
Volume 4 - Issue 2 , 2010 - Interview: Cardiology Leaders

Interview with Dr. Ralph Brindis: President-Elect of the American College of Cardiology

Dr. Ralph Brindis joined Kaiser Permanente in 1963 and is a luminary in the field of invasive cardiology. Among his many roles, he is Regional Senior Advisor for Cardiovascular Diseases for Northern California Kaiser. He serves on many California State and national task forces, boards and committees that focus on improving the quality of care of patients with cardiovascular disease. He is Clinical Professor of Medicine at UCSF. His major interest is in process measures and outcomes assessment in cardiovascular disease and he plays an active part in the conception and implementation of cardiovascular guidelines for Northern California Kaiser. Here, Dr. Brindis tells Cardiology Management how his current role as President-Elect of the American College of Cardiology (ACC) and his duties leading Kaiser Permanente, have taken him temporarily out of the cath lab, and shares the story of one of his most memorable life-saving interventions.

What motivated you when you first decided to pursue a career in cardiology, and later on in invasive cardiology?

Early during my residency at UCSF I narrowed my choice of specialty down to GI and cardiology. As I wished to remain in the San Francisco Bay area, I applied to UCSF in GI and UCSF in cardiology. I was accepted to both, and when walking into Bill Parmley's office (shortly thereafter ACC President!) I was not even sure what I would say. The bottom line was that I decided not to work in lumens that "were already there" - GI colonoscopy/endoscopy - but instead to "create my own lumens" - cardiac cath. I was trained by colleagues at San Francisco Kaiser as an interventional cardiologist, learning on the job, and became board certified in interventional cardiology in '99.

Please describe your typical day's work.

I have no typical day, which is what makes my job so interesting. With the intense leadership responsibilities at the ACC, I have had to step away from many of my clinical duties. At Kaiser, I was a true "in-the-trenches" cardiologist taking interventional call, regular hospital call, seeing clinic patients, and reading/performing non-invasive imaging. Up to recently I was in the cath lab twice a week and have now stopped performing cardiac cath. This was painful for me as I still enjoy being in the lab, but the ACC responsibilities and the marked decrease in the availability of cath lab time galvanised my decision to step away from the lab. I have pretty much put my outpatient clinic on hold though I still take 10 full weeks a year of hospital call, and do essentially only Kaiser administrative work, with the rest of my time devoted to ACC endeavours.

What is the most demanding and timeconsuming part of your working life?

Probably the intensive travel. ACC work represents 8 - 11 hours a day and I have forecast that I will travel almost 300,000 miles this year for the ACC with 10 - 12 international trips, multiple state chapter meetings and probably 30 trips to Washington DC. This is particularly burdensome for a "west coaster". Also, the email burden is incredible - I get up to 250 emails a day, many requiring short or immediate turnaround.

Since you began as President-Elect of the American College of Cardiology (ACC), what new directions has the college taken?

The major direction for the college is the increasing development of a portfolio of "tools but not rules" for the practicing cardiologist in the transition now occurring related to healthcare reform. This is reflected by our inpatient registry portfolio and an officebased ambulatory physician registry called PINNACLE. This registry looks at adherence to secondary CAD measures along with diabetes management, atrial fibrillation, anticoagulation, and hypertension control. We will shortly have created an 'Appropriate Use Criteria' decision support tool that will hopefully replace radiology benefit managers (RBMs) as a way to avoid inappropriate imaging testing. To be successful, this needs to be implemented at point of ordering not just by cardiologists, but by all who order tests, from internists to family practitioners. Our aggressive lobbying and meeting with congress and other healthcare leaders will ensure that cardiologists influence and are part of healthcare reform.

Is management an important learning topic in your department, and within the ACC?

Most physicians are not innate managers or leaders. Mentorship and coaching has occurred in my own career both within Kaiser but also on a national level through the ACC. Skills in running meetings, being an effective chair, understanding and planning budgets and project planning were learned through incredible mentors, over the years. Kaiser Permanente prides itself on being a physicianrun organisation. Individuals with the desired values are mentored and offered leadership and management/business course retreats to better understand non-medical aspects of leadership. The ACC is also about to launch a "Leadership Institute" to help develop cardiology leaders on a nationwide level.

Is it challenging to keep up with the latest developments in invasive cardiology?

It is incredibly challenging to remain at the leading edge of one's field. That is what makes cardiology so stimulating - all that we know has basically been continually learned or implemented since my training days. It's hard to fully predict the future, though I've been surprised by the accuracy of my assessments of needs for Kaiser Permanente related to cardiology based advancements - invariably I predict that their impact will occur in a sooner timeframe than actually happens. The reality is that actual diffusion of new technology or even practice management related to new clinical trial findings, takes time to be fully embraced in clinical practice.

What are your predictions for the future of this part of the cardiology spectrum?

Percutaneous valve replacement/repair will clearly make a big impact. Managing and overseeing the skills of the physicians who take on this exciting and challenging advance will be critical. Atrial fibrillation ablation techniques similarly need to be monitored for safety and effectiveness - best carried out via a registry as new technology is diffused into the community. Understanding non-invasive imaging and ordering the best test the first time for a clinical scenario, and then further understanding how proper imaging actually affects outcomes is a whole new science unto itself. The whole role of comparative effectiveness research has a huge role in understanding best practices in cardiovascular disease. This again is critical for our nation when realising that 43percent of Medicare expenditures are on CV disease.

How important is it that outcomes and the quality of patient care are emphasised?

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This is the most critical initiative for the ACC and our profession. The ACC has taken on a true leading role in the definition and evaluation of quality in the management of CV disease. The following is only a short example of the many initiatives that the ACC uses to lead development in quality of care:

- Clinical practice guidelines;
- Data standards;
- Clinical competency documents;
- Performance measurement development;
- Appropriate use criteria for imaging and procedures (revascularisation);
- NCDR registry – six registries with 11 million patient records in 2,400 hospitals;
- Continuous quality improvement programmes;
- A hospital-to-home national programme to decrease CHF re-admissions;
- Door-to-balloon initiative to improve timely access to PCI in management of heart attacks and,
- Science and education initiatives – e.g. a life-long learning portfolio.

What sort of tactical advice would Vyou pass on to the next generation of cardiologists, to help them advance in their career?

Love what you do, choose a career path that you are passionate about. Think outside yourself and try to see the big picture. The greatest thrill I get is what I call “connecting the dots”. That is, there are so many terrific people in cardiology and connecting ideas and seeing ideas germinate and flourish as a result is an incredible honour.

How does it feel to save a life?

Saving a life is an amazing privilege. One story comes to mind of a 45-year-old patient arriving to our cath lab in the setting of a heart attack with recurrent ventricular fibrillation. We must have shocked him 30 times. Between each shock I would perform little “mini-steps” of performing an emergency cath and PCI. Shock the patient, put in the femoral sheath, shock the patient, put in the catheter, shock the patient, move the catheter up to the coronary artery, shock the patient, perform a coronary angiogram documenting the occluded artery shocking the patient between each picture. The performing angioplasty (opening up the coronary artery blockage) repeating the scenario of doing small mini-steps and shocking the patient each time he went into ventricular fibrillation. Then, when finally able to open up the totally occluded left anterior descending coronary artery, the patient stopped going into cardiac arrest and was stabilised. Incredibly, he left the hospital three days later in great shape without any neurologic damage. Pretty amazing!!

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