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Who Should Perform Cardiac Imaging?

Dear readers,

The controversy regarding who should undertake and report imaging investigations has been with us for many years and is ongoing. The increased complexity of imaging equipment, the wide range of imaging investigations and the depth of knowledge required to provide a comprehensive investigation service has strengthened the role of the radiologists and the economics of imaging has made the concentration of equipment and imaging staff into one department: this has been a key factor.

The complexity of and detail provided by modern imaging systems has also required radiologists themselves to focus on specific areas after the initial overall training in order to understand and respond to the requirements of clinical specialties. It is correct to say that radiologists need to understand the function and physiology as well as the anatomy and pathology of the body systems that they are imaging in order to provide a meaningful opinion in many disease processes and this must be incorporated into their training. In this sense, cardiology, the focus of this edition, is no different from other body systems. However, the debate in cardiology is compounded by the focused nature of the organ and the detailed knowledge required to understand its function.

In this cover story, the cardiologist makes the assertion that they have the expert knowledge of function and physiology as well as anatomy and have been doing most of the angiographic work over the last years, although this was developed by radiologists. The radiologist makes the point that cardiologists undertaking all the imaging through self referral increases the amount of imaging undertaken and thus the overall cost. The complexity and sophistication of all the different imaging modalities is highlighted by our third contributor.

Much of this equipment requires considerable investment, detailed knowledge of its physical principles and capabilities and a very detailed knowledge of anatomy and pathological features. The equipment is also used for multiple systems and not limited to the heart although some dedicated equipment is available. In management terms it is not a good use of resources to have multiple separate clinical departments with their own complex equipment used for their own purposes. It is also a challenge for clinicians to keep up with the technological developments and their own clinical developments while running busy clinical departments.

Ultimately for the patient, the important issue is whether the clinicians providing their care, whether they be cardiologists or radiologists, are properly trained and competent. This does mean that radiologists providing cardiac imaging must undergo subspecialist training following their core general training in order to understand the complexities of function and physiology as well as pathology and anatomy. The European Society of Radiologists (ESR) in conjunction with the European Society of Cardiac Radiologists (ESCR) are providing a number of subspecialist training fellowships per year to ensure that this happens.

The solution for the patient and the healthcare economy is for cardiologists and subspecialist cardiac radiologists to work closely together using the centralised complex equipment with the more versatile and relatively inexpensive ultrasound equipment being immediately available adjacent to the clinics.

If you wish to send your opinions and feedback regarding any of the articles within, please do so by emailing our Managing Editor at editorial@imagingmanagement.org

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