



The Society for Cardiovascular Angiography and Interventions

President's Page

Competent Care Through The Lens of the Vascular Patient: Next Steps in Quality

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The field of invasive/interventional cardiology and the SCAI have made dramatic strides in assessing quality of care and developing tools for continuous quality improvement. For decades, we have demonstrated leadership in this area and have been gratified by the enthusiastic participation of cardiac catheterization laboratory teams in the United States and throughout the world. We have embraced data collection and analysis, practice guidelines [1], appropriate use criteria [2], and performance measures, and now we are taking leadership in public reporting of outcomes [3]. Although we all know of cardiologists' varying skills and expertise across regions and countries, these efforts have somewhat "leveled" expectations for quality. While many express concern that these efforts hamper the "individuality" of the practice of medicine, there is little doubt that raising the standard of care and demanding transparency are important for the future of healthcare.

For various reasons, our efforts in quality have largely been focused on the diagnosis and treatment of coronary artery disease. While not neglected, vascular disease has been a secondary, perhaps tertiary, target for our quality improvement mission. The reasons for putting coronary disease first and vascular disease further down the list of priorities are numerous and prag-



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matic. However, the time has come to put the same effort into evaluating and improving the quality and outcomes of our vascular interventions as we have successfully invested in coronary interventions.

Patients, policymakers, regulators, and payers expect quality in all aspects of healthcare. They have every reason—and every right—to expect that they will receive quality care across their health care continuum. Their expectations are not, nor should they be, different depending on whether their intervention is delivered in the limbs versus the heart or the neck, or by an interventional cardiologist, vascular surgeon, interventional radiologist, or neurosurgeon. Their perfectly reasonable expectations of competency and professionalism,

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regardless of their doctor's specialty, mean that we have a responsibility to support efforts that lead to excellent care, no matter the practitioners' specialties.

As in most things, the challenge has been, and will continue to be, in implementation and execution. Although we have faced hurdles in achieving our quality goals in coronary care, vascular disease has proved much more difficult. One recent example was an effort to publish multispecialty cerebrovascular guidelines [4]. Despite efforts to include the input of all of the major subspecialties, confusion arose when one society subsequently published an update [5] with substantive differences from the earlier multisocietal document. The result was confusion for the primary care practitioner and, as importantly, competitive ill will among specialties. We believe it is time to put aside arguments and competition for patients and procedures.

Given the history of our best collaborative strategies, we suggest that the time has come for a different approach, and more specifically a different target. Let us begin again, but not in guidelines. Rather, we propose that the subspecialties committed to optimal care of patients with vascular disease come together again, this time focused on achieving consensus for the evaluation and management of patients with non-coronary vascular disease. All participants must come to the table with the singular goal of generating expert consensus, defining appropriateness of care, and insuring transparency in reporting.

We have seen in our work in the coronary space that practice will follow the evidence. We must work together to design and run a small number of impactful clinical trials that will be powered to provide the evidence we need but will withstand concerns about who performed individual procedures and whether the benchmarks were balanced. All of the subspecialties must convene to define the endpoints and enrollment criteria, and the investigators must include a broad and even distribution of specialists.

Achieving balance in clinical trials will seed the ground for achieving excellence across the entire spectrum of vascular care. With a few more positive experiences to learn from, we can then turn (or return) to equally important goals in credentialing, appropriate

use of varying devices and techniques, guidelines, and public reporting of outcomes.

Excellent patient care is what we all want. It is time to put aside our differences and deliver. Our patients expect this from us, and it will be far more constructive coming from us rather than from *Consumer Reports* [6].

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