Of great interest to cardiologists who perform invasive procedures is the new added qualification certification program of the American Board of Internal Medicine (ABIM) in interventional cardiology. Those of us with gray (or little) hair not only remember when cardiology training was only 2 years in length, but also remember those oral examinations in cardiology. Since then, the oral examination has disappeared, and training for cardiology has been increased from 24 months to 36 months. The first added qualification certificate in cardiology was electrophysiology, which required an additional year of training. Now, a new added qualification is available to interventional cardiologists. The first annual certification examination in interventional cardiology will be offered at multiple sites throughout the country on November 3, 1999. Of great importance is the fact that for the first three examinations, candidates will be admitted through a practice pathway, or “grandfather” pathway. After the year 2001, only fellows who have had 12 months of formal training in interventional cardiology in addition to the required 3 years in cardiology will be admitted. Although the ABIM rightly indicates that certification is not required of practitioners in interventional cardiology and that the certificate does not confer privileges to practice, it is clear that more and more hospitals will probably use this as a hurdle for those who wish to practice interventional cardiology.

There will be four components to the program, including 1) admission requirements, 2) practice experience and training requirements, 3) clinical competence requirements, and 4) the interventional cardiology certification examination. Admission requirements include a valid unrestricted license to practice medicine and current certification by the ABIM in cardiovascular disease. The practice experience and training requirements for the years 1999 to 2001 require performance as the primary operator of at least 150 cardiac interventional procedures in the 2 years before application for certification, or 500 interventional procedures during the candidate’s career. Candidates will be required to generate procedural logs for the 2 years before application. The accuracy of this log must be verified by each catheterization laboratory director before submitting an application to the ABIM. A procedural experience form will require a careful description of all the procedures performed at each institution where the candidate performs interventional procedures. The ABIM will verify a sample of procedure reports with the catheterization laboratory director, who will be asked to provide copies of the candidate’s log and attest to its accuracy. Furthermore, all candidates must save their procedural logs for 5 years. The training pathway requires 12 months of satisfactory fellowship training in interventional cardiology in addition to 3 years of cardiovascular fellowship. One cannot double count a given year in this sequence. Until interventional cardiology training programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME), the interventional cardiology training must occur within accredited cardiovascular training programs. During training in interventional cardiology, the fellow must have performed at least 250 cardiac interventional procedures that must be documented and attested to by the training program director.

Clinical competence requirements will require substantiation by local authorities that the candidate’s clinical competence as an interventional cardiology consultant is satisfactory and that the candidate is in good standing in the medical community. The certification examination itself will be a comprehensive 1-day examination of multiple-choice questions in the one-best answer format with an absolute standard for passing. Registration for the first examination (November 3, 1999) will extend from January 1 to April 1, 1999. The examination will assess the candidate’s knowledge and clinical judgment in case selection (25%), procedural techniques
(25%), basic science (15%), pharmacology (20%), imaging (10%) and miscellaneous items (5%).

I anticipate that not every cardiology training program may necessarily have the ability to certify every fellow in interventional cardiology. It is likely that this will result in a pyramidal system so that only a selected few will meet the required training numbers. It is incumbent on training programs to be sure that they can provide the appropriate experience for interventional training before accepting fellows for this additional year.

It appears that the minimum number of cases required by the American College of Cardiology/American Heart Association guidelines, coupled with specialized training for interventional cardiology, may reduce the numbers in the future who wish to engage in this subspecialty. Alternatively, the establishment of a separate Board examination for an added qualification may increase the incentive for more individuals to qualify for the examination to broaden their options. In any event, this is another important step by the ABIM, and the purpose of this Editor’s Page is to widely disseminate this information among cardiologists and cardiovascular trainees.