SPECIAL REPORTS

Issues and Challenges for Academic Cardiology

Introduction to Views of the Future Leaders

A wind of change is blowing across medical practice, but whether it will be acknowledged as being good or ill is still unclear. Each facet of medical care is involved nor is any subspecialty excepted. Profound changes can be anticipated both in clinical and academic medicine. As usual, when times are unsettled, it is the younger individual who becomes greatly concerned about the effects of change on a personal career.

Some months ago the American College of Chest Physicians decided to host a weekend for younger academic cardiologists. This was done not only to provide a forum for their discussions but particularly to learn what problems were deemed by the future leaders of their specialty as being particularly important. In addition, it was felt that very useful advice to the current leadership would emerge, but even if not, that it would be of great importance for all of us to be aware of the concerns expressed by those in whose hands the future of academic cardiology is being entrusted.

Directors of cardiology were contacted and asked to nominate junior members of their staff to participate in such a conference. From more than 160 names submitted, 36 were selected and the conference was held at Pheasant Run, near Chicago.

During a preliminary plenary session the participants themselves chose five topics for detailed discussion from the more than 45 that they originally suggested. These five were:

Career Development for the Academic Cardiologist
Manpower Challenges in the Future of Cardiology
Cardiology Fellowship Training
Uncontrolled Proliferation of Technology
Interrelationship of Federal Government and Research

Having chosen these topics, the participants then reconvened in smaller groups. The topics were discussed for many hours and a preliminary report completed by the end of the weekend. Summaries of these reports were subsequently written and it is these that appear below.

What emerged during the plenary and other sessions? The younger academic cardiologist is as frustrated as his older colleague with the problems now being faced. Can academic cardiology remain an attractive career for the physician in training? Will there be available resources so that academic cardiology can be competitive with private practice? How can a very demanding academic career be entered into with no certain assurance for the future? Limited time for research, uncertain career planning and the vagaries of academic promotion were all felt to be areas of great concern.

Fellowship training was often haphazard and unstructured—too many individuals were being trained in a superfluity of programs, some of which were distinguished neither for the academic nor for the clinical training being provided. The role of the outstanding clinician within an academic center—a career clearly attractive to some of the participants—was felt to be a vexed one, as was the interaction between the researcher and clinician. Would a dual track training system help by defining an individual’s role early on as a researcher or clinician and providing training accordingly? Could this be achieved in proper balance without one or the other track being perceived as superior?

The permissive attitude toward the proliferation of technology was felt to be a matter of grave concern. While recognizing the importance of technological advances, participants were greatly concerned about introducing techniques into clinical practice before their usefulness had been fully appraised. Similarly, physicians familiar with certain diagnostic techniques were often loath to recognize that these methods had now become obsolete and should be abandoned. It was felt that the escalating cost of medical care demands a more critical attitude to diagnostic methods, as well as a careful assessment of costs and benefits.

Manpower needs for the future of the specialty were felt to require particular definition to prevent an excess of those trained as cardiologists with little outlet for their years of extra training. Geographic maldistribution of trained individuals might well worsen were the proliferation of trained individuals permitted to continue. It was noted with great concern that more and more basic research was being undertaken by Ph.D.s and less by M.D.s who were, in contrast, gravitating in greater numbers to clinical practice. A continuation of this could only weaken cardiology still further as an academic discipline.

But how is financial support for basic and clinical
research to be insured? Recent changes in funding policies by government agencies were viewed with grave concern. Alternate funding sources were badly needed. Improvements in clinical care follow painstaking careful research. It was proposed that it would not be unreasonable, therefore, to invest part of patient care funds into research activities.

These were just some of the topics the younger academic cardiologists discussed. As can be read in the following pages, many suggestions were made to improve the areas of concern. Herein lies the importance of the weekend of discussions. Problems and difficulties in academic cardiology abound as in any other specialty. There was, however, an unwavering desire to overcome these difficulties thereby to insure that academic cardiology remains an attractive and worthwhile career.

We should all take heed of the opinions expressed. We should consider them carefully, including the possible solutions suggested. We badly need a partnership between the older and more established physician and the younger academician to insure that academic cardiology will overcome its current problems and grow from strength to strength. The future of our specialty lies within the hands of those who attended the conference and the many similar thoughtful younger physicians who were not able to do so. Let us recognize problems where they exist and plan effectively for the future, permitting us to continue a tradition of outstanding and consistently improving clinical care, teaching and research.

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Career Development of the Academic Cardiologist

Chairman: Marvin W. Kronenberg, M.D., Nashville
Secretary: Stanley A. Rubin, M.D., Los Angeles
Participants: Floyd Atkins, Jr., M.D., F.C.C.P., Kansas City, KS; Paul E. Fenster, M.D., Tucson;
James D. Marsh, M.D., Boston; Michael B. Pine,
M.D., Long Beach, CA

There can be major rewards for a career in academic cardiology. The incentives to undertake and continue an academic career include: presence at the forefront of new, exciting developments in medicine, association with stimulating colleagues, re-examination of knowledge and values, direction of effort toward academic rather than financial goals, appreciation by society, and freedom of career choices.

However, there are important problems, which are dis-incentives. First, the private practice of cardiology can also deliver good-quality clinical care with considerable financial benefit. Second, the formative years for career development are difficult due to financial pressures (basic salary and research funds), limited time for research, uncertainties of career planning, and difficulties in promotion. Third, there is little participation by young cardiologists in decision-making. Fourth, there is a need for education in methods of administration, grant writing and teaching.

The committee identified several goals and remedies. Universities and cardiology societies should promote the achievements of the academic community to the public and to the government. The difficult formative years for the academic cardiologist should be eased by protected time for research, and more grants designed for the young investigator. A combination of grants and institutional funds should raise the salary scale of the academic cardiologist to levels which provide attractive alternatives to private practice. More grants for young investigators and a redistribution of wasted federal funds toward medical research would help pay for these changes. Unless this occurs, further numerical attrition can be expected; such attrition constitutes a national waste of talent and of the money previously spent on the development of each young cardiologist.

Young cardiology should be represented on all relevant decision-making bodies to provide this necessary experience. Promotions should be based on the quality of publications, not quantity. Finally, there should be continuing education courses aimed at teaching, administration, grant writing and instructional methods. American medicine will benefit by restoring the dwindling academic group who are responsible for research, teaching, and patient care in medical schools.

Marvin W. Kronenberg, M.D.

Manpower Challenges in the Future of Cardiology

Chairman: Craig January, M.D., Ph.D., Chicago
Secretary: Jeffrey L. Anderson, M.D., Salt Lake City
Participants: Jack P. Bandura, M.D., Ph.D., Memphis; Harold Dash, M.D., Hershey, PA; Robert E. Foules, M.D., Palo Alto, CA; John B. O'Connell, M.D., Maywood, IL

Future manpower needs in cardiology must provide for patient care at the highest level, yet be responsive to the economic impact of medicine on society.