Reply to Joshi

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It is always difficult to reply to someone who is so enthusiastic about his training program, as Joshi appears to be [1]. Looking at the Cardiothoracic Surgery Syllabus [2], it is getting even more difficult to do so, since I have to admit that at the end of this training, each trainee in the UK should be competent in the critical care of patients who have undergone cardiac surgery. However, this competency includes clinical and technical skills that require time to build up. Put simply: only practice makes perfect. If trainees in the UK had the opportunity to get enough training and experience in the various issues of critical care outlined in the Syllabus, without spending night shifts on the ICU, this would be fine and there would be nothing left to say about it.

However, in the paper by Sádaba et al., nearly all of the respondents from various European countries were “…of the opinion that a 48-hour week would be insufficient to meet their learning needs.” The issue of structure of training and education was not the subject of my comment and it is beyond the scope of this reply to comment on it [3].

One final remark: Joshi points to the fact “that junior doctors are contacted when escalation of patient care is needed, ensuring they are kept in the loop when important decisions need to be made.” At first glance, this might work; however, one of the predominant goals of critical care after cardiac surgery is to prevent, rather than to treat, problems. For that purpose, you must become aware that a patient is going to develop a problem, and this can be done only by being near to the patient.

In summary, whatever the structure of a training program may be, reaching full competence in treating a cardiothoracic patient on an ICU takes time. I do not say that night shifts must be a part of this time, but working at night on an ICU may help to attain competencies in the field of critical care.

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REFERENCES