Editorial

Downsizing Cardiology
Getting the Process Started

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Few Americans dispute that health care in the United States has become too expensive. Many believe that a substantial fraction of the high cost can be attributed to an excess of specialists who order too many expensive tests and treatments. Not surprisingly, cardiologists figure prominently among those identified as “the problem.” All major educational organizations concerned with internal medicine, including the Association of American Medical Colleges (AAMC), the American Board of Internal Medicine (ABIM), the American College of Physicians (ACP), the Association of Professors of Medicine (APM), and the Federated Council of Internal Medicine (FCIM),* as well as a myriad of health policy and governmental groups, agree that the workforce in cardiology needs to be reduced.

Not everyone agrees with this premise. Most cardiologists believe that their management of most complex clinical problems achieves better outcomes in a more cost-effective manner than that of other physicians. Unfortunately, data to support this opinion are lacking. Studies are needed to identify the unique contribution of cardiologists and to protect that contribution as the delivery of health care is reformed. But, important as they would be, future studies are unlikely to change the conclusion that there are too many cardiologists. Why is this? And what should be done?

In the United States there are currently more than 16 000 practicing cardiologists¹ and approximately 2600 trainees in cardiovascular disease programs; between 1988 and 1992 the number of training positions increased by one third.² During this same period, the proportion of health care provided by health maintenance organizations (HMOs) with capitated payment plans has increased dramatically, changing the demand for cardiologists. Even where HMOs fail to hold, fee-for-service practices are influenced by capitated systems. This shift to an HMO-dominated healthcare system has far-reaching implications for the delivery of health care; the most dramatic initial effect will almost certainly be on the number of physicians, particularly specialists, that the country requires. Most predictions regarding the number of specialists needed in the future are based on experience in HMOs and on comparisons with other countries. Using an average of the hiring practices of five established HMOs in 1989, Kronick predicted a need for 8.5 cardiologists per 300 000 people.³ These estimates have led some to conclude that there are already twice as many cardiologists as “needed.”⁴ Of course, these predictions, which depend on the characteristics of the population, may need revision as more data are collected. If universal coverage is achieved, the total population will be older and poorer than the sample on which these estimates were made.

Comparison of the United States with similar countries also supports the conclusion that there is an excess of cardiologists in this country. In the United States we have 6.5 cardiologists per 100 000 population; in Canada there are 2.5, in Germany 2.9, and in Great Britain 0.4 cardiologists per 100 000.⁵ Furthermore, many point to studies that show that, despite more cardiac catheterizations, angioplasties, and coronary artery bypass procedures performed in the United States, the in-hospital death rate from acute myocardial infarction in the United States is similar to that of Canada.⁶ But again, conclusions are based on data that are readily available. These studies are based on the end points of death and reinfarction. In the GUSTO trial, quality-of-life outcomes were compared for US and Canadian patients with acute myocardial infarctions treated with thrombolysis. After 1 year, Canadian patients had more physician visits, a higher incidence of chest pain and dyspnea, and lower functional capacity than US patients (personal communication, Robert Califf, MD, and Eric Topol, MD, June 1994).

It is clear that better data are needed to accurately predict how many cardiologists we should be training. It is also clear that we have more cardiologists than we will need and that, if we continue to train cardiologists at the current rate, soon some will not be able to find practice positions. We would be irresponsible if this were allowed to happen. Therefore, there is only one realistic solution: cardiology training programs must be downsized.

Many of the healthcare reform plans, including the President’s Health Security Act, recommend creating a national physician workforce commission to achieve a more even (ie, 50:50) ratio of specialists to generalists, the latter defined as internists, family practitioners, pediatricians, and sometimes, obstetrician-gynecologists.

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*The Federated Council for Internal Medicine (FCIM) comprises the American Board of Internal Medicine, American College of Physicians, American Society of Internal Medicine, Association of Professors of Medicine, Association of Program Directors in Internal Medicine, and Society of General Internal Medicine. The Council was established in 1975 to speak with a collective voice for the specialty of internal medicine.
To many, creation of a workforce commission that would determine the number of cardiologists represents, simply, too much governmental intervention. But having no plan would be worse. Voluntary reductions are unlikely to have an appreciable effect in the face of local incentives to maintain or increase the size of training programs. The lag time before market forces influence the size and number of cardiology training programs is too long. And, perhaps most important, there is a likelihood that federal support of graduate medical education will decrease as Medicare responds to competitive market forces. In 1992 $5.2 billion of support, or $70,000 per resident, was provided by Medicare funds through direct and indirect medical education adjustments.7

The internal medicine community finally has begun to respond to the healthcare reform debate by supporting a rational process for downsizing. The balance of subspecialists and generalists would be maintained by tying certification and the accreditation of training programs to the funding of graduate medical education. According to this construct, all of graduate medical education would be funded by a single source to which all third-party payers would contribute. A federal agency would specify targets for the size and distribution of physicians within the workforce. Determination of which training programs and positions to fund would be made using the independent evaluation criteria of the Accreditation Council for Graduate Medical Education (ACGME), or a similar body. Certification would be available only to individuals who train in accredited positions.

Reductions in cardiology training programs must be accomplished without damaging the programs that produce clinical and basic science researchers and the clinician scholars who teach cardiologists and primary care physicians. These academicians are the nation’s investment in the future. The ABIM, FCIM, ACC, and others have begun to develop criteria for rating the quality of fellowship programs so that, in making reductions, quality can be the primary determinant along with other important factors. A preliminary list of program characteristics reviewed by representatives of nearly every internal medicine subspecialty organization at two national meetings sponsored by FCIM includes (1) the quality of the general internal medicine training program and other subspecialty training programs, (2) the opportunity for high-quality clinical teaching experiences (including technical and procedural experience), (3) the opportunity to participate in research, (4) the size of the training program, (5) the pass rate on the ABIM subspecialty certifying examination, and (6) a program’s history of producing academic subspecialists and clinical investigators.

To ensure that reductions in trainee numbers are based on quality rather than by across-the-board cuts, leaders of the internal medicine and subspecialty community must be involved. To this end, representatives of nearly all the organizations of internal medicine and the subspecialties, including the ACC, recently participated in a national symposium on subspecialty training sponsored by FCIM. At this meeting consensus was reached on the following positions.

1. There must be a limit on the total number of first-year postgraduate training positions. This single measure is predicted to have the greatest direct effect on the cost of health care. A cap of 110% of US medical graduates, which has been suggested in several reform proposals, is supported. (At present the number of PGY-1 positions exceeds the number of US medical graduates by 25%.)8

2. The number of subspecialty fellowship positions must be reduced. This will be painful and difficult. The fairest way to regulate the downsizing is to have the number of positions needed determined by a national workforce commission. The commission must be composed of medical educators, training directors, and others knowledgeable about training programs. Ground rules must be established to ensure that high-quality programs will be preserved in the downsizing process. The quality of the programs should be rated by a separate organization, such as the ACGME.

3. An all-payer system should be established that will fully fund all accredited postgraduate medical education positions. No training should be allowed outside of this system.

To minimize the detrimental effects of downsizing and protect the high quality of subspecialty training programs, the profession must influence plans for healthcare reform. Taking political action to support a workforce commission with representation by cardiology training program directors, coupled with a dependable, dedicated funding source for graduate medical education, might enable decisions about the number of cardiology trainees to be based on factors such as the quality of trainees, the quality of the educational environment, and the capacity of the program to produce tomorrow’s academicians. Finally, in the debate about appropriate numbers, cardiology, like the other subspecialties, has found it difficult to defend its belief that cardiologists take care of patients with heart disease better than generalists because of the paucity of data to demonstrate the unique contribution of cardiologists to health care. Fledgling attempts to collect such data have begun, but major cardiology organizations now must put their energy and resources behind this effort. Without objective, valid data, policymakers are likely to ignore the collective voice of cardiology. The danger of this outcome cannot be overestimated.

References


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