Dr Karl Karsch has always found living in different places to be a way of life. He was born in Germany, near Dortmund, but his father’s career took the family to Hamburg, then Dusseldorf, Neuss, and back to Dusseldorf. When Dr Karsch began his studies, he continued the traveling trend, starting with Bochum, Germany, from 1969 to 1970, where he studied biology and physics. From there, he went to medical school in Dusseldorf until 1976. During his medical training, he spent 6 months doing cardiology research at the University Hospital in Zurich, and he topped up his clinical experience for a couple of months in Vienna.

After medical school, he went to the University of Göttingen to study internal medicine and cardiology until 1979. A stint abroad followed, with Dr Karsch’s appointment as assistant professor at Mount Sinai School of Medicine, New York, NY. He was joined by his supervisor, Peter Rentrop, MD, professor of cardiology at the University of Göttingen, who received an appointment of full professor. Together, they worked on treatment of acute myocardial infarction with thrombolytics and mechanical recanalisation.

Dr Karsch returned to Germany in 1981 to take up a specialist registrar post at the University of Tübingen, where he stayed until 1999. He says, “In Germany, you have certain career pathways, which are different from here in Britain.” After writing his habilitation, a major work undertaken in Germany, Dr Karsch received an appointment of associate professor and consultant in 1984. He became a full professor of cardiology in 1990, and he carried out a combination of clinical work, research, and teaching.

Then, in 1998, came the offer of a post at Bristol University, England. Having reached such a senior position in Germany, Dr Karsch took the unusual step of considering such a move. “Most people wouldn’t take up the challenge and the intense work,” he says. Advice from colleagues varied, with some saying, “You must be an idiot to go.”

Bristol University had a complicated history, according to Dr Karsch. “There were problems with cardiac surgery, especially in children. Cardiology was at a very low level. It was a small department, with not many people; the service was not adequate, the equipment was terrible, and the whole situation was a disaster.” He explains, “They were looking for a very senior person, and I think they wanted to have somebody with a strong personality.”

Eventually, he decided to go and see what he could do about the situation. He moved in 1999, to take up the post of professor of cardiology at the University of Bristol. “I looked for a challenge,” he explains. “I’ve always done that in my life.” He found the move far from easy; he describes it as incredibly stressful. He brought 2 of his senior doctors with him, both cardiologists he had trained. He says, “If you start alone, there are always people on your back, so you need people to cover you.”

German born and trained, Dr Karl Karsch gave up a senior cardiology post in Germany for a troubled hospital in the United Kingdom. He did not find it an easy decision, as he explains to Jennifer Taylor, BSc.
According to Dr Karsch, funding presents one of the major downsides of being a cardiologist in the United Kingdom. He went to Bristol after negotiating a total of £3.5 million (€5.1 million) for refurbishing and improving the whole department. Of that, £1 million (€1.48 million) came from the British Heart Foundation and the remainder from the Strategic Health Authority and the hospital trust.

The department desperately needed a facelift. Dr Karsch says, “We had just 1 cath lab. Equipment was a real problem; space was a problem; staffing was a problem.” Cardiology beds were spread all over the trust, and ward rounds could take 3 to 4 hours. “We had so many outliers. Now, we have concentrated our patients in one place, and we have a new area for noninvasive and invasive procedures.” Two years from now, Bristol will have a new cardiothoracic centre, a purpose-built building at the back of the hospital, funded by the UK Department of Health for £60 million (€89 million). Staffing also has improved, with 7 consultants instead of 3, and 8 specialist registrars instead of 2.

But, despite increases in staff, Dr Karsch describes the United Kingdom’s 2000 cardiologists as “a rather low number for 62 million people,” compared with nearly 10 000 cardiologists in Germany for 81 million people. “This clearly has an impact on the practice of cardiology. In Germany, there is virtually no waiting list at all.” Dr Karsch feels concerned about the UK government’s targets for waiting lists. “They are a problem,” he says. “Even if you dictate that your waiting list has to be lower than 18 weeks, it is very hard to achieve that if you don’t have enough staff. I don’t think that we are badly organised here in the United Kingdom, and at least for my department I can say we have a rather good German organisation here. But we still have quite a bit of waiting, although we have reorganised our way of working.” And, he comments, “German patients are much more demanding than British ones. They would never accept these waiting times. They expect prompt services.”

On the plus side, he says cardiologists in the United Kingdom have a different way of treating patients compared with Germany. “Here, we talk more to patients rather than putting them in the cath lab.”

With regard to the training of doctors in the United Kingdom, Dr Karsch deplores the Modernising Medical Careers reform of doctors’ training in the United Kingdom. “Modernising Medical Careers is a killer for clinical academics,” he says. “Applying for a job, if you have done some research and if this just counts for 1 point, why on earth should a junior doctor bother to do research at an early stage? But if you write a nice little essay, it counts for 3 points.” And, he says, “The United Kingdom’s Department of Health needs more medical professionals to give sound professional advice. In the United Kingdom, as in Germany, at least in the past, the managers have too much power.”

In addition to adapting to a new health system and way of working, Dr Karsch has had to get used to many lifestyle changes. He points to the much higher cost of living in the United Kingdom, with prices 20% to 25% higher than in Germany. He describes the United Kingdom’s public transport as a “nightmare,” with “absolutely ridiculous” prices. And, although funding has become better for the National Health Service, “it is still quite low compared with other countries.” He also expresses dismay at the council tax on owner-occupied homes, paid to support community services, which he describes as “embarrassing.” And local councils “could be a little bit more organised—a good example is the rubbish collection and disposal; that could be done much better.”

On the plus side, Dr Karsch says that people in Britain “are more relaxed” and easier to socialise with. “The system in Germany is very hierarchical, and everything is strictly ruled.”

So, on balance, does Dr Karsch feel glad that he made the move? He hesitates before answering, then says, “I don’t know... I have no idea. You never know what might have happened back home. I was looking for an interesting life. I ask myself from time to time whether I would have done anything differently.” He says, “The challenge here was quite demanding, and the problems I had to overcome to achieve what we have achieved were considerable. It was quite a stressful time.”

As for the future, Dr Karsch is undecided. “I wouldn’t make the same move, at least not in the same position.” But then he adds, “I have learned in my life to never say never.”

Would he take on another Bristol? “It all depends on the conditions. It would take a lot of negotiating.” He concludes, “I am certainly not looking forward to having the same sort of stress. I like stress—it’s good for my heart; it’s good for fighting against heart attacks—but I think it must be more organised stress. But I certainly would take on another challenge if it comes to that point, depending on the workload.”

Jennifer Taylor is a freelance medical writer.
The Republic of Armenia (Figure 1) is approximately the same size as Belgium and occupies the area between Europe and Asia that separates the Black Sea from the Caspian Sea in the southern part of the Caucasus; it has a population of more than 3.2 million. Armenia has a long, traumatic history, and the last century saw huge upheavals in population; estimates have more than 9 million people of Armenian descent living outside the country. Formerly part of the Soviet Union, Armenia gained full independence in 1991, ending more than 70 years of Soviet control. The decades since independence have seen severe socioeconomic decline as Armenia has struggled for economic progress and stability during a period of radical reforms. A central postindependence reform has been a complete overhaul of the country’s health service, which formerly had modelled itself exclusively on Soviet lines.

Most of the major hospitals and teaching centres are based in the capital city, Yerevan, where Dr Karlen Adamyan practices as professor of cardiology. Faced with high rates of cardiovascular disease, Dr Adamyan remains stoic about the lack of progress during the last 2 decades. He says, “The health system under the former Soviet Union was better funded, and facilities and equipment were renewed annually. Since the Soviet period, there has almost been no renewal. There was also much better drug provision than now, as current health budget funding is very scarce.”

Specialised cardiology services have been available in Armenia since 1980, and this represents a popular subject choice for medical students. Postgraduate training takes 3 years in the department of clinical cardiology of the National Institute of Armenia, Yerevan (Figure 2). Although cardiology attracts postgraduate doctors, it offers few rewards and modest salaries, and the specialty receives no priority funding because most resources go towards underpinning the health service infrastructure and providing basic treatments to people in extreme poverty.

Dr Adamyan is 1 of 250 trained cardiologists in the country, 110 of whom belong to the Armenian Cardiologists Association and the European Society of Cardiology. Most of the trained cardiologists practice in the capital city. The lack of trained medical personnel and functioning facilities outside the main centres of population presents major challenges to reforming the health system. Lack of basic facilities and trained doctors in deprived regions prevents many people from accessing health care. And, according to a report from Médecins Sans Frontières, the international independent humanitarian medical aid agency based in Geneva, Switzerland, the World Bank initially encouraged health reform that aimed to contain healthcare spending and reduce the state’s role in healthcare delivery by promoting the introduction of user fees for public services in Armenia. This resulted in nearly half of all households in some rural areas reporting in a survey in 2003 that they did not seek care, mainly because of cost.

Hospital admission can incur catastrophic costs for families; these costs might involve going into debt or even selling property. Although in principle, health services are free to the most impoverished, the shortage of medicine, coupled with underfunding, means that doctors often have to charge patients in order to guarantee their treatment. Armenia is typical of the south Caucasus region (including Georgia and Azerbaijan) in this respect, and the impact of introducing charges has not offset low funding, but it has left the system...
open to corruption and has rendered even basic health services unaffordable for many.

As a further difficulty that might stem from the Soviet era, individuals seem unable to take responsibility for their personal well-being. Dr Adamyan identifies public information and raising awareness of heart disease as the main developments urgently required in his field. “People here still don’t understand the very real dangers of smoking, obesity, and lack of exercise, and for us it is important to bring information about heart disease, its risk factors, and prevention to the people,” he says.

Currently, the government is focussing its resources on growing and stabilising the economy, with investment in the health service dependent on future economic performance. Total expenditure on health in 2004 was only 5.4% of gross domestic product. However, the World Bank has provided loans to fund a series of long-term initiatives aimed specifically at renewal and reconstruction of the health service.

Against this challenging background, the Armenian Cardiologists Association is updating and coordinating activities by “harmonising and optimising the training of cardiologists, and by the development of prevention programmes and improvement of practice.” Dr Adamyan says, “The main area of activity is to realise government programmes, particularly in primary and secondary prevention of cardiovascular disease, and to work with the government and healthcare organisations to provide them with the necessary understanding of the impact of heart disease on the general population.”

The association has identified heavy smoking in men and obesity in women as the main risk factors. Some cardiologists have initiated voluntary activity to provide the public with preventive information about the dangers of smoking. The Coalition for Tobacco Free Armenia, set up in 2004, is a union of nongovernment organisations aiming to promote the benefits of nonsmoking and to press for effective legislation.

Dr Adamyan also believes that important goals for the Armenian Cardiologists Association include the promotion of earlier diagnosis, the introduction of the newest diagnostic methods, and the use of novel treatments. These advances will help decrease morbidity and mortality and improve the prognosis of patients with a variety of cardiovascular disorders.

Without international aid or grants, however, Armenian cardiologists will not be able to bring their services into line with countries in Western Europe in the short to medium term. Despite the existence of large concentrations of specialists abroad who are Armenian nationals, particularly in the United States and Europe, Armenian cardiologists see little exchange of expertise and practical assistance. In particular, Dr Adamyan points to a lack of relations with the Armenian Cardiologists Association.

Despite all these difficulties, the relatively high numbers of trained clinicians and life science students means that research is well established in Armenia. Armenian cardiologists are currently conducting research into acute myocardial infarction, acute coronary syndromes, arterial hypertension and heart failure, and arrhythmias. Priorities for the future include large-scale epidemiological surveys into heart failure and hypertension. However, clinicians will find it difficult to translate their findings into interventions and therapies without an adequate health service infrastructure.

These challenges are well documented, and the World Bank’s current funding programme aims to establish a network of regional medical facilities and to provide access to family doctors for the entire population. The second phase of the programme was announced in March of this year; it includes a gradual increase of funding for preventive services and for noncommunicable diseases. Dr Adamyan hopes this will offer some hope to Armenia’s hard-pressed cardiologists.

Judy Ozkan is a freelance medical writer.

References


The opinions expressed in Circulation: European Perspectives in Cardiology are not necessarily those of the editors or of the American Heart Association.
The 18-article Heart Health Charter, launched by 16 European health organisations and professional societies on June 12, 2007, aims to make the prevention of cardiovascular disease and the fight against it among the highest priorities of public health policy within the European Union. It aims ultimately to reduce the cardiovascular disease burden and the inequalities of heart health in different countries throughout the European region of the World Health Organisation (WHO). Further details of the Heart Health Charter and its objectives can be found on its Web Site at www.heartcharter.eu (Figure 1).

The European Society of Cardiology (ESC) and the European Heart Network served as the leaders in the origins of the declaration. The signatories all affirmed, “We will work in close collaboration with all signatories, at the European and national levels, within the profession and through all potential partners, political as well as non-governmental organisations, to promote strongly a future heart healthier Europe.”

Lars Rydén, MD, FRCP, FESC, (Figure 2), former president of the ESC and cochair of the ESC committee for European Union relations, stressed at the launch that doctors and politicians should focus on prevention. “What we have to concentrate on now is prevention. We cannot continue to create a society that makes people ill and then invest a lot of money into curing them,” he said.

Jill Farrington, MB, BS, MRCGP, (Figure 3), the noncommunicable diseases coordinator of the WHO regional office for Europe, said that the charter has the full support of both the WHO and the European Commission. “It provides a clear message that the WHO and the European Commission are working hand in hand with cardiologists from the ESC and public organisations from the European Heart Network for a strong, visible alliance against Europe’s greatest killer.”

The details of the charter include the promotion of the most recent European guidelines on cardiovascular disease prevention produced by the Joint European Task Force; these guidelines will be published in September 2007. The promotion includes the translation of the guidelines into local languages, their adaptation to national specifications, and the support of their dissemination among all medical professions and other allied partners involved in health.

**Figure 1.** For further details of the European Heart Health Charter, visit www.heartcharter.eu.

**Figure 2.** Dr Lars Rydén.
The charter also includes a direction to “prioritise research on the effectiveness of policy and preventive interventions including aspects on health care expenditures.” The research agenda includes the intent to address the fragmentation of research in European cardiovascular diseases by promoting and funding further cooperation, expansion, and coordination of research projects.

The parent organisations of the European Heart Health Charter are the European Society of Cardiology and the European Heart Network. Other signatories at launch were the World Organisation of Family Doctors, the Comité Permanent des Médecins Européens (the Standing Committee of European Doctors), the European Institute for Women’s Health, the European Men’s Health Forum, the European Network for Smoking and Prevention, the European Public Health Alliance, the European Health Management Association, EuroHealthNet, the European Atherosclerosis Society, the European Society of Hypertension, the European Association for the Study of Diabetes, the International Society on Behavioural Medicine, the European Association for Cardiovascular Prevention and Rehabilitation, and the European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions.

Robert Short is a freelance medical journalist.

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**European Educational Courses Update**

### September–November 2007

**13–15 September**  
Seventh Cardiovascular MRI Workshop and Ninth International Symposium on Echocardiography  
Onassis Cardiac Surgery Center, Athens, Greece  
For further details, contact soma@aias.gr

**14–15 September**  
European Association of Echocardiography Teaching Course on Imaging in Heart Failure  
Venice, Italy  
For further details, contact congress@keycongressi.it

**20–21 September**  
Heart Failure and Cardiac Resynchronisation Therapy  
Diegem, Belgium  
For further details, contact uems@skynet.be

**10–13 October**  
Second European Echocardiography Course on Congenital Heart Disease  
Prague, Czech Republic  
For further details, contact kongres@hotel-ilf.cz

**4–6 October**  
Management of Heart Failure in Primary Care  
Sophia Antipolis Cedex, France  
For further details, contact seminars@escardio.org

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**12–13 October**  
Pulmonary Arterial Hypertension: Clinical Experiences and Scientific Evidences  
Sophia Antipolis Cedex, France  
For further details, contact seminars@escardio.org

**15–17 November**  
The Everyday Challenge of Prevention—From Guidelines to Effective Intervention  
Sophia Antipolis Cedex, France  
For further details, contact seminars@escardio.org

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If organisers of cardiology-related accredited educational courses, or cardiology meeting organisers, would like to have their event considered for inclusion in future updates in *Circulation: European Perspectives in Cardiology*, please contact the managing editor at Keith.Barnard@wolterskluwer.com

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