Since the events of last September, we have heard many questions about where our concerns and our responsibilities must lie in this new world transformed so dramatically early one autumn morning. The questions are many and the answers difficult. But one answer, particularly for us as physicians, stands out above all the rest. We now know that our concerns can no longer be limited to a personal agenda, to a national interest, or to any single corner of any particular market. We now know that the proper sphere of influence for every responsible man and woman is this entire fragile sphere called earth. Y2K, pregnant chads, and errant politicians fade into the mist of dreams when held up to the pleading realities affecting our world. It has become blindingly clear that our concerns must encompass the relief of misery wherever we find it. And that means that we, as physicians and cardiologists, must expand our vision to include all of humankind.

For if we did not know it before, we now know that when a single child in Peru goes to sleep hungry, then the entire planet is malnourished.

When oceans of the homeless drift through the streets of Calcutta, then the equanimity of all good people becomes profoundly disturbed.

And when a heart stops beating in Afghanistan, the silence that follows envelops the world.

So we, members of the American College of Cardiology and citizens of that world, must be both global and national, both parochial and diverse. We must hold close to us not only those who are near but also those who are far away.

How can we do this? How can we communicate both near and far? Your College in many ways is currently addressing these needs, both national and international. For example, with the development of ACCardio, we are building a system, partnered with Elsevier, that will be the premier digital source of knowledge and information for physicians and other health care professionals who treat patients with cardiovascular disease.

ACCardio is our new Internet-based learning-management system. This online site is a breakthrough initiative that will transform how we handle in-house educational activities—how we store, tag, and retrieve data. And, at the same time, it will provide us with a vibrant and robust search engine that is available around the clock and seven days a week.

But, more than anything else, ACCardio transforms your College into an international source of knowledge and, in so doing, into an international organization as well.

Because, both at home and abroad, we need the ability to cope with the volume of information that affects the practice of cardiovascular medicine.

Because, both at home and abroad, we need the ability to cope with the speed at which scientific breakthroughs are now realized and disseminated.

Because, both at home and abroad, we need the ability to access the archived and the new knowledge that extend across disciplinary boundaries.

Because, both in this country and in Europe, Asia, Africa, Australia and South America, we need the ability to identify and acquire the knowledge that meets our individual needs, while maintaining the ability to access a broader and more generalized range of information.

We need to achieve new heights of collaboration with colleagues throughout the world.

We need to streamline and simplify the lives that we lead in a world that continues to grow more and more complicated and more and more interconnected.

Our world has been likened to a beautiful book that is of little use to those who cannot read. And in a similar sense, our knowledge as physicians is a fine and priceless asset whose value is vastly diminished unless it can be taught, disseminated, and practiced throughout the world. In Peru, Calcutta, and Afghanistan.

How else can we learn? For example, how can we teach technical skills? Mostly, they cannot be learned in books. One new approach will be simulation-based training, which uses mannequins and computers in place of real patients to help physicians learn new procedures.

I have written about it in one of my president’s pages, and I like to call it a “patient in a box.” It is designed to teach physicians at all stages of their careers how to use new medical devices and perform new procedures.

It will allow trainees to practice new techniques without fear of harming patients. In fact, in the future a certain number of practice hours logged on a simulator will prob-
ably become required before performing a procedure on a patient.

It will help us to work and train as a team, along with our nurses, technicians, and physician colleagues. Dealing with rare or infrequent complications, such as cardiac perforation and tamponade, can be practiced many times on the simulator, so that when it actually happens, the cath team can respond like a crack drill squad.

In the near future, from the first venopuncture that a medical student performs to a complex angioplasty in the last year of cardiology fellowship training, procedures will be taught in such “virtual reality” settings. Perhaps, also in the future, low volume operators will be able to make up for lack of patient numbers by documented hours spent practicing on a simulator.

I submit to you that virtual reality is an unquestionable part of our educational future, and it is a means through which we can spread knowledge all over the world. It will change forever how we teach, test, and treat. And it is available for you to experience at this meeting.

At the same time, if our voice is to be heard across geographic boundaries and political borders, it first must be heard in the health policy arena of our own country. Toward that end, the College is expanding its advocacy efforts. There are two components of this plan that are of particular importance. One is the establishment of a Political Action Committee, and the other is increased state and federal activities at the grassroots level. Clearly, these are two closely related initiatives, intricately interwoven and interdependent. They are part of the movement to make the voice of cardiology echo in the halls of Capitol Hill and in state legislatures across the country. They are vital components of the College’s plan to improve the treatment of cardiovascular disease in this country and, in time, all over the world. Certainly we must not neglect repairs on our own house as we go forth to help our neighbors with theirs.

Our international outreach also extends to the development and dissemination of practice guidelines. As far back as 1980, the College, in collaboration with the American Heart Association, undertook its first practice guideline. Since then, dozens more have been published. These guidelines are irreplaceable tools for practicing physicians, who cannot possibly know very well that you have a heart when it aches. And you know very well that you have a heart when your chest hurts.

And you know very well that you have a heart when your chest hurts.

It is then that your body talks to you.

We physicians tend to see people when they are most

able to improve the quality of patient care by taking the guidelines off the shelf and putting them to work in daily practice. GAP will do this.

We physicians tend to see people when they are most aware of their bodies, when their bodies are talking to them a lot. Which means that we see them when they are at their most vulnerable.
We see them when they are undressed in every way—physically, emotionally, and spiritually. To see them so places us in a position of enormous privilege and responsibility.

Because we are all the same when we are naked.

The wise and the foolish.
The mighty and the weak.
The wealthy and the woebegone.

All the same . . . all vulnerable.

And it is this vulnerability that endows the physician with stunning privilege, and an equally stunning responsibility.

For it is our privilege to shield our patients when they are bare and without defenses.

And to listen to the voice of the patient, not the voice of the disease.

And to clothe them not only with health but also with the ability to thrive once they have left our care.

And to be their friend, their counselor, their trusted advisor.

These are concerns that apply to every physician in the world. It has nothing to do with national borders, with ethnicity, or with religious affiliation.

It has everything to do with the framework of humankind that needs our constant support, not just as physicians but as men and women of sensibility and conscience.

It has everything to do with the achievement and exportation of excellence and it has everything to do with the Hippocratic oath, which many of you recited with me last year.

It has everything to do with putting the patient first, above our own interests.

And we have a great deal to give, a great deal to share with the world.

We in this College have come together not only to enhance the state of the art with the excellence of our medicine, with cutting-edge projects like ACCardio and new teaching technologies, but to be the state of the art. We are the state of the art.

And while technology like ACCardio and medical simulation reflect the educational excellence that we wish to export to the world, we must always bear in mind that excellence is elastic. It knows no limits. And it must be maintained not only by the preservation of the best of the past, but by the brilliance of the future, by the need to dare, and by the willingness to embrace both innovation and experimentation, and to stay abreast of these advances.

For excellence is a reflection of spiritual wealth, and the exportation of that wealth is a notion that we cherish. And to me that notion is what defines the difference between a profession and a calling.

Because a profession is something that you train to do. A profession is something that you can change; it has impermanence about it. A profession is something that you are likely to find routine in later years.

A calling, on the other hand, is something that captures you, entrances and embraces you, and keeps you enchanted for the rest of your life.

You see, those who have the calling must be healers by conviction, not simply by virtue of a medical degree.

We become healers when the identifiable purpose of our lives is forever bound up with the relief of suffering, with the forestalling of death or its embrace when the time has come, and with the creation of environments where our patients can flourish.

We become healers when the relationship between our patients and us is a covenant of faith, not a business contract; an article of trust, not simply a fee for services.

We become healers when we come to understand that healing is hard work, for both the patient and the physician, that the amount of health that we can actually promote is relatively small when weighed on the scale of human mortality.

And we become healers when we ignore that scale and fight for every inch of health, against the odds, as if embedded in our fingertips is the ability to create that body that does not talk to you.

These are the sort of healers that our profession cries out for—men and women who are willing to labor in the trenches.

Who are willing to treat all patients equally.

Who are willing to touch what others see as untouchable.

Who are willing to strive for nothing less than the Churchillian promise of blood, toil, sweat, and tears in return for nothing more than the privilege of healing and saving.

To treat each day as if it were your last, and each patient as if he or she were your first.

A great American educator, Horace Mann, once said that we should be ashamed to die until we have won some victory for humanity. Saving one life helps save that humanity.

These are thoughts worth remembering as we reach out our hands to the rest of the world. And as we renew who we are and what we do in the scientific halls of this great congress of the American College of Cardiology.

Thank you.