In This Issue

Heart of the Matter

What Is a Cardiologist?

BY SIDNEY GOLDSTEIN, M.D.

There was a time when one could almost explain what a cardiologist does. But things are changing. The boundaries of professional performance and competence are expanding and becoming increasingly blurred.

The traditional domain of the interventional cardiologist has been expanded to include the carotid artery and peripheral vessels. If we can dilate and stent a coronary artery, why not do the same to the carotid or femoral artery? The improvement in imaging also has led to the cardiologists invading areas traditionally assigned to radiologists. And in a very short period of time we have challenged the turf of many of our colleagues in vascular, cardiac, and neurologic surgery.

Many of these changes are driven by new technologies that have expanded the clinical parameters of skilled physicians. They also have occurred as a result of the dynamic changes in therapy that have evolved at the same time. The urgency for care and the desire for cardiovascular "one-stop" therapy have made accessibility an important driving force. If you saw a tight iliac lesion as you passed a catheter toward the coronary artery in a patient with claudication, wouldn't you take care of it?

The shifting of therapeutic boundaries also has occurred within cardiology as we see the transfer of clinical responsibility from the electrophysiologists to the general cardiologists for pacemaker and defibrillator implantation to meet the increased demand for these devices. We may even see cardiac surgeons implanting these devices as they did in years past as they find time on their hands.

As the parameters of cardiology expand, it is becoming clear that we are unable to meet the demands for our core clinical services. Emergency and internal medicine physicians, who can now be trained and certified in echocardiography, play a large role in providing echocardiographic services. This has occurred as a result of the availability of inexpensive and portable echocardiograph equipment. The need for heart failure care has led to the training of internal medicine physicians outside of the cardiology fellowship tract in this field.

These unrestrained movements are reflected in cardiology training programs. Young physicians who wish to become cardiologists are limited by the scarcity of training positions. Many trainees find that the programs are inflexible, making it impossible to concentrate in certain areas of interest. Significant changes in training programs must be made to address the needs of trainees who wish to pursue training exclusive of interventional procedures. Every cardiologist does not need to know how to push a catheter. In fact, pushing a catheter may become a lost art as MRI and CT technologies advance.

The direction of patient care will remain with the physician who provides the care. For the most part, the treatment of cardiovascular disease in the broadest sense remains in the hands of the cardiologist. It is the cardiologist who answers the call at 3 in the morning. No one is going to call the neighborhood radiologist for chest pain or the neurosurgeon for syncope. The cardiology community must ensure the availability of a sufficient number of cardiologists for the future. It will also need to provide more flexibility in training to provide the diversity of services for the 21st century. ■

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