Commentary: The train has left, but Elvis is still in the station

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A good decision is based on knowledge and not on numbers.

—Plato, *Laches*

Readers of the *Journal* will find interest in the treatise in this issue by Nguyen and colleagues¹ on the need to revamp cardiac surgical training to address the disruptive advancement of catheter-based technologies in structural heart disease. The passion of Nguyen and colleagues¹ is evident in their use of phrases such as “burning platform” and “call to action,” along with the admonition that failure to address inadequacies of surgical training “will exclude surgeon involvement in the future.” I compliment Nguyen and colleagues¹ on bringing this discussion to the *Journal*, but I also raise the concern that the authors have significant conflict of interests.

Nguyen and colleagues¹ ask to what extent any individual adult cardiac surgeon should be proficient in catheter-based therapies. In an unspoken renouncement of the heart team, they state surgeons are uniquely positioned to offer the full spectrum of therapy in structural heart disease. This is an inward-looking view that ignores the catheter-based training and expertise of the interventional cardiology team, which in most cases is 5 years—an extensive experience that must be weighed against the 6 to 12 months recommended for surgeons in the proposed training paradigm.

The American Association for Thoracic Surgery is quite clear about the importance of the heart team.² The 2018 Consensus document (of which J. E. Bavaria was lead author) states, “One of the cornerstones of the success of transcatheter valve programs is partnering between cardiologists and cardiac surgeons, the underlying principle being that no one individual, group, or specialty possesses all the necessary skills for optimal patient outcomes. The success of these programs depends on a group of professionals, each with their own skillset, working together to provide the best possible patient-centered care.”² The heart team is a good thing, and it must persist.

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Central Message

Catheter-based skills are probably best learned within the confines of the local heart team. Proficiency can be achieved. The contribution to the surgeon is to the betterment of the heart team.

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I also believe that surgeons need better training in catheter-based therapies to add value to the Heart Team. Nguyen and colleagues¹ state that lack of a standardized curriculum and training programs is a major factor keeping surgeons from obtaining the necessary catheter-based skill set (see their Table 1). I submit that their statement ignores the programs listed in Table 2 of their article.¹ The lack of standardization is not limited to catheter-based therapies, however, as the only really standardized aspect of cardiac surgery training in general is the required case numbers put forth by the American Board of Thoracic Surgery.

Surgeon-specific training in catheter-based skills is a smart ideal. The question is how to achieve that end. Is the answer to be found with legislated minimal case number requirements or training paradigms? Exposure is not expertise. Not all surgeons need catheter-based skills, just as not all surgeons need ventricular assist device skills. I have participated in the advance case planning and the procedural and postprocedural management of 900 of my institution's 1500 transcatheter aortic valve insertions. I have found that the overarching rule to success is deliberate practice within the confines of the heart team.³ That is best done at the local level. And, unfortunately, it probably can't be legislated.

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