College of Physicians and sees the practical supervision of Trainees by clinicians as the cornerstone of cardiology training. Although he says it is challenging for busy clinicians to find the time to supervise training, supporting trainees and their supervisors by providing better quality educational materials and streamlining the supervisory process is a future priority.

Australia has a proud history of providing good healthcare and medical training and of encouraging research. The health system is jointly funded by the Federal and State Governments. This can cause ambiguity, but fundamentally the system ensures everyone is covered for basic acute healthcare. There are however, Kritcharides says, ‘disparities in health outcomes relating to social factors, geography and ethnicity—Australia’s Aboriginal population for example—are still over-represented in all analyses of cardiovascular morbidity and mortality’. The increasing specialization and cost of service delivery requires that some invasive services are restricted to certain major teaching hospitals requiring well-established networks of communication and patient transfer between health care sectors. Cost and access to care are perennial themes.

He also serves on the National Board of the Heart Foundation of Australia and is chairman of the Board of Governors of the Heart Research Institute, where he undertook his PhD. He sees it as a privilege to be able to contribute to the CSANZ, and to the Heart Foundation and the Heart Research Institute, which supported his early research.

The Australia and New Zealand are the two unique countries separated by the Tasman Sea but united in their dedication to providing good cardiac health services, training, and research. The CSANZ is central to this as ‘the conduit’ to the profession of cardiology and the voice of individual medical and nursing practitioners.

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Australasia Leader in Cardiology

Mark Webster MBChB, MD, FRACEP

Outgoing President of Cardiac Society of Australia and New Zealand (CSANZ) is New Zealand-based Mark Webster who trained in cardiology in Christchurch, Auckland and at Mayo Clinic, Minnesota, USA

Medicine appealed to him as an interesting, challenging and satisfying discipline which offered a chance to make a difference to people’s lives. Cardiology, he says: ‘offered a bit of everything; the need to sort out complex cardiac conditions clinically, and the opportunity to do interesting procedural work’. It was also a rapidly evolving specialty leading the way with game-changing, large, randomized trials.

During his training, Webster remembers John Neutze, at Green Lane Hospital, Auckland, New Zealand, as an influential figure and ‘an outstanding and committed paediatric and adult cardiologist—a superb clinician with an incisive mind who did pioneering research and supported others in their research’. During his 3 years at the Mayo Clinic, Webster undertook platelet-thrombosis research with Jim Chesebro, a world expert in the field known for an idiosyncratic approach to his work.

As an interventional Fellow, he particularly valued working with David Holmes, then head of the cath lab, and the highest volume operator at Mayo. Holmes had unequalled procedural skills, which he combined with a strong research career.

Webster started out as a consultant at Green Lane Hospital, a stand-alone public cardiothoracic hospital with a strong international reputation partly derived from pioneering cardiac surgical work. In 2003, the inpatient unit moved to the new Auckland City Hospital. He counts himself fortunate in having a varied, high volume interventional practice. Following the move across town, he was involved in developing the systematic provision of primary PCI for all Auckland (population 1.6 million) patients presenting with STEMI. The topography of Auckland—a city on a narrow isthmus between two harbours—presents transportation challenges.
During working hours, primary PCI is provided at three public hospitals—one in the north, one in the centre, and one in the south. After hours, all STEMI patients come directly to the central Auckland City Hospital. The call roster involves all 13 interventionalists from the region’s public hospitals. The system works well from both a clinical and economic perspective.

Webster undertook a study many years ago which demonstrated the increased prevalence of patent foramen ovale (PFO) in young stroke patients. Only in recent years has it been confirmed that closing the PFO in these patients helps prevent recurrent cerebrovascular events. His unit has undertaken many first-in-man coronary, structural, and related device trials. Collaborative work with a colleague, John Ormiston, on bench-top testing of coronary stents provided insights leading to improved stent designs and stent deployment techniques, particularly in bifurcation lesions. His interest in designing and developing new interventional devices has led to STARSystem, an adjustable radial access support with radiation protection for the operator performing radial access angiography and intervention. This was developed in collaboration with Adept Medical, a local Auckland company, and has been well-received by clinicians both at home and world-wide.

Acute hospital health care in New Zealand is provided by government-funded public hospitals. About 30% of the population have private insurance, which covers specialist assessment and elective surgical and other procedures undertaken at separate private hospitals. Most cardiologists undertake both public and private work. He says, ‘Although no health system is perfect, ours is generally efficient, even though the absolute amount spent on health in New Zealand is below the OECD average, which limits what can be offered to patients.’

The CSANZ alliance with neighbouring Australia works well and New Zealand rotates with the Australian states when it comes to hosting the CSANZ Annual Scientific Meeting. He says: ‘Australia has a lot of good things happening and most Society activities benefit from a combined approach’. Wider international collaboration in some areas is also important. Webster has an interest in spontaneous coronary artery dissection (SCAD), an uncommon cause of acute coronary dissection which often affects younger women; 160 patients with SCAD from the Auckland region have been followed for up to 20 years. Webster notes: ‘The recently established ESC SCAD Registry, coordinated by Dave Adlam from Leicester, is a good example of how collaborative registries can advance understanding of uncommon conditions. This sort of pan-European scale registry provides critical mass; we can start looking at patient subsets and embed clinical research studies’.

New Zealand faces challenges with introducing new drugs and technology. The national pharmaceutical purchasing body (Pharmac) has been effective at constraining pharmaceutical costs via bundling drugs and keeping pricing confidential. However, introduction of unequivocally effective new drugs is often slow, with many only becoming available once off patent as cheaper generic versions. Pharmac have recently started national purchasing of medical devices but it is uncertain whether this will be as successful.

Webster’s 8-year involvement with the Data Safety Monitoring Board of the Health Research Council of New Zealand has provided insights into trial design and conduct, particularly in a resource-constrained environment. This has convinced him that large, simple trials, ideally embedded into established registries and linked to national datasets have a lot to offer. This type of research was pioneered in Scandinavia and with our ANZACS-QI national registry capturing all patients presenting with an acute coronary syndrome, and all those undergoing coronary angiographies, we are similarly well-placed. Outcome data can be obtained from linkages with national mortality, hospital discharge code, pharmaceutical prescribing, and laboratory databases.

New Zealand has regional issues regarding the health of the indigenous Maori population, and a large Pacific Island population, which both tend to higher rates of obesity and diabetes leading to ischaemic heart disease developing at a younger age. The same groups also experience acute rheumatic fever—a third world disease. Although working is ongoing to tackle these problems, rheumatic heart disease remains a common problem in New Zealand.

Conflict of interest: Mark Webster receives a royalty on sales of STARSystem.