It’s news to none of you here today that the Annual Scientific Session offers an important glimpse into the future of our profession. The future is by no means a novel topic of discussion. But it’s an especially pertinent issue to contemplate at this time, when there are so many obstacles and challenges that await all of us in our professional and personal lives.

When I think of the future, I’m reminded of two quotes from two very different people that—in their own way—make very important points.

“The empires of the future,” Winston Churchill said, “are the empires of the mind.”

And then there was Yogi Berra, who mused: “It’s tough to make predictions, especially about the future.”

Today, I’m not going to undertake the arduous task of making grandiose predictions about the future. But I would like to stir up some thoughts about the possibilities for constructing the empires of our collective minds, as it were.

Before I do that, however, I think it’s important to consider some of the trends we are witnessing in 2003—trends that will undoubtedly have an influence on where we will be as a profession a decade from now.

One of the difficult issues facing our nation today is the growing shortage of cardiovascular specialists. According to a recent American College of Cardiology (ACC) survey, by the end of 2003, only one-third of the available openings for cardiovascular specialists will have been filled. The shortage is much worse in academic medical centers—a troubling development given that, in the past, shortages in physician educators and trainers were offset by part-time and volunteer faculty from the private sector.

For all of you, this is, in a sense, good news. You are in a buyer’s market! You can launch your cardiology career in whatever setting you wish: an urban multi-physician practice; a Midwest academic medical center; a small, private practice less than an hour’s drive from the Atlantic.

Yet, this is also cause for significant concern. The baby boomers are aging and people are living longer. In 2000, approximately 13% of the population was 65 or older. By 2030, that number is expected to be approximately 20%. Given today’s epidemics of obesity and diabetes, we’re very likely to see a substantial increase in the prevalence of cardiovascular disease. As a result, you are likely to have more work than you will want or need. One potentially detrimental by-product of this scenario could be a perception among patients and their families that you are disinterested—only there to diagnose the problem as quickly as possible, write a script, order some diagnostic and interventional procedures, and move on to the next warm body. We must all guard against this.

We are also in an era where economics has become one of the most powerful and intrusive drivers of medical decisions. In 2001, spending on health care in the U.S. was $1.42 trillion. This is nearly a 9% increase over 2000 and brings health care spending up to slightly more than 14% of the U.S. gross domestic product—a staggering statistic. Because of this spending explosion, insurers, policymakers, and employers are understandably looking to rein in costs:

- Reimbursement has been slashed and private payers are increasingly prone to bundling payments for various components of treatment. Simply put, reimbursement is discordant with the cost of providing cardiovascular specialty care.
- Employers are looking to reduce expenses and ensure a better return on the investment in their employees’ health.
- States are in difficult financial positions and are reducing Medicaid roles and cutting back on public health programs. Meanwhile, the downturn in the economy has increased the ranks of the unemployed. The combined result is a growing number of people who have no health coverage, a situation that could have devastating repercussions for the nation’s general well-being.

These are not the subjects that we studied in medical school, but they will clearly affect how you care for your patients.

Thankfully, though, the news is not all dire. In fact, there is far more good news than bad news to report—much of it on display here in Chicago. A brief trek around this convention center offers a powerful testimonial to the extraordinary progress being made in cardiovascular medicine: from new information about the role of inflammation
in disease to incredible innovations like drug-eluting stents, biventricular pacemakers, and cellular and gene therapy.

The pace of the advances is dizzying. I suspect that many of you feel like you are drunk from imbibing the results of so many important studies and clinical trials and meta-analyses. And yet, for all of the advances we have seen, I believe the best is yet to come.

Which delivers me back to where I began today: The future.

As Churchill said, we have empires to build. And I believe that the College—and, as a consequence, each of you—has the potential to be an integral part of that construction. So let me play the role of cheerleader for a moment and talk about the grand opportunities that exist for the College and for all of you as ACC members.

I'll begin with something particularly close to my heart: the move of the College's headquarters to the District of Columbia. I don't know how many of you have been to Heart House in Bethesda, Maryland, just around the beltway from downtown Washington, D.C. Heart House is near and dear to many ACC members. In particular, the Learning Center at Heart House is deeply valued by many senior members. And there is no arguing that the hundreds of high-caliber educational programs that have been held at the Learning Center have helped to improve the care of tens of thousands of patients.

But times have changed. In an effort to become even more relevant and offer members more and more services, the College has continued to expand. This expansion, of course, means more services, tools, and resources for ACC members such as Cardiosource, the soon-to-be-released Web-based quality improvement tool for catheterization laboratories, or the College's expanded presence with policymakers at the federal and state level.

Because of this expansion, the College simply has outgrown Heart House. After weighing various options, a Task Force that I chaired recommended to the Board of Trustees that the College move its headquarters into the District of Columbia. A recommendation that was unanimously approved.

Exactly what this new headquarters will look like is still a long way from being decided. But imagine a facility that is the preeminent showcase for the treatment of heart disease. A state-of-the-art building in the heart of the Capitol where visitors could take tours of exhibits that provide information about the cutting-edge of cardiovascular care, detailed procedure simulations, and kiosks where they can enter in their health information and get back details on their risk factors and potential diagnostic procedures—along with a listing of the FACCs in their vicinity who could aid in their care.

Dignitaries, lawmakers, and others could participate in prevention and treatment programs run at the new Heart House, with access to exercise machines and dieticians and an on-staff cardiologist. Will any of this happen? I can't say.

But I'm going to encourage the College's leaders and its membership to think big.

This leads me to an area where the College has traditionally not played a prominent role, but where I believe there are boundless opportunities: educating the public about heart disease. There is a growing sentiment among ACC members that we need to do a better job of reaching out to our patients—not only to educate them about the perils of and potential treatments for cardiovascular disease, but also to make them better appreciate that those four uppercase letters that follow our names—FACC—mean that they are in the hands of a skilled physician specialist who is committed to providing the highest quality care possible.

Physician education is another area where we are likely to see large-scale changes in the future. In addition to hosting the preeminent meeting on cardiovascular medicine each year, the College is already well down the path of Web-based learning, including interactive programs and the vast depths of knowledge available through Cardiosource. And I suspect that we will see more continuing education available on the Web, much of which will be interactive, involving technologies that are probably not even available yet that five years from now could be the standard of care.

With the Foundation for Advanced Medical Education (FAME) project, the College also has entered the realm of simulation training. This is an extraordinarily exciting area of investigation. Using simulation technology, physicians are beginning to acquire and practice their technical skills, learn new procedures, and maintain competence. Much of the simulation training currently being done in the cardiovascular arena centers around interventional procedures. But hopefully we will see it expand to areas such as electrophysiology, treatment of heart failure, bypass surgery, and other treatments.

As I talk about these initiatives, I would be remiss if I failed to remind you that those at the fore of them are ACC members. Because the College is, in most respects, dependent upon its physician members who have the expertise and commitment to moving our profession forward.

But what about the other members of the cardiovascular care team? There are approximately 200,000 dedicated cardiac nurses in the U.S. and there is no group with which they affiliate. There are PharmDs who have moved over to hospital-based care and are dedicated strictly to cardiovascular care. There are exercise scientists operating state-of-the-art prevention and cardiac rehabilitation programs. Quality cardiovascular care, in other words, is not relegated to the care provided by the physician. The time may be coming for the College to welcome these health care professionals into its fold. I know that this is a controversial issue for some members, but I only hope that we can discuss it in an open, honest manner and do what is best for the College, for our profession and for our patients.

Already we are starting to see a move in this direction. After all, team-based care is an important theme of this
year's Scientific Session. And rightfully so. Initial findings from investigations of well-coordinated, team-based care include improved patient outcomes, as well as more satisfied patients and members of the health care team. This is progress, and I believe that we all have a duty to promote it because it is in the best interests of our patients.

I'd like to conclude today by reminding all of you that, on many different levels, you are respected leaders. In an editorial in the *New York Times Magazine* (1) earlier this year, for example, the award-winning novelist Ann Patchett expressed her satisfaction with the selection of Bill Frist as the new majority leader in the U.S. Senate. Ms. Patchett based her optimism not on Senator Frist's acumen as a legislator or his charming demeanor. Rather, she was sanguine about this change in leadership because Senator Frist is a physician.

She wrote: “We still believe, no matter what the wait or cost or tortured insurance forms, that this person is here to help us. What he or she knows we could not possibly figure out on our own.”

Ms. Patchett was correct. People still believe that physicians are there to help them, to make them feel better. In everything you do, I encourage you to take steps to reinforce that belief, strengthen that expectation, and live up to that high ideal.

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**REFERENCE**