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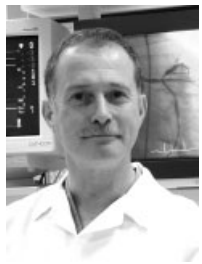

Meetings, Meetings, More Meetings. . . Are There Too Many Interventional Meetings?

Ted Feldman, MD, FSCAI
Evanston-Northwestern Healthcare,
Evanston, Illinois
President
Society for Cardiac Angiography & Interventions

Meetings, meetings, more meetings. . .

Each week there is at least one national or international cardiology meeting. There is a dedicated interventional meeting almost as frequently. When regional and local meetings are considered, the numbers grow still larger. Add local dinner talks and weekend symposia and there is a CME program almost daily. The number of meetings has continued to increase while the constraints on healthcare spending have become more stringent. The time and resources devoted to these meetings are remarkable.

What is the purpose of all of these meetings? Most broadly, education is the major objective. Many types of education are transmitted by meeting activities. Cutting edge techniques and technology in live case demonstrations, basic research results and techniques, broad clinical review, board review, and some of the indefinable information that is transmitted only in the corridors or of the lunch breaks among colleagues. All these represent the menu of offerings that make meetings so continuously varied and engaging. For the interventional physician, there a critical need for updates on trial results, and on the proliferation and refinement of interventional equipment. Equally vital is the informal exchange of information regarding procedure technique that can only come from face-to-face interaction with our colleagues.

Numerous other agendas are served by the various meetings. For many years education translated to cutting edge demonstrations and lectures. Some meetings seemed to showcase what most of us would never do, rather than what we should actually do or learn about. The introduction of the Interventional Board exams has changed our focus, and meeting content has consequently become more balanced. Review material has taken a major role in many meetings in response to the importance of core curricula.

It is hard to imagine how so many meetings can be sustained. The resources necessary to put on even small regional or local meetings are substantial. Very roughly, an interventional program costs about a thousand dollars per person per day or two. The use of live case transmissions is a major contributor to these costs, and even

*Correspondence to: Ted Feldman, MD, FSCAI, Evanston Hospital, Cardiology Division-Burch 300, 2650 Ridge Ave., Evanston, IL 60201. E-mail: tfeldman@enh.org

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without case transmissions, the meetings are phenomenally expensive. The cost of the meeting place, food, syllabus materials and expenses for faculty add up very rapidly. The costs to prepare presentations and live cases is also great, though not part of the direct meeting budget. The overkill in meetings is demonstrated by the often declining audience size as the day wears on. Morning enthusiasm may be transformed into a half empty meeting room by mid-day.

Who pays for these meetings? The cost of meetings is only marginally subsidized by registration fees. Unrestricted grants from industry are the major source of funding. It is remarkable that an industry is able to continue funding so many meetings. It is as remarkable that we attend as many of them as we do. Some of the larger meetings keep growing, despite the newspapers telling us that travel has declined.

Who benefits from these meetings? Our quality of practice is highly dependent on the dissemination of new technology. Our field has probably the most rapid rate of change in all of medicine. A colleague recently remarked that when he returns from a 2-week vacation, he feels completely out of date and needs to depart again for a meeting to catch up. The transmission of real practical approaches to interventional problems is as much by word of mouth in the meeting corridors and lunchrooms as it is by lectures and case demonstrations. The globalization of interventional practice has been part of the field since international training meetings with live case demonstrations were pioneered as PTCA was pioneered by Andreas Gruentzig.

Why not have teleconferences? I have repeatedly gone to the "web" to sample teleconference offerings. Even when the speaker is a well-known colleague or friend, I see a familiar face lip syncing to his or her own voice, and find the experience difficult to watch. I am easily distracted by the phone ringing, people coming and going from the office, and all the paper that accumulates on our desks. Web casts are developing, but are not really there yet as a substitute for the experience of the live speaker.

There are many measures of meeting success. The number of attendees, the amount of support from industry sponsors, the number of abstracts submitted, and importantly, the impact of a meeting on changes in practice and possibly even on patient outcomes.

How can we choose which meetings to attend? While each of us would benefit from going to many meetings each year, our commitments to patients, partners, and family force us to make some choices. In deciding on which meetings to attend, I can share my personal experience.

Overall, the meetings I have enjoyed most consistently are those that the SCA&I puts on every May. The mix of cutting edge development, case material, review and most importantly, collegiality distinguish the SCA&I meeting from many others. The size of the meeting is ideal. There are not so many people that every interaction is brief and superficial and not so much going on that you cannot actually participate in the meeting. The attendees are all committed interventional physicians. The informal conversations are rewarding and ultimately lead to the kinds of collegial relationships in medicine that make the interventional community unique. I especially enjoyed last year's annual meeting in Seattle, the largest and most exciting we have had to date, and I look forward to this spring's meeting in Boston with equal enthusiasm.

The choice of which meetings to attend is made easy by the special mix offered by the SCA&I annual meetings. See you in Boston, May 7-10, 2003!

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