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Podcast_20230913: "Ivory Tower Cardiologists"

In a recent conversation about heart failure with preserved ejection fraction with a group of cardiologists in academia who are in full-time practice, I was told that I was suffering from the "Ivory Tower Cardiology Syndrome". When I inquired, what the terminology meant, I was told that there are two groups of cardiologists in academia and there is a major separation between the two. One group is in the full-time practice of cardiology and takes care of patients daily like those in private practice, and the second group is the "ivory tower cardiologists", who infrequently, if at all take care of patients and yet write guidelines, re-classify diseases, and tell those who are at the forefront of patient care how to practice medicine. My colleagues pointed out that "Ivory Tower Cardiology" has become a financially and academically rewarding trade operated by a select group of cardiologists who organize meetings, sit in the panels, write guidelines, and travel the world to lecture and receive honorariums. Because few if any have made original discoveries, the lectures are repetitions and review of the literature ad nauseam. There is also a subgroup of "ivory tower cardiologists", who serve as paid consultants to the industry but have not developed the scientific maturity to maintain their independent critical analysis of the data. These cardiologists redefine diseases to fit into the purpose of the research programs of the industry.

The comments of my colleagues, while disheartening, should not be dismissed as trivial. The comments remind me of Sir William Osler's statement: "To study the phenomenon of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." The former represents my colleagues who practice cardiology full-time and do not engage in research and the latter comprises those ivory tower cardiologists who are not involved in the patient care and yet write guidelines to tell the practitioners how to diagnose and treat patients.

The two groups must merge. Unfortunately, for financial reasons, many cardiologists in academic institutions simply function as private practitioners without being engaged in research. A major change, at least in the academic institutions, is needed. To begin, there must be no practitioner in an academic institution who is not involved in research, whether basic or clinical research. Likewise, there must be no investigator, clinical or basic researcher in a clinical department, who is not directly involved in patient care. The dichotomy in academic institutions is dangerously wide. Brave visionary leaders with the power to implement are needed to tackle this serious division. Until then, the problem of the imaginative world of the "ivory tower cardiologists" will remain remote and irrelevant to those who are at the forefront of patient care. The separation is consequential to patient care.

Sincerely,
Dr. Ali J. Marian
Editor-in-Chief of the *JCA*