INVASIVE THOUGHTS

Thoughts on the Future of the Interventional Cardiology Workforce

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As we enter the interviewing season for interventional cardiology training, there seems to be no dearth of ready, willing, and able physicians eager to join our ranks. Competition remains fierce, and the talent exceptional. Yet, I remain at times conflicted on where our field is going and whether we need more or fewer of us due to forces that have seemingly conspired against us. Let’s lay them out.

First, coronary volume nationally has declined, some say as much as 20% over the past several years. Although there are myriad reasons, chief among these are lingering concerns regarding late stent thrombosis and/or the risks of prolonged dual-antiplatelet therapy, high-profile yet still contested “unnecessary stenting” cases, recent large-scale yet poorly-generalizable trials indicating no survival benefit to PCI in stable CAD, having to place square-peg PCI into neat little appropriate-use criteria (AUC) holes, and then perhaps the improved medical therapy that has led to declining ACS incidence. I will admit, however, that I’m not entirely sold on this last one; certainly the impact of more efficacious medical therapy would not be evident quite so rapidly.

Second, there is the attack on reimbursement, with this year alone seeing a nearly 20% drop in payment for our most important family of codes: coronary stenting. And, this was despite the fact that both SCAI and ACC worked tirelessly to prevent further steeper cuts. Third, innovation and technology are fleeing the United States and moving to Europe and Asia. To wit, TAVR has been readily utilized in Europe for years, only reaching Australia and Asia. To wit, TAVR has been readily utilized in Europe for years, only reaching commercial availability in 2012 in the US, and we are just now ready to start the bioabsorbable stent trials while Europe has already been implanting them.

And finally, the job remains more stressful than ever, with door-to-balloon time mandates, additional value-based purchasing and PCI readmission rate limits, long hours even when we’re not on call, high-risk of malpractice litigation, and the increasingly complex subsets of patients we now see on a daily basis.

So, why enter a field where you will undoubtedly feel persecuted, the salary is decreasing, and where you can’t even get the new tools and techniques on time? And all this on a backdrop of ever-increasing medical school loans and taxes. I know what you’ll say. One should choose a specialty solely based on the personal and intellectual satisfaction you derive from patient care itself. And of course you get to save lives, and it is indeed true that those appreciative patients are the main reason I keep doing what I’m doing. But, I say it’s not enough in the long run. Eventually, the applicants to fellowship training will realize that there are plenty of other fields that are personally and intellectually gratifying without the stress, duty hours, malpractice concerns, general persecution and drastically declining remuneration. Anyone hear of the term “brain drain”?

Even worse, there are many interventionalists who feel that the solution to declining volume is to decrease the number of fellowship spots nationally. We are training too many, they say, despite the growth of structural, peripheral, and other ancillary procedures, such as renal denervation. Their solution to a decreasing pie is to decrease the number of slices. The problem with that, however, is that we expedite the death of our own field. We stop procreating.

So, how do we fight? What can we do to get interventional cardiology back on track? First, if we believe there is additional value to PCI beyond the ACS presentation, we need to find the data or fight for the appropriately designed trials to be done; that is, if we believe PCI improves quality of life in patients with angina, we argue and prove that it is an important endpoint and that it is indeed the case. If we believe ischemia reduction is beneficial, we must prove it, as with the upcoming ISCHEMIA trial. And, if we believe complex, multivessel PCI can improve ejection fraction or heart failure, as shown in PROTECT 2, we defend it. It’s hard to argue with solid and consistent data.

Second, we need to get all much more involved. We need to pay our dues to SCAI, the only society dedicated to our field, so that they can fight for our reimbursement and our viewpoints. They know how the machinery works behind the scenes, and having sufficient resources makes a world of difference. Third, we need to get the ACC to help, as we are all exquisitely interconnected; there is not much need for a nuclear stress test or CTA if only left-main disease and reduced ejection fraction are worrisome findings. Fourth, we need to get political. Medicare is bankrupt and docs are easy targets, especially docs who take care of the #1 DRG for both inpatient and outpatient services. Finally, we need to continue to innovate, convincing our friends in industry to keep the research dollars in the United States, fund new ideas and technology, and work with us to modify the antiquated Food and Drug Administration approval process to something more rapid and realistic. Nothing moves a field like breakthrough, irrefutable technology, and new techniques.

I’m writing this because I think we’re at a potential inflection point. We can cower and go quietly into the night, or we can stand up for what we believe to be true based on our day-to-day interaction with real-world patients. If we rally together, find the evidence we need, talk to our patients and politicians, donate to SCAI political action committee (PAC), self-govern our quality, and stand behind our society 100%, we may be able to preserve our field and even grow. Yes, I believe we can and should grow the pie, and not just in structural and peripheral intervention, but also in coronaries. And that would indeed be welcome news as I still have to respond to all those fellowship applications.

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