Editorial

Cardiology at the crossroads

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The difficulties of obtaining promotion in the career structure jungle of cardiology have long been a matter of serious concern, and this concern is underlined in a recent detailed paper on "staffing and facilities in cardiology in England and Wales."¹ This paper is a valuable addition to the report published two years before under the auspices of the Cardiology Committee of the Royal College of Physicians of London.² Three years have passed since the first report and nearly one year since the second, yet what has been achieved?

The first paper drew attention to the unevenness in geographical distribution of cardiological consultants. Of a total of 201 cardiologists (including both those fully committed to cardiology and those working as physicians with a major interest in cardiology), 66 were working in the four London regions. Inevitably, of course, the metropolitan areas attract more cardiological attention, and the special responsibilities and problems of the London teaching hospitals demand larger numbers of posts. Some unevenness in distribution of posts throughout the country cannot be entirely avoided, but the problems are aggravated when the total number of consultants is less than desirable. Compared with one specialist cardiologist for every 220 000 population in England and Wales, there are 10 cardiologists for 200 000 people in the United States of America and many more cardiologists relatively in other nations in the European Economic Community than in the United Kingdom. Even allowing for the difficulties of direct comparison between the different nations, cultures, and environments, the United Kingdom seems to be distinctly short of specialist cardiologists.¹⁻³

Such shortages have at least two serious consequences: firstly, the denial of essential cardiac services to

populations in need, and, secondly, the denial of a realistic career structure and reasonable prospects of appropriate promotion to the rank of consultant for experienced and competent "junior" doctors and, in particular, for the senior registrars in cardiology. The report in 1981 stressed both these problems and urged the appointment of more consultant physicians with a major interest in cardiology as posts became vacant in district general hospitals.² The report stressed the paradox of a pressing need for more consultant cardiologists existing alongside a relative excess of senior registrars available to become consultants in the ensuing 10 years. Thus expertise urgently needed by the community was not being made available.

In the light of that report, the recent paper, prepared by the Centre for Medical Research of the University of Sussex in collaboration with the Cardiology Committee of the Royal College of Physicians of London and the British Cardiac Society, is particularly interesting and welcome.¹ It reports both encouraging trends and disquieting situations. The major piece of good news is the increase, by 27, in consultant posts in England and Wales from 223 in 1980 to 250 in 1982. This has occurred as a result both of new posts and of changes in designation of new appointments to existing posts. Furthermore, when Scotland and Northern Ireland were included in the survey the total number of posts was 308. A further encouraging feature is the improved prospect for senior registrars in cardiology. The number of senior registrars available for consultant posts decreased from 71 in 1980 to 63 in 1982. Hopefully, the balance of the expiry dates of senior registrars' contracts related to the expected dates of retirement of consultants will become steadily more favourable to senior registrars throughout 1983-6, but unless more posts become available the position will actually worsen.

Against these satisfactory trends must be set the replacement of cardiological physicians in four dis-

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districts by consultants with different skills and the deficiencies in numbers of consultant cardiologists and technical services in many parts of the country. For example, a total of 63 health districts in England and Wales (in Wales hospitals rather than districts were counted because the number of major district general hospitals outnumbers the health districts by two to one), serving a population of nearly 12 million apparently have no consultant cardiologist as defined in the survey, although a few hospitals are adequately served by frequent visits from neighbouring major centres by consultant cardiologists.

The current report covers a wider field than its predecessor by including technical services. Four regions, including Wales, even now have only one centre for permanent implantation of pacemakers, and, of greater concern, 42 health districts do not have facilities even for temporary pacing. Seven major cardiology centres were without facilities for cross sectional echocardiography in July 1982, and facilities for effort testing were available in only 185 of 215 districts, 46 of them having only a bicycle ergometer, usually without any means of standardising the workload. Excluding the postgraduate institutes in London, 76 districts have no beds for cardiac care with immediate access to facilities for image intensification. Coronary ambulances are available in only 21 districts. Although not mentioned in the report, there are serious lacunae in the provisions for cardiac surgery in parts of the United Kingdom.

These deficiencies in facilities for cardiac care, when added to deficiencies in manpower, indicate a real and formidable need that is not at present being met realistically. It may be argued that this is no time to plead for more services in any one specialty when problems exist in all specialties and resources are becoming ever tighter, but situations such as that in cardiology must be kept constantly under review to reiterate firmly the case for better provision of services and to provide an example to other specialties with similar problems.

Clearly, some rationalisation must take place and some priority guidelines be laid down. Certain conclusions seem inescapable: it is for consultant cardiologists to urge that filling a consultant cardiologist's post with a consultant with different skills should stop; more consultant posts are needed, as are more facilities for temporary and permanent pacing and more equipment for echocardiography and effort testing. Although there is no immediate prospect of dispensing with coronary arteriography (which has been recognised by the Department of Health and Social Security as being underfunded), many patients can be screened non-invasively (for example by effort testing) to judge whether arteriography is necessary, and many patients who are candidates for cardiac

operations other than coronary artery bypass grafting may not now need invasive investigation. In addition, the unevenness in distribution of essential cardiac surgical services throughout the country should be corrected.

The change in direction of investigative trends and techniques may have implications for training also. As one who was largely responsible (when chairman of the Cardiological Committee of the Royal College of Physicians of London and president of the British Cardiac Society) for introducing the concept of two forms of cardiological work (type I: pure cardiology; type II: general medicine with an interest in cardiology) I would not hesitate to say that the time has come to review this concept in the light of changed circumstances. The recognition of two basic types of cardiologists in the 1960s was appropriate at that time when definition of what constituted a cardiologist was vague and imprecise. Because more general physicians with a special expertise in cardiology than pure cardiologists are needed in the United Kingdom adequate training in general medicine was rightly emphasised, but to train candidates for either type of post emphasis was placed on the need for quite extensive experience in cardiac catheterisation and coronary arteriography.

Since the 1960s, however, at least two major changes have occurred in cardiological practice. Firstly, specialised non-invasive techniques have been developed, many of which can be carried out at the level of the district general hospital, and, secondly, cardiologists have shown an elaborate concentration on coronary artery disease. Both these changes have emphasised the role of the general physician with a cardiological interest who can now investigate patients in the district general hospital extensively by non-invasive methods. Although experience in coronary arteriography must form part of the training of cardiologists, undue emphasis on this may not be appropriate for all trainees, many of whom will not need the invasive skills or, if they do, can gain more experience in them later. Thus the differences between the two types of cardiologists may be expected gradually to become blurred. The term "cardiovascular physician" may become appropriate for both types of cardiologist, and the specialist advisory committee in cardiology of the Joint Committee on Higher Medical Training of the Royal Colleges of Physicians is planning a new training scheme for the accreditation of such posts.

That dedicated and competent men and women, on whose training a great deal of time and money has been spent, should be able to obtain a consultant post is of first importance, particularly when more cardiovascular physicians are greatly needed. The anomaly of famine in the midst of plenty should not be

allowed to continue. All of us who are concerned with cardiovascular diseases, whether in respect of provision of services, assessment of training programmes, or research and clinical practice, must bear some responsibility in this matter.

Editor's note: We plan to publish the details of the training programme agreed by the Specialist Advisory Committee in Cardiovascular Disease in a forthcoming issue.

References

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