

Too Many or Too Few Cardiologists?

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Cardiology has undergone explosive growth in recent years. This has been attributed to a series of factors, especially to scientific and technological advances, greater opportunities for the adequate treatment of many cardiovascular disorders and the growing public awareness of the magnitude of the problem created by these diseases. Moreover, the public has access to increasing amounts of information concerning the right to receive proper health care and the options that go with it. As new diagnostic and therapeutic techniques develop and those existing are made available to ever greater segments of the population (for questions of age, indication, or geographical accessibility), the demand for cardiologic care increases. Meanwhile, Spain is beginning to experience the difficulties involved in meeting this demand because of the shortage of qualified cardiologists. Not only is unemployment among Spanish cardiologists nonexistent; there are vacancies owing to a lack of candidates. True, these positions are not always the best ones, but that is another story. This circumstance, especially in small regional hospitals, obliges the limited number of available cardiologists to concentrate on doing what other specialists are less prepared to perform: technical procedures. In the meantime, who is seeing the patients? Who is practicing clinical cardiology at these locations? In general, specialists in internal medicine, intensive care or family medicine. Without going into unnecessary controversies, and acknowledging the qualifications of these professionals and their necessary participation in the treatment of cardiovascular diseases, this is not the ideal situation for the patients. The best care in the case of cardiovascular diseases is that provided by those who know the most about them: the cardiologists. What is more, in contrast to what might be suggested at first glance (that the greater the demand, the better the wor-

king conditions), this is not beneficial either to cardiology as a specialty or to the cardiologists themselves as professionals. The reason for being of cardiology, and of medicine in general, is to provide care for patients; this is also its strength. If the suspected trend continues—and, as we will witness, this is the foreseeable scenario, cardiologists may find themselves reduced to performing technical procedures, diagnostic, or therapeutic, requested by the clinicians treating the patients, who will not be cardiologists. If, in the future, technology offers us techniques that replace those existing and that are not carried out by cardiologists (consider the ongoing controversy regarding the introduction of new imaging techniques), cardiology, as a specialty, could become devoid of substance.

The present situation shows no signs of improving. The demand for professionals continues to grow, and early retirements will only magnify the problem. However, the number of cardiologists trained annually remains the same. Year after year, the National Cardiology Commission asks that the totality of the accredited positions for residents, roughly 120, be filled; but, year after year, around 112 candidates are appointed. In any case, this slight difference would not change things much, although it does reveal the lack of awareness of the problem on the part of the Spanish National Board of Medical Specialties and the Spanish Ministry of Health. The Spanish Society of Cardiology has commissioned a study on the future needs of Spanish cardiologists which will, in all probability, help us to establish a plausible future scenario. But not the only one. The possible needs will depend on the role assigned to the cardiologist. If we consider that all the patients with heart disease should always be seen by a cardiologist, the needs will differ markedly with respect to the situation if we consider that cardiologists should be concerned only with the complex technical procedures. One does not have to be very discerning to predict that if the patients with cardiovascular disease, present or potential, were to be consulted, they would tend to prefer the first of these two alternatives, although it may not be feasible.

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Meanwhile, we should start to study the short to medium-term options. Taking into account the 5-year latency period required to train residents, if we want the supply of cardiologists to meet the foreseeable demands, we should begin to act now. However, if the objective is to maintain the present high standards, the capacity of the residency program to train cardiologists can not be increased in the short term. Other alternatives include the incorporation of cardiologists from Latin America or Eastern Europe, or perhaps the establishment of different levels of specialization in cardiology, creating the figure of the clinical cardiolo-

gist, training or qualifying specialists from other fields, but integrated into cardiology services. Another possibility would be the massive incorporation of nonmedical technicians to perform certain tasks, or other formulas that are difficult to envision now. In any case, the issue is important enough to spark extensive debate in our society, and I would like to take advantage of this opportunity to invite all our members to participate in said discussion. There may have been few occasions like this on which it could more rightly be thought that the future of cardiology is in our hands...although, unfortunately, not in ours alone.