



## The Society for Cardiac Angiography & Interventions

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### SCA&I President's Page



## Cardiovascular Subspecialty Societies Summit

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On November 7th and 8th, 2002, several cardiovascular professional societies met in Washington DC to discuss intersociety relationships. Until recently, there was little dialogue among the various cardiovascular subspecialty societies and the American College of Cardiology. Thanks to much hard work by all concerned, the November Leadership Summit filled that void and began what will hopefully be an era of stronger partnerships. This was a meeting of substance and accomplishment, and I would like to let you know what happened.

Beginning about two years ago, my two predecessors as SCAI President, Drs. Carl Tommaso and Joe Babb, began discussions with their ACC counterparts regarding the relationship of SCAI with ACC. The initial discussions were based on recognition that ACC produces many guidelines regarding angiography and interventions, often without consultation with SCAI, and certainly without representatives from SCAI on writing committees. The result—thanks to much encouragement from SCAI—was the November Leadership Summit.

The Summit was attended by representatives from the American College of Cardiology, including President Bruce Fye, President-Elect Carl Pepine and Vice President Michael Wolk. Represented societies included the American Society of Echocardiography, The American Society of Nuclear Cardiology, Heart Failure Society of

America, North American Society of Pacing and Electrophysiology, SCAI, Society for Cardiovascular Magnetic Resonance, Society of Geriatric Cardiology, Society of Thoracic Surgeons, and the Society for Vascular Medicine and Biology. SCAI was represented by myself and President-elect John Hodgson, M.D., our executive director Norm Linsky, and our staff Bea Reyes and Rick Henegar. The other societies were represented by their presidents.

The meeting was intense, candid and fruitful. A key area involved discussion of principles for cooperation. These included the recognition that the societies have mutual interests, and are much stronger when they partner on areas of common concerns. Clearly, the majority of subspecialty society members also belong to the ACC; “they are us”. Nevertheless, the independence and value of active subspecialty organizations was acknowledged as a vital component of the continuum of care.

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November 2001 meeting where need for leadership summit was first identified. Participants (left to right; titles as of Nov 2001): SCAI President Dr. Joseph Babb, ACC CEO Chris McEntee, ACC President-elect Dr. Bruce Fye, ACC President Dr. Douglas Zipes, SCAI President-Elect Dr. Ted Feldman.

Principles of the meeting: partnership, respect, accommodating differences, well-documented expectations and recognition that both cooperation and simultaneous competition among society interests are critical elements of a working relationship. Fundamentally, the communication at this summit represented a very positive first step.

Four areas of focus were ultimately identified as common interests among societies. These include patient education, physician education, advocacy, and guidelines and policy statements. Groups broke out to discuss specific programs that could be pursued in each of these four areas.

**Patient education.** Although SCAI's involvement in patient education has been relatively limited, some innovative ideas came from the meeting. Web links for patient education and distribution of existing patient education materials represents the simplest program to initiate. One promising idea: hold patient education events (such as interviews on the local media) in cities where we hold our annual scientific meetings.

**Physician education.** Cooperation among meeting planners for the various subspecialty society meetings, and co-promotion of those meetings is another clear avenue for relatively easy cooperation. Opportunities to have representatives from various societies present at other society meetings became obvious. For example, review sessions on general cardiology at the annual SCAI meeting could be sponsored by NASPE, the Heart Failure Society, and the Society for Vascular Biology and Medicine.

**Advocacy and government relations.** Voting representation of the various societies on the ACC Advocacy Committee was recognized as the most efficient way to avoid re-duplication of efforts. Since most of the subspe-

cialty societies already have lobbying efforts, creating a third intersociety group would be expensive and inefficient. Voting membership on the ACC Advocacy Committee was recognized as a best step forward in unified advocacy efforts. This point was discussed at length, and agreed to by all concerned.

**Guidelines.** Historically, SCAI has produced many guidelines over the years fundamental to the practice of invasive/interventional cardiology. While this will continue, the ACC/AHA Task Force on Guidelines is of course a major force in this area. At the summit, we (as well as the other subspecialty societies) stressed that subspecialty organizations need to be more closely involved in those ACC/AHA efforts. Currently, we are represented on the PCI Guidelines writing committee, and produce the guideline in a joint fashion with the ACC/AHA Task Force Writing Group. We look forward to continued progress in this area.

The commitment to an intersociety effort will find substance in hiring a new staff person to be housed at the Heart House to coordinate intersociety efforts. True commitment to stronger intersociety partnership will be best demonstrated by supporting funding for this staff person. SCAI is enthusiastically supporting this position, and looks forward to the fruits of intersociety cooperation.

Ultimately, intersociety relations are about leadership, cooperation and representation. Leaders from each society came together for this meeting at considerable expense, in terms both of time and money. While the fundamental goals were the same, each society's mission, membership and expectations were by definition unique. Nonetheless, all recognized that through collaborative effort our members and patients will ultimately benefit.

For the American College of Cardiology, President Bruce Fye (who also is ACC's official historian) perhaps put it best by terming the Summit "a historic event." This meeting represents an important turning point by recognizing that subspecialty society members are also ACC members, and that true leadership is best demonstrated by being IN-clusive, not EX-clusive. As further demonstration that this belief was sincerely felt, all societies at the Summit had an equal (and frequently loud !) voice, and the Chair of the Coalition will rotate annually (with the smaller societies going first).

Cooperation among societies is necessary to further our interrelated interests. For example, as delivery of electrophysiologic care becomes more and more interventional, our points of overlap with NASPE will grow. Our interrelationships with The Society for Vascular Medicine and Biology are rapidly growing as extracardiac vascular intervention becomes part of our practices. The Society of Geriatric Cardiology, The American Society of Echocardiography, The American Society of

Nuclear Cardiology, and many others: closer partnership is a “win-win” situation. Cooperation among societies will have a clear, positive impact on our own practices and on the quality of care we deliver to our patients.

As we forge those diverse partnerships, at the same time it is vital to note that SCAI’s own membership base is equally diverse. An SCAI member recently wrote noting that the leadership of most of the cardiology organizations comes predominantly from academic institutions. The member felt that the viewpoints of those in private practice are often poorly represented in medical specialty societies.

SCAI is proud that in our society this has never been the case. Since SCAI’s inception nearly 25 years ago, well over half of our presidents (including me !) have been in private practice – a very rare (perhaps even unique) occurrence in medical associations. Currently well over 50% of our Board of Trustees and committee

chairs likewise are in private practice. The key point: as we work more closely with other specialty organizations (and on SCAI’s own activities), the viewpoints of both private practitioners and academic members (who themselves of course practice in the lab each day) will be aggressively represented.

In sum, representation of both our own members, and the members of the other subspecialty societies, is a key element in intersociety cooperation. ACC has taken a large step toward recognizing that its members have multiple interests. Representation of SCAI members at the larger table of cardiology is a clear goal of this effort.

We are the voice of our membership and look forward to using our voice in these major areas of patient and physician education, guideline writing, and advocacy. By being integrally involved in this emerging Coalition of Clinical Organizations, the impact of that voice will continue to grow.