

Editor's Note

Some Concerns about the Future of the Practice of Cardiovascular Medicine



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There is no question that all cardiologists are concerned about diminishing reimbursement and the high cost of malpractice insurance. In my state, Florida, it has become the main topic of conversation when any of our societies meet. There is grave concern that physicians (cardiologists)

will be leaving the state for these two reasons. However, I have no data that this has occurred, although there is a general sense that there is a growing need for cardiologists in Florida and that fewer cardiologists are coming into the state. Time will tell whether there is any truth to that concern.

In this editorial, however, I will concentrate instead on the need for more cardiologists in the twenty-first century.

In 1995, in an editorial entitled, “Are There Too Many Cardiologists?—A Cardiologist’s Opinion,”¹ I commented that, yes, there are too many cardiologists; in particular, there are too many low-volume coronary interventionalists and noninvasive cardiologists poorly trained in echocardiography and nuclear cardiology. But I also pointed out that in the twenty-first century, major medical and societal concerns will enter into the management of patients who are living into their 80s and 90s. The vast majority of these men and women will have complex cardiovascular problems related to age and co-morbid disease. The solution to many of their problems will require the expertise of the general cardiologist as well as the subspecialty cardiologist.

In 1995, downsizing cardiovascular training programs was in vogue. In the twenty-first century, in 2003, instead of downsizing, we should be right-sizing cardiovascular training programs to meet the future needs not only of subspecialty cardiology, that is, interventional, electrophysiology, cardiac transplantation, noninvasive imaging, and so forth, but also of general cardiology. In the past, the general cardiologist has usually been around cardiovascular medicine for some time and acquired “senior clinician” status, usually by choice but often related to the unbelievable newer talents and skills of the younger cardiologists. General cardiologists include those who have broad experience in cardiovascular medicine and

continue to practice or teach. The practicing physician frequently is knowledgeable in many areas but usually limits practice to a few areas, for example, diagnostic cardiac catheterization, reading electrocardiograms, reading echocardiograms, or nuclear studies. The academic general cardiologist must have a working knowledge of most aspects of cardiovascular medicine, if for no other reason than to guide trainees.

To emphasize what I have said about our manpower needs in cardiology, I quote from an article written by the current president of the American College of Cardiology, Carl J. Pepine, M.D., M.A.C.C., who wrote in his President’s Page,

One of the difficult issues facing our nation today is the growing shortage of cardiovascular specialists. According to a recent American College of Cardiology survey, by the end of 2003 only one-third of the available openings for the cardiovascular specialist will have been filled. The shortage is much worse in academic medical centers, a troubling development given that, in the past, shortages in physician educators and trainers were offset by part-time and voluntary faculty from the private sector.²

In addition, he makes the point that

... in 2000, approximately 13% of the population was 65 years or older. By 2030, that number is expected to be approximately 20%. Given today’s epidemic of obesity and diabetes, we are very likely to see a substantial increase in the prevalence of cardiovascular disease.²

Another editorial, written by J. Willis Hurst, M.D., F.A.C.C., gives us plenty to think about regarding the need for cardiologists.³ Hurst argues persuasively that there is a need for general cardiologists and provides some suggestions for how that need can be filled.

According to Hurst, the general cardiologist is a well-trained physician with an interest in the diagnosis and long-term management of patients who have risk factors for cardiac disease or who in fact have chronic cardiac disease. As mentioned, many of these cardiologists have performed high-tech procedures in the past but now no longer do, and instead have evolved as general cardiologists. Hurst opines that these individuals need to have a very good working knowledge of current literature, guidelines, and indications for all of the procedures performed on cardiovascular patients. Hurst agrees with my editorial of 1995 that we have too many cardiologists who subspecialize, but also agrees that without these subspecialists,

cardiovascular medicine would not have advanced to the degree of sophistication that it enjoys today.

Another issue that warrants concern involves medical school graduates and their career choices. Since 50% of our medical school graduates are women, we should be attracting more women into cardiology. This does not seem to be the case and may be due in part to the perception that modern cardiology is too demanding of physician time. I believe there is an opportunity for both men and women to select a career in cardiology that does not encompass the demanding requirements of "on call" interventional cardiologists. However, it does require sophisticated skills in history-taking, physical examination, and the interpretation of the common tests that should be part of the cardiac examination, namely, electrocardiography, chest x-ray, exercise testing, and several indicated diagnostic tests such as transthoracic and transesophageal echo, cardiac magnetic resonance, and chest computed tomography. The general cardiologist must be better trained than the general physician when it comes to evaluation and management of the cardiac patient.

Hurst indicates that once the physician gathers the clinical data this must be "followed by thinking." Unfortunately, as I have said in the past, "Thinking is hard work. That's why so few people do it."⁴

One of Hurst's plans to remedy the lack of general cardiologists is the following: three years of internal medicine, as is usual, followed by a two-year program in general cardiology. This would allow the individual to sit for the boards in internal medicine, but the subspecialty board of cardiology would have to make adjustments to the test and award a certificate in general cardiology to the trainee. Alternatively, a physician could spend two years in medical residency followed by three

years of cardiology. In this instance, the internal medicine boards would have to make the adjustments so that the candidate is eligible for certification in medicine and cardiology. This may not be easy to accomplish since the American Board of Internal Medicine and Subspecialty Board of Cardiology tend to move with glacial speed when considering changes in requirements for certification; but that should not preclude its consideration as a potential solution to what many consider a crisis in cardiology.

Finally, some would argue that a generalist, whether in cardiology or internal medicine, makes less money than a super-specialist performing high-tech procedures. I don't think there is any question about the truth of that, but, as I have said many times to students and housestaff and fellow trainees, if one has to work for a living, then one needs to enjoy going to work in the morning. Being happy in what you do is the only thing that really matters. If that is not the case, then one should do something else.

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References

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