EDITORIAL

2012 BJCA trainee survey

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The 2012 British Junior Cardiologists Association (BJCA) survey of cardiology trainees gives an important insight into what is happening in cardiology training in the UK.[1,2] Conducted six times since 2004, it was most recently performed in 2009. The authors should be congratulated on the effort that has clearly been involved. Several important issues emerge from these data, which, if the survey is truly representative of all UK trainees, necessitate some radical thinking. The issues that I shall discuss are: working hours and the role of general medicine, imaging training, and the percentage of female trainees.

Response rate and working hours

Although typical of similar surveys, the response rate was disappointingly poor at 35% (261 of a total of 745 trainees enrolled with the Joint Royal Colleges Physicians Training Board [JRCPTB]). This limits, partially, the conclusions that can be drawn from the data as the sample may not be representative. However, given that important workforce planning decisions are made from these data, trainees should be strongly encouraged to take part, and it has even been suggested that the survey should be made compulsory through the Annual Review of Clinical Performance (ARCP) process.

A majority (66%) of respondents say that on-call commitments are the greatest obstacle to subspecialty training, and the vast majority of trainees (93%) have worked on days off or post nights, over half of whom did this to achieve training requirements or adequate clinical exposure. Only a fifth of trainees are compliant with the European Working Time Directive (EWTD – 48 hours a week averaged over six months) and 40% of trainees report working more than the contractual maximum of 56 hours. These findings are in keeping with the Royal Colleges of Physicians (RCP) 2010 Census (page 251).[3]

Combining the relevant statistics like this makes for uncomfortable reading. Whatever one may think of EWTD, it is a legal requirement. And doing clinical work on days off can be problematic too – for instance it has even been suggested that a hospital is not obliged to indemnify a doctor if he or she is working beyond their hours and an error takes place – perhaps if a trainee stays on to do a list in the cath lab after a night shift. It may be that many respondents are counting other non-clinical activities, such as research, in their working week, but, if the survey results are correct, then urgent action is required as most trainees are working way in excess of their contracted hours.

Are the 48 working hours of the week being spent efficiently? Are they mainly being spent doing activities that can be considered as training, or not? And if not, what radical steps can be taken to ensure that time is spent training? For example, if 66% of respondents say that on-call commitments get in the way of training, does this mean that 66% of respondents would like to have a reduced on-call commitment to improve opportunities for specialty training? Do all trainees need to do on-call for all five years of the programme? Would trainees be willing to come off the on-call rota (and be unbanded with an ensuing pay cut) to improve training? Is this a case of 'be careful what you wish for?'

While cardiology on-call is likely to remain an important part of cardiology training, the role of general medicine is more debatable. Only 51% of trainees wish to accredit in general medicine (a steady decline: 2004, 89%; 2005, 75%; 2007, 68%). So why are trainees who do not wish to accredit in general medicine spending two or sometimes three years on the general medical on-call rota, given the large time requirement and the subsequent loss in training opportunities (e.g. a week of nights followed by a statutory week off meaning two weeks away from cardiology)? True, there is much acute cardiology on the general medical take, but the respondents to the survey have identified these on-calls as an obstacle to training, not an opportunity for training. Currently, apart from the out-of-hours supplement, cardiology trainees' salaries come from the deaneries, and it is not the primary role of cardiology trainees to ensure that the general medicine rota is covered. Again, radical thinking is required.

Imaging training

One of the main findings of the 2012 survey is that 23% of trainees have identified imaging as

their primary speciality (up from 12% in 2004). This is now equivalent to intervention (25% in 2012, 19% in 2009, but 41% in 2004). Electrophysiology is unchanged at 12% (perhaps reflecting that atrial fibrillation ablation remains a relatively specialised procedure). The increase in non-invasive imaging should be welcomed: over the last 50 years there has undoubtedly been a shift from more invasive to less invasive. Broadly, non-invasive testing is safer, more acceptable to patients,[4] and often cheaper. Recent developments in non-invasive imaging have been dramatic, in particular in computed tomography coronary angiography (CTCA) where we have come from the first commercial scanner in 1971, to four-slice (1998), 16-slice (2002), 64-slice (2005) and 320-slice (2007) technology, and along with rapid hardware development, radiation doses have dropped from about 20 mSv to single figures, and the sub 1 mSv scan is currently a reality.[5] It is highly likely that within one to two decades the majority of coronary assessment will be performed non-invasively. Having a significant cohort of cardiologists fully trained in imaging is, therefore, vital.

When asked about their primary imaging modality the results were: nuclear 0%, echo 40%, and cardiovascular magnetic resonance (CMR) 45%. These findings are surprising. Although nuclear assessment is perhaps less fashionable in the UK, it is widely used, and it is a cause for alarm that no respondent is planning a career in nuclear cardiology. For CMR the concern is the opposite. If the survey is representative, then the number of trainees in the UK whose main interest is CMR would be 77 (45% of 23% of 745). As of 2010, there were 30 CMR centres in the UK, with a target of 42 (i.e. all cardiothoracic centres) and a suggested cap of 50 according to the combined British Society of Cardiovascular Magnetic Resonance (BSCMR)/British Society of Cardiovascular Imaging (BSCI) working group.[6] This may of course change, but it is still a cause for concern that there are perhaps over two trainees currently in training for every CMR unit!

It is vital that CMR training is of high quality, yet in the survey poor access to CMR is identified as the second most common complaint of *all* trainees (34%), after poor access to CT (37%). Subspecialty imaging training is clearly stratified with British and European accreditation processes for echocardiography (transthoracic [TTE] and transoesophageal [TOE]) and level 1, 2 and 3 accreditation in both CT and CMR. But according to the 2010 working group report, for level 3 accreditation the trainee needs to have reported 300 scans (including performing 100),[6] and the BSCMR training guidelines state that CMR trainees require a minimum of one-year full-time training.[7] I suggest that within subspecialty imaging training, dedicated CMR programmes/fellowships should be developed to ensure that we have an appropriate number of individuals trained to a high level in CMR, rather than a larger number of individuals trained to a level where they may not achieve independent status.

Female trainees

Women only represent 21% of survey respondents. If this is representative of the national situation then action is required. Women have accounted for over 51% of medical students since 1991,[8] and so must be regarded as significantly underrepresented in cardiology. Why are more female senior house officers (SHOs) not considering careers in cardiology? What are their concerns? What is being done to make part-time training and job-sharing easier for trainees? What provision is being made to assist with childcare out of hours? And what is being done to encourage female SHOs to seriously consider cardiology? The British Cardiac Society had a working group to investigate this issue back in 2004, when women represented 16.8% of trainees.[9] And they commented in the 2010 RCP Census that "The BCS is attempting to address the gender imbalance by promoting the specialty to female trainees" (page 92),[3] but these efforts seem to be taking time to bear fruit; perhaps a more radical approach is required?

Conclusion

The BJCA survey is a considerable achievement, but the findings need to be taken seriously if it is to be worth carrying out. Some of the results are surprising and identify issues in working practices, subspecialty training, and gender inequality that need to be addressed. The main priority should be that high-quality training is delivered within an appropriate working week. And when it is repeated, participation needs to be much higher!

Conflict of interest

None declared.

Editors' note

See also the news article by David Holdsworth giving the results from this survey on pages 22–4.

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