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A Most Egregious Example of Labor Discrimination in US Healthcare

Sergio Bartakian, MD

The Equal Employment Opportunity Commission (EEOC) oversees the major federal labor discrimination laws in the United States to protect employees based on protected characteristics. Key laws include: Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on: race, color, religion, sex (including pregnancy, sexual orientation, and gender identity), and national origin; the Americans with Disabilities Act (ADA); the Age Discrimination in Employment Act (ADEA); and the Equal Pay Act. The latter of these is as simple as its name suggests, equal pay for equal work. More completely stated, this provides protection for men and women, regardless of their position, who perform equal work in the same establishment, ensuring they receive equal compensation.

Although in the U.S. healthcare industry there are those that continue to fight against ongoing discrimination based on race or gender, there is another area of outright labor discrimination which urgently needs to be addressed; that of the pediatric vs adult medicine trained physician.

In the recently published Medscape Physician Compensation Report for 2026 (<https://www.medscape.com/p11/return-normalization-medscape-physician-compensation-report-2026a10009um>), pediatrics ranked last among 29 categories for average compensation. But this table was in fact greatly misleading and failed to demonstrate just how much worse the truth really is. Among the 29 categories the table lists internal medicine and family medicine at 23rd and 24th,

respectively. All of the other specialties are in fact representative of only the adult counterparts (Internal medicine trained adult medicine specialty physicians). Pediatrics, the 29th position on the list, is a mashup of everything pediatrics to include general pediatrics as well as all of the pediatric specialties all lumped into one. Therefore, we can definitively state that the picture for the general pediatrician is in fact significantly worse than this table suggests as their salaries would be falsely represented as being higher by averaging with somewhat higher specialty salaries within pediatrics. That said, to keep this as short as possible, I will only discuss the specifics of my own specialty of congenital (formerly referred to as pediatric) interventional cardiology; a specialty which functions 100% in the hospital setting.

One attempt at arguing against this claim is for some to state that adult physicians are paid more because they see more patients and therefore bring more revenue to the hospital system. Let us be clear, it is not that pediatric physicians are working any less, rather, they simply are capable of seeing less patients or performing fewer procedures in the same amount of time. The opponents unknowingly present a wonderful argument in support of the underlying discriminatory problems inherent to the payment systems in healthcare. The American Medical Association (AMA) established the Relative Value Update Committee (RUC) in 1991 to continually develop and recommend Relative Value Unit (RVU) values for the Resource-Based Relative Value Scale (RBRVS) payment process. Medicare officially implemented this payment system on January 1, 1992.



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The fundamental hallmark of the process in valuing a new Current Procedural Terminology (CPT) code is to capture the work performed. The major component of calculating the reimbursement rate is the physician work, with the other two components being practice expense and malpractice expense. In the hospital setting particularly, where my specialty exists, any differences in the latter two would for the most part be inconsequential, therefore leaving work performed as the sole determinant in the contribution a physician brings to the hospital revenue. To clarify this point, for procedures performed in the hospital, there is in fact no practice expense included in the RVU calculation at the RUC. This is because those overhead costs, unlike for a private practice, are covered by a separate hospital fee payment through either the Diagnosis Related Group (DRG) payment for inpatient procedures, or the hospital Outpatient Prospective Payment System (OPPS) scale for outpatient procedures.

This then brings us down to the simple point which clearly demonstrates the problem at hand; if the adult interventional cardiologist works an average of 10 hours per day and performs six procedures per day while the congenital interventional cardiologist works the same average of 10 hours but is only able to perform two to three procedures per day, then the AMA RVU system should clearly have reimbursements for the latter to be three to four times greater than the former to credit the same relative reimbursement for the same amount of work performed. As stated above, the RVU system is not based on relative number of cases, rather on actual physician time spent. It is a well-documented fact that the congenital cardiac catheterization procedures require a significant amount of greater time. This is multi-factorial including: the requirement of general anesthesia for congenital cases, the greater complexity of dealing with infants with congenital heart defects, and the overall limited or even totally lacking resident, fellow, and physician extender support in the typical congenital catheterization program.

However, the discrimination does not end merely with a lack of appropriate relative reimbursement. On average, between 60-80% of all patients in a children's hospital across the United States are reimbursed by Medicaid. There is an outright discrimination to pediatric physicians with Medicaid reimbursements being significantly lower than those from the Medicare benchmark or private payers which dominate the bulk of adult healthcare reimbursements. This is often referred to as the "pediatric penalty" or "pediatric tax" on physicians and is the leading contributor to the current crisis of worsening pediatric physician shortages caused by fewer medical students choosing to go into pediatric medicine coupled with the increasing number of early retirement of experienced physicians. Although some statistics will claim that the difference in Medicaid payment is only a 20% reduction compared to Medicare, this is also false and is a best-case estimate of only certain areas such as simple outpatient clinic visits.

Let us look at a factual example of how significant this discrepancy is for cardiac catheterization. *CPT® code 93580 Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant.* This procedure includes a total time of 210 minutes

(including pre, intra, and post procedure) of which 120 minutes alone is the intra-procedure portion; the actual time to perform the procedure in the lab. As described by the procedure's short descriptor above, as well as by the description of work, and all other references, the procedure is for device closure of intra-atrial communication, specifically atrial septal defects and Fontan fenestrations. The CPT panel rules are very specific on usage of ie as compared to eg for describing which instances the procedure is to be used for. Since the code's creation, the non-congenital community began to also use the code to close the much simpler patent foramen ovale (PFO) in adult patients with normal hearts. PFO device closure takes significantly less time as compared to a true atrial septal defect (ASD) as evidenced by the period from 2006-2019 when PFOs were being closed for migraine headache indication. A single physician would perform anywhere between 10-15 of these in a single day back-to-back. Something absolutely impossible if even just half of the cases approached the typical intra-procedure time of 120 minutes. In contrast, the typical number of ASD cases in most congenital heart centers is two to three per day. No matter how you dissect the numbers, an ASD procedure should reimburse roughly four to five times that of a PFO, where in fact the exact opposite is happening.

As a specific real world example, in 2024 at one combined adult/pediatric institution which I will not mention, an adult interventional physician closed a PFO in a 67 year old woman with a total intra-procedure time of 17 minutes, then two months later, a congenital colleague closed a true and very complex ASD in a three-year-old child requiring two devices with an intra-procedure time of 140 minutes. The hospital was reimbursed \$27,000 by Medicare for the PFO requiring 17 minutes, and \$7500 by Medicaid for the ASD requiring nearly two and a half hours. Aside from any arguments on whether or not the use of code 93580 is appropriate for a PFO, if there was not deliberate discrimination, both should have at the very least reimbursed the same. In reality, in that scenario the ASD case should reimburse nine times that of the much less complex PFO procedure if physicians were truly recognized for time of the work performed. But here comes the most egregious part of the issue. Hospitals know this problem exists, the American Academy of Pediatrics knows the problem exists, yet none have taken any steps in advocating to correct this discriminatory behavior. Further, the entire establishment holds the pediatric physician responsible for a broken system by having salaries at a rate of around one third of the adult interventionist's. In fact, even worse, in many regions, a congenital interventionalist with 15 plus years of experience is paid an annual salary of roughly half of that for a brand-new adult interventional colleague straight out of fellowship.

Another example involves payer refusals to recognize increased reimbursements for more complex cases; namely modifier 63 for procedures on infants 4kg or less in weight. Despite the AMA and CMS having recognized and approved our revision application of this modifier in 2019 (effective 1/1/2020), throughout the United States payers are nearly universally ignoring the additional payment when modifier 63 is appropriately attached.



MOST EGREGIOUS EXAMPLE OF LABOR DISCRIMINATION

Unfortunately, the only potential remedy may be for the specialty to seek class action litigation against payers, similar to previous cases for modifier 25 in the early 2000s. Such cases are typically based on allegations of breach of contract or unfair business practices, especially if the insurer's policy violates the established CMS recommendations or contracted reimbursement agreements. If provider contracts with a facility explicitly incorporate CMS payment methodologies, which generally require a 120% payment adjustment for Modifier 63, the refusal to pay is a potential breach of contract. Such cases often arise when an insurer applies a broad, systematic policy of denial or underpay a specific modifier across the board, rather than just isolated errors, which is precisely what we are seeing with modifier 63. As one case law example among many, in 2007, 24 BCBS member companies agreed to a \$130 million settlement to resolve claims from 700,000 providers regarding the improper cutting of payments for modifier 25.

Now, to be clear, I am not merely advocating for congenital interventional cardiologists, these same irregularities can be found across the board in pediatric medicine in all specialties. Pediatric specialists all train for an additional year of fellowship after residency as compared to the typical internal medicine specialty fellowships. They work the same number of hours, with significantly less support staff and resources, and most importantly, provide care to the most important population of patients which exists, children – our future. The fact of the matter

is, children simply do not matter to the U.S. healthcare system. Medical students have historically been told, you do not go into pediatric medicine for the money, rather because you love what you do and you care about your patients. This inappropriate and deceptive mentality implies that adult physicians do not care about their patients, which is clearly and categorically false. No one in the modern era decides to go to medical school as a path to wealth. It is time this discriminatory practice ended and physicians across the board were recognized with equal pay for equal work – in accordance with the law.



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BOND Trial Aims to Improve Support for Families Facing Congenital Heart Disease

Large multicenter study, conducted through the Pediatric Heart Network, will test new ways to strengthen parent well-being, bonding and infant development after diagnosis before birth or soon after delivery.

Nadine Kasparian, PhD, MAPS

For many parents, the first weeks after learning their baby has a serious heart condition can be filled with fear, exhaustion and uncertainty.

Congenital Heart Disease (CHD) affects about 40,000 babies in the United States each year. These conditions can include holes in the heart, missing or poorly formed heart valves, or more complex problems such as hypoplastic left heart syndrome.

Instead of cuddling their newborn, beginning breastfeeding, changing diapers and preparing to go home, parents of newborns with critical CHD often face a very different beginning. They find themselves in the high-tech world of cardiac intensive care, where they have to scrub in to visit their baby, who they see plugged into machines and monitors with tubes and cords everywhere.

They do not know whether their child will live to leave the hospital. And even though most do go home, families can not know what the journey ahead will be like.

To describe such an experience as stressful would be an epic understatement. However, few parents get the emotional and practical support that all parents need when their child is diagnosed with CHD. Now, a major clinical trial – set to begin this summer – seeks to change that.

The BOND trial is short for **B**uilding **O**ptimal Strategies to **E**nhance Parent and Infant Wellbeing in Congenital Heart **D**isease. Scientists and clinicians across 12 core Pediatric Heart Network centers and five additional heart centers will recruit 350 families over the next three years. They will study the best ways to support parents and babies from diagnosis through the first year after birth.

The study is being conducted through the Pediatric Heart Network, a group of hospitals funded by the NHLBI to improve outcomes for children and families affected by heart disease. The BOND trial will explore two new approaches:

- A psychological support program called HeartGPS for parents who learn during pregnancy that their baby has CHD.
- And a clinical practice guideline to support infant breastfeeding during and following intensive care stays.

HeartGPS will be led by Nadine Kasparian, PhD, PMH-C, who founded the Heart and Mind Wellbeing Center at Cincinnati Children's in 2023.

The breastfeeding intervention will be led by William Mahle, MD, at Children's Healthcare of Atlanta.



"For too long, many families affected by congenital heart disease have had to be extraordinarily resilient within systems that were not always designed to support their emotional wellbeing," Kasparian says. "BOND is about changing that. We are asking, with scientific rigor and deep respect for families, how we can build care models that help parents feel supported, connected, and capable from the earliest moments of diagnosis."

Thriving with CHD vs Surviving

This research is needed because care for babies with CHD has improved greatly. Thanks to better surgical and intensive care technologies, many newborns who once were not expected to survive CHD are getting opportunities to begin growing up.

But survival is only part of the story. Children with critical CHD can face ongoing challenges with feeding, growth, brain development, and mental health. Patients and parents navigating this journey often experience high levels of anxiety, depression, traumatic stress, and financial strain.

Today, heart centers vary widely in the psychological support they offer parents and in the resources available for parent-infant bonding, breastfeeding, and infant development. The BOND trial plans to generate more robust data about what interventions work, for whom, and when support should begin.

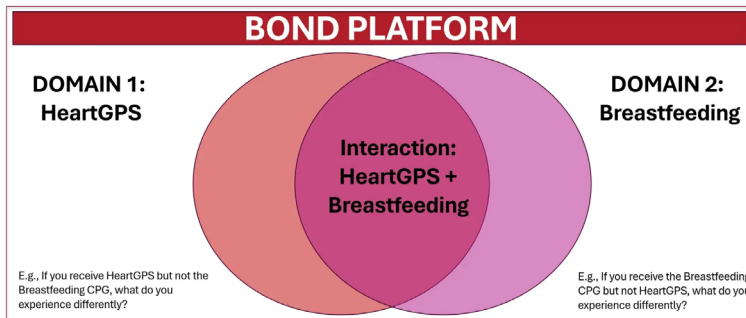
One key innovation of BOND is its "adaptive platform" structure. This means the platform can test several strategies within one larger project instead of studying one approach at a time and waiting years to begin the next. The aim is to build evidence that can grow over time as new interventions are added and less effective approaches are dropped or revised.



Risk factors associated with adverse mental health outcomes among individuals with CHD

- Genetic and epigenetic factors
- Altered fetal circulation
- Altered cerebral hemodynamics
- Altered placental environment
- Hypoxia
- Altered brain development
- Cardiac arrest
- Perioperative neurological injury (e.g., seizures, stroke)
- Use of mechanical cardiopulmonary support
- Medications (including anesthetics)
- Acute and persistent pain
- Prolonged hospitalization
- Exposure to stress or trauma, including adverse childhood experiences (ACES)
- Severe and persistent caregiver psychological distress
- Adverse parent and family mental health outcomes
- Individual subjective beliefs and negative perceptions of illness
- Limited practical and social support and resources
- Social inequities and health disparities

The results of the BOND trial could affect care well beyond the study sites. Findings could help shape clinical guidelines for prenatal counseling, mental health prevention and early intervention programs, and early developmental care. The findings may also help hospitals make the case for services that families often say they need but do not consistently receive.



Long-Lasting Impacts of Stress During Pregnancy

Many parents of children with CHD have expressed a need for mental health care during pregnancy. Previous studies have described profound and enduring psychological distress, disrupted bonding, and difficulties adjusting to parenthood. A common comment from parents: "I was numb. It was like I was on the sidelines watching somebody else's experience."

Meanwhile, as many as half of people with CHD are later diagnosed with anxiety or depression.

"The foundations of brain development begin before birth," Kasparian says. "The BOND trial gives us an opportunity to study this period and beyond with rigor and to test whether intervening earlier can change trajectories for children and their families. The right intervention early enough could have profound benefits for parent mental health, parent-infant bonding, and child developmental outcomes."

A key aim of the BOND trial will be to test the effects of HeartGPS, which stands for **G**uiding parents through emotions, **P**roviding education and support, and **S**trengthening connections. This program envisions

providing psychological intervention promptly after prenatal diagnosis of CHD and continuing throughout pregnancy and after baby is born. HeartGPS will be delivered via telemedicine by a trained group of medical psychologists at the Heart and Mind Wellbeing Center, which is where the PHN Perinatal Mental Health Core is based. Outcomes will be compared to families of children with CHD who received usual fetal cardiac care.

"With HeartGPS, we expect that mothers who receive psychological support beginning before birth will experience lower anxiety, depressive symptoms and traumatic stress. We also will examine whether the program strengthens parent-infant bonding, maternal stress physiology, and infant development. This is prevention science grounded in empathy and compassion," Kasparian says.

Can Low Breastfeeding Rates for Children with CHD be Improved?

The other key aim of the BOND trial focuses on supporting breastfeeding, which often gets put to the side during periods of intensive medical care — only to discover difficulties later.

Research suggests that direct breastfeeding may help reduce medical complications for infants with CHD. Breastfeeding also may benefit mother-child bonding and enhance maternal mental health.

"Infant development is shaped by many different factors, with breastfeeding serving as one way to nurture this growth," Mahle says. "It transcends nutrition, fostering connection."

This aspect of the study will explore whether increasing breastfeeding rates impacts a variety of health measures for children with CHD.

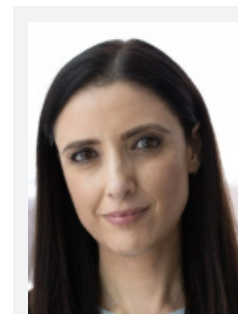
What Will Participating Families Experience?

Participants will be evaluated at six key points beginning shortly after prenatal diagnosis and continuing until about one year after birth.

Research teams will collect information about each family's background and clinical care, as well as infant development and maternal health and wellbeing. Teams will collect samples, including blood, to help understand how the body responds to each intervention.

At the end of the study, participants will receive a summary of the overall study results, plus contact information for asking further questions.

"Survival is not the finish line. We want children with Congenital Heart Disease and their families to have the best possible chance to thrive," Kasparian says.



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Pediatric Cardiology Opportunities

Ochsner Children's Hospital – New Orleans

Ochsner Children's Hospital is seeking BC/BE Pediatric Cardiologists to join and help lead our growing pediatric cardiology program in New Orleans. Current opportunities include Inpatient Pediatric Cardiology, Advanced Imaging Cardiology, and Director of Pediatric Heart Failure/Heart Transplant Cardiology within the only pediatric heart transplant center in Louisiana.

Ochsner Children's provides services across all pediatric cardiac subspecialties, including heart failure/transplant, electrophysiology, adult congenital heart disease, interventional cardiology, imaging including echocardiography and cardiac MRI/CT, fetal cardiology, a comprehensive single ventricle program, and a neurodevelopmental clinic. The heart center includes 21 cardiologists, 3 congenital heart surgeons, 6 cardiac intensivists practicing in a dedicated pediatric 12-bed cardiac intensive care unit, and 3 pediatric cardiac anesthesiologists.

The program performs approximately 250 cardiac surgeries, 400 cardiac catheterizations, 75% of which are interventional, and 19,000 ambulatory visits across 15 locations in Louisiana and Mississippi each year. Ochsner Children's heart center has been ranked by U.S. News & World Report for the last seven years and is the only ranked program in Louisiana; survival after cardiac surgery for the most complex patients, STS STAT 4 and 5 categories, is in the top 10% of programs reporting to STS.

Current Opportunities:

Inpatient Pediatric Cardiologist

This role focuses on leading inpatient care in the cardiology inpatient unit and consultation service, including care connected to a 67-bed Level IV NICU. The inpatient cardiology team is supported by inpatient physician assistants and nurse practitioners and includes teaching of medical students and residents. The position also involves quality improvement activities, including national registries such as PC4 and PAC3.

Advanced Imaging Pediatric Cardiologist

This role focuses on all aspects of non-invasive imaging, including fetal echocardiography, transesophageal echocardiography, telemedicine and general echocardiography, with teaching responsibilities for pediatric residents, medical students, and sonographers. There is also an opportunity for cross-sectional imaging as part of the growing cardiac MRI and CT program.

Director of Pediatric Heart Failure/Heart Transplant Cardiology

Ochsner Children's Hospital is seeking Director of Pediatric Heart Failure/Heart Transplant physician to join two existing pediatric heart failure/heart transplant cardiologists and a newly hired heart failure/transplant physician assistant in the only pediatric heart transplant center in Louisiana. The position includes care of patients with cardiomyopathies, heart failure, transplant, congenital heart disease, and ventricular assist devices. The transplant team is supported by a dedicated physician assistant, two transplant coordinators, a transplant psychologist, a transplant social worker, and a transplant pharmacist. Ochsner is an active participant in PHTS and ACTION. Interested applicants should be BC/BE in pediatric cardiology and have completed an advanced fellowship in pediatric heart failure/heart transplant.

About Ochsner Children's

Ochsner Children's is the region's leading integrated provider of multispecialty care for newborns, infants, children, adolescents, and young adults. The program offers a full range of pediatric complex specialty services, including liver and bone marrow transplantation, a comprehensive surgical subspecialty group, advanced GI and hepatology, advanced spine surgery, hematology-oncology and AYA oncology, cleft palate/craniofacial surgery, and the region's only comprehensive multidisciplinary developmental pediatrics center.

Ochsner Children's currently cares for patients in a 67-bed Level IV Neonatal Intensive Care Unit, a 14-bed PICU, a 12-bed pediatric CV-ICU, a NAEC-accredited Level IV 4-bed Pediatric EMU, and a 44-bed pediatric acute unit with a dedicated pediatric emergency room. The program is supported by a 24/7 dedicated pediatric and neonatal transport team utilizing rotary wing, fixed wing, and ground transport.

Ochsner Children's began construction last year on a new, comprehensive, dedicated 5-story Children's Hospital on the main campus in New Orleans, with expected opening at the start of 2028.

Academic, Teaching, and Research Opportunities

In addition to direct patient care, Ochsner Children's Hospital has an ACGME-accredited pediatric residency program, is in the process of applying for ACGME approval to start a pediatric cardiology fellowship program in 2028, and is responsible for teaching pediatric residents from the Tulane-Ochsner Pediatric Residency Program, as well as medical students from Tulane and the University of Queensland, Australia. Ochsner Health and Xavier University of Louisiana recently established the Xavier Ochsner College of Medicine, which will enroll its first class in Fall 2027. Faculty have opportunities for academic appointments at the University of Queensland and Xavier Ochsner College of Medicine, participation in numerous research studies and multicenter trials, and scholarly publications.



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Johns Hopkins Medicine Forms Nation's Only Female Leadership Pair in Pediatric Cardiology and Congenital Heart Surgery

As Co-Directors of the Blalock-Taussig-Thomas Pediatric and Congenital Heart Center, Aimee Armstrong and Stephanie Fuller are building on a legacy of innovation.

Karen Nitkin

In June, Aimee Armstrong, MD, became Division Director of Cardiology for Johns Hopkins Children's Center, Director of Congenital Interventional Cardiology in the Department of Pediatrics and Co-director of the Blalock-Taussig-Thomas Pediatric and Congenital Heart Center.

Also new to Johns Hopkins Children's Center is Stephanie Fuller, MD, who joined in December 2025 as Chief of Pediatric and Congenital Cardiac Surgery and Co-Director of the Blalock-Taussig-Thomas Pediatric Heart Center.

Armstrong and Fuller co-direct the Heart Center alongside Dheeraj Goswami, MD, Chief of Pediatric Cardiac Critical Care and Anesthesia. Together, they lead one of the nation's premier pediatric and congenital heart programs. Armstrong and Fuller also represent the only female pairing in the United States of a Director of Pediatric Cardiology and a Chief of Pediatric and Congenital Cardiac Surgery.

Building on a Strong Foundation

Armstrong and Fuller are articulating bold goals for the Heart Center, building on its history as a clinical and research leader dating back to the pioneering work of Cardiologist Helen Taussig, who created the field of Pediatric Cardiology in 1944 when she worked with Johns Hopkins Hospital Chief Surgeon Alfred Blalock and Surgical Assistant Vivien Thomas to palliate patients with tetralogy of Fallot, known as blue babies.

"We want to be the best congenital heart center in the world," says Armstrong. "We want to be the most innovative, to deliver the highest quality care, and to show our patients and families how much we care about them and their experience here."

Armstrong earned her medical degree from Northwestern University Medical School, followed by a pediatrics residency at Riley Hospital for Children at Indiana University Health and fellowships in pediatric cardiology

and pediatric interventional cardiac catheterization at University of Michigan's C.S. Mott Children's Hospital. After 11 years on faculty at the University of Michigan as an interventional cardiologist, she most recently worked 11 years as the director of cardiac catheterization and interventional therapies at Nationwide Children's Hospital in Columbus, Ohio.

Fuller earned her medical degree from Eastern Virginia Medical School, followed by a general surgery residency at Albert Einstein Medical Center, cardiothoracic surgery residency at Thomas Jefferson University Hospital, and a fellowship in congenital cardiothoracic surgery at Children's Hospital of Philadelphia (CHOP). Before joining Johns Hopkins Medicine, she practiced at CHOP and the University of Pennsylvania for 18 years as the Thomas L. Spray Endowed Chair of Pediatric Cardiac Surgery and the director of adult congenital cardiac surgery.

Better Care, Now and in the Future

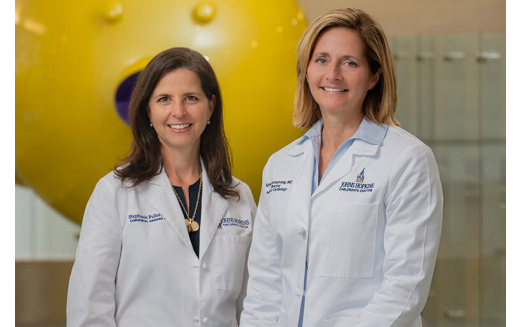
Armstrong and Fuller both say they chose Johns Hopkins Medicine for the opportunity to care for patients over their lifespan.

"It's a really extraordinary place that can take care of all age groups, from fetus to geriatrics, all under one roof," says Armstrong.

The result is better care, now and in the future, says Fuller, who studies longitudinal outcomes of cardiac surgeries. "Following patients throughout their life helps us better understand which interventions allow us to improve survival and enhance quality of life," she says. "That includes the neurocognitive outcomes of heart disease," she notes.

After she was hired, one of Fuller's first assignments was working with Department of Pediatrics Director Brenda Banwell, MD, to recruit Armstrong.

"If I could have picked anybody in the world, it would have been Dr. Armstrong," says Fuller. "She brings with her an amazing



Drs. Fuller (left) and Armstrong are the only female pairing in the United States of pediatric cardiology and congenital heart surgery leadership.

clinical experience along with an incredible research background. She's an innovator. She is always seeking alternative pathways for our patients. I think a lot of her ideas are going to contribute to the future of cardiology for decades to come."

Both physicians take a keen interest in novel devices and innovative procedures, such as implantable heart valves that can grow with patients and catheterization guided by MRI instead of radiation. Armstrong is leading efforts to make pediatric heart procedures more effective and less invasive.

"What I didn't know when I started interviewing here is how much Hopkins has done in the interventional MRI space, which is where much of my research is focused," Armstrong says. "I also have a particular interest in fetal cardiac intervention, and Hopkins has a world-renowned center for fetal therapy."

More than 80 years after Helen Taussig founded the field of Pediatric Cardiology at The Johns Hopkins Hospital, the institution is now home to the nation's only female Director of Pediatric Cardiology and Chief of Pediatric and Congenital Cardiac Surgery leadership pair. Together, they bring talent, sensitivity, drive and passion to transform the future of Johns Hopkins Medicine while preserving its legacy.





Ascend Cardiovascular's Comprehensive Pediatric Cardiology Platform

The comprehensive pediatric cardiology platform is designed to modernize Congenital Heart Disease management, without forcing programs to abandon decades of valuable legacy cath data.

Ascend Cardiovascular launched its reimagined pediatric cardiology product, a comprehensive solution specifically designed to meet the unique, lifelong demands of Congenital Heart Disease (CHD) care — from the fetal through adulthood. By combining modernized Mullins diagrams with an integration-first architecture, ASCEND is ending the era of “good enough” legacy systems for pediatric programs.

For decades, pediatric cardiology has been underserved by rigid, imaging-centric platforms that fail to capture the complexity of Congenital Heart Disease. Ascend's new offering replaces these workflows with a multi-modality reporting platform that connects the entire cardiovascular ecosystem — from cardiac catheterization and EP to fetal and pediatric echocardiography.

A Modern Approach

At the heart of the pediatric offering is a modernized, interactive Mullins atlas. Unlike static legacy illustrations, Ascend's SVG-designed diagrams allow clinicians to:

- **Tailor Patient Anatomy:** Add, resize and edit devices like ASD/VSD closure devices, stents and coils to reflect patient-specific conditions.
- **Automate Data Entry:** Populate diagrams with hemodynamic measurements (pressures, saturations, and calculations)
- **Utilize Advanced Editing:** Use specialized tools for documenting conduits, shunts and ligatures to accurately capture complex procedural anatomy and outcomes.

A Consolidated Solution

Congenital Heart Disease is a lifelong journey, and Ascend's architecture ensures that care is never compromised as patients transition through different life phases. By consolidating data from the moment of fetal or neonatal diagnosis throughout adulthood, Ascend creates a rich, longitudinal data foundation that enables proactive and targeted care that can be leveraged to:

- **Streamline Workflows:** Support multi-modality workflows across fetal, pediatric, and adult congenital care to deliver seamless, specialized care throughout every stage of life.
- **Manage Aging CHD Populations:** As pediatric patients reach adulthood, the system tracks historical surgical data that can be used to recommend adult-congenital procedures, such as TAVR or complex electrophysiology mappings for arrhythmia management.
- **Simplify Device Integrations:** Automate data ingestion directly from DICOM SR, VMS+, hemodynamic systems, and other specialized pediatric devices to improve accuracy and allow clinicians to spend more time with patients and less time on documentation.

“Cardiology deserves more than adaptation; it deserves intention,” said Dr. Jeff Soble, CEO of Ascend Cardiovascular. “We believe pediatric cardiology programs should never have to choose between their clinical history and modern capability. Our solution provides the clinical depth required for CHD, while leveraging existing enterprise investments in EHR and imaging systems.”

Remote Collaboration

Recognizing that pediatric expertise is often concentrated in specialized centers, Ascend has created Catalyst telepresence, which transforms how pediatric care can be delivered across distances, providing:

- **Real-Time Specialist Consultation:** Clinicians can consult with remote pediatric sub-specialists in real time, as if they were physically present in the room. This enriches clinician-to-clinician collaboration and allows for more meaningful, immediate interactions between specialists and the patient's family.
- **Remote Imaging Oversight:** Cardiologists can remotely oversee image acquisition for pediatric procedures. By ensuring that



every necessary view is captured with diagnostic-grade quality the first time, Catalyst reduces overall procedure time, saves valuable cardiologist time, and—most importantly—eliminates the need for stressful re-imaging sessions for young patients.

Advancing CHD Care with AI

The impact of this offering is further amplified when combined with advanced AI solutions to provide a complete, intelligent end-to-end reading and reporting workflow that addresses the most persistent challenges in clinical practice.

By pairing Ascend's structured reporting and zero-footprint DICOM viewer with Ventripoint's AI-based diagnostic technologies, the combined solution delivers a level of clinical insight previously unavailable in standard workflows. This synergy powers the construction of a 3D model of the heart generated from 2D echo data, enabling calculation of volumes and ejection fractions for all chambers with accuracy comparable to MRI, providing a critical diagnostic alternative for young CHD patients who may not tolerate or have access to traditional cardiac MR. This partnership represents a shared commitment to novel solutions that ensure pediatric specialists have the technical expertise and research-grade capabilities required for complex heart analysis.





Regional Pediatric Cardiologists

Ochsner Children's Hospital

Ochsner Children's Hospital seeking BC/BE Pediatric Cardiologists to join our successful regional practices in Baton Rouge, Lafayette, and Monroe, Louisiana and Gulfport, Mississippi.

Responsibilities will include outpatient clinic including fetal echocardiography if desired, inpatient consultations, and regional clinic activities. Interest and advanced training in fetal echocardiography is highly desirable. The Baton Rouge, Lafayette, Monroe, Gulfport campuses are integral components of the Ochsner Children's Hospital cardiology network.

Ochsner Children's provides services for all pediatric cardiac sub-specialties including heart failure/transplant, EP, ACHD, interventional cardiology, imaging including echocardiography and cardiac MRI and CT, and fetal cardiology, comprehensive single ventricle program, and neurodevelopmental clinic. The heart center includes 21 cardiologists, 3 congenital heart surgeons, 6 cardiac intensivists practicing in a dedicated pediatric 12 bed cardiac intensive care unit and 3 pediatric cardiac anesthesiologists. The program performs approximately 250 cardiac surgeries, 400 cardiac catheterizations (75% interventional) and 19,000 ambulatory visits at 15 locations across Louisiana and Mississippi per year. Our heart center has been ranked by US New and World Report for the last 7 years and is the only ranked program in Louisiana; survival after cardiac surgery for our most complex patients (STS STAT 4 and 5 categories) is in the top 10% of programs reporting to STS.

Our comprehensive Ochsner Children's program is the region's leading integrated provider of multispecialty care for newborns, infants, children, adolescents, and young adults. We offer a full range of pediatric complex specialty services including, liver and bone marrow transplantation, a comprehensive surgical sub-specialty group, advanced GI and Hepatology, advanced spine surgery, Hematology-Oncology and AYA Oncology, Cleft Palate/Cranio-Facial Surgery and the region's only comprehensive multidisciplinary developmental pediatrics center.

Ochsner Children's currently cares for patients in a 67-bed Level IV Neonatal Intensive Care Unit, a 14-bed PICU, a 12-bed pediatric CV-ICU, a NAEC-accredited level IV 4 bed Pediatric EMU and a 44-bed pediatric acute unit, with a dedicated pediatric emergency room, supported by a 24-7 dedicated pediatric and neonatal transport team utilizing rotary and fixed wing as well as ground transport. ***And we recently began construction on the building of a new, comprehensive, dedicated 5-story Children's Hospital on our main campus in New Orleans, with expected opening at the start of 2028.***

In addition to direct patient care, Ochsner Children's Hospital has an ACGME-accredited pediatric residency program and is also responsible for teaching pediatric residents from the Tulane-Ochsner Pediatric Residency program as well as medical students from both Tulane and the University of Queensland, Australia. Ochsner Health and Xavier University of Louisiana recently established a joint allopathic College of Medicine, the Xavier Ochsner College of Medicine (XOCOM) which will enroll its first class in Fall 2027. Our faculty have an opportunity for academic appointment at the University of Queensland and XOCOM, participate in numerous research studies and multi-center trials, and publish hundreds of research papers annually.



For more information, please contact:
Courtney Lawhun
courtney.lawhun@ochsner.org

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The Ripple Effect

For decades, Dr. Michael Womack has quietly mentored pediatric interventional cardiologists throughout Central America. Traveling, often alone, he invested countless hours supporting physicians in Panama and Costa Rica as they raised the standard of care for children with congenital heart disease. Every visit became an opportunity to invite colleagues from across the region to learn together. Whether the program was in Costa Rica, Panama, or, more recently, Nicaragua, the goal was never simply to provide the safety net needed to treat more complex procedures. It was to build a regional team of physicians who would one day support one another.

Every trip became an opportunity to celebrate successes, work through frustrations, and train anyone committed to improving pediatric heart care in the region.

Over the past several years, that focus shifted to Nicaragua. Visit by visit, Mending Kids and our partners worked to strengthen the country's pediatric interventional cardiology program while shining a spotlight on the growing need. The Ministry of Health took notice and, last year, invested in a new cardiac catheterization laboratory. We celebrated as the team performed its first cases independently. We returned with additional specialists to strengthen other aspects of the program and continued building the confidence and skills needed to expand care safely.

This summer marked another milestone.

For the first time, Mending Kids supported a pediatric interventional cardiology trip to Nicaragua without Dr. Womack at the table. Instead, the physicians from Panama and Costa Rica, who have trained alongside him for years, came together to support their Nicaraguan colleagues. Together, they safely treated children while providing the mentorship, confidence, and safety



net needed by the next generation of pediatric interventional cardiologists.

That was always the plan.

This was not a transition away from mentorship. Dr. Womack will return this fall to continue expanding the complexity of cases that can be treated locally and to strengthen echocardiography training. But this milestone demonstrated something we have been working toward for years. Between those larger teaching trips, the region is beginning to support itself.

That means physicians can travel more frequently within Central America, continue learning from one another, and help more children receive lifesaving cardiac care without waiting for the next international mission.

That has always been the vision, not simply to build programs, but to build people. Because when one physician teaches another, and one country begins supporting the next, there is no telling how many children will ultimately benefit.

Together, we are Mending Kids.

Contact us at hello@mendingkids.org with any questions or to learn more.





Nicklaus Children's Hospital Performs Transcatheter Fontan Completion on Two-Year-Old Child

Novel transcatheter-based approach allowed a child with Congenital Heart Disease to avoid additional open-heart surgery.

The Nicklaus Children's Hospital Heart Institute has successfully performed one of the first Fontan procedures in the United States utilizing a transcatheter-based approach on a child, marking an important advancement in care for children born with complex Congenital Heart Disease.

In this novel procedure, the team used a catheter-based approach, rather than open-heart surgery, to guide specialized equipment through a blood vessel to complete the child's Fontan circulation. The child, a two-year-old born with a double-outlet right ventricle, is recovering well and has returned home.

Transcatheter Fontan Completion

For children who are candidates for the catheter-based approach, the procedure offers the advantage of no incisions, a shorter hospital stay and a faster recovery compared with traditional surgery.

The procedure was led by Dr. Shyam Sathanandam, Chief of Cardiovascular Medicine at Nicklaus Children's Hospital, Co-Director of the Nicklaus Children's Heart Institute and Clinical Professor at FIU Herbert Wertheim College of Medicine, in collaboration with Dr. David Kalfa, Chief of Cardiovascular Surgery and Professor and Researcher at FIU Herbert Wertheim College of Medicine. Together, the interventional cardiology team and cardiovascular surgery team came together to carefully plan the procedure in the ongoing effort to offer less invasive approaches to care for children with congenital heart defects.

The Fontan procedure, which is traditionally the final planned stage in a series of operations for a child born with a single-ventricle heart defect, is designed to reroute the blood flow so that blood returning from the body goes directly to the lungs, without needing to be pumped there by a ventricle. In a single-ventricle heart defect, only one of the heart's two pumping chambers can effectively support circulation. The Fontan completion directs oxygen-poor blood returning from the lower body to the lungs without first passing through a pumping chamber of the heart. The prior surgeries prepare the heart for the final step.

"This achievement reflects an extraordinary level of collaboration and coordination between our surgical and interventional cardiology team," said Dr. Sathanandam. "It demonstrates what is possible when clinical expertise, innovation and teamwork come together to



The Nicklaus Children's Hospital Heart Institute Interventional Cardiology team. (Photo: Nicklaus Children's Health System)

expand treatment options for children with the most complex heart conditions."

The Nicklaus Children's Heart Institute provides comprehensive care for infants, children and adults with congenital and acquired heart conditions. Its multidisciplinary specialists offer cardiac imaging, interventional cardiology, electrophysiology, cardiovascular surgery, critical care and long-term follow-up, with treatment plans tailored to each patient's needs. The Heart Institute provides access to consultations and follow up care to pediatric cardiac specialists in more than 13 locations spanning Miami-Dade, Broward, Palm Beach and Martin counties.

For more information visit nicklauschildrens.org/Heart



CHIP NETWORK
CONGENITAL HEART INTERNATIONAL PROFESSIONALS



Click the position title to view the full job description

Pediatric Interventional Cardiologist

Banner Children's
Mesa, Arizona



Phoenix
Children's

Assist / Assoc Professor of Clinical Pediatrics & Child Health

Phoenix Children's
Phoenix, Arizona



Phoenix
Children's

Pediatric Cardiologist

Loma Linda University
Children's Hospital
Loma Linda, California



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The Pediatric Specialty Group
at Kaiser Permanente Santa
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Children's Health
Stanford, California



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MEDICINE
School of Medicine



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Pediatric Cardiology Opportunities

Ochsner Children's Hospital
New Orleans, Louisiana



Pediatric Cardiologist Advanced Imaging with Cross-Sectional Focus

MaineHealth Maine
Medical Center
Portland, Maine



MaineHealth

Division Director of Pediatric Cardiology

University of Minnesota
M Health Fairview Masonic
Children's Hospital
Minneapolis, Minnesota



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Monroe, Louisiana
Gulfport, Mississippi



Pediatric Cardiologist

The University of Utah
Primary Children's Hospital
Las Vegas, Nevada



HEALTH
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Pediatric & Congenital Interventional Cardiologist Faculty

Cincinnati Children's Hospital
Medical Center
Cincinnati, Ohio



ACHD Faculty Director Noninvasive Imaging Faculty Acute Care Faculty

UPMC Children's Hospital
of Pittsburgh
Pittsburgh, Pennsylvania

UPMC | CHILDREN'S
HOSPITAL OF PITTSBURGH

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CE Mark Granted to BrightHeart's Prenatal AI Platform

BrightHeart will introduce the B-Right AI platform, encompassing advanced prenatal AI solutions, directly into routine prenatal care in the European Union, improving the detection of major CHDs, reducing false positive errors and false negative errors.

BrightHeart has received the CE mark for its flagship medical devices, enabling commercialization of the B-Right AI Platform across the European Union. The company will make its European debut at the Fetal Medicine Foundation (FMF) World Congress in Vienna, Austria.

Fetal ultrasound is among the most technically demanding imaging examinations in clinical practice, requiring the systematic evaluation of dozens of structures within a limited time window and under highly variable conditions. Despite significant progress in prenatal medicine, detection rates for congenital anomalies remain highly variable across centers with up to 50% remaining undetected prenatally; driven by differences in operator experience, available expertise, and workflow consistency.

BrightHeart addresses this directly through two complementary capabilities. Live acquisition guidance supports sonographers at each step of the scan, reducing procedural variability and improving protocol adherence. Advanced morphological evaluation of critical fetal organs then delivers structured, expert-level analysis that mirrors the diagnostic reasoning of a senior clinician; regardless of operator experience or site resources.

The platform's performance is backed by two peer-reviewed studies published in *Obstetrics & Gynecology*, conducted with leading academic centers and drawing on data from 11 centers across two countries. In a standalone validation of 877 examinations against an expert cardiologist reference standard (Zelop et al., *Obstet. Gynaecol.*, 2026), the software identified findings associated with severe defects with 98.7% sensitivity and 97.7% specificity among conclusive exams, returning a result in 98.7% of cases, validating BrightHeart's ability to improve detection rates and deliver consistent, protocol-driven evaluations.

BrightHeart's Mission

"Obtaining the CE mark is a critical step in BrightHeart's mission to make high-quality prenatal screening accessible to every patient, in every center," shared Cécile Dupont, chief executive officer at BrightHeart. "Fetal ultrasound is one of the most operator-dependent examinations in medicine, leading to significant variability in quality. BrightHeart is built to close that gap, starting with cardiac screening, and extending to brain analysis and support for the full prenatal ultrasound workflow. The FMF World Congress in Vienna is the right stage to introduce this platform to the global fetal medicine community in Europe."

At the FMF World Congress, BrightHeart's presence will include key presentations by Pr. Laurent Salomon, past ISUOG president and professor of obstetrics and gynecology at the Necker-Enfants Malades Hospital, Paris, and BrightHeart Clinical Advisor.

Professor Salomon said, "In routine clinical practice, the quality of prenatal ultrasound screening remains substantially operator-dependent. Standardized, protocol-driven examinations have been



associated with improved detection of congenital anomalies, yet achieving that level of consistency reproducibly and at scale remains a persistent challenge. BrightHeart is designed to support this standardization within the examination workflow itself, in real time, without disrupting the clinical process."



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OCTOBER

01ST - 02ND

Joint AEPC/EACVI Echocardiography Course on Pediatric Cardiology & Adult Congenital Heart Diseases - 2nd Edition

Malaga, Spain

<https://www.aepc.org/events/joint-aepc-eacvi-echocardiography-course-on-pediatric-cardiology-and-adult-congenital-heart-diseases-2nd-edition>

02ND - 04TH

CSI Asia-Pacific 2026

Bangkok, Thailand

<https://www.csi-congress.org/conferences-courses/conferences/csi-asia-pacific/registration>

19TH - 20TH

V Euro HeartCare & Cardiovascular Medicine Conference

Berlin, Germany

<https://heart.plenareno.com/>

NOVEMBER

13TH - 14TH

Transcatheter Pulmonary Valve Summit

Istanbul, Turkey

<https://tpvs2026.org/en/registration-accommodation.html>

17TH - 18TH

British Congenital Cardiac Association (BCCA) Annual Scientific Meeting

Leeds, United Kingdom

<https://bccaconference.co.uk/>

Program Directory 2026-2027

Directory of Congenital & Pediatric Cardiac Care Providers in North America

Electronically available on CCT's website

CongenitalCardiologyToday.com/Program-Directory

Each program's contact information for Chief of Pediatric Cardiology & Fellowship Director

Lists each program's Pediatric Cardiologists & Cardiothoracic Surgeons

Lists Pediatric Cardiology Fellowships

Need to update your listing?

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