HEART OF THE MATTER

How Many Cardiologists Do We Need?

BY SIDNEY GOLDSTEIN, M.D.

The nature and distribution of the cardiology workforce has been at issue for the American College of Cardiology for more than 20 years. It impacts the college's ability to meet community requirements for quality care, and it affects the income of cardiologists.

On the basis of current projections, there will be a major shortfall of cardiologists in 2025, according to a recent Lewin Group report. To some extent, the shortage will affect interventional cardiologists, but the major impact will be felt in the ranks of general cardiologists like me, where the current shortage of 1,600 will swell to 16,000 by 2025.

Projecting the future is, at best, uncertain. These predictions are based on two measurements: first, that there are 1.8 applicants for every cardiovascular training slot, and second, that based on ACC academic, pediatric, and private practice surveys, there is "substantial excess demand for new cardiologists which cannot be met with the current number of fellows completing training annually." The foundation of these estimates is open to some question.

Not too long ago, the size of the cardiovascular workforce was deemed adequate, with the expectation that interposition of managed care in the medical marketplace would limit patients' ability to get onto our appointment schedules. But then, managed care went up in smoke, and interventional cardiologists found vascular targets not only in the coronary bed but in the head and the legs, not to mention the aortic and mitral valves.

What the future holds for our specialty is uncertain, but if health care reform actually happens and the millions of the uninsured begin to seek medical care, one could anticipate an increase in demand for cardiology services. But in reality, most of people in need of our cardiac services are already covered by Medicare.

Also, it is worth considering that much of the increase in cardiology service demand is a "bubble." The development of degenerative disease in the aging population speaks to increased volumes, but interventions that have been applied to younger patients may not be applicable or beneficial to the aged.

The Lewin Group report considered a number of solutions to expand the cardiology workforce and meet community needs, including more efficient use of support staff and delaying the retirement of older cardiologists.

The report does not touch on the unlikely possibility of the expansion of training programs. Currently, the number of hospital training slots is limited by the Balanced Budget Act 1997, passed at a time when there was no perceived increased need for specialists. This act fixed the number of training slots by limiting Medicare payments. Hospitals that expand their house staff beyond those limits, would do so at their own expense.

The alternative would be to take on more trainees and have the hospital pay for them. At a time when cardiology is a marketing target, this would not be at all unreasonable.

Even if more slots were provided, it is not certain how many institutions that are not already training cardiology fellows could meet the increased and more stringent quality, volume, and faculty requirements established by the Accreditation Council for General Medical Education.

One proposal, which could increase the number of clinical cardiologists in short supply, was to shorten the training programs for general cardiologists by telescoping their training into the last year of general medicine training. That proposal died a slow death at the hands of the ACGME.

Thus, it is clear that in the current political environment, an increase in cardiology workforce is unlikely.

However, much of what we see as our prime therapeutic domain—hypertension, angina, and heart failure—is treated predominately by noncardiologists. To provide the community we need, we may have to develop a more integrated and collegial relationship with the general internist and family physician. The solution for cardiologists to meet the clinical needs lies in our more efficient integration of cardiology into the general medical community. ■

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