some as an attempt to 'de-politicise' control of medical training, Tooke advocates creation of a new and independent body, 'NHS Medical Education England,' which, crucially, will be empowered to commission higher medical training at local deanery level. In a stinging rebuke, Tooke laments that "the medical profession's effective involvement in training policy-making has been weak": an assessment no witness to the recent House of Commons select committee into the implementation of MMC could argue with. While intentions may have been noble and reform inevitable, the impression remains that a hitherto latent disconnect between the medical professional bodies allowed a rushed, politically driven and fundamentally untested scheme to progress unchecked. Confirmation that none of the medical Royal Colleges inspected a full MTAS application form prior to launch of the scheme merely cements these suspicions.[5]

Trainees' views

In this context consideration of the views of trainees is clearly important. To ensure effective engagement of trainees, the British Junior Cardiologists' Association (BJCA) strives to establish the views of cardiology trainees and ensure they are represented at a national level.[6] Information obtained by deanery representatives through formal surveys, local discussion or personal communications informs the opinions that are taken forward by BJCA representatives to national committees, including the Cardiology Specialty Advisory Committee (SAC), British Cardiovascular Society (BCS) and Royal College of Physicians (RCP). Links exist between these bodies at various levels, for example the chair of the SAC (Professor Cobbe) is also Vice-President of the BCS and the BJCA has dedicated representatives who sit on a number of key committees.[7]

BJCA surveys in 2007 showed overwhelming opposition by trainees to the proposal of non-selective 'run-through' training for cardiology, which was planned under MMC. Trainees felt strongly that competitive selection into cardiology specialist training was fundamental to maintaining high standards in clinical training and that it should occur at a local level. Since trainees would have to compete for posts as consultants, the rationale behind discouraging competition at earlier stages of training was felt to be myopic and unhelpful to training. There were also concerns that run-through training would force trainees to make career choices too early, while lacking the relevant clinical experience to make a well-informed choice. As mentioned, trainees' views are regularly fed back to the BCS and SAC, and a situation whereby the views of BCS were ignored with respect to cardiology specialist training was widely regarded as unacceptable by trainees.

In the face of such responses from the profession, the final report of the Tooke inquiry published in January 2008 recommended that competitive selection into higher specialist training should be reintroduced and be "informed by the Royal Colleges working in partnership with the Regulator".[4] This has resulted in changes

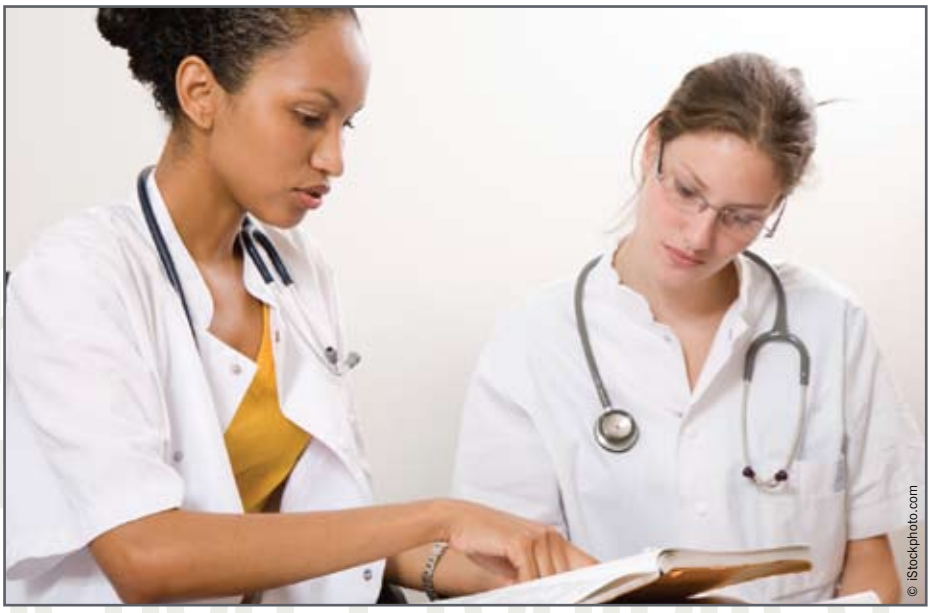
to the MMC process with 'uncoupling' of specialty training from core medical training and open competition to ST posts for specialties where this is felt to be desirable, such as cardiology.[1]

Assessing competence

In addition to the structural changes in postgraduate training brought about by MMC, major changes have already occurred in the assessment of trainees' competence. June 2007 saw publication of the revised Department of Health document *A Guide to Postgraduate Specialty Training in the UK* (the 'Gold Guide').[8] Assessments of competence from the Foundation Programme have been adopted by the Joint Royal Colleges of Physicians Training Board (JRCPTB) for use in assessment of specialty training, including directly observed procedural skills (DOPS), mini clinical evaluation exercise (mini-CEX), multi-source feedback (MSF), and case-based discussion (CbD).[9] These assessments are already being applied routinely to cardiology specialist registrars (SpRs) appointed since 2003. The issue of knowledge-based assessment (KBA) by means of a specialist examination in cardiology has, however, caused greater controversy.

The Gold Guide states that "assessment strategies will normally also include well-constructed and 'fit-for-purpose' professional examinations which map back to the curriculum". This has been accepted in principle by the cardiology SAC, and the JRCPTB website reported in early 2008 that development of a cardiology specialist examination was expected in autumn 2008 or spring 2009.[9] The BJCA recently surveyed trainees to establish their views on whether there should be an exit exam in cardiology. Over half felt that there should not be an exit exam, but a substantial proportion believed that some form of examination-based knowledge assessment was appropriate and/or inevitable.

Opponents argued that a general cardiology exit exam was unnecessary as knowledge can be adequately assessed within the existing framework of annual review including mini-CEX, CdB and clinical supervision. If these time-consuming assessment tools were insufficient then some felt that their usefulness and validity should be questioned. Other trainees were concerned regarding the impact of burgeoning assessment methods on clinical training and family life, a situation potentially exacerbated by the introduction of sub-specialty exams such as those required by the British Society of Echocardiography and Heart Rhythm Society.



Those in favour of an exit exam argued that a formalised KBA would ensure that all trainees demonstrated satisfactory knowledge across a broad range of general cardiology and would serve as proof of a standard of training. It was noted that other specialties have successfully implemented similar examinations. However, the timing of a cardiology summative examination was clearly highlighted by trainees as an important issue. They argued that assessment of general cardiology knowledge should be performed at the end of generic cardiology training before subspecialisation, supporting the model of the cardiology pilot KBA conducted in 2006. This would therefore not be an exit exam. The cardiology SAC have supported "the concept of a test of core knowledge mid-way through training".[10] There was a strong feeling that if fees were levied for this compulsory examination they should be limited to the minimum amount necessary for administering the exam rather than being revenue generating.

Negotiations have occurred between the SAC, BCS and the Federation of Royal Colleges over the format of the proposed KBA. Options include a high stakes and potentially costly summative exam linked to the Colleges, similar to that being adopted by other specialities, resulting in award of a 'Certificate in Cardiology'. However, the SAC and BCS have argued on behalf of trainees for a formative exam that could potentially be delivered more cheaply. It seems likely that the KBA will be linked to the European Society of Cardiology (ESC) with the content based on the ESC Core Syllabus / ESC Textbook of Cardiovascular Medicine and a 'best of five' multiple-choice format. Present plans are for this to occur around ST5, after general cardiology training but before subspecialisation. The exact format and timescale for its introduction remain to be confirmed, but a further pilot is planned for 2009.

What works?

Amid the technical issues surrounding MMC and the rapid pace of change in medical training, it is reassuring that some elements remain constant. Over the years, cardiology has attracted highly motivated and determined individuals; training opportunities today are perhaps better defined and more accessible than ever thanks to the efforts of these same individuals. The parallels between historical training models, Tooke's vision of training and the recent emphasis on modular 'senior registrar' sub-specialty experience in

years 5 and 6 has not been lost on trainees. Perhaps a pragmatic selection of 'what works' is the best way forward for training – 'back to the future'?

Developments in higher specialist training in cardiology continue apace. It is vital that trainees are actively engaged and represented in these processes. Lack of medical involvement in policy-making around training was criticised in the Tooke report as contributing to the failings of MMC and it is important that these lessons are learnt.

The BJCA seeks to establish and represent the views of trainees and we urge trainees to engage with their local representatives to this end. Cardiology trainees are fortunate to benefit from the efforts of the BCS in fostering equitable access to high-quality training opportunities throughout the UK, and for this reason we recommend all cardiology trainees become members of the British Junior Cardiologists' Association and BCS. Together we can continue this process and safeguard the future of cardiology training in the UK

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Conflict of interest

MSC, DJK, TK, HS and CPG are cardiology trainees and current or past members of the BJCA committee.

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