Who Should Treat Vein Disease?

Defining higher standards for vein specialists.

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I've moved your mountains and marked your cards.
But Eden is burning, either brace yourself
for elimination
Or else your hearts must have the courage for the
changing of the guards

Bob Dylan, "The Changing of the Guards"

The question "Who should treat vein disease?" is difficult to answer, but in attempting to do so, we feel that "treat" is the key word to address. Vein disease treatment is largely procedure-based in 2012. With the exception of thrombotic complications, medications are rarely effective to treat vein disease, and compression stockings are only useful to manage symptoms; they do not treat the underlying disease. To adequately treat vein disease, today's vein specialists must be adept at all currently available minimally invasive procedures.

Because venous disease may involve the superficial or deep systems, lower or upper extremities, chest, abdomen, or pelvis, comprehensive knowledge and procedural skills are required for the vein specialist to feel comfortable treating the breadth of issues with which patients may present. Comprehensive knowledge can be acquired via instructional courses, textbooks, online study, etc., by all practitioners who manage vein disease. Comprehensive knowledge must be a given. However, procedural skill sets at this comprehensive level are usually acquired via advanced fellowship training in a procedure-driven specialty such as vascular surgery, interventional radiology, or interventional cardiology and may not be achievable by all. But many of today's vein care practitioners have evolved from nonprocedure-oriented specialties such as family medicine, internal medicine, dermatology, etc., and are only able to treat superficial venous disease. Herein lies the rub when trying to answer the question as to who should treat vein disease. The more pertinent question is, "Who should treat which type of vein disease?"

> We need to ensure that vein care be knowledge-driven, not procedure-driven.

EXPANSION OF THE VENOUS FIELD

What was once the domain of general and vascular surgeons has also fallen into the hands of anesthesiologists, dermatologists, internists, family practitioners, obstetrician/gynecologists—or, if one prefers, the "phlebologist." Phlebology traditionally encompassed the evaluation and treatment of superficial and perforating

WHAT IT TAKES TO BE A VEIN SPECIALIST

1. The knowledge, skills, time commitment, and experience to provide high-quality care to patients with a full spectrum of acute and chronic venous diseases affecting the superficial and deep veins
2. Credentialing via an ACGME-accredited training program and receive continuing medical education
3. Follow accepted clinical guidelines for prevention, prediction, evaluation, and management
4. "Own" the disease by performing venous research
5. Board certificate approved by a credentialed national organization (ABMS)

leg veins (not deep veins) in patients with spider and varicose veins or venous ulcers, using minor surgery or sclerotherapy.

The subspecialty of phlebology has been trying to find its proper place in our medical system for the past 25 years. Until that time, the field of phlebology was not even on the radar screen—and only a few physicians practiced it. However, soon after radiofrequency ablation garnered FDA approval in 1999, then laser ablation in 2002, the field of venous disease therapy officially embraced the minimally invasive revolution and boomed. The influx of specialists from many other fields of medicine swelled, and the landscape changed. Physicians who had never managed vein disease in the past now were doing so. Therefore, the question becomes, "How do we ensure that the right vein specialist is treating the right patient for the right reasons?"

Physicians who have completed a formal residency/fellowship approved by the Accreditation Council for Graduate Medical Education (ACGME) have a better chance of delivering high-quality patient care. The scope of a practice can only be determined by an ACGME-approved specialty board and a board certificate approved by a credentialed national organization (ABMS). ABMS certification is about training—not test taking.

Whereas hospitals have credentialing committees that grant privileges, there is no office equivalent. Once the treatment of superficial venous disease moved from the (regulated) hospital operating room into the (unregulated) physicians' office, an eclectic mix of medical specialties entered the arena of superficial venous disease. The unregulated office environment offered the proverbial "pot of gold" for performing venous work: short procedures, low risk, adequate reimbursement, and no oversight. Medical societies involved with venous disease, such as the Society for Vascular Surgery, American Venous Forum, American College of Phlebology, and Society of Interventional Radiology, have no oversight in the credentialing of physicians performing venous procedures in an office-based setting; almost anyone who wants to treat vein disease can do so in an office setting. This cannot be universally good for achieving optimal patient outcomes.

The vein specialist must have the knowledge to make the correct diagnosis, not just the technical skills required to ablate incompetent veins.

We are now at a point of critical mass, and government and third-party payers are increasingly examining high procedure volumes and indications for treatment. Physicians need to respond by hitting the standard-of-care reset button. In other words, we need to narrow indications, narrow the focus of clinical efforts, and raise the bar. If not, outside parties will do it for us. We need to ensure that vein care be patient outcome–driven, not procedure volume–driven. As an example, endovenous ablation of a 4-mm great saphenous vein with 1.2 seconds of reflux in a massively swollen leg has become commonplace, is clearly inappropriate, and illustrates a knowledge gap in the venous field. The vein specialist must have the knowledge to make the correct diagnosis, not just the technical skills required to ablate incompetent veins. He needs to treat the patients and not just their veins. He needs to not tolerate those physicians that treat any "abnormal" vein just because they can.

ACCREDITING THE VEIN SPECIALIST

The concerted efforts of physician leaders and venous-involved societies are driving us away from the term *phlebologist* and toward a newer definition of a *vein specialist* (see *What It Takes to Be a Vein Specialist* sidebar). Because the appropriate certification is being redefined for the future and will take time to implement, something more immediate should be considered (see *Who Benefits From Vein Facility Accreditation?* sidebar). If quality of care is the goal, perhaps accreditation and not certification is the answer. Accreditation may drive quality and efficiency. The Intersocietal Accreditation Commission is a nonprofit organization sponsored by 32 organizations with six divisions: vascular laboratories, echocardiography laboratories, nuclear

WHO BENEFITS FROM VEIN FACILITY ACCREDITATION?

1. Patients: Improved quality and outcomes
2. Physicians: Reimbursement
3. Payers: Reduced costs and improved efficiency

medicine laboratories, magnetic resonance laboratories, computed tomography laboratories, and carotid stenting facilities.

The Intersocietal Accreditation Commission Vein Treatment Facilities (IACVTF) had its inaugural meeting on June 4, 2012, and will develop standards determined by published evidence. Accreditation will be based on adherence to standards and risk-adjusted outcomes. Success is related to conditional reimbursement. The IACVTF is composed of eight sponsoring organizations: the American College of Phlebology (two directors), American Venous Forum (two directors), Society for Vascular Surgery (two directors), Society for Vascular Medicine (one director), Society for Vascular Ultrasound (one director), Society of Interventional Radiology (two directors), American College of Surgeons (one director), and Society for Clinical Vascular Surgery (two directors).

THE RIGHT SKILLS

It is clear that the treatment of deep venous disease requires different skill sets than that of superficial venous disease. Some areas of medicine, such as internal medicine and family practice, are not heavily procedure oriented. Although not impossible, it is hard to gain acceptable competency in advanced catheter/surgical techniques if one was not previously exposed to them during residency training. This differs from those who only need to "reawaken" these skills that were learned in training programs for vascular surgery, general surgery, interventional cardiology, and interventional radiology.

Just as there is a minor subset of physicians treating superficial disease without adequate training, there will be physicians attempting to treat deep venous disease without adequate skill sets. Pharmacomechanical thrombolysis, vena cava filter insertion/retrieval, venoplasty/stenting, and open thrombectomy require advanced formal training. We, as vein specialists, need to answer the question, "Who should treat which type of vein disease?" before patient outcomes suffer and adverse events occur.

If the management of deep venous pathology remains within the hospital setting, privileges and outcome assessment will be monitored. However, if the treatment of deep venous disease takes a similar path as superficial venous disease (ie, increasing performance in the unregulated office setting), significant quality-of-care issues could emerge. Already, self-proclaimed "interventional nephrologists" are performing procedures in private access centers (offices) under the auspices of an interventional radiologist with minimal oversight. Would patients be ideally served by self-proclaimed "interventional phlebologists" performing iliac vein stenting or vena cava filter insertion/retrieval in the unregulated or nonaccredited office setting? Of course not.

RAISING EXPECTATIONS

What we as vein specialists should expect of ourselves and our colleagues in 2012 is much different from what was expected in 2002. The understanding of vein disease has expanded. The bar has been raised, and the focus has narrowed. The concerted efforts and mutual cooperation of physician leaders, societies, and industry are driving us toward a clearer definition of the "vein specialist." What type of education and knowledge base do we expect? What procedural/technical expertise do we expect? Should everyone who wants to treat vein disease be allowed to? The answers to these questions will emerge, but we must think about the future before it becomes the present. We should not tolerate outpatient vein specialists treating superficial and/or deep venous disease without proper oversight. IACVTF accreditation may be the best route for the near future. We all want the right doctor to care for the right patient for the right reasons.

As Bob Dylan aptly states in his song, "The Ballad of Frankie Lee and Judas Priest":

Well the moral of this story,
The moral of this song,
Is simply that one should never be
Where one does not belong. ■

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