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Please be advised that this information was generated on 2017-11-13 and may be subject to change.
Furthermore, high quality teaching and learning do not happen by accident; a curriculum is initially no more than a document. Medical schools must engage with the foundation programme, helping to develop expertise in medical education and ensuring that the years spent as junior hospital doctors are part of a smooth transition for graduates. There will have to be rapid expansion in the number of medical graduates who have been taught to teach—those with formal training in methods of teaching and learning. Postgraduate training in medical education may have to become a formal requirement for at least some clinicians in each teaching facility, and medical education may develop into a formal postgraduate medical specialty. Lastly, the current difficult pathways for medical practitioners to gain formal educational qualifications may need to be simplified, with more flexible professional doctorates or membership courses.

The success of the foundation programme, then, will require genuine academic development and support throughout the entire healthcare system, rather than in a relatively small number of elite teaching facilities.

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Coronary heart disease in women
Is underdiagnosed, undertreated, and under-researched

Coronary heart disease remains the leading cause of death in men and women worldwide, and cardiovascular deaths exceed the number of deaths from all cancers combined. In the United Kingdom, coronary heart disease causes almost 114 000 deaths a year, and one in six occurs in women. In the UK and Europe, one woman dies every six minutes of heart disease and in the United States, one every minute. Moreover, in Europe, cardiovascular disease kills a higher percentage of women (55%) than men (43%). Yet coronary heart disease is still considered a disease of men.

Many women are unaware that coronary heart disease is their main killer; their biggest fear is breast cancer. Even more worrying, however, is the apparent lack of awareness of cardiovascular disease in women among healthcare professionals. At the time of presentation with heart disease, women tend to be 10 years older than men, and at the time of their first myocardial infarction they are usually 20 years older.

As coronary heart disease is a disease of the older woman, many women believe that they can postpone their disease. They are also less likely to have appropriate medical help and tend to present late in the process of diagnosis more difficult. Women are less likely to seek medical help and tend to present late in the process of their disease. They are also less likely to have appropriate investigations, such as coronary angiography and, together with late presentation to hospital, this can delay the start of effective treatment.

There are particularly clear sex differences in patients undergoing coronary revascularisation: mortality in women is notably higher.

At the time of presentation with coronary artery disease, women are more likely to have comorbid factors such as diabetes mellitus, hypertension, hypercholesterolaemia, peripheral vascular disease, and heart failure. In addition, context suggested in the Cochrane review by Fahey and colleagues. Consultation at the practice at least once a year seems necessary to check whether the conditions for successful self measurement of blood pressure are still in place. But practice based self monitoring, as introduced by McManus and colleagues, offers a greater safety net. It allows active participation by patients without losing professional supervision, which may prove to be a considerable advantage over self monitoring at home.

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Risk factors for heart disease differ between the sexes. For example, women with diabetes have 2.6 times the risk of dying from coronary heart disease than women without diabetes compared with a 1.8-fold risk among men with diabetes. Similarly hypertension is associated with a twofold to threefold increased risk of coronary events in women. Low concentrations of high density lipoprotein seem to be a better predictor of coronary risk in women than high concentrations of low density lipoprotein. Furthermore, high levels of triglyceride are associated with greater risk among women than men.

Women and men with heart disease tend to differ in their presenting symptoms, their access to investigations and treatment, and their overall prognosis. Women may have more atypical symptoms than men—such as back pain, burning in the chest, abdominal discomfort, nausea, or fatigue—which makes the diagnosis more difficult. Women are less likely to seek medical help and tend to present late in the process of their disease. They are also less likely to have appropriate investigations, such as coronary angiography and, together with late presentation to hospital, this can delay the start of effective treatment.

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