Because cardiovascular magnetic resonance (CMR) methods are rapidly increasing in clinical importance, it is clear that in the era of healthcare reform, the certification of physician competence is essential. Fortunately, unlike nuclear cardiology in the United States, where a governmental agency, the Nuclear Regulatory Commission, is responsible for ensuring safety, thus playing a major role in clinical practice, magnetic resonance does not have such governmental oversight. Nevertheless, the procedures embodied by CMR are complex and diverse.

It is now clear that CMR has a tremendous clinical future and that industry has recognized its clinical importance and is emphasizing and marketing to cardiovascular specialists. Previous papers on CMR published as early as 1980 suggest considerable potential (1). For example, in patients being evaluated for coronary artery disease, a CMR study is capable of generating a series of images that allow assessment of regional and global ventricular function, myocardial perfusion, epicardial coronary artery anatomy and disease distribution, and myocardial viability. This would be the veritable “one-stop shop.” New innovative magnetic resonance systems with funnel-shaped openings and rapid acquisition times would reduce the incidence of claustrophobia. Future improvements in high-speed imaging should allow freeze-frame depiction of perfusion and of improved coronary angiography. Phosphorus-31 spectroscopic imaging should provide a means to evaluate myocardial viability. Magnetic resonance is the most versatile cardiovascular imaging modality for the future, yet it provides considerable information even at the present time.

A diverse group of professionals is generally involved in CMR studies, especially in the development of new methods. Chemists, biochemists, physicists, engineers, adult and pediatric cardiologists, cardiac radiologists, and cardiovascular surgeons are some of the many disciplines involved. It is indeed a complex technology, yet the newer imaging systems provide improved ease of use and more numerous applications. It is no wonder that many clinicians want to be active participants in CMR.

In view of the diversity of physicians interested in this discipline, there will necessarily be more than one approach to certification. For example, certification for the cardiologist is likely to be different from that for the radiologist. For example, board certification in radiology might be required for the radiologist, whereas cardiology board certification might be required for the cardiologist. In addition, a standardized subspecialty examination in CMR might be developed and used to ensure the appropriate knowledge and experience in both magnetic resonance and in cardiovascular disease. The Society of Cardiovascular Magnetic Resonance (SCMR) is attempting to fairly represent all physicians with an interest in the subspecialty of CMR. However, the politics of medicine could interfere with optimal application of CMR. In the best of all worlds, cardiologists, radiologists, and other physicians with appropriate expertise would be able to interpret these studies.

Of course, a strong knowledge in cardiovascular pathophysiology and biochemistry would be ideal for those clinicians involved in the new applications of magnetic resonance imaging and spectroscopy in patients with possible cardiovascular disease. With the amount of data that can be extracted from the multiple magnetic resonance approaches, the clinical and technical knowledge needed is complex. The problem is further confounded by the fact that HMOs and other third parties have restricted interpretations of such studies. For example, some HMOs have a policy of crediting only radiologists for interpretation of magnetic resonance studies.
This is a very narrow view and is not in the best interest of patient care. If patient care is important to such HMOs, the appropriate approach would be to credit the interpretation of these studies to physicians with experience and competence. With CMR, this would naturally include not only expert radiologists but also appropriately experienced adult and pediatric cardiologists.

One solution to this problem is to develop the certification examination process mentioned earlier for credentialing purposes. A board of examiners could include representation from each relevant discipline. The SCMR is presently considering the option of developing a certification examination. The Journal will keep you abreast of news related to the credentialing process.

A note about the present issue of JCMR. As with any new journal, there is a start-up period. The first issue was very successful and included the abstracts from the First Annual Meeting of the SCMR and a number of manuscripts, some peer reviewed and others invited. Without the abstracts and without the benefit of enough time for the first issue to have had its impact on manuscript submissions, the rate of manuscript submission was constant. Accordingly, the present (second) issue has fewer pages than the first. Nevertheless, I am now seeing the effect of the success of the first issue and the rate of submissions has increased remarkably. In conclusion, the Journal is off to a good start and the number of pages will increase to that of the first issue by the time of the publication of the third issue. This trend will continue now that the inertia of the early start-up has been overcome.

I would like to end this editorial by remembering a dear friend who was extremely helpful to Dr. Pennell and myself in bringing to fruition this new journal: Graham Garratt, who was a dedicated and beloved employee of Marcel Dekker, Inc., our publisher, also respected friend of Dr. Claude Lenfant, Director of the NHLBI. Mr. Garratt was referred to me to edit a volume of cardiovascular magnetic resonance. At about the same time, I mentioned to him the possibility of a new journal for a new rapidly evolving organization, the SCMR. While our finances were not great enough, he saw the great potential and enthusiastically supported our new journal. Had it not been for Graham’s enthusiasm, his very positive personality (the “you can make anything happen if you want it badly enough” type) and his organizational skills, the JCMR might not exist.

It is with sadness that I announce the untimely death of our most committed advocate. I know that he would be delighted by the journal that he helped to bring to fruition. In view of his contribution, I would like to dedicate this second issue of the Journal to the memory of our dear friend, Graham Garratt.

Gerald M. Pohost, MD, Editor

REFERENCE

Graham Garratt