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Editorial

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Extending fellowship for specialised training in paediatric cardiology: deciding when "enough is enough" and when "the sky's the limit"

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Those people who develop the ability to continuously acquire new and better forms of knowledge that they can apply to their work and to their lives will be the movers and shakers in our society for the indefinite future – Brian Tracy

"What next?" We ask ourselves this at every step of our education and training. Once the novelty and excitement of entering paediatric cardiology fellowship starts to wane, confusion and uncertainty soon arise. The end is nowhere near, and a huge conundrum lurks near our training horizon. Extend the fellowship at least another year to specialise further? Stop at 3 years and pursue a career as a general cardiologist?

Ipso Facto

All of us imagine the perfectly fulfilling opportunity after fellowship, and after years of rigorous training, the ultimate goal would be to get *that* job. In a field like paediatric cardiology – historically speaking a relatively new field of specialisation, the job market is a treacherous sea, with dramatic high and low tides. More than 50% of the newly minted paediatric cardiologists enter advanced-year fellowships after the core programme.[1] With the uncertainty in the job markets, it has been reported that 10–20% of graduating fellows may end up jobless or working in a non-cardiology job.[2] Hence, it becomes imperative to weigh the pros and cons of choosing to subspecialise after the categorical paediatric cardiology fellowship.

Pro Forma

The classic paediatric cardiology training trajectory includes a 3-year fellowship, usually pursued after a paediatrics residency, to acquire the knowledge base and procedural expertise to provide high-quality care.[3,4] After the 3-year categorical paediatric cardiology fellowship, there are many opportunities to proceed further, if one has the passion and another year or two to spend for training, in areas like non-invasive imaging,[5] cardiac critical care,[6] electrophysiology,[7] cardiac catheterisation,[8] pulmonary hypertension, heart failure and transplantation,[9] adult with congenital heart disease (ACHD), and preventive cardiology. There are also opportunities to acquire specialisation in genetics, cardiac morphology, research methodology, and statistics.[10]

The tremendous advancements in the management of CHD have resulted in more than 90% of diagnosed children surviving to adulthood. With more adults living with CHD than children, a great need has emerged for physicians with expertise in ACHD to care for them. ACHD, quite naturally, turns out to be a specialty unto itself, with unique training requirements. The multiple tracks via adult cardiology or paediatric cardiology have been outlined in these two task force documents.[11,12] With demand building rapidly, ACHD is attractive to many aspiring candidates. Those seeking a career path in ACHD, or any of the congenital heart subspecialties would be well advised to choose a programme that would yield the most learning and case volumes, combined with the required amount of procedural skills.[4]

Carpe Diem

Education is not the filling of pail, but lighting a fire – W B Yeats

Driven by intellectual curiosity, competitiveness, and perhaps an inherent prodigal nature, paediatric cardiologists often seek to "up their game" by pursuing additional training after the categorical fellowship. Extra training makes you a more desirable job candidate and can serve as leverage in employment negotiations.[13] Frankly, there is a prestige that comes with being a transplant doctor or a catheterisation doctor. Who can deny the satisfaction that comes when

a senior colleague approaches *you* for your expertise? Has it become quaint to be "just" a general paediatric cardiologist in today's world?

For good reason, narrowing one's field of expertise is the current trend. After all, it has become very difficult to achieve and maintain excellence across broad areas of medicine. More generally, whether inside or outside of medicine, we all now seem to be evolving towards our own professional niches. Individuals who are driven by their own interests and pursue highly focused passions with enthusiasm and vigour are responsible for advances throughout our society. So, if you have the desire to pursue that additional year (or two), fuel your passion and go seize that opportunity – Carpe Diem!

Caveat Emptor

Change is the end result of all true learning – Leo Buscaglia

The decision to pursue subspecialisation is intensely personal and is best approached with sensitivity to the emotional context. We cannot deny that finances often play a big role, particularly the burdens of large educational loans. The security of immediate employment goes far to justify the expense of the years of training, and provide for family needs.[14] Compensation in medicine does, rightly, seem to track time invested to train (think neurosurgery[15]), so there is some incentive to defer the big income stream just a little longer. But, will that position in subspecialty paediatric cardiology be there for us when the training is completed? There are fewer retirees (and job opportunities) in electrophysiology and cardiac catheterisation, but the pendulum swings every few years. Due to variations in the job market, an individual may end up in an undesirable geographic location or practice setting. Subspecialisation within paediatric cardiology, may also dictate a highly academic work environment, which may or may not be part of your vision.[2] Currently, paediatric cardiac critical care and ACHD fields remain on top in terms of job availability.

Subspecialty paediatric training does not guarantee ones' work will be exclusively within the specialty area, and this can be a source of frustration. It is best to recognise that programmes almost all come with general paediatric cardiology responsibilities. While a certain amount of more general work may provide needed context and enhance satisfaction, it is important to negotiate the terms of employment to assure that coverage of this important work does not unfairly limit the time available to practice the subspecialty.

Quid Pro Quo

We give to get. We *give* by deferring gratification and by investing large amounts of our time and effort in a longer fellowship. We *get* to pursue our passions, land a (desirable) job, and enjoy a certain prestige. So, as we asked ourselves at the beginning, what next? The answer is different for each of us. Some of us will be general paediatric cardiologists, and some will specialise further. We will carefully weigh all the pros and cons, through sleepless nights and fretful days, but in the end, we take comfort in knowing that almost everyone lands on their feet and finds a context in which we will make meaningful contributions to the care of patients with CHD.

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