Journal of the American College of Cardiology
© 2008 by the American College of Cardiology Foundation
Published by Elsevier Inc.

Vol. 52, No. 21, 2008
ISSN 0735-1097/08/$34.00
doi:10.1016/j.jacc.2008.10.015

EDITOR'S PAGE

The Enlightenment of Travel

Anthony N. DeMaria, MD, MACC
Editor-in-Chief, Journal of the American College of Cardiology

I write this Editor's Page on the last leg of a trip taken to Asia to attend several medical conferences. Actually, the bulk of the time was spent in Vietnam. It is said that travel is very broadening. However, to say that this trip was eye opening for me would be a gross understatement. The sights that I saw, the hospitals that I visited, and especially the people that I met gave me a unique perspective of just how narrow my vision of cardiology, and medicine in general, actually was. My experience in the U.S. and abroad suggests that I am not alone in this perspective.

The trip to Vietnam had some special significance for me. As someone of military age during the Vietnam War (referred to as the American War by the Vietnamese), I was particularly affected by this tumultuous period. I tended to many servicemen and women who were injured in the conflict while I served in the U.S. Public Health Service. (I should have been excluded from military service due to recurrent pneumothoraces, but an exemption was made because I was a physician.) Therefore, many of the places we visited or topics we discussed provoked memories of a time when travel to Vietnam was dangerous and many of the inhabitants were enemies. I assumed that the same was true for many of my Vietnamese contemporaries. Nevertheless, in the 30 or so years that have passed, most of this seems to have been forgotten. We were greeted warmly by our hosts, and there was no evidence of residual anger or hostility. In fact, many of the younger physicians manifested little knowledge or interest in the conflict. It is a wonder to see how rapidly our best instincts can be restored after our worst instincts have been operative. Perhaps because we are physicians and are dedicated to reducing morbidity and mortality it is easier for us to put the insanity of armed conflict behind us.

The scientific sessions were generally of a high caliber. Leading edge topics were discussed, and I participated in a session on basic science that included futuristic subjects such as stem cell transplantation. Although many of the presentations were made by speakers from abroad, there were a number of fine reports from Vietnamese faculty. I was assured by colleagues that interventional cardiology was practiced at a very high level in some centers in Vietnam. This high level of intellectual activity would contrast significantly with what I subsequently learned about the medical facilities and working arrangements of Vietnamese cardiology.

I spoke to a number of Vietnamese cardiologists about their professional lives. I was impressed by how hard they worked and by the equanimity with which they dealt with a number of challenges that we never face in the U.S. I was told that a very senior full professor of cardiology might earn $4,000 to $5,000 per year for a full 5-day work week, while junior faculty would earn less. Since this compensation is not adequate, most physicians work in a private clinic (often in their home) from 5:00 PM to 9:00 PM for a typical 12-h workday. The opportunity to conduct such clinics is not afforded to all cardiologists, but has to be earned through excellent clinical skills. Such clinics could be expected to yield an additional $100 per session at least for professors. However, in return for this private practice, the physicians expose themselves to a considerable risk of

The scientific meeting discussed the proper use of magnetic resonance imaging, drug-eluting stents, ablation of atrial fibrillation, and the potential for cardiac regeneration, while at the hospital patients were sometimes ventilated by family with an Ambu bag.

JACC Vol. 52, No. 21, 2008
November 18, 2008:1745–6

malpractice litigation. Because patients pay extra money for the clinics, they expect that good health will be ensured. An example was given of sudden death; the fault for such an event would often be laid at the feet of the doctor, since money had been paid to acquire good health. I was told that malpractice claims were common and were successful approximately 25% of the time. Virtually all of the cardiologists I met used motor bikes as their means of transportation, and did not seem to regard the lack of a car as a deprivation.

The cardiologists with whom I talked spoke of these above conditions matter-of-factly and without rancor or self pity. They were more interested in discussing how they could improve the quality of clinical care in their country. Young cardiologists were interested in how to perform research and turned out in large numbers to hear a lecture on how to publish a paper in a competitive journal. I heard much less discussion of the economics of medicine in Vietnam than I do in the U.S. Despite the limitations of financial compensation, the dean of the medical school in Ho Chi Minh City told me that annually there are some 35 to 40 applicants for every position in the medical school. While this may reflect the fact that the life of a physician is more comfortable than most in Vietnamese society, I had the distinct impression that the old-fashioned satisfaction derived from patient care was the major attraction for a career in medicine.

The challenges faced by physicians paled compared to those faced by many hospitals. We visited the largest government hospital in Ho Chi Minh City and witnessed the difficult reality of providing medical care to a large population in the face of limited resources. Although the hospital has 1,700 beds, the census often exceeds that number, resulting in the sharing of a single bed by multiple patients. The beds themselves were placed almost everywhere, including the hallways, with relatively little separation by either space or dividers. Since the patients are often accompanied to the hospital by their family, the halls and wards are filled with people. In fact, the family often assists the medical staff in the care of patients. I witnessed at least 2 instances in which family members ventilated patients with endotracheal tubes using an Ambu bag. I was impressed that, despite these hardships, the doctors and nurses delivered skilled and empathetic care and pursued contemporary diagnostic and therapeutic strategies. I had nothing but admiration for their ability to make the most of the facilities and supplies available.

I cannot help but reflect on the contrasts that were observed during this travel. The scientific meeting discussed the proper use of magnetic resonance imaging, drug-eluting stents, ablation of atrial fibrillation, and the potential for cardiac regeneration, while at the hospital patients were sometimes ventilated by family with an Ambu bag. It placed in context issues such as the use of potent antiplatelet agents in patients with stable coronary artery disease to obtain an absolute reduction of events of less than 2%. I recognize that there are no new revelations here, but witnessing the disparities in the flesh gave them a new meaning. It is not that any of the above scientific issues are unimportant, it is just that there is a lot of low-hanging fruit in the world with which to achieve a reduction in mortality. There are also dedicated and skilled physicians grappling with strong challenges to harvest this fruit.

I have had the good fortune to be able to travel extensively in my career. Each trip has been enlightening on its own, and each has made a significant impression. However, the trip to Vietnam was special in a number of ways. The contrasts witnessed medically and politically over time were dramatic. The lessons that I took away from this travel were much greater than those that I imparted, and will surely have an effect both scientifically and personally.

Address correspondence to:
Dr. Anthony N. DeMaria
Editor-in-Chief, *Journal of the American College of Cardiology*
3655 Nobel Drive, Suite 630
San Diego, California 92112
E-mail: ademaria@acc.org