Is it All Downhill After Fellowship? Continuing Procedural Training for Practicing Physicians

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Following the completion of interventional fellowship in 2004, I started my career in an academic center armed with a comprehensive range of procedural skills. The early years as a faculty member consisted of developing my clinical expertise. I focused on growing my procedure base and developing a busy practice. Unfortunately, acquiring new procedural skills took a backseat.

Initially, the benefits and confidence from a high-volume training fellowship allowed me to progress swiftly in my academic practice. I tried my best to keep up with new devices and improved techniques as they became available. As I evaluated the technologies and techniques that piqued my interest, I realized that there was no clear path to obtain appropriate training and garner helpful feedback. Furthermore, there were no metrics to define proficiency, competency, or mastery.

In my mind, a clear irony was present: procedural disciplines are encouraged to continuously evolve and innovate, yet the current training mechanisms for this purpose are inherently flawed. The conversion of our practice from femoral to radial artery access for cardiac intervention serves as an illustrative example. My partner suggested we consider using the radial approach after observing cases at a European interventional meeting. As the “operations guy” in the department, I worked on the logistics of how to bring this technique to our center.

At that time, there were very limited educational opportunities, primarily supported by industry. Accepting industry funding to attend courses or to visit practicing physicians was not an option. I hoped to evaluate the technique in a less biased setting. The thought of seeking computer simulation was very brief, as I realized that it would not provide the haptic feedback of a real-life scenario and would only be applicable to part of the procedure. It became apparent that the most optimal way to learn this technique was to teach ourselves. The journey was slow and steady as we faced challenges commonly experienced by new operators. As the primary operators at our institutions, we were able to decrease the overall caseload so that we could focus, learn, and master this technique. This is a luxury many practicing physicians do not have.

Like anyone trying something absolutely new, there were multiple sources of frustration: process inefficiencies, “recreating the wheel,” and a lack of structured feedback. We reorganized our equipment inventory, changed our workflow, and began to innovate within this space. This incredible journey allowed our team to compile our experiences. Sharing them with trainees and physicians outside the institution only shed more light on the limitations of the current education system. We were fortunate to obtain unrestricted educational grants from industry to fund CME-approved courses. Separating pure, unbiased education from the natural influences of the grant sponsor was an implicit challenge. Open criticism is rare, but open endorsement impairs objectivity.

Current choices to learn new techniques include reading about it, watching other people perform it, attending an industry-sponsored training event, or going abroad to train with someone. Each method has limitations, ie, they’re unlikely to reach a large number of interested physicians, may lead to biased or non-uniform training experience, and might not address the important financial and medicolegal issues that are relevant to many physicians. Recently, I had the opportunity to develop a training program with one of our professional societies. This effort stemmed from comments made by many leaders in the field, who were searching for a method to distance the relationship between industry, learners, and themselves. Within this effort, I faced the challenge to garner the appropriate funds, provide relevant content, and create a sustainable education program. Objectively assessing the impact of such training on daily practice and outcomes remains a challenge. “With whom does the responsibility for training lie?” was the natural question we faced.

Creating an environment that is akin to fellowship training is likely the closest to the ideal situation. In this scenario, both the “trainee” and proctor are practicing physicians, but the proctor provides direct, hands-on training to a colleague. Both would be covered by malpractice insurance and reimbursed for their time. The trainee would not be penalized for seeking this time off and would be similar to educational time off. Specific metrics regarding each technique, such as time requirements and procedure volumes, could be defined on an individual procedure basis. Specific techniques that would be eligible for a training program could be identified from physicians in practice or their respective professional societies. These groups are positioned to also suggest potential proctors, educational content, and goals. Dedicated educational or training companies would coordinate the training at either the proctor or trainee’s site. Much work would have to be completed to fill in the details of such a program, but it holds the promise of providing much-needed training to a large number of practicing physicians.

In retrospect, I was naïve in thinking that I would always remain at the top of my field without a clear plan as to how I would learn new skills and incorporate them into my practice. Developing new techniques, improving older approaches, and incorporating new technologies are critical to the advancement of one’s career and the profession as a whole. We are at an important juncture in medicine today. It is imperative that we create a responsible, bias-free, and standardized program to disseminate procedural skills to practicing physicians. If we do not address this issue, we are all destined to start our careers at the top, only to be slowly left behind as our field evolves.

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