

Joseph Babb, MD

Dr. Babb discusses the development of the East Carolina Heart Institute, the importance of fellowship-in-training programs, and future challenges in interventional cardiology.

What can you tell us about your practice and your facility at Eastern Carolina University? We are a university-based academic practice at East Carolina University Brody School of Medicine. Our hospital, Pitt County Memorial Hospital, is home to both university-based and community-based practitioners. Within the last year the university and hospital collaborated in the construction of two new buildings: East Carolina Heart Institute at ECU, which houses our administrative offices, clinics, and research space, and East Carolina Heart Institute at PCMH, which is the hospital component. We occupied the new office building last fall and our new hospital structure on January 5.

In conjunction with the development of the East Carolina Heart Institute, the School of Medicine voted to form the new Department of Cardiovascular Sciences. We have brought cardiology, cardiac surgery, and vascular surgery together into a single academic administrative unit. The cardiology and interventional cardiology training programs remain with their former lines of communication and support through the Department of Internal Medicine, however.

What areas of cardiology need the most attention from physicians and industry in the next several years? I think that one of our challenges has been to develop an information base that helps guide our decision making. I'm not talking just about different techniques and tools to do endovascular procedures but developing and understanding appropriate outcomes and measures.

It is evident that information is now much more readily available and even more rapidly disseminated than it used to be. I'm not opposed to publicly available data. What I am concerned about is the misinterpretation of that information by people who are not skilled in reading it. In this context, administrative data can easily become confused with clinical data and clinical outcomes. Careful validation of publicly available information focused on quality outcomes is a challenge we need to meet head on, and I think we are meeting it. We in the Society for Cardiac Angiography and Interventions (SCAI) have been working in conjunction with the American College of Cardiology (ACC) and its National Cardiovascular Data Registry to develop a base of information that is validated and carefully analyzed.

We also need to work with industry to meet upcoming demands. A major factor is to maintain the development of useful new technologies. As we carefully examine the cost of health care, we do not want to inadvertently throw the baby out with the bath water and take a step that curtails innovation or makes it too risky for people to think about developing new technologies and new techniques. This also means that we need to be careful and thoughtful about

how best to support these new technologies through appropriate research to validate their clinical utility and improved safety and/or outcomes. Currently, the growth areas in interventional work have been in noncoronary and structural heart disease—very exciting, ground-breaking, cutting-edge technology. That needs to be addressed and supported through properly funded research and development. The other big area is in stroke therapy. We need to forge ahead in these evolving areas in

peripheral vascular and cerebral vascular interventions, as well as structural heart disease.

You are involved with physician training programs for interventional cardiology fellows-in-training. What are the objectives of these programs, and how are they important to the field of cardiology?

We have an aging population. What becomes more prevalent as people age? Cardiovascular disease. It is expensive to be trained in medicine; it always has been and is more so today. Because of the development of new technologies and new areas of specialization, it is taking longer to train people. It is important that we maintain a standard of excellence but also find ways that do not prohibitively prolong training so that people will turn away from these areas of medicine because they cannot afford the prolonged training.

There is no federal funding available for more advanced training. In the past, educational grants from industry have helped support such training. Absent increased federal funding for such training, there were not other avenues of support. To address issues raised about industry influence on medical education and physicians, the medical device and drug industry developed new standards for such funding. I think a challenge for industry has been to meet their AdvaMed and Pharma rules but also to keep up the good

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work they have been doing for decades in terms of supporting graduate medical education. The SCAI Fellows-in-Training Program is an example of how this can be done in partnership with industry by removing any influence of sales and marketing from the granting process. Industry, instead of giving their own training grants to institutions, allocates money to SCAI as a restricted educational grant—it can only go to institutions for the purpose of training interventional cardiovascular physicians. We want to give a meaningful amount of money to programs but also make sure that they are quality programs. Through an online process, applications are reviewed by at least three different independent reviewers. Grants are given to those with the most competitive scores based upon a broad review of the program, its faculty and facilities, and its past education record. We work with those who do not receive funding in order to help them strengthen their programs—informing them where they may have fallen a little short and what they may want to focus on—because we want them to reapply and be successful the next year.

The ACC and the American Heart Association issued an update to their Unstable Angina/Non-ST-Elevation Myocardial Infarction guidelines in 2007. How have these changes affected your practice? Guideline, evidence-based medicine is, in my opinion, good medicine. The guidelines that have come out are very helpful—they are very rigorous and well researched. They are not perfect, however, and the new effort to produce Appropriateness Use Criteria helps move evidence-based practice to a new level. I try to teach our fellows the guidelines and Appropriateness Use Criteria as a basis for their practice. The new publications have been the focus of many of our recent conferences and discussions, not only with our fellows, residents, and trainees, but also among our catheterization lab user groups and other venues when we are all together. We have a program here in North Carolina called the RACE (reperfusion of acute myocardial infarction in Carolina emergency departments) Project. This started several years ago with the intent to improve the delivery of myocardial infarction reperfusion therapy. Some basic research indicated that much of the impediment to faster and more widespread reperfusion was system based. So, the RACE Project, with the aid of the state ACC chapter, was implemented across the state. We divided the state into divisions and had a lead hospital in each division whose job it was to work within their region to help all the hospitals develop a strategy of care and facilitate working with emergency medical services and emergency rooms. We are very active in this RACE Project and have found that this comprehensive, system-based approach to treatment based on the guidelines has been effective in improving care to patients. Our treatment times have shortened dramatically and our partnership with emergency medical services has greatly strengthened our regional efforts. ■