Kidney Biopsy Training and the Future of Nephrology
What about the Patient?

Robert S. Brown

In the literature, including in the *Clinical Journal of the American Society of Nephrology*, there have been several recent articles on the role of the kidney biopsy in the training of nephrology fellows (1–3). Considerable discussion has focused upon whether every nephrology fellow in training should be required to competently perform the percutaneous kidney biopsy as currently demanded by the Accreditation Council for Graduate Medical Education (ACGME) (4) and the American Board of Internal Medicine (ABIM) (5). In general, the arguments in favor of maintaining this requirement have centered on the importance of the kidney biopsy to nephrologists and the need to keep the biopsy in our domain, in part to bolster the declining interest in our specialty among medical students and residents (1,3,6). The counterarguments that kidney biopsy performance should no longer be a requirement for nephrology certification are that about 65% of practicing nephrologists do not perform biopsies (2,6), the standards for evaluating biopsy competency of graduating fellows are not defined despite the risk of the procedure (7–9), and in two recent surveys of United States nephrology training program directors, 45%–51% thought that biopsy competency should not be required for fellowship completion (2,10).

Of note, there is no mention in this discussion of our patients or of the effect that maintenance of this requirement has on their risks and quality of care. Yuan et al. (2) reported that the median number of native kidney biopsies performed per fellow in their program was only four in 2016–2017. It is well recognized that experienced proceduralists have lower complication rates than those doing only a few procedures or their first four procedures. When surgical residents do their first surgeries, it is in the setting of training for a surgical practice for almost all of these residents. How can we defend exposing patients to the increased risk of a trainee when two thirds of them will never do another kidney biopsy in practice? Further, if some fellows could elect to forego biopsy procedural training, those fellows wanting to do procedures will do more biopsies and be better qualified at graduation. One report noted the interesting finding of an increase in the biopsy rate when the program elected to open referral to interventional radiologists by their nephrologists to save the nephrologist’s time (1,2), raising the possibility that, previously, some indicated biopsies were not being performed. Moreover, the performance of biopsies by nephrologists or interventional radiologists appears to have similar outcomes regarding adequacy of tissue and complications (2,3).

Having just completed 6 years as the Chair of the Beth Israel Deaconess Medical Center’s Credentials Committee, the Committee and I had to ascertain the competence of those on our professional staff requesting procedural privileges. I found it uncomfortable dealing with training program directors waiving over the certification of procedural competency, and unfortunately, most of this uncertainty appeared to be in the medical specialties. The training program directors are faced with the need to certify procedural competency for ACGME graduation and ABIM certification whether they are assured of the fellow’s ability or not. I doubt that there has been a single fellow that was not allowed to complete the fellowship because of inadequate kidney biopsy technique, yet in two surveys, 16% of training program directors thought that their fellows were not capable of independent biopsy performance (10) and 17% of the fellows admitted to inadequate biopsy preparation (2). If we are to maintain requirements for procedural competency in the medical specialties, we need to set minimum standards for our training program directors to follow in certifying their graduates (7–9). Then, it only makes sense that there should be a pathway for fellows to graduate who are not interested in performing procedures to meet those standards. Certifying those lacking procedural competency is unfair both to them and those who are competent. Suggestions to develop evidence-based standards for competency have been made repeatedly over the past decade (7–9), but the ACGME and the ABIM requirements remain unchanged despite knowing that there are inconsistencies in the procedural certification process.

Patients who undergo biopsies by trainees deserve to know that these procedures are really needed for training to perform them in the future, not to take an examination. And patients who undergo procedures by privileged specialists need to know that those specialists meet reasonable standards of competency. That is not always true now, but it should be!

Acknowledgments

The content of this article does not reflect the views or opinions of the American Society of Nephrology (ASN) or the
Disclosures
None.

References