Training in Cardiology Fellowship Programs

The study by Gurvitz et al. (1) provides a measured and reasonable assessment of the workforce of cardiologists to care for adult patients with congenital heart disease (CHD), the exposure of adult and pediatric cardiology fellows to adult patients with CHD, and several excellent suggestions to augment the workforce.

The recommended training for physicians who care for adult patients with CHD has been influenced by, 1) the approach to the patient population, and 2) the perspective of the individual or group making training recommendations.

In regard to the approach to the patient population, care of patients can be dictated by 1) the age of the patient, or 2) by the patient’s disease. In most situations, patient care is divided by age. Internists and family physicians care for adults, and pediatricians care for infants, children, and adolescents. This paradigm makes sense for diseases that are unique to different age groups.

However, it may not make sense to use this paradigm if one group of physicians inherently is better trained to care for the specific disease than is another group of physicians. For diseases that occur in all age groups, what is important is whether or not the physician is trained to treat the specific disease; not whether the physician is trained to care for children or adults. The management of CHD is taught in pediatric cardiology training programs. Thus, in the case of patients with CHD, physicians trained in pediatric cardiology are most appropriately trained to take care of these patients regardless of the patient’s age. Of course, the pediatric cardiologist should work in conjunction with the patient’s primary care internist, family practitioner, or internist cardiologist.

Regarding the perspective of the individual or group making training recommendations, several attempts have been made to define appropriate training for physicians who care for adult patients with CHD. The perspective primarily has been from the viewpoint of training internal medicine cardiologists. This is understandable because in most internal medicine cardiology training programs, there is minimal exposure to CHD. Relatively few, if any, graduates of internal medicine cardiology training programs are trained to treat patients with CHD. For these physicians, one or more years of training in CHD, beyond standard fellowship, is essential.

This contrasts with training of pediatric cardiologists, who are fully trained to care for patients with CHD during standard (three year) fellowship. Pediatric cardiologists need not (and perhaps should not) be the primary care physician for adult patients with CHD but certainly can function as their CHD cardiologist.

The anticipated shortage of physicians trained to treat adults with CHD may, in fact, be much less when the contributions of pediatric cardiologists to the care of these patients are recognized.

REFERENCE


REPLY

We appreciate the interest Dr. Driscoll expresses in our study (1). In his letter, Dr. Driscoll suggests that pediatric cardiologists are better equipped to treat adult congenital heart disease (CHD) patients because they are “inherently better trained” in the underlying diseases, and that they should “work in conjunction with the patient’s primary care internist, family practitioner, or internist cardiologist.” There is no reasonable dispute with this premise as pediatric cardiologists often receive more training in the underlying diseases at issue. We respectfully disagree, however, with Dr. Driscoll’s conclusion that care for an emerging population of adult CHD patients should be committed solely, or primarily, to pediatric cardiologists.

Instead, several considerations favor the conclusion that adult and dual-boarded cardiologists should be properly trained to take an increasingly significant role in the care of adult CHD patients.

1. The numbers favor a greater and necessary role for adult cardiologists. As noted in our study, we estimate that the number of adult CHD patients is growing relatively quickly. Adult cardiologists in the U.S. outnumber pediatric cardiologists by a factor of 10 to 15 (1). A strategy that relies on pediatric cardiologists to treat new and existing pediatric patients as well as adult CHD patients will worsen the ratio of patients to cardiologists.

2. Adult CHD patients have other adult-onset medical issues. The CHD requires management in conjunction with acquired conditions of adulthood, including pregnancy, acquired heart disease, and other adult diseases such as diabetes and cancers. Adult cardiologists are better trained to deal with these acquired medical issues in which pediatric cardiologists have little or no training.

3. Practical difficulties accompany adult CHD inpatients. Children’s hospitals often cannot admit adult patients, and pediatric cardiologists may not be able to obtain admitting privileges at adult-care facilities.

Ultimately, the argument is not about which group should contribute more care for adult CHD patients. The question is how we can supply the needed care to this growing population given a potential provider shortage, coupled with shortages in training of most adult and pediatric cardiologists. As mentioned in our study, this care will currently need to be provided in a number of different combinations and arrangements. Our assessment is that pediatric cardiologists, adult cardiologists, congenital cardiac surgeons, and...