One of my agenda items this year is to further enhance the American College of Cardiology's efforts to provide better value for cardiology subspecialty societies and for our subspecialty members. The ACC Board of Trustees (BOT) feels strongly that the College should always strive to build activities and services that increase the value of ACC membership for its members, including the subspecialists, and we attempt to do so in ways that are not detrimental to cardiovascular subspecialty societies. The ACC firmly believes that, particularly as our profession faces issues regarding physician reimbursement and talk of health care reform, cardiovascular societies need to stand together. However, as each society, including the ACC, strives to be a strong and meaningful organization for its members, the image as partner society may not always seem clear.

By now you have probably read that the Society of Cardiovascular Angiography and Interventions (SCAI) and ACC will not again combine the SCAI Annual Scientific Sessions with the ACC’s Innovation in Intervention: i2 Summit at ACC.09 in Orlando, Florida. Despite what was an exceptional meeting at ACC.08 in Chicago, Illinois—in terms of attendance and the ability to provide cross-specialty education between interventional cardiology and general cardiology—we could not resolve some basic differences on educational goals. Both the SCAI and ACC respect and understand each other’s positions. After all, this was about only one meeting.

It is important to note that the inability to resolve each group’s needs in no way detracts from other activities on which the ACC and SCAI are working closely together. It could be said that we are working together even more effectively. The SCAI has recently taken a much greater role in document review, the National Cardiovascular Data Registry's CathPCI Registry, and committee representation than they did before the Interventional Scientific Council was established.

The ACC Interventional Scientific Council and the i2 Summit meeting were established by the BOT at the behest of ACC members who are interventional cardiologists. These members felt that they had an insufficient voice in the College. Interventional cardiologists represent our largest subspecialty group. The Interventional Council has been unbelievably productive in identifying educational needs, document revisions, and advocacy needs—and it has stepped up to fulfill those needs much better than the ACC could have done in the past.

Likewise, the ACC’s relationship with the Heart Rhythm Society is more synchronized and more effective than in the past. Our combined ICD Registry has been very successful, was produced in record time, and has truly been a joint effort. Individually, we could not have been so successful.

This past year, the ACC and Heart Rhythm Society also worked together advocating to Congress against legislation that would have, in effect, stopped funding for Medicare beneficiaries who participated in clinical trials of new technology. The legislation may have provided some short-term benefits in reducing Medicare costs, but it would have
stifled innovation and precluded our doing studies to learn more about the appropriate use of these technologies.

**New Partnership on Imaging**

Most recently, the ACC helped to form an Imaging Council to work on two pressing needs for all cardiovascular professionals—development of educational curricula and appropriateness criteria for multimodality imaging. In addition to the ACC, the Imaging Council is comprised of representatives from the American Society of Echocardiography, the American Society of Nuclear Cardiology, the SCAI, the Society of Cardiovascular Computed Tomography, and the Society of Cardiovascular Magnetic Resonance.

Cardiovascular professionals are being severely criticized by payers for the growth in imaging tests and the lack of guidance for when an imaging test should be done and which test should be used. Our current documents focus on single imaging methods when they should probably center on symptom and disease states. It is a legitimate criticism because we do not have readily available criteria for what should be done when and first. The College is working hard to show payers that we can help define what quality practice is and in doing so, perhaps force a change in the payment paradigm from the number of encounters to doing the right thing first. Success in this area will resonate loudly, and success is not possible without engaging each of our subspecialty expert societies in formulating this guidance.

We also worked hard this year to support the Heart Failure Society in their efforts to have the American Board of Medicine recognize them as a subspecialty.

Sometimes our support has been of a different nature. Heart House houses some subspecialties such as the SCAI, Society of Cardiovascular Computed Tomography, and at one time, the Society of Geriatric Cardiology and the Society of Vascular Medicine and Biology. We have provided staffing for the basic needs of some societies such as the Association of Black Cardiologists or for advocacy with others.

So why do we all need to be unified in the “bigger house of Cardiology?” First, as a united voice, we make more noise—not only for our advocacy efforts but also for our clinical practice guidelines and appropriateness criteria. Except for a few, all of us practice general cardiology, and we have patients who need a complete doctor and not one who is simply involved in only one small aspect of their care. I believe most of us realize that further fragmentation of care is a recipe for more patient dissatisfaction and medical errors. If anything, we should be moving in the other direction.

In general, the training opportunities for both fellows and the membership are greatest with the ACC, and every cardiovascular professional needs some subspecialty training. The ACC’s Quality initiatives and Quality First campaign will not be restricted to performance in a single area, and for the tools and measures we are building to be truly effective, we must be inclusive in building them. Working as one together, we can build the best tools and ensure the best possible care for our patients and the greatest professional satisfaction for our members.

**Address correspondence to:**

W. Douglas Weaver, MD, FACC
American College of Cardiology
2400 N Street NW
Washington, DC 20037