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vidence is mounting in support of stenting in unprotected left
main coronary arteries, leading interventional cardiologists
to call for revision of clinical guidelines that have thwarted
adoption of the procedure in the United States, even as it has become
commonplace in other parts of the world.

“Left main PCI has been a taboo in the U.S. for many years,” said
Ted Feldman, M.D., FSCAI, director of the cardiac catheterization
laboratory at Evanston Hospital in Evanston, IL. “We now have
a lot of evidence that left main PCI is at least safe. And the
SYNTAX trial results make it clear that certain types of
patients can do very well with this procedure.”

Not everyone agrees with that viewpoint. Although new
data raise interesting questions about an expanded role for
percutaneous coronary intervention, they are a long way from
being definitive, said Michael Mack, M.D., a cardiac surgeon
and director of cardiovascular medicine at The Heart Hospital
Baylor Plano, in Plano, TX.

(continued on page 6)
SCAI Partners with Mended Hearts to Support Cath Lab Patients

When his father had quadruple bypass surgery last year, J. Jeffrey Marshall, M.D., FSCAI, of the Northeast Georgia Heart Center saw first-hand how valuable patient-to-patient education and support can be. Volunteers from the patient advocacy group Mended Hearts stopped by to visit his dad before and after surgery.

“They eased his mind as best they could as he faced this big operation and then afterwards reassured him that he would be feeling a lot better soon,” remembers Dr. Marshall. “These folks do a great job of helping people before and after revascularization via surgery.”

Now SCAI and Mended Hearts have launched a pilot project that will bring that same kind of support to cardiac catheterization patients. At five sites around the country, interventional cardiologists are supporting Mended Hearts chapters’ expansion into working with this new population. After a few months, an evaluation will identify what works and what doesn’t. Dr. Marshall’s prediction? “I see this spreading like wildfire,” he says. “This is a great service for our patients and a great partnership opportunity for SCAI’s members.”

Patient-to-Patient Support

Mended Hearts has been sending volunteer “visitors” to provide education and hope to patients and families for more than 50 years. Drawing on extensive training and their own experiences, Mended Hearts chapter members are active in 460 hospitals and rehabilitation clinics. They visit patients, hold support group meetings, and sponsor educational events.

The pilot project with SCAI will allow Mended Hearts to expand its efforts to reach the growing number of patients undergoing cardiac catheterization. And by doing so, says Dr. Marshall, they’ll help interventional cardiologists solve a challenging problem—convincing cath patients that they need to change their lifestyles and stay on their medications.

“Hearing from somebody who’s actually living it—someone who has had an angioplasty and changed their lifestyle—can be much more motivating than some cardiologist telling you to do it,” says Dr. Marshall.

That’s what happened to Steve Stanko of Las Vegas, NV, a long-time Mended Hearts volunteer who is chairing the new cath patient outreach project along with Dr. Marshall.

Together Ms. Larson and Dr. Bailey hope to reach younger patients in particular.

“People in their 30s, 40s, and 50s are being diagnosed with heart disease and often think that because they got stents they’re cured,” says Ms. Larson. “What Dr. Bailey is trying to do is get people educated about heart disease, to let them know that they’re not cured. They’re living with heart disease.”

SCAI Helps Mended Hearts Launch New Chapter

After Catherine Case Larson of Austin, TX, had surgery to correct a congenital heart defect in 2002, she was desperate to talk to others who had experienced valve replacement. That search led her to the patient-to-patient support group Mended Hearts — and a whole new mission in life. Today she is assistant regional director for the group’s Southwest region.

One of her goals is to revivify the San Antonio Mended Hearts chapter. And to do that, she’s working with SCAI President Steven R. Bailey, M.D., FSCAI, who is Chief of Cardiology at the University of Texas Health Sciences Center. “He really wants this to happen!” says Ms. Larson.

Dr. Bailey has joined Ms. Larson in welcoming members to the new chapter at a kick-off event and invited the chapter to launch a visitation program in his cath lab’s waiting room. The chapter will also hold its meetings at the center, which will facilitate his goal of inviting members into the cath lab itself for a tour. Dr. Bailey has even suggested a patient of his to head up the chapter.

Together Ms. Larson and Dr. Bailey hope to reach younger patients in particular.

“People in their 30s, 40s, and 50s are being diagnosed with heart disease and often think that because they got stents they’re cured,” says Ms. Larson. “What Dr. Bailey is trying to do is get people educated about heart disease, to let them know that they’re not cured. They’re living with heart disease.”

A Win–Win Collaboration

SCAI’s pilot project will take place at five sites:
Walnut Creek, CA; Munster, IN.; Arlington Heights, IL.; Lynchburg, VA.; and Dr. Marshall’s hospital in Gainesville, GA. The Northeast Georgia Heart Center won Mended Hearts’ 2009 Hospital Award.

At each site, the participating cardiologist will work with the hospital to facilitate volunteers’ access to patients. They may provide a private space for patients, families, and volunteers to meet. And they encourage their patients to meet with a volunteer and read a co-branded brochure developed specifically for the project and titled, “Life After Angioplasty.”

Dr. Marshall has even brought Mended Hearts volunteers into the cath lab to watch procedures as a way of supplementing their training. “Many of them have had the procedure, so they’ve seen it from the supine position,” he says. “Now they’re seeing it from the standing position.”

The chapters will collect data on the number of patients visited, barriers faced, and what percentage of patients attend a Mended Hearts meeting or join the organization. SCAI and Mended Hearts will make any adjustments necessary to the program and brochure, then introduce both on a wider scale in early 2010.

In the meantime, Dr. Marshall is convinced that collaborating with a patient advocacy group like Mended Hearts will help both organizations in their fight against heart disease.

“As cardiologists face more and more pressures, we’re going to have less time to do the teaching we want to do at the bedside,” says Dr. Marshall. “We’re going to need some help, and who better to help us than these volunteers?” Collaborating with patient groups will also strengthen advocacy efforts, he adds. “This type of partnership is the future for SCAI,” he says.

To learn more about SCAI’s collaboration with Mended Hearts or to participate in the program, contact SCAI at 800-992-7224 or email kbdavid@scai.org.

Interventionists Can Help Heart Patients Avoid the Flu

In the coming months, an important step interventional cardiologists can take to support the well-being of their patients may be among the simplest: encouraging patients to receive a seasonal flu shot. Currently, an estimated 40 percent of adult patients who have heart disease do not receive an annual influenza vaccination. As an increasing body of evidence suggests that influenza can increase complications in patients with cardiovascular disease, including triggering myocardial infarction in some patients, the medical community is stepping up efforts to educate both patients and physicians about the repercussions heart patients risk if they skip the flu shot.

The American College of Cardiology (ACC) and the American Heart Association (AHA) issued an advisory statement on flu vaccines in 2006. “Once that came out,” says Jeffrey Cavendish, M.D., FSCAI, an interventional cardiologist for Kaiser Permanente in San Diego, “more and more evidence came out, with some trials looking at this closely in terms of what the flu vaccine or preventing flu does for patients, and there is good evidence that it prevents cardiovascular events—both morbidity and mortality.”

Next came the 2007 update to the ACC/AHA/SCAI 2005 practice guidelines on PCI, which added the influenza vaccine as a recommendation for patients (see Table XVII at http://www.scai.org/PDF/2007PCI-update.pdf). Most recently, an article in the October issue of The Lancet Infectious Diseases analyzed 39 heart patient studies and found a significant link between influenza and myocardial infarction in patients with existing cardiovascular disease.

Steven Fera, M.D., FACC, a cardiologist and president of the Rhode Island Division of the AHA, sees this study as firming up data that had been soft. “The evidence is shaping up that this really is important—more important than we thought,” he says.

Dr. Fera is working with the patient advocacy group Mended Hearts, Inc. on “I Heart Flu Shots,” a patient education campaign with the goal of increasing the number of heart disease patients who get vaccinated for the seasonal flu. (To download the communication from Mended Hearts President Raul Fernandes to the group’s members, visit http://www.SCAI.org, or check out the patient education website at www.IHeartFluShots.com.)

Mr. Fernandes knows that heart patients have many concerns, and getting a flu shot may not make the top

(continued on page 4)
Avoid the Flu (cont’d from pg 3)

What About H1N1 Swine Flu?

This year, the seasonal flu has been largely overshadowed by concern about the H1N1 (swine flu) virus. What are the risks presented by swine flu for PCI patients? And what are the practice implications for interventional cardiologists?

“It’s certainly a common question from patients this year,” says Dr. Cavendish. “I’ve been telling patients that they probably should get vaccinated for HINI. It’s a flu, and you want to prevent all forms of flu.”

Still, Dr. Cavendish tempers his recommendation by acknowledging that the H1N1 vaccine is new, and questions remain about its availability this year. “We are going to have to see what the firm recommendations are, as far as who the most at-risk patients are for the swine flu and who should get the vaccine,” he says.

As of press time, the Centers for Disease Control and Prevention was recommending that, as a front line, pregnant women, children, and health care workers receive the vaccination. Because the H1N1 strain has most seriously affected children, older heart patients should keep their focus primarily on the seasonal flu, says Dr. Fera. “I think it is important that we don’t get so distracted with concern about the swine flu that people wait on their vaccines until the swine flu vaccine becomes available,” he says. “The real threat, and very well-proven threat, for older patients with cardiovascular disease is the seasonal flu, and that should be our first priority. Over the next two months we should learn more about the impact of H1N1 in older individuals. And these observations are likely to define the importance of the H1N1 flu vaccine for adults with chronic diseases and the elderly.”

of their list of priorities. “Many may not be aware that getting a simple flu shot can help protect them from serious complications associated with this common disease,” he says. Complications related to influenza in heart patients can include inflammation, secondary bacterial and viral infections, and myocardial infarction.

Some of Dr. Cavendish’s patients see him weeks or even months before their next scheduled appointment with their primary care physician, which is why he also urges patients to get vaccinated while they are under his care. At Kaiser Permanente, the cardiology clinics are set up as a “one-stop-shop” for patients who would like to receive an influenza vaccine right away. “I think as interventionalists if we can have the flu shot available in our offices or clinics, that would be great; if not, then just making sure our patients are considering it or planning on getting it is important,” he says.

In addition to PCI patients, the seasonal flu vaccine is recommended for most heart patients. Patients should be vaccinated by injection, rather than intranasally, because the “flu mist” contains live virus.

It is also important to note that the flu shot is contraindicated for patients who have had a severe reaction to the flu vaccine in the past, including Guillain-Barré syndrome, or who are allergic to chicken eggs. Patients of all ages can receive the vaccine, including children. According to SCAI Immediate Past President Ziyad M. Hijazi, M.D., MPH, FSCAI, pediatric interventional cardiologists recommend that most children with congenital and structural heart disease receive the annual influenza vaccination.
these concerns and was urged to not include this highly suspect data until it could be validated. Unfortunately, CMS has not acted upon this information."

CMS is knowingly ignoring the previous data quality standards set by legislation and regulation regarding practice expense data (Public Law 106-113; SEC. 212, dated 11/29/1999), asserted Dr. Babb. “We believe CMS’s failure to apply the data quality standards required for the Supplemental Survey data to PPIS and to use these data despite the concerns raised regarding their validity is an abuse of CMS’s discretionary authority.”

CMS is now going on three years without a permanent, congressionally confirmed administrator, leading many to suspect that the lack of a permanent appointee has resulted in a void of accountability for the decisions made by the agency.

**Strategies for Halting the Cuts**

SCAI’s conference call focused on SCAI’s strategies for halting the cuts as well as what members can do to try and effect change before the cuts go into effect. SCAI Advocacy Committee Chair Mark Turco, M.D., FSCAI, detailed legislative and potential legal plans to combat the cuts and defined what SCAI is asking Congress to do, namely:

1. Demand that a permanent CMS Administrator be appointed.
2. Immediately instruct CMS that any data used in setting practice expense reimbursement rates must adhere to the congressionally mandated standards previously set in regards to the supplemental surveys.
3. Direct CMS to conduct a new practice expense survey or create a mechanism for the submission of practice expense data that adhere to the quality standards previously mandated by Congress.
4. Continue to work to identify a Senate or Congressional bill sponsor who will support the above legislative actions. The bill would ask for immediate congressional action to the proposed CMS action until further data are obtained as it applies to cardiology.

**SCAI Answers Members’ Questions**

A significant portion of SCAI’s conference call was devoted to questions and answers, opening frank dialogue with Society leaders and the membership. A panel composed of Steven R. Bailey, M.D., FSCAI, Joseph D. Babb, M.D., FSCAI, Ralph Brindis, M.D., FACC, FSCAI, Mark Turco, M.D., FSCAI, and Carl Tommaso, M.D., FSCAI, fielded an array of questions.

Several members asked whether they should continue to accept Medicare patients in light of these cuts. Dr. Turco responded: “This is actually a complex question. There are actually several options practices may consider, and SCAI cannot and does not advocate for any particular option with each practice having to make its own determination as to what is best for their patients and their practice.”

SCAI provided education on the barriers and potential implications for the options available to members, including becoming a non-participating Medicare provider, opting out of the Medicare program altogether, or electing to refuse to see new Medicare patients.

**Non-Participating** – Non-participating providers are subject to a “limiting charge” in billing Medicare patients. The limiting charge for assigned claims is 95 percent of 115 percent of the Medicare Physician Fee Schedule (MPFS) allowed amount, which is less than 110 percent of the reimbursement rate for participating providers. For non-assigned claims, the limit is 115 percent, but Medicare payment is made directly to the patient and the provider must collect the full amount from the patient. Increased administrative costs and bad debts need to be carefully considered before pursuing this option.

**Opting Out** — Electing to completely “opt-out” of the Medicare program requires individual contracts with all patients, and providers must ensure that no claim is submitted to the Medicare program for their services. This means patients receive no remuneration from Medicare for those services and must absorb the entire cost themselves.

**Refusing to Accept New Patients** — Under the Medicare program, providers are not required to accept and schedule new elective patients at their offices, so refusing to accept new patients does not impact existing contractual relationships with Medicare. However, this option would have an impact on office revenues and should be discussed carefully with the practice administrator.

For more detailed information regarding these options, email dhopkins@scai.org
“I’m open-minded about it, but sometimes the interpretation of evidence gets a little too enthusiastic and a little too ambitious,” Dr. Mack said. “Although there’s some promising data, you can’t come to a conclusion too soon.”

Positive findings from several meta-analyses and the large MAIN COMPARE registry set the stage for what has been a lively debate about the role of PCI in an unprotected left main coronary artery. But it’s the two-year results of the SYNTAX trial that many interventional cardiologists consider most compelling.

In the overall SYNTAX trial, 1,800 patients with three-vessel or left main coronary artery disease were randomized to undergo coronary artery bypass grafting (CABG) or PCI with Taxus drug-eluting stents. About one-third of patients in each treatment group had left main disease. An analysis in the left main subgroup showed that, overall, there was no significant difference in rates of major adverse cardiovascular and cerebrovascular events (MACCE), nor in individual rates of death and myocardial infarction (MI), with CABG or PCI. However, the rate of stroke was four times higher in the CABG group when compared to the PCI group (3.7% vs. 0.9%, p = 0.01), while the rate of revascularization was significantly lower (10.4% vs. 17.3%, respectively).

A telling pattern emerged when patients were divided into terciles by SYNTAX Score, an index of coronary anatomic complexity. In the first and second terciles (SYNTAX Scores of 0–22 and 23–32), there remained no significant difference in the cumulative MACCE rates among patients treated with CABG or PCI. Equally important, PCI was not linked to an excess in repeat revascularization in these patients with low and
intermediate SYNTAX scores. However, in patients with a SYNTAX Score of 33 or higher, cumulative MACCE rates were significantly lower with CABG (17.8% vs. 29.7%, p=0.02), driven largely by differences in rates of revascularization (9.2% vs. 21.8%).

These findings provide important clues to the types of patients who are good candidates for left main PCI, and those who are not. “In the SYNTAX trial we really pushed the limits on complexity of disease treated with PCI,” Dr. Feldman said. “I think we found the limit in the left main group with a high SYNTAX Score.”

The results of SYNTAX and other studies have prompted calls for reconsideration of American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Interventions guidelines, which categorize left main PCI as a Class III indication—a procedure that should not be performed because it is potentially harmful. One example of how views are changing is a white paper published in the October 20, 2009, issue of the Journal of the American College of Cardiology. Written by the ACC’s Interventional Scientific Council, it cites new data on the equivalent safety of CABG and PCI for treatment of left main disease and advocates reappraisal of the clinical guidelines.

Issam D. Moussa, M.D., FSCAI, agrees with the need to take a fresh look. The existing classification does not reflect current knowledge or state-of-the-art PCI, he said. “Why is PCI Class III? It’s not based on high-quality evidence. It’s based on observational data reflecting the use of PCI in high-surgical-risk or inoperable patients,” said Dr. Moussa, an associate professor of medicine at Weill Medical College of Cornell University and director of endovascular services at NYU/Weill Cornell Medical Center, both in New York City. “We have better-quality data now that’s sufficient to support a change from a Class III to a Class II indication.”

With a Class II indication, interventional cardiologists could be more direct with patients when discussing the comparative clinical outcomes with left main CABG and PCI, pointing out the differences in rates of stroke and revascularization. This would allow patients to make a more informed decision, Dr. Moussa said. “It would give me a comfort level to give patients the facts. CABG is the standard of care, but there are new data that left main PCI is a safe alternative,” he said.

Dr. Feldman also strongly favors a classification change, but noted that guidelines tend to evolve slowly. He predicted that if a soon-to-be-released update to the PCI guidelines includes any change in the classification of left main PCI, it will be to a Class IIb indication, though he would prefer Class IIa.

But Dr. Mack said the facts aren’t so clear. First, he points out that in the overall SYNTAX trial, PCI failed to show noninferiority when compared to CABG, so no subgroup analysis can be considered definitive. “SYNTAX was a failed trial for PCI. Therefore, everything else in the trial is observational and hypothesis-generating only. All you can say is you need another randomized trial.” In addition, two years of follow-up is not enough, he said. Over the longer-term, surgery is likely to look better than PCI.

One thing everyone is likely to agree on: Patient selection is key, and the SYNTAX Score is critical tool in that process.

Planning is under way for a new trial that is expected to bring further clarity to this issue. Dubbed EXCEL (Evaluation of Xience prime versus Coronary artery bypass surgery for Effectiveness of Left main revascularization), the trial will enroll 2,500 patients and have a three-year follow-up. The primary endpoint will be combined rates of death, MI, and stroke. Patients in the highest-tercile SYNTAX Score will not be included in the study.
In response to user feedback and rapidly advancing information technology, SCAI has enhanced both the Interventional Fellows Institute (IFI) and Interventional Cardiology Institute (ICI) so that training and practicing interventionalists can access the sites’ in-depth educational resources with greater speed and easier navigation. Still a complimentary benefit of SCAI membership, the two online curricula – IFI for fellows-in-training and ICI for practicing cardiologists – now operate off a new faster platform, complete with expanded navigation and search functions.

“Users told us, ‘This program is great … it’s exactly what we need to prepare for the Boards and stay up-to-date, but make it faster,’ so that’s what we’ve done,” explains IFI and ICI Program Director Manish Parikh, M.D., FSCAI. “The new Flash-based platform runs within all web browsers and on all computer operating systems. That translates to faster access for users.”

In addition to speedy uploading, users asked SCAI to enhance the sites’ search functions. Now interventionalists can quickly find key terms named in any of the e-learning modules, regardless of whether they appear on a slide deck or in an audio transcript. “This will be a big time-saver for our busy users. They don’t have time to scan through the whole curriculum to get an answer to a specific question. Now they don’t have to,” says Dr. Parikh.

Each IFI and ICI course now includes a detailed outline of the topics covered, thumbnail images of each slide, and a full transcript of the audio lecture. That means round-the-clock quick, easy, and free access to more than 70 educational modules in any of the following IFI/ICI courses:

- Basic Science Concepts for the Interventional Cardiologist
- Cath Lab Basics
- Valvular, Structural, and Congenital Heart Disease
- Intracoronary Imaging and Physiology
- Patient- and Lesion-Specific Approaches
- Acute Myocardial Infarction and Thrombus
- Anticoagulation in the Cath Lab
- Coronary Stenting
- Coronary Stenting: Drug-Eluting Stents
- Advanced PCI Techniques and Devices
- High-Risk Groups and Complications
- Cardiac Imaging
- Peripheral Vascular Disease
- Carotid Artery Disease

Each course is still supplemented with case studies that cover the newest techniques and developments in the field. In addition to the comprehensive online curriculum, the IFI and ICI programs connect interventionalists to important information, including meeting calendars and career-development tools.

IFI or ICI? Which Is Right for You?

Should you enroll in IFI or ICI? The answer depends on where you are in your career as an interventional cardiologist.

Dr. Parikh explains: “IFI is pure didactic curriculum, specially designed for interventionalists-in-training. The beauty of IFI is that each lecture is given by one of the world’s authorities on the topic, plus you get interactive activities, narrated case studies, practice questions, and instant feedback on password-protected assessment results. It’s an indispensable tool for Board preparation.”

Some interventional cardiology program directors are using IFI as a core curriculum for their fellows, requiring fellows to complete the IFI curriculum and thereby freeing up precious fellowship time for other activities.

IFI automatically transmits test results directly to each enrolled fellow’s program director, making it easier for both teacher and student to monitor progress and complete documentation requirements.
How is ICI different? “ICI is for practicing cardiologists. It’s the same content as IFI, but the results of the assessment activities are sent to the individual user, not to a program director,” explains Dr. Parikh.

Interventionalists who had used IFI when they were fellows contacted SCAI and asked if they could continue to access the site to help them stay up-to-date as the field evolved. “That’s how ICI came to be,” says Dr. Parikh. “Past users asked for it, so we developed a counterpart to IFI just for the practicing interventionalist.”

Complimentary Enrollment for SCAI Members

The IFI and ICI programs are supported by an educational grant provided by the Cordis Cardiac & Vascular Institute. Registration for both IFI and ICI is complimentary. To register and learn more, visit www.interventionalcardiologistsinstitute.com or www.interventionalfellowsinstitute.com. Or contact SCAI’s online education manager, Stephanie Mathias, at smathias@scai.org or 800-922-7224.

What’s new on IFI and ICI?

- Faster load time for all courses
- Compatible with Windows and Mac OS
- Enhanced search functions, allowing users to search for terms across audio transcripts and slides
- Improved navigation, featuring course outlines, thumbnails of every slide, and audio transcripts
- Access to meeting information and career development tools grouped according to what is useful for fellows-in-training, practicing physicians, and international users

SCAI Fellow Appointed to National Quality Forum Steering Committee

One in 125 infants in the U.S. is born with a heart defect. Now the National Quality Forum (NQF) is working to ensure that those infants get the best treatment possible. And pediatric cardiologist Mark H. Hoyer, M.D., FSCAI, will be helping to lead the charge.

Dr. Hoyer, director of cardiac catheterization and interventional cardiology at Riley Hospital for Children in Indianapolis, was appointed as SCAI’s representative to NQF’s Pediatric Cardiac Surgery Steering Committee in October. The group will identify and endorse performance measures for public reporting and quality improvement related to pediatric cardiac surgery processes, structure, and patient outcomes. The group’s ultimate goals are to further reduce mortality, prevent morbidities, and make more efficient use of resources.

The project will involve representatives from across the health care arena, whose work will be guided by the steering committee.

“Mark is a superb choice as our representative to the NQF Pediatric Cardiac Surgery Steering Committee,” says SCAI President Steven R. Bailey, M.D., FSCAI. “I am certain that he will be up to the task and provide the committee with sage insight and guidance.”

Dr. Hoyer has worked with pediatric cardiac surgeons throughout his career.

“I have many of my own patients whom I have seen since birth, and I see many who have undergone surgery,” he told NQF in his letter of interest in the steering committee position. “This requires understanding of what actually happens in the operating room and what technical aspects are needed to achieve a good surgical repair.”

The development of “hybrid” procedures has brought even closer collaboration and familiarity with pediatric surgical procedures, he says. Dr. Hoyer often uses this innovative approach that allows surgeons and cardiologists to work together on the same procedure and gives patients the benefit of their combined expertise.

Dr. Hoyer is also involved in quality improvement efforts at Riley Hospital. He has developed and maintained a database of all cath lab procedures and set performance and quality standards. For example, he tracks procedural contrast doses, fluoroscopy times, and complications as a way of evaluating cath lab performance and providing feedback to operators. As the cath lab’s primary administrator, he also seeks to ensure his equipment’s quality and works with hospital leaders to address any concerns.

“Because of my years of experience in the field of pediatric cardiology, I believe I am well-suited to review and provide insights for policies and proposals directed at performance and quality measures in the area of pediatric cardiac surgery,” Dr. Hoyer told NQF.

For more information about the project, visit www.qualityforum.org/projects/pediatric-cardiac-surgery.aspx.
When he was in medical school, Robert N. Vincent, M.D., FSCAI, never suspected he would ever find himself on Capitol Hill. "If you'd asked me even five years ago, I would have said 'No way!'" says Dr. Vincent, a pediatric interventional cardiologist who is director of the cardiac catheterization lab at Children’s Healthcare of Atlanta. "Until recently, I was the typical physician with my head in the sand, saying, 'I'm a doctor, so I all I need to do is take care of my patients.' Although I still feel that way, I've also learned that if we don't advocate for ourselves, our practices and our profession won't survive the way they are today."

In July, Dr. Vincent joined other SCAI members and representatives from other medical specialties who met with legislators and aides as part of the Alliance of Specialty Medicine Legislative Conference. (See “SCAI Delivers Specialty Care Concerns to the Hill” in the September/October issue of this newsletter, at www.SCAI.org.)

The advocates’ goal was to help Congress understand the needs of specialty medicine providers and their patients as legislators debate Medicare and healthcare reform. For Dr. Vincent, the experience was both surprising and energizing.

A Growing Interest

This visit to Congress wasn't Dr. Vincent's first time on the Hill. In September 2008, he participated in the American College of Cardiology's annual legislative day in Washington.

That initial visit was awe-inspiring, he says. "The first time I went I thought, ‘Wow! This is really neat!’” he says. "You see all these famous faces and huge buildings."

It's sort of like being backstage with a bunch of rock stars.”

His more recent visit was just as fascinating. The House of Representatives had just released its healthcare reform bill, so Dr. Vincent was able to see firsthand how the legislative process works.

Still, there were some surprises.

One surprise was the extreme partisanship from both sides of the aisle. Another was the amount of information legislators and their aides are expected to process. "There were things going on that the legislators and their staffs didn’t really have a clue about,” says Dr. Vincent. "It’s scary when you realize that people are voting on 1,000-page bills without having read them or understanding all that's in them."

Dr. Vincent and fellow Georgian Christopher U. Cates, M.D., FSCAI, visited the offices of their state’s congressional representatives, accompanied by Wayne Powell, SCAI's senior director for advocacy and guidelines. They had a chance to meet briefly with Sen. Johnny Isakson (R-GA), then spent time with staff of other members.

They wanted to make sure members understand that specialty care and subspecialty care are just as important as primary care. “It’s not going to be your primary care physician who treats your stroke or cerebral aneurysm or eye disease,” says Dr. Vincent. “But with cuts in reimbursement, fewer and fewer people are going into the subspecialties. If that continues, we're going to have a doctor shortage.”

Cuts in reimbursement also affect patients' access to care, they emphasized. "We treat everybody regardless of their ability to pay, but when reimbursement gets cut back and cut back, there comes a point where you can no longer function," says Dr. Vincent. "If we have to close outreach offices in rural communities and make people drive to Atlanta for care, that's not good for our patients."

They also urged legislators to take the time to get healthcare reform right.

Being involved is especially important during this time of radical change, Dr. Vincent emphasizes. “Reform is necessary, but we need to get it right,” he says. “If we're not involved, we could end up with something that does not serve our patients or our profession. That could be worse than where we are now.”

Dr. Vincent urges other interventional cardiologists to get involved in advocacy, whether that means joining SCAI's Advocacy Committee, sharing concerns with legislators via phone calls or emails, donating time or money, or making the trip to the Hill. “It’s time to step up and play a role,” he says.

For information on how you can help with SCAI’s advocacy efforts, visit the SCAI Advocacy Action Center at www.SCAI.org.
CAI’s 33rd Annual Scientific Sessions in San Diego, May 5–8, 2010, will once again offer interventional cardiologists the premiere platform for presenting their work to colleagues and the media. Presentations at last year’s meeting informed a record number of attendees and generated national headlines.

Why Present?
Presenting your findings is an efficient and effective way to improve patient care. With the full attention of interventional cardiologists from all over the country, many from around the world, you can share information they will take back and immediately apply in their daily clinical practice.

Of course, as an early-career interventional cardiologist, you’ve heard it. Presenting at conferences is good for your career. It adds depth to your CV. Planning to share your results at next year’s meeting also gives you a firm deadline. It’s a formal commitment to finish your work on schedule. Then, when you present your findings, you have the added benefit of getting immediate feedback from your peers, brainstorming next steps, and meeting potential collaborators for future trials.

Why SCAI?
As every physician knows, meetings abound throughout the year, but few are specifically for interventional cardiologists. SCAI’s Annual Scientific Sessions are very well attended but less crowded than meetings for cardiologists from all specialties. Every day of the meeting is about interventional cardiology, so your results are less likely to get lost in the shuffle of other subspecialties.

The Society’s annual meeting also attracts local and national media with its promise of late-breaking trials. Last year, SCAI featured two news conferences and garnered Wall Street Journal’s most watched video of the day as well as more than 50 articles in the press, including a top story of the month in theheart.org. SCAI provides a detailed media kit and an on-site newsroom for direct communication with mainstream and trade journalists.

As an added benefit, if accepted and presented, your abstracts will be published in a special section of the Society’s website and its journal, Catheterization & Cardiovascular Interventions.

Where to Sign Up?
Interventional cardiologists who submit their abstracts by Dec. 18, 2009, and late-breaking clinical trials by March 19, 2010, will be considered to present their results at next year’s meeting. Submit abstracts and late-breaking trials electronically at www.SCAI.org or for further information email rhenegar@scai.org.
Finishing fellowship and deciding on your next career move is an exciting but scary time. Finally all of the work you’ve put into your college and medical school efforts and the sacrifices you’ve made to become a cardiologist are coming to an end – you’re going to finally get to do what you’ve been dreaming about for years! It’s important at this time to think about more than just the increase in income after fellowship. You'll need to have developed a plan that will allow you to land a job that will fulfill you personally and professionally and satisfy your family as well.

Since this is such a crucial time you should plan to think methodically. This means defining your needs and evaluating pros and cons of options by writing them down. Nothing makes decision making easier than seeing the choices in front of you.

The first and most obvious thing to decide is whether you want to stay in academics or go into private practice. This article will not focus on the difference between the two, as not only does there tend to be overlap between academics and private practice for many cardiologists, but there is great variability depending on the setting.

Deciding whether location is important is a pivotal first step. For many this is easy: family, personal obligations, or individual desires will dictate this. For others the quality of the job will be the determining factor. The reality is that finding the exact job you want in the place you most want to live is impossible for most of us. Deciding what a community must have (and what, in some cases, it must not have) is a good start. Take into consideration proximity to family, nearness to large cities, climate, schools, lifestyle issues, recreation options, and housing.

Major consideration must be given to the needs of your spouse. One of the primary reasons cardiologists leave their first job is dissatisfaction of a husband or wife with their new community or the job opportunities available for them. It's critical that you keep your spouse's needs on par with yours – if he or she is not happy, you won’t be either.

Decide...what the “must haves” and what the “deal breakers” are before agreeing to interview for a job. The following list is a good place to start:

- Minimum compensation you’ll accept
- Call schedule
- Time off for:
  - Vacation
  - CME
- Time to partnership
- Buy-in for partnership
- Size of the group
- Ancillary support (independent licensing professionals, such as nurse practitioners and physician assistants)

Once you do start talking to a group (or their recruiter) there are several things to keep in mind:

- What is the history of the group?
- How long has it been together?
- Was it always one group, or was it formed by a merger of two or more groups?
- What is the age range of the current partners?
- How many of the current cardiologists are employed, and how many are partners?
- What has the turnover of the group been? Do they have a history of hiring physicians and then not offering partnership at the end of the employment contract?
- What is the reputation of the group in the community and among other physicians not associated with the group?
- Is there a teaching program at the hospital? If so, are you able or expected to teach? Does
It may be time consuming to find answers to many of these questions, but the effort will be well worthwhile – if you do end up joining the group you’ll find out anyway – and these are things that you’re better off knowing up front.

The more specific you can be in defining the parameters of the job you want, the more satisfied you will be with it. While this may require quite a bit of soul searching and long discussions with family, and may actually limit the number of opportunities you choose to pursue, your reward will be a job that meets and exceeds your expectations, both personally and professionally.

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The program include medical students, residents in family practice, internal medicine, or cardiology fellows?

- Is this a single-specialty cardiology group or part of a multispecialty clinic?
- Does the group have (or plan to have) availability of all of the subspecialists you would like to work with?
- If you are a subspecialist, does the group already have someone doing what you’re expecting to do, or will you be developing this field for them?
- Is the equipment in the office/clinic owned by the practice?
- Do they work out of one hospital or travel to two or more?
- How many clinics do they staff? If it is more than one, how close is it? And how often will you be expected to be on the road?
- What is the culture of the group? Do they share your values for patient care and respect one another? Do the physicians in the group have a strictly business relationship, or do they truly value and admire one another? This is perhaps the most important question of all.
In the Trenches

Interventional Cardiologist Leads Call to Action

One day, after 10 years as an SCAI Fellow, Tony G. Farah, M.D., FSCAI, picked up his phone, called SCAI, and asked how he could help the Society further its mission. He was beginning to realize that he could help SCAI make a difference. “A lot of physicians don’t think they can have an impact on a national level, and I was one of them,” says Dr. Farah. But after a series of opportunities, many of his own making, he changed his mind. Now he hopes to help others do the same.

It all started when, like many physicians, Dr. Farah grew concerned about the growing number of “hyped-up” headlines and the “skewed coverage” of certain studies. “It was inciting divisions within the healthcare field and diverting attention away from what really counts—the patient’s welfare. Each individual should be treated based on his or her needs, not on the headlines.”

Meeting the Press

Dr. Farah has practiced interventional cardiology for the last 20 years and has been instrumental in building one of the biggest practices in Pittsburgh, while at the same time continuing to teach and conduct research. His administrative responsibilities have grown over the years, especially since becoming Chief Medical Officer of Allegheny General Hospital, but he still spends at least 50 percent of his time with patients.

“Patients come into my office every day with clippings from the newspaper and Internet and say, ‘How come, Dr. Farah, you’re saying this and they’re saying that?’ It reinforced a concern of mine, which is everyone—physicians, policymakers, and reporters—has a different goal in mind and patients are confused by all the conflicting messages.”

Dr. Farah had this concern in mind when he met Barbara Walters during a TCT conference. “I came up to her after her speech and said, ‘That was very nice. You sat down with several doctors and the media, and because you were sitting there, people listened. My problem is people don’t listen’.”

Her reply to Dr. Farah was along these lines: “You know, you’re absolutely right, for the longest time the media was at fault, and the media had no interest whatsoever in input from the medical community because that didn’t make news. Now, in the last several years, the media is all over that issue because they feel it is beneficial to them, and obviously, by extension, it benefits society. So if I were you, I would take advantage of your local media and start spreading the word.”

“That’s what made me pick up the phone and call SCAI,” says Dr. Farah. “I was already on my way, but she pushed me farther in that direction.”

In recent years, Dr. Farah has developed a good rapport with the local media in Pittsburgh. When cardiac stories break nationally, reporters come to him as well as other physicians in the area to get their opinion. “The feedback from patients, both positive and negative, reinforced in my mind the need to keep doing it,” he explains.

Involving Physicians

Dr. Farah understands that many physicians don’t want to talk to the press—it makes them uncomfortable, they’re busy, or they believe it won’t matter. “I didn’t want to talk to the press either; it’s more fulfilling to care for patients. But the more I became involved, the more I felt that I had to keep speaking up.”

He thinks improving communication with the media will benefit physicians, too. “We all want what’s best for our patients, but it’s not that simple—we have medical guidelines, variations in practice, different reimbursement models, and malpractice premium rates. We get drawn into sound-bites that can affect our practices and that’s dangerous.”

Broadening the Scope

Dr. Farah worked with SCAI to organize an education program with local journalists, physicians,
business leaders, legislators, and patients to discuss advances in cardiovascular care, treatment options, health care reform, and impact of media coverage on quality care. Dr. Farah hopes it will serve as a model for SCAI to help other physicians around the country hold similar forums in their own regions. (See the next issue for a report on the program.)

“We need to convince physicians that they can make a difference,” says Dr. Farah. “We’re at a pivotal point in time right now where a lot of things are going to change, with or without us.” He suggests doctors should talk to anyone, including patients and policymakers, who can help. “If you dissect the mechanism of change,” explains Dr. Farah, “it’s one person talking to another. If we voice our concerns, I guarantee that there are enough people who have the contacts in their communities to make a meaningful impact.”

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2009 SCAI ADULT AND PEDIATRIC FALL FELLOWS COURSES

Date: Dec. 7–11, 2009
Location: Las Vegas, NV
Directors: Michael J. Cowley, M.D., FSCAI, Bonnie Weiner, M.D., MBA, MSEC, FSCAI, Christopher U. Cates, M.D., FSCAI, and Ziyad M. Hijazi, M.D., MPH, FSCAI
For more info: www.scai.org/Fellows

SOLVING THE MYSTERIES OF THE HUMAN HEART:
INNOVATIONS IN CARDIOVASCULAR INTERVENTIONS (ICI)

Date: May 6–8, 2010
Location: Tel Aviv, Israel
Directors: Rafael Beyar, M.D., and Chaim Lotan, M.D.
For more info: www.congress.co.il/ici2010

GLOBAL INTERVENTIONAL SUMMIT, IN COLLABORATION WITH THE TURKISH SOCIETY OF CARDIOLOGY

Date: Oct. 22–24, 2010
Location: Istanbul, Turkey
Directors: Ziyad M. Hijazi, M.D., MPH, FSCAI, Ted Feldman, M.D., FSCAI, and Oktay Ergene, M.D., FSCAI, FESC
For more info: www.scai.org/GIS

ADVANCED CURRICULUM IN ACUTE STROKE INTERVENTION AND CAROTID STENTING

Date: March 12–13, 2010
Location: Atlanta, GA
Directors: Christopher U. Cates, M.D., FSCAI, and Bonnie Weiner, M.D., MBA, MSEC, FSCAI
For more info: www.SCAI.org

SCAI 33RD ANNUAL SCIENTIFIC SESSIONS

Date: May 5–8, 2010
Location: San Diego, CA
Directors: James B. Hermiller, M.D., FSCAI, Christopher J. White, M.D., FSCAI, Frank F. Ing, M.D., FSCAI, and Daniel S. Levi, M.D., FSCAI
For more info: www.SCAI.org/SCAI2010

SCAI-COSPONSORED PROGRAMS

INNOVATIONS IN CARDIOVASCULAR INTERVENTIONS (ICI)

Date: Dec. 6–8, 2009
Sponsor: Innovations in Cardiovascular Interventions (ICI)
Location: Tel Aviv, Israel
Directors: Rafael Beyar, M.D., and Chaim Lotan, M.D.
For more info: www.congress.co.il/ici2009

SECOND ANNUAL PAN VASCULAR SUMMIT

Date: Feb. 19–20, 2010
Sponsor: University of Utah School of Medicine
Location: Midway, UT
Directors: Andrew D. Michaels, M.D.
For more info: www.panvascularsummit.org

INTERNATIONAL SYMPOSIUM ON ENDOVASCULAR THERAPY (ISET)

Date: Jan. 17–21, 2010
Sponsor: Complete Conference Management
Location: Hollywood, FL
Directors: Barry T. Katzne, M.D., James F. Benenati, M.D., Alex Powell, M.D., Ramon Quesada, M.D., FSCAI, Shaun Samuels, M.D., and Constantino Pena, M.D.
For more info: www.iset.org

CRT 2010

Date: Feb. 21–23, 2010
Sponsor: Washington Hospital Center
Location: Washington D.C.
Directors: Ron Waksman, M.D.
For more info: www.CRTOnline.org

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PEDIATRIC AND ADULT INTERVENTIONAL CARDIAC SYMPOSIUM

Date: July 18–21, 2010
Sponsor: The PICS Foundation in Collaboration and Rush Center For Congenital & Structural Heart Disease
Location: Chicago, IL
Directors: Ziyad M. Hijazi, M.D., MPH, FSCAI, FACC, William E. Hellenbrand, M.D., FSCAI, John P. Cheatham, M.D., and Carlos Pedra, M.D.
For more info: www.picsymposium.com

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