A Cardiologist in Congress?

Interventional cardiologist Chris Cates, MD, discusses his bold decision to run for a seat in the United States House of Representatives.

On January 21, 2010, Chris Cates, MD, announced his candidacy for the open seat to represent Georgia's Ninth District in the United States House of Representatives. Dr. Cates has most recently served as the Director of Vascular Intervention at Emory University Hospital in Atlanta, Georgia, and is currently Vice President of the Society for Cardiovascular Angiography and Interventions. Endovascular Today *recently spoke with Dr. Cates about this dramatic change in his career, health care reform, and the goals he hopes to accomplish.*

What prompted your decision to run for Congress?

Dr. Cates: I've been involved in the leadership of the Society for Cardiovascular Angiography and Interventions for many years and also with the Coding and Nomenclature Committee of the American College of Cardiology. About 20 years ago, I began directing the American College of Cardiology conference on cost-effective health care with Gail Wilensky, PhD, who used to run the Centers for Medicare & Medicaid Services.

Last fall, I traveled with a group of physicians to Washington, DC, to meet with members of Congress to lobby for sensible changes to our health care system. We were in Washington the day that the health care reform bill came out of the House Ways and Means Committee. We had a meeting with Rep Steny Hoyer (D, Maryland), who is the Majority Leader of the House of Representatives, beseeching him to work with specialists such as us to fix what is wrong with health care. We told him that we know that there are problems with health care, but we know how to fix them because we are the doctors who deal with these issues every day. We asked him to work incrementally on a patient-oriented bill and not some 1,000-page bill that no one has read. Health care represents one out of five jobs in America and 18% of the gross domestic product, but more importantly, it touches every American's life. Our country is the undisputed best in the world in terms of medical care, even with the present system's flaws. Physicians and patients from around the world want to come to our country because of our health care system. Patients want the best medical care in the world, and physicians want to learn how to be the best in their field. Our medical device industry leads the world in innovation, and our pharmaceutical products are distributed across the globe, so the United States is doing something very right, even if we still need to fix it. So we pleaded with him, "Don't throw the baby out with the bath water. Let's do this thing right; let's focus on the patient, and let's do this incrementally."

I can't quote precisely what Representative Hoyer said to us because it wouldn't be printable, but in effect he said, "You doctors better get on board or we will crush you. We haven't been trying to do this [pass health care reform] for 3 weeks or 3 months, but for 40 years. I don't need to read the bill. We're going to pass it. You guys better get on board or get out of the way."

At that moment, we all knew that it wasn't about health, it wasn't about care, it certainly wasn't about patients, and it wasn't about quality. It was about control. What we were witnessing was the biggest power grab in the history of our nation, all under the guise of health care reform. Because if the government can choose who will undergo a procedure and who will not, who lives and who dies, who can get that hip replacement or that stent, then they control the very soul of every American; this is why health care reform debate has caused such a visceral response across America.

Last month, President Bill Clinton went to a New York hospital and received a couple of coronary stents and was released from the hospital the next day while touting the greatness of our American medical system. The irony is that at that same time he was touting our American health system's greatness, Congress was denigrating and demonizing medicine and trying to pass a bill that—had

it been in place—would have prevented a patient in President Clinton's condition from receiving those stents because of comparative effectiveness of some of the health technology assessment groups.

After that meeting, I spoke to a friend and I told her the story of what happened in DC, and she said, "Well, what did you expect? You're not going to make a difference even as the president of some medical association. You're an outsider. If you want to make a difference, become the only cardiologist in the Congress of the United States." That is when I made my decision to run.

Were there other issues aside from health care reform that prompted your decision?

Dr. Cates: My wife Joy and I are also small business owners. We have developed a retirement community that is one of the largest employers in a North Georgia county, so we understand the real issues regarding entrepreneurship and taking risks to create jobs. That spirit of American entrepreneurship is also being stifled by the policies presently being pursued by the federal government. Our country was not founded by career politicians; it was founded by people who were doctors, lawyers, clergymen, printers, and farmers, who were good at what they did and who were leaders of their communities. They took time out of their practice or work to lend their expertise to Congress during a time of need to form our nation and then went back home and lived under the laws that they created as any citizen must. The concept of citizen legislators is completely foreign to our government today. We have a bunch of career politicians who have never even tried to succeed in the real world or who do not know the challenges that most Americans face every day.

So, I decided that if I was dissatisfied with the direction of government, I needed to get out of the stands, come down on the field, and play the game, even if it puts my reputation, my family, and my livelihood at risk. We need to stand up as average Americans who excel in our respective fields and lend our expertise to our country.

As an interventional cardiologist, what health care reforms would you advocate?

Dr. Cates: There is no question that we need to reform health care, but the bill that was passed is the wrong bill. We need to start over and propose positive reforms that will bend the cost curve, provide portability for insurance, and fix the medical malpractice problem in the United States.

We need to fix the portability issue so people are not fearful that if they lose their job, they won't have insurance. Insurance needs to follow the patient, not their job. We should provide uninsured people with vouchers and tax credits that let them use the free market system to buy insurance that best suits their needs. We need to fix the preexisting condition issue. We also need to help small businesses by encouraging the pooling of their insurance purchases. Even though the retirement community enterprise we started is a large business in our county, it's still a small business to the insurance companies, and we have trouble competing for affordable insurance coverage. We also need to allow people to buy insurance across state lines. For example, there's only one insurer (Blue Cross) in Alabama, which naturally gives them a monopoly. That is not good for the people of Alabama or for America. We need the ability to have insurance be competitive across state lines, which will drive down the cost for individuals and small businesses.

How do you propose we change medical malpractice?

Dr. Cates: We should create a mechanism for medical peer review organizations to review cases for malpractice and ascertain whether the alleged malpractice bears a relationship to the patient's injury before letting the case proceed. Every physician knows that there is a constant threat of malpractice, influencing our behavior and driving up unnecessary costs within health care.

We also need to implement guideline-based safe harbor laws because bad things in medicine do sometimes happen. It is a fact of medicine and of life that patients sometimes die, but that doesn't always mean that someone was negligent. If physicians and hospitals follow the guidelines, those guidelines should be safe harbors that are free from litigation. In addition, we need to stop frivolous lawsuits and cap judgments for pain and suffering on a national level so that lawyers are discouraged from filing suits solely to extract a settlement that will raise the cost of insurance for everybody, and more importantly, drive physicians to use more costly, defensive medicine. For example, when a 35-year-old woman comes to the hospital complaining of chest pain, we know that she most likely does not have coronary disease, and by careful history and physical examination, you can determine whether or not the patient needs to be admitted. However, at many hospitals around the country, such patients are admitted to the hospital, undergo a battery of enzyme tests, electrocardiogram stress tests, or a thallium stress test, or some other type of diagnostic intervention entity even though we all know that those patients don't have significant coronary disease as the etiology of their symptoms. And yet those sorts of unnecessary, defensive medicine tests drive up health care costs. It's the threat of lawsuits that drive physician behavior to

cover themselves and their hospital. These costs could be eliminated with thoughtful malpractice abuse reforms.

How do you manage the quality of patient care while also trying to drive down costs?

Dr. Cates: We need to align incentives within health care; let doctors and hospitals talk about efficient ways to take care of patients with an eye on both quality and cost. There have been about 20 Medicare demonstration projects over the years. We took part in a project aimed at coronary bypass surgery in the early 1990s when I was in private practice at St. Joseph's Hospital, where we implemented quality standards for efficiently getting patients through the system after coronary artery bypass graft surgery. We measured quality indicators such as morbidity, mortality, length of stay, reinfection rates, bleeding, readmission rates, etc. We found that quality went up and costs went down by approximately 30%, allowing physicians and hospitals to focus on and streamline the patient care process in disease state management. It drives a lot of costs out of the system while maintaining and improving quality. The resulting cost savings were shared between Medicare and the providers, and everybody won.

These projects have historically improved value and quality by every measure but have never been implemented by Congress. It's crazy. These medical demonstration projects ought to be allowed to continue and should be used to generate more data to drive quality care. We need to move toward a medical system that measures and rewards value rather than just volume.

How else do you "bend the curve" of medical costs?

Dr. Cates: In order to drive down costs, patients need to have some "skin in the game." They must have an incentive to be partners in their care instead of just users in care.

A few years ago, the insurance company Humana had some quality issues that resulted in a lawsuit. The court appointed me and about seven others to oversee quality at Humana as part of their Physicians Advisory Board. The company implemented a new insurance product that was different from all others. The insurer provided the patient with a pot of money up front for the patient to use, but that money belongs to the patient before their deductible kicks in, making the first dollar the patient spends be his or her own money.

Therefore, the first $500 the patient spends comes directly from that pot of insurance money. What does that do? It gives the patient skin in the game. Now they're going to be spending their own money first, so instead of running to the doctor four times for the sniffles, they say, "I know what the doctor is going to say, 'Go home, take some pain reliever, drink plenty of fluids, and call me if you're coughing up yellow or green stuff, likely showing that you have bronchitis.'" So, instead, the patient reduces unnecessary medical visits. If the patient starts to have symptoms of bronchitis, they will then go to the doctor, who may order a very expensive medicine like a Z-Pak. Instead of just filling the Z-Pak prescription, which costs $100 or more, the patient may ask their doctor if there is any reason why they can't just take amoxicillin, which they can buy at Walmart for $4. We need to bring this so-called Walmart mentality to medicine and encourage patients to shop for value and not just automatically do whatever they are told and not question the cost of their care. Patients need to be a partner in their care. The present House and Senate bill is a step in the opposite direction; it removes patient choice and put government in the middle of the doctor-patient relationship. What the physician community should do is to empower the patient with a sense of partnership in their own health care.

So, those are the things that I would propose to bend the cost curve, improve care, empower patients, and not add to the deficit. There's nothing in this bill that's going to bend the cost curve. It's all top-down regulation, which is the antithesis of patient choice.

Your primary race has changed to a special election. What can you tell us about this?

Dr. Cates: Rep Nathan Deal (R, Georgia) was the sitting Congressman and is running for Governor of Georgia. He was planning to resign after this term, but recently announced that he was going to resign immediately so that he could better focus on the gubernatorial race. The Governor announced that the special election to fill the remaining term of that seat will take place on April 27. Therefore, it is possible that I could be the seated Congressman from Georgia almost immediately; so, this race is now much more than just a primary and has national implications with the health care debate still raging and every vote so crucial.

For those members of the interventional community who wish to support your candidacy, what can they do to help?

Dr. Cates: Well, I need my colleagues in endovascular medicine and cardiology across the nation to go to my Web site at www.catesforcongress.com and send me their financial support so I can stand as a voice for the doctor-patient relationship, improve vascular care at a lower cost, and lock horns with those who wish to put the government between the doctors and our patients. ■