T here was a time when clinical investigation could coexist in academic medical centers with basic scientists and full-time clinicians. Not anymore. With the intensified emphasis on bottom-line efficiency, value-based health care, reduction in variation, and declining margins, the ability for clinical heart failure investigators to exist has diminished significantly over the past decade. There are a number of possible explanations for this.

First, we have seen a reduction in the ability to train our fellows in clinical investigation. There is no longer time that can be spent with mentors protected from clinical duties for prolonged periods of time. It is a rare event that 1 to 2 years of protected time are allowed in clinical training programs for heart failure-oriented fellows. A reduction in funding for fellowships from external sources has forced program directors to emphasize the clinical rotations, the coverage of significantly expanding heart failure services without the commensurate balance of protected time for training, learning, and investigation. The transition from fellowship to faculty has become equally daunting for the clinical investigator. No longer does the discussion with the program directors and the division chiefs focus on academic output, and protected time; pro formas are now created beginning with relative value units, clinical full-time equivalents, and how will the salary be accounted. Rarely is there a discussion about a clinical investigator’s package to support unfunded activities prior to receiving external funding. As the clinical investigator moves through the ranks of academic medicine, continued pressure is applied to cover the salary and obtain funding from limited sources while maintaining larger and larger panels of patients, rounding services, and outreach activities. The coalescence of these forces has resulted in the significant diminution of clinical heart failure investigators. In a recent analysis of our journal submissions, two-thirds of the academic medical centers in this country are not represented with a single publication. Furthermore, the over 100 independent academic medical centers have even less representation of clinical investigation in JACC: Heart Failure. As health systems consolidate across the country so does the survival of heart failure clinical investigators into the programs that are able to have the vision, mission, and the economic support to develop this dying breed. In a recent interview with a clinical investigator at a top 20 academic medical center, he described his 26 weeks on the rounding service with an average census of 20 patients and consults; on the weeks he was not rounding, he was expected to participate in outpatient clinical activities for 9 one-half days per week and the remaining one-half day were protected time to do his clinical research, writing, submissions, participation in clinical trials, recruitment, teaching, and administrative duties. This month’s issue of JACC: Heart Failure is dedicated to the clinical investigators who continue to push through, despite reductions in resources and protected time to do this important work.

Does the death of the clinical heart failure investigator reflect the academic leaderships at the dean level not understanding the importance of this species? In a retrospective analysis of the past 30 years, contributions of smoking cessation, diet, exercise, psychosocial risk factors, systems engineering approaches, such as time to treatment and early
follow-up, have resulted in a greater reduction in morbidity and mortality of heart failure patients than have many of our novel molecules and receptor antagonists. As a community of heart failure clinicians and investigators, let’s put forth initiatives to save the bald eagle of heart failure: the clinical investigator. Why? Because it is what our patients deserve, a better quality and quantity of life through clinical investigation.

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