

## Interventional Pulmonology Employment Data An Important Milestone in the Development of the Field

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It has been a long road for interventional pulmonology in the United States. Over the last 2 decades, I have watched us move slowly from “What’s an interventional pulmonologist?” to “I do bronchoscopy, so I’m an interventional pulmonologist,” to the development of increasingly specific criteria for defining interventional pulmonologists. Along the way, the field has grown to include dedicated 1-year training programs and a board examination administered by the American Association of Bronchology and Interventional Pulmonology (AABIP) (1). The good news is that we are moving to a defined field with defined practitioners. The less good news is that we have some distance to go.

In this month’s issue of *AnnalsATS*, Lee and colleagues (pp. 549–552) have presented the first detailed survey of employment data for fellowship-trained interventional pulmonologists in the United States (2). They looked at a recent 3-year cohort of trainees to determine whether, once trained, they took positions in academic or private settings, whether they were employed primarily as interventional pulmonologist (defined as >60% time commitment), and the geographic distribution of these practices. Fifty-three fellows responded (88.5% rate), and 75% took academic positions, several of which were abroad. Most new growth was in academic centers. Five took noninterventional pulmonology positions. More joined existing practices, but some were asked to develop new programs. The field is predominantly male, but the number of female trainees is growing. Only 8 (15.1%) took positions west of the

Mississippi River. Rightly, the authors believe there is continued need for new program development and geographic spread, with the market not yet saturated.

I compliment Lee and colleagues for adding data to our understanding of the development, current availability, and future needs of interventional pulmonology. It is sobering to see the limited numbers and geographic distribution of interventional pulmonology training programs and practitioners in the United States. Interventional pulmonology is a maturing field but is perhaps earlier along the growth curve than many of us have realized. Viewed differently, these limitations can be seized on as an advantage, in that they allow for planned further growth of the field at a well-reasoned and deliberate pace. The question is not primarily whether there will be an adequate supply but, rather, can we support those supplied? And how should they be distributed?

How do specialized medical fields develop? What is the initiating spark, and what stimulates growth? A practice area takes root because there is a broadly perceived clinical need and because trainees take interest in meeting that need. As a young field grows, scientific interest is piqued, answers to questions are sought, and funding for research is obtained. Reimbursement for the activity sustains the field and largely determines the size of the practitioner community as it matures.

Similar to many other areas of medical specialization, interventional pulmonology took root within academic medical centers, initially in Europe and Asia, and later in the United States. Historically, academic

physicians have been somewhat freer and more incentivized to try new things. In academic medical centers, financial barriers were either less well emphasized or less well understood. Clinical volume and time commitments, and the drive to publish new ideas and information, gave enterprising clinicians an opportunity to push the envelope.

To the extent these observations hold true, we might expect expansion of a new field to start geographically close to those academic medical centers that pioneer in development of the field. Academic physicians try something new, trainees are exposed and trained, the trainees mainly move locally to practice, and acceptance spreads with them. It is then easier to grow where acceptance has been achieved. Academic programs may proliferate on the basis of publications, presentations, meetings, or faculty migration. From all of this, it is easy to see why Lee and colleagues found a propensity for interventional pulmonology training program graduates to remain in academic settings and to join established programs distributed disproportionately within limited geographic areas.

Where are we presently with interventional pulmonology? There is a growing clinical need. Although fully trained interventional pulmonologists deal with diverse pathology, lung cancer, the highest cause of cancer death in our society (3), dominates the field. Lung cancer screening, which is already accepted practice in some countries, is now coming online in the United States (4). Interventional pulmonologists are well positioned to provide the minimally

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invasive procedures for initial diagnosis and staging, restaging, and end-stage palliation of lung cancer.

Counterbalancing this clinical need, poor reimbursement for interventional pulmonology procedures in the United States places a burden on the institutions and practices that choose to support such services. The bottom line is that we have a burgeoning clinical need in an environment of dwindling reimbursement.

So where do we go from here? Because most interventional pulmonology procedures are performed in outpatient settings, that patient care can be regionalized to avoid duplication of effort and cost. Not every institution needs to offer the service or fund the technology. Further, the reimbursement for each procedure is currently so low as to minimize cost to society. Frankly, the poor reimbursement incentivizes appropriate procedure use, rather than financially driven procedure use. A potential upside of lower reimbursement rates is that rational decision making should then support regionalization to best handle the cost burden and optimize efficiency. We in the United States should follow the regionalized model used by many of our colleagues abroad.

There must be continued geographical spread of practitioners, not only in North America and Europe but also in the developing nations of the world, where population density is highest. Specialized centers should develop and be regionalized on the basis of care needs, avoiding duplication of efforts. I have always felt that interventional pulmonology lends itself to having the number of practitioners proportional to the population in a region. Future research could determine the optimal ratio. Once these numbers are determined, the interventional pulmonologists in a region could collaborate across institutions to best serve the regional needs. This would require institutions to move away from the current model of competition and ego. This is perhaps a pipe dream, but it is worth considering.

The future requires further formalization of training criteria and certification of programs. Major strides in this regard have been made in the United States by the AABIP and Association of Interventional Pulmonology Program Directors (5). Some advocate that the roles currently handled by these organizations should, if accepted, move to the American Board of Internal Medicine and Accreditation Council for Graduate Medical Education, as with other fields.

Perhaps this is best, but it is sometimes hard to see the benefit of ever-growing layers of bureaucracy.

In essence, we have reached the point of surveying the interventional pulmonology workforce. This is a good first step. The interest, scientific curiosity, and clinical need are present. The funding for training, research, and clinical reimbursement is less available. Looking forward, I see the relatively slow growth of interventional pulmonology as an opportunity for us to do things right. In an idealized world, once a clinical need is identified, it is met by the evolution of new technologies, appropriately trained practitioners, and continued optimization of care delivery. We should seek the safest, most efficacious, efficient, and cost-effective care possible. Interventional pulmonology lends itself beautifully to this model. We can further develop the field in the crucible of the new and ever-changing health care environment. True need can be met while minimizing costs. And applying innovative models and a scientific approach to analyzing new technologies can garner the respect the field deserves. ■

**Author disclosures** are available with the text of this editorial at [www.atsjournals.org](http://www.atsjournals.org).

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