Spanish Society of Cardiology

“Only About 2% of People Who Have Had a Heart Attack or Who Have Heart Failure Use a [Cardiac Rehabilitation] Centre”

Maria Jesus Salvador, MD, PhD, president of the Spanish Society of Cardiology, talks to Robert Short, BSc, about how the SSC is working to improve the cardiovascular health of the population in Spain.

EuroAspire III—a survey of the practice of preventive cardiology in 22 countries (Belgium, Bulgaria, Croatia, the Czech Republic, Cyprus, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, the Netherlands, Poland, Romania, Russia, Slovenia, Spain, Turkey, and the United Kingdom)—has identified Spain, in results reported at the European Society of Cardiology in 2007, as having virtually no prevention or rehabilitation centres. Only 0.6% of patients receive recommendations to follow a cardiac prevention or rehabilitation programme, and only 0.2% attend such a programme.

Maria Jesus Salvador, MD, PhD, who became president of the Spanish Society of Cardiology (SSC) in October 2007, comments: “Yes, this is the sad truth. The results of the EuroAspire survey are derived from centres designed to represent Spain. The only region actually represented is Valencia. In this region there is only 1 centre with a complete rehabilitation programme. Our working group explained to me that there are actually perhaps 20 cardiac rehabilitation centres throughout the country—complete rehabilitation, not just exercise—in our national health service. It seems also that there are only 20 centres in private health systems as well. But, clearly, they are not large enough or many enough. Only about 2% of people who have had a heart attack or who have heart failure use a centre.”

Cardiovascular Disease Risk Has Increased in Spain

Spain is 1 of only 3 countries in Europe for which cardiovascular disease does not represent the main cause of death in men (with France and the Netherlands as the other 2...
Box. Practice of Cardiology in Spain

Number of Cardiologists
Spain has fewer cardiologists than other European countries (see Table): 3.6–4.0 per 100 000 inhabitants according to different sources as follows.

- In 2004, 1903 cardiologists were members of the SSC, 1537 under 65 years of age.2
- In 2005, 2287 cardiologists were members with specialist qualification of the Association of Spanish Professional Medical Bodies.
- The SSC has 4102 members according to the European Society of Cardiology Web site.
- There are about 14% fewer active cardiologists in Spain than are needed.2
- In 2004 there was a deficit of 253 cardiologists, and this will increase each year, reaching 343 in 2020.
- Over 25% of cardiologists who are members of the SSC work in hospitals with more than 20 cardiologists.
- Over 20% of cardiologists who are members of the SSC are the only representatives of their speciality in the hospital where they work.

Numbers of Intervention Facilities and Procedures
- Over 112 cardiac catheterisation laboratories.3
- In 2002, of 22 countries ranked according to number of coronary angioplasty procedures, Spain was third from bottom; and of 19 countries ranked according to number of coronary bypass grafts performed, Spain was bottom.

In 2003 Compared With 2002
- With 40 584 procedures, the number of coronary interventions (969 per million inhabitants) increased by 14.4%.
- Coronary stents used in 92.5% of procedures (22% increase in number of units used).
- With 6080 procedures, percutaneous interventions carried out in patients with acute myocardial infarction increased by 27.5%.
- Number of percutaneous mitral valvuloplasties increased by 21.6%.
- Number of atrial septal defect closures increased by 86%.
- Number of paediatric interventions increased by 13.3%.

Table. Number of Cardiologists per 100 000 Inhabitants 2002–2006 by Country4

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
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<tbody>
<tr>
<td>Ireland</td>
<td>0.6</td>
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<tr>
<td>England</td>
<td>4</td>
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<tr>
<td>Spain</td>
<td>5.5</td>
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<tr>
<td>Switzerland</td>
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<td>Greece</td>
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The SSC Intends to Establish Rehabilitation Centres Throughout Spain
Speculating on the reasons for the failure in the use and provision of cardiac rehabilitation in Spain, Professor Salvador says, “It may have to do with the long-established political priority towards ensuring that everyone has access to a catheter laboratory for treatment, with prevention and rehabilitation being put further down the list of priorities. This must change.”

The Spanish Government has signed the European Heart Health Charter, and Professor Salvador sees this as a useful way to put pressure on politicians to meet prevention centre goals of the charter. Professor Salvador says, “Our government health minister is a doctor. We talked to him about this when he came to our society’s annual conference in 2007.” Since then, the SSC has had additional contact with the health minister over health education, but government elections have interrupted progress.

Some Areas of Spain Lack Cardiologists
Spain has a state-funded National Health Service. “All people in Spain have the right to be treated by the National Health Service. Many years ago, it was only for poor, working people, but now it is open to all people in Spain,” Professor Salvador says. Spain also has a national strategy for ischaemic heart disease and vascular disease. Professor Salvador adds, “This plan was developed in collaboration with the different professional societies and the health authorities of the regional governments. Importantly, the director of the plan is a former president of our society, and members of our working groups are on the development committee for the plan.”

Professor Salvador sees Spain as a leading country in Europe in delivering care to patients across the country. She says, “Our national health system tries to ensure that all patients, throughout the country, have an opportunity for treatment of all types. This is not exactly the way it works at present, but it is a strongly held aspiration.”

Spain faces 2 major barriers to achieving a consistent service throughout the country: the total number of trained cardiologists and the willingness of cardiologists to work in all parts of the country (see Box). Professor Salvador says, “It is a career advantage and generally more attractive to cardiologists to be in the big cities. This means that there is a lack of cardiologists in some areas of the country.”
Combining Forces With the Spanish Heart Foundation and Becoming More Open to the Public

As the principal challenge of her presidency, Professor Salvador is continuing the campaign started in an earlier presidency to make the SSC well known to the Spanish public. The previous president carried out a survey to gauge what the population knew about the SSC. Professor Salvador reports, “From that, we realised we were a closed-in group and not open to the Spanish public. At the moment, when we talk to the media, the public do not know who we are and what authority we have.”

Professor Salvador says that her strategy involves combining forces with the Spanish Heart Foundation and becoming more open to the public. She adds, “This way, we can give the public direct answers to all the questions that they have on their health, guide them on the rules of healthy living, and tell them how to access good health care.”

The Spanish Heart Foundation already sits physically close to the SSC: both institutions have their headquarters in the Heart House in Madrid. They also share the same administration.

Professor Salvador explains: “Our administration is in common, but until now we have worked in 2 separate departments, the society being a traditional scientific society and the foundation a fundraising body that also gives out heart-healthy messages to the public. So, the foundation was a little bit better known than the SSC, but it also was not well known, as we discovered on the same survey. Despite being in the same Heart House, the public did not know the society existed under the foundation.” She says that by combining forces they can send out a consistent and strong message to the population from leading cardiologists who would become public figures.

Encouraging Young Doctors to Become Clinician–Scientists

The SSC plays a very active role as a cardiology society, holding congresses and having a large programme of continuing medical education. It has many working groups, and spends more than €1 million a year in research and on grants for young cardiologists.

However, like many other countries in Europe, Professor Salvador admits that Spain has a problem with recruiting clinician–scientists. She says, “There is no shortage of young talented doctors, but there is not a research branch in the medical degree in Spain. We are trying, with various government departments, to create a new degree, but we are just in the first few steps of this process.”

Professor Salvador says that they are trying to encourage young doctors to get to know the basic sciences and to transport this knowledge and attitude into their clinical work. She adds, “It is not easy. We are working hard to create a culture on basic research in Spain.” She stresses that the problem lies more in basic research than in clinical research. She says, “Clinical research is easier for young doctors to have access to, because it takes place in the big hospitals that are closely related to the universities.”

“It Is Not Easy to Rise to the Top of a Career in Cardiology for a Woman, but It Is Not Easy for the Men Either”

As the first woman president of the SSC, Professor Salvador might serve, for some female medical students and young cardiologists in Spain—and in the European Society of Cardiology—as a role model for their own careers. She says, “In Europe, there are women in cardiology in senior positions. They got there because of their work, their ability,
Spotlight: Fokko de Haan, MD

German Cardiologists in Private Practice Face an Uncertain Future

Fokko de Haan, MD, second chair of the German Association of Cardiologists in Private Practice (Bundesverband Niedergelassener Kardiologen), talks with Barry Shurlock, MA, PhD, about why he chose to work as an office cardiologist and the fast-changing role of office cardiologists in Germany.

The German Association of Cardiologists in Private Practice (Bundesverband Niedergelassener Kardiologen [BNK])—the professional organisation of office cardiologists in Germany—currently faces the challenge of matching the budgetary needs of government with best practice, according to Fokko de Haan, MD, second chair of the BNK.

“The Past Few Years Have Been a Very Difficult Period”

An office cardiologist, Dr de Haan grew up in Solingen, Germany, a city in the North Rhine-Westphalia region of Germany celebrated for the manufacture of fine knives, scissors, and swords—and home of the Wilkinson Sword company. For almost 25 years he has worked there as a cardiologist in private practice. When he started in his own office in November 1983, he hoped to offer local people the clinical skills he had acquired under Franz Loogen, MD, professor of cardiology, during his long training in the nearby University Clinic of Düsseldorf, Düsseldorf, Germany. But it has not worked out that way, he says. “The past few years have been a very difficult period. When you start in private practice you want to practice the best possible medicine, as you learnt at medical school. But you soon discover that this is not enough—you have to learn also to cope with the economics, or you can’t exist!”

After a lifetime in the practice of cardiology, Dr de Haan now spends much of his time as the second chair of the BNK balancing budgets and getting the best deal he can for its members. This has become a major commitment, taking several hours a day, together with a whole day each week, when he either works in the small BNK office in Munich or travels to Frankfurt to meet with pharmaceutical companies.

Representing 95% of Office Cardiologists in Germany

The BNK began in 1979 (as the ANK), with only 100 members, under the chairmanship of Guenther Kersten, MD, of Cologne, Germany. It now represents 95% of all office cardiologists in Germany, and it operates independently of the German Society of Cardiology, but it maintains close contacts with the “mother society.”

The 2 societies have different agendas (the German Society of Cardiology serves as the national cardiac society), but Dr de Haan considers that at some time in the future they might merge. The BNK has representatives on national bodies, including the Clinical Commission (Klinische...
Kommission), which sets national guidelines for clinical practice.

Dr de Haan receives a salary for his BNK job, which he has performed since 2002 when he first became chair of the society. Three years later (2005), he gave way to Sigmund Silber, MD, an office cardiologist from Munich, Germany, and in 2007 members voted the top job to Norbert Smetak, MD, from Kirkheim in southern Germany.

Of the 1350 BNK members, 70% work only in private practice and the other 30% share their time between the office and the hospital.

The key role in Germany of the office cardiologist, who might seem ubiquitous in the United States and elsewhere, is somewhat unusual within the European Union and differs from the role of many cardiologists in other European Union countries who practice privately but generally also work in state hospitals.

Office Cardiologists Are Forming Group Practices

The growth of group practices represents a major trend among BNK members, largely for economic reasons, according to Dr de Haan, who himself started as a “lone wolf” but who now works with 2 other cardiologists. Each of the 3 partners has a special interest, and they split the workload between interventional procedures, exercise testing and general cardiology, and cardiac rehabilitation.

Dr de Haan comments, “Whereas in the past there often was only 1 cardiologist working alone, now there generally are 2 to 3 or even 4 to 5 in a practice, with perhaps 2 of them also working in a local hospital.” Dr de Haan predicts that the trend will accelerate as diagnostic and treatment procedures multiply and cardiologists become more involved in other areas of medicine such as prevention and rehabilitation.

Budgetary Constraints Have Resulted in Long Waiting Lists and Little Choice in Appointment Times

Patients with heart problems in Germany generally receive referrals by their general practitioners to office cardiologists. Until the past few years, patients could expect appointments with minimal delays at times convenient to them, but budgetary constraints have led to the growth of long waiting lists and little choice in appointment times, according to Dr de Haan, who says, “Now, if the general practitioner sees a patient with an urgent problem, he will often refer the patient immediately to hospital rather than face the delay of an appointment with a cardiologist in private practice. This is not very good economics. It occupies hospitals with patients who could have been treated in the office, and it makes it less easy for clinicians to treat the very sick patients, such as someone with, say, endocarditis and malignant arrhythmia, who must be treated in hospital.”

Currently, about 250 to 300 hospitals in Germany employ cardiologists, but Dr de Haan predicts that this number will grow and that more and more patients will receive direct hospital referrals from general practitioners. Germany Could Resemble Other European Union Countries in 5 Years Time, With Most Cardiologists Working in Hospitals: “This Is a Pity”

At a time of extreme budgetary stress in Germany, when politicians “have a new idea every 3 months,” Dr de Haan feels uncertain as to whether the cardiologist in private practice has much of a future.

Dr de Haan believes that Germany could resemble other European Union countries in 5 years time, with most cardiologists working in hospitals. He comments, “This is a pity—it might be good to have 50% of cardiologists working in hospital, but I’m afraid of it reaching 100%! There are many advantages to working in your own practice in a small town. You can contact general practitioners easily and get to know them and their patients better. It’s easier to help patients to change their lifestyle and manage their problems, particularly those with conditions such as diabetes and hypertension. But it’s very expensive to have specialist cardiologists working in their own practice, as well as other specialists in a nearby hospital. More and more, we have to work together.”

After World War II, Germany enjoyed a huge growth of social medicine that led to what Dr de Haan calls a “cost explosion.” Since the unification in October 1990 of the former German Democratic Republic (East Germany) and the Federal Democratic Republic (West Germany), the reunited country of 82 million has had to cope with severe
economic problems. At the time of reunification, many believed that the German Democratic Republic had a lot of catching up to do. But, in public service cardiology, the trends seem to have begun in the East, where private practice virtually did not exist and all patients received treatment in state-run polyclinics, according to Dr de Haan.

**In 1998, Each Patient Had an Allocation of €180; Today, Each Patient Is Allocated €90**
The motor of change in the practice of cardiology in Germany lies in the national government, which directs health policy, decides how many cardiologists the country needs, and fixes budgets. In the past decade, the government has argued that Germany has too many doctors and too many hospitals: it certainly trains far more cardiologists than any other European country (the German Society of Cardiology has a membership of about 6000 compared with 2500 and 1450 in the national societies of France and the United Kingdom, respectively).

But the bleak policy that results from this credo has an indirect impact on cardiologists in private practice by means of an annual contract negotiated between the BNK and a group of health insurance companies, whose members have government appointments. This contract sets standard payment amounts for the treatment of every condition, independent of severity.

Some believe that after a lot of computerised number-crunching and paper shuffling, the German government remains solvent and the German heart patient receives good treatment, but Dr de Haan has grave doubts. “This is a very new system that only came in this year. The budget stops at the end of the financial year, and then I’m afraid that the government will lower the budget again. Many German doctors are leaving to work in other European countries, including the United Kingdom. The health budget has been reduced every year for the past 10 years, so that whereas in 1998 each patient with a recognised category of heart disease was allocated €180 [or equivalent], today it is only €90.”

**The Central Concern of BNK Officers Involves Intensive Academic Training for Members**
Although negotiation of the contract represents a major occupation of BNK officers, their central concern involves intensive academic training for members, which undergoes regular review by a “quality assurance” perspective (the so-called “QuIK register”). Other major tasks include publication of the BNK journal, Herz [Heart], and organisation of the annual meeting. This took place during the first 10 years of the BNK at the luxury resort of Bürgenstock, Switzerland, but the BNK now stages its annual meeting more economically in the Frankfurt area. The BNK also offers members the “clout” of bulk purchase from companies supplying medical equipment—everything from electrocardiographs to echocardiographs and Halter monitors. Dr de Haan comments, “In the future, the BNK may also negotiate special prices for drugs with pharmaceutical companies.”

**A Period of Huge Change**
After qualifying in medicine at the University Clinic, Düsseldorf, Dr de Haan opted for 5 years of training in internal medicine and found cardiology by far the most interesting part of the course. Although he had moved 25 km for training at what he calls his “mother school,” he never doubted in his mind that he would return to set up practice in his home town of Solingen. He says, “In 1983, when I left Düsseldorf after qualifying, I had a family and decided it would be easier to work in private practice back in Solingen. Without a family, I might have gone into hospital practice.” He recalls those at Düsseldorf who had a profound influence on him, including Professor Loogen (now retired), Günter Breithardt, MD (now at Münster), Ludger Seipel, MD, and Horst Kuhn, MD. For many years after leaving, he often referred difficult patients to his mentors.

Dr de Haan would like to become more involved in research, but time constraints in private practice have made it difficult. He and colleagues have managed to carry out some studies of patient compliance in antihypertension therapy, although he regrets that he has not done more. In these changing times, what advice would he give to the young cardiologist embarking on a career? “Think very carefully before you start. Decide beforehand whether you want to practice alone, in a group practice, or in a hospital. If you opt for a hospital career, you need to spend some time abroad, in the United States or elsewhere, and in private practice you obviously need patients! In some cities, such as Cologne or Hamburg, you will earn more in private practice than in a hospital, but in others, including Berlin, you will probably earn less.”

Dr de Haan has practised cardiology during a period of huge change, technically and professionally, but as a reward he has enjoyed a life in his hometown, where he spends much of his spare time tending his 120-hectare [3000-acre] estate and the many farm animals (and fish) that share the space with him. One of his daughters intends to become a surgeon; his other children have sought fresh fields—architecture, law, and theatre management. As he approaches the age of 60, he feels unsure of what the future holds, but he has the knack of spicing his conversation with a hearty chuckle, which signals that he intends to take things as they come: “I may finish with the BNK in the autumn [2008] or, perhaps, later, and then we shall have to see what happens.”

*Barry Shurlock is a freelance medical journalist.*