In 1981 the Graduate Medical Education National Advisory Committee projected 70,000 excess physicians by 1990 and 145,000 by the year 2000. The Council of Graduate Medical Education (COGME) has recommended a 1:1 ratio of primary care physicians to specialists. The existing ratio is 1:3 and moving in the wrong direction. If only half the U.S. population were in a managed care health system by the year 2000, there would be a need for 49,000 more primary care physicians and a surplus of 90,000 specialists. These dire predictions, if even close to the mark, suggest that many specialists will function in the future as primary care physicians.

One model worth discussing is the multispecialty general medicine clinic. I was a participant in such a clinic in the late 1960s at the then Peter Bent Brigham Hospital in Boston. In each evening clinic there would be internists, a cardiologist, a pulmonologist, a rheumatologist, etc. For practical purposes, each subspecialty in medicine was represented in each clinic. Although there was some triage of new patients to an appropriate specialist, the majority of patients presented with general medical problems. If I encountered a gastrointestinal problem that I couldn’t handle, I would get a quick curbside consultation from the gastroenterologist in the clinic but still remain the primary caregiver. Similarly, I was consulted in this fashion on difficult cardiology problems. When this system worked well, it provided high quality care, delivered by one physician, and without the extra cost of formal consultations. It only worked well, however, if there was a willing and collegial relationship between all physicians in a given clinic. This model may be worth trying again.

A plethora of other approaches to solve the shortage of too few generalists have been suggested apart from numbers of physicians. For example, there are currently about 25,000 physician assistants (PAs) in practice. By the year 2000, this number will almost double. They can provide much mid and low level care for a variety of common ailments and thus free physicians for more difficult problems. They may be especially useful in rural systems of care, public health settings, geriatric care, correctional health systems and in university student health facilities. There are currently 30,000 nurse practitioners in this country, with 3,500 new graduates each year. They will continue to play an important role in education, nutrition, maternal and child health care, immunization, health screening, treatment of common diseases and injuries and management of chronic illnesses.

The Federated Council on Internal Medicine (FICM) recently took a strong stand to promote generalism in the medical schools and residency programs, reduce the number of subspecialists and more effectively use physician extenders. The FICM also recommended an increase in most subspecialty training from 2 to 3 years. They were supported for a commission to allocate subspecialty training positions with the hope of maintaining those programs that best trained physician/scientists.

It seems clear from all of the above that there are going to be changes in the ratio of generalists to specialists. It will be important for cardiovascular specialists to be an integral part of the evolution. Because of the magnitude of cardiovascular disease, especially in an aging population, it is important that our skills are appropriately used in a cost-effective manner. We must participate in this dialogue in a meaningful way at the national, state and community levels. The FICM adopted a definition of the general internist (1) that might well serve as a definition of the future “general” cardiologist. I have inserted “cardiologist” in place of “general internist” in the definition:

Defined as a specialist in the care of adults, the cardiologist combines the characteristics of a humanistic clinician, diagnostician, primary care physician, consultant, and expert in prevention, health promotion and continuing care, and in the management of patients with advanced disease. The cardiologist must be prepared to meet the demands of a
rapidly changing and complex health care system while serving as the patient's advocate, being a wise manager of costly resources and adapting to constant alterations in the medical practice environment.

Although many cardiologists may function as "general" physicians in the future, it is self-evident that our special skills will always separate us from the general "internist." Interventional cardiology and electrophysiology are but two examples of the special skills that will always play a role in the care of sick patients. It is unrealistic, however, for cardiology trainees to automatically assume that training in interventional cardiology will ensure a job in the catheter laboratories of the future. In any event, I am confident that we can function in a more general way as well as we do as subspecialists.

Reference