The future of cardiology

Competition and the survival of the fittest are essential for the success of any effective enterprise. Medicine is no exception. Indeed, one of the anxieties expressed about the guidelines for accreditation of the joint committees on higher medical and surgical training of the royal colleges has been the lack of competition in a system of automatic progression up the rungs of a carefully constructed ladder leading to a pot of gold in the shape of a consultant appointment at the top. At present, however, the converse is true: in some cases competition is so fierce that opportunities of promotion are denied even to successful and able trainees.

A paper in the current British Heart Journal by Chamberlain et al draws attention to the current manpower statistics in cardiology and makes sober reading. There are 103 physicians fully committed to cardiology and 98 general physicians with a major interest in cardiology in England and Wales. The figures for paediatric work are 19 and three respectively. The geographical distribution of these consultants is extremely uneven. The North-west Thames region, with a population of 3·5 million, has a total of 27 cardiologists of both types, whereas the East Anglian region with a population of 1·8 million has four. The Wessex region has a population of over 2·5 million but only two full-time cardiologists, and the South-western region but four. The four London regions, with 13·5 million population, have 36 full-time cardiologists and 30 physicians with a special interest in cardiology.

These figures have considerable implications for the cardiologist-in-training. The 223 cardiologists of all types in England and Wales are supported by 71 senior registrars in cardiology, including honorary posts held by lecturers and research fellows. Since the working life of a consultant is likely to be around 25 years and since the training period of a senior registrar is supposed to be four years, this ratio of 3·14 consultants to one senior registrar is plainly inappropriate and has led to a serious backlog. The Department of Health and Social Security has long insisted that the numbers of senior registrars should be geared realistically to the numbers of consultant posts, but this has not been achieved in cardiology mainly because technical advances and the need for increased numbers of training and research posts have outpaced the growth in the numbers of consultant posts available. The Chief Medical Officer’s initiative in setting up discussions is welcome, though his mention of “control” of numbers of academic appointments must be viewed with care.

Modern medicine with its complex technology demands a larger number of skilled junior staff in training posts than can be eventually accommodated in the consultant ranks. After one or two years in cardiology many trainees at registrar level decide to move into another branch of medicine and the experience and training that they have had stands them in good stead, but senior registrars are usually committed to the subject and cannot easily switch to another specialty. Yet the numbers of senior registrars cannot be reduced without seriously compromising the training programmes and the service to patients and damaging the discipline—while apparently the numbers of consultant posts cannot be substantially increased in the present restricted financial climate. Thus an irresistible force is meeting an immovable object.

The authors of the manpower report believe that there is a very strong case for more consultant appointments to be created now. In England and Wales there is one specialist cardiologist for every 220 000 people, whereas in the United States the ratio of cardiologists to population was 5·1 per 100 000 in 1974, and a figure of 6 per 100 000 has been recommended. In the EEC most member nations have two to 10 times more cardiologists in relation to population than England and Wales. Strict comparisons cannot be made between nations, and the definitions of cardiologists and cardiological work vary widely, but the authors of the report believe that serious deficiencies exist.

The increasing development of non-invasive techniques of investigation that can properly be developed in district general hospitals and the linking of district general hospital appointments in cardiology with special cardiac centres will increase the need both for more consultants in general medicine who have a major interest in cardiology and for more full-time cardiologists. The second report of the Joint Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England has recommended six full-time cardiologists for each major cardiac centre, and while the numbers of cardiac centres might in the future be reduced by amalgamation these recommendations would require an expansion in the numbers of cardiological posts.

All senior registrars in cardiology must be prepared to consider appointments either as fully committed cardiologists or as general physicians with a major interest. They should realise that energy, enthusiasm, originality, and vision can often bring success. The senior registrar in cardiology has the prospect of building a useful and much needed department in a district hospital environment, using the appropriate cardiac centre as his point of reference. Competition for the most exciting posts will encourage the best candidates and will ensure the stimulus essential for the progress of research and for the continued flowering of cardiology in the 1980s. Senior registrars should therefore include in their training period adequate general medical experience. Consultants should advise, counsel, and guide them in this direction.

Senior registrars of four to eight years’ standing in cardiology cannot be expected to “retrain” in another specialty. That is unfair to the individual and wasteful in economic terms when the skill is sorely needed by the community. The problems of the time-expired senior registrars are urgent and insistent; they cannot be brushed under the carpet and forgotten, nor can they be expected to go away if they are ignored. If more consultant posts were created now that would both serve the needs of the community and provide the fully trained senior registrars with the opportunity to be the consultants and teachers of the next two or three decades. Ways should be explored of making more money available for this purpose without causing disadvantage to other aspects of the Health Service. Failure to appreciate the need for more consultants may result in talented young men and women turning away from cardiology as a career with disastrous results. Cardiology is not alone in having problems of career structure; other disciplines are also sorely pressed. Nevertheless, the problems that have been clearly outlined by the cardiology survey and the general principles that these problems embody are surely applicable to all specialties in medicine. The cardiologists have a good case—and one supported by epidemiological data: not only does cardiovascular disease cause much morbidity, it also kills more than half the men who die after the age of 50.