It is indeed an honor and a privilege to be installed as the president of the American College of Cardiology. There is no greater organization for physicians. As we celebrate the College’s 50th anniversary this year and reflect upon what this organization has contributed to the specialty of cardiovascular medicine, being selected as the ACC president is that much more of a humbling experience.

In 1978, as a pediatric cardiology fellow, I was asked to give a talk in Southeast Asia. I was very impressed that I was giving my first international talk. A government official met my plane, and, as we were traveling in from the airport, I asked her how many pediatric cardiologists there were in the entire country. She said, “Eight.” And I said, “My gosh, eight! How many do you need?” She said, “None.” And that put me in my place.

I am pleased that the American College of Cardiology feels differently about pediatric cardiologists.

It has been 18 years since the last pediatric cardiology president, Dan McNamara, also from Baylor in Houston, and I am honored to follow my mentor and lead the American College of Cardiology into the new millennium.

Let me tell you a little bit about Dan McNamara. He was one of the world’s great teachers, and he got me involved with the ACC as a fellow by teaching at Heart House. Dan McNamara was a gentle giant. He turned out not only a large number of fellows but also an incredible number of leaders. Dan died last year, leaving every one of his trainees better people—not just better cardiologists.

In his memory, I’d like to talk a few minutes about leadership.

In all areas of cardiovascular medicine, whether you are in adult cardiology, pediatric cardiology or cardiovascular surgery, leadership is important. You new Fellows are among the intellectual leaders of medicine. We, as cardiovascular specialists—through the ACC, its chapters and as individuals—will be called upon to lead.

My message to you as incoming Fellows is something I wish someone had defined simply for me a long time ago. Leadership can be defined in one sentence:

- We’re. We do the job together. We have to lead from among our peers—not so far out in front that they can’t see us. Our peers must respect us as one of them. A great leader is a great role model, with integrity, seeking input objectively (listening), taking decisive action and being accountable.

- A great leader does not ask others to do what he would not do; he shows them how to do it.

- Being a good leader is also being a good follower. Dan McNamara gave an incredible amount of support and credit to the people around him. I think one of the biggest mistakes I’ve seen in leaders is that they surround themselves with people who are not as good as they are. The most important thing is to surround yourself with people who are better than you are. It makes them feel good, and it makes you look better.

- Above all, great leaders should take the job—but not themselves—too seriously. I learned that lesson in Southeast Asia long ago.

- Going there. Let’s start with “there;” you have to know where you’re going before you know how to get there. A good leader provides a broad vision but also has to be very specific about what that vision means in terms of individual goals and timed objectives. A leader then has to identify how we’re going to get there. You need both the vision and the method.

- Fire. A great leader has fire in the belly—passion and enjoyment for getting there. It’s both the journey and the destination that drive a great leader. Can you imagine a great leader saying, “We’re going there with boredom?” Instead, it’s we’re going there together and going there with enthusiasm. We’re going there with fire.

Now that I’ve explained to you how I see leadership, I’d like to take the middle two words and talk about where I think we’re going.

Where we are going? The American College of Cardiology is 50 years old, and it gives us a real sense of pride to be able to celebrate the extraordinary accomplishments of this organization and of cardiovascular medicine. The National Aeronautics and Space Administration (NASA) in Houston was recently celebrating its own milestones. I had the pleasure of being invited to its 40th anniversary luncheon. It was a momentous occasion. John Glenn was orbiting the
earth and spoke to the group via satellite. Dan Golden, the administrator of NASA, was there, as was Walter Cronkite and our own Dr. Michael DeBakey.

Dan Golden predicted that in the next 40 years we will know whether there is life somewhere else in the universe. That’s a fairly heady prediction. Walter Cronkite then said that the last time John Glenn was orbiting the earth, in 1962, he made a prediction that taught him to think twice about prognosticating. He described a type of black tape that was fastened to the inside of the capsule door. One side was fuzzy; the other side had tiny hooks. It was called Velcro. He recalled, “And I said in front of two hundred million people that it would never work on earth, only up in the air.”

My ability to prognosticate may be more like Mr. Cronkite’s. Nonetheless, on the occasion of the ACC’s 50th anniversary, I feel compelled to make a few predictions. However, considering the realm of predictability, I’ve decided to go no further than the next 10 years and to limit my predictions to three.

THE NEXT TEN YEARS

More cardiologists. First, by the latter part of the next decade, we’re going to need more cardiologists. We think we have a fairly sufficient number of cardiologists in certain areas right now. But within the next 10 years, I suspect we will need more cardiologists for several reasons.

1) Heart disease is a chronic illness, and we are keeping people alive longer. As such, there will be more patients with heart disease and a greater need for cardiologists to care for them; 2) Quality will become routinely measured and meaningful. We baby boomers are about to get a bolus of savvy 60-year-olds into the population. We will “have it our way.” We will insist on cardiovascular specialists for quality; 3) It’s clear that minorities will become pluralities. There will be relatively more African Americans and Hispanics in this country than there are now. The prevalence of coronary artery disease in African Americans is actually less than in Caucasians; however, their mortality is double. We will need more cardiologists—of all ethnicities—caring for all ethnicities; 4) Cardiovascular medicine is such a broad disease category that it will generate new subspecialties of its own—for example, cardiovascular gene therapists and sinus-node replacement doctors. The concept of what a “cardiologist” does will expand due to the phenomenal advances in “cell-to-bedside” medicine.

What can the American College of Cardiology do? We should develop methods for assessing the true needs of patients for cardiologists and continually monitor those needs. We must develop criteria for great training programs in cardiology and help keep those programs open. We must foster research and prepare cardiology fellows for life-long learning through their newest college: the American College of Cardiology.

Higher costs. My second prediction is that there will be higher costs. For example, gene therapy to prevent atherosclerosis will be expensive. Prevention costs money; prevention also extends life, and that is what we are about.

What can we do about higher costs? As a specialty, as individuals and as an organization, we have to become more cost effective. Cost effective does not mean cheap. Cost effective is an expression with a numerator—cost—and a denominator—effectiveness. Cardiovascular specialists must strive to become more effective at the same or lower cost. We must be able to demonstrate the quality of our contributions. This is our challenge.

Current medical management is taking away everything we cannot measure; when we can measure it, we will take it back.

Improved health care system. My third prediction follows from my first two: With a greater need for quality and increasing costs, there will be a need for an improved health care system.

At a minimum, we need to have universal coverage. The ACC has championed this concept, and there are many ways to achieve it. The entire system will improve if we do. What better time to take such a step, when we are predicting a trillion-dollar budget surplus?

We must provide quality care—the right service by the right physician at the right time—with compassion. We’ve got to wring waste out of the system, including undue profits. We must reduce the bureaucratic burden to patients and physicians. Somehow, with all of these challenges, we must retain and foster the capacity for innovation and for important advances in research.

These are a few predictions for the next 10 years; but now, to get down to business, I want to address my goals for going there in the next year.

GOALS FOR 1999–2000

1. Value. The ACC must increase its value to you, its members. There are several activities underway to achieve this goal. We will do a better job of communicating to our membership what the ACC can do for all of us—for example, how ACC chapters can help each of us in our current challenges, such as managed care consolidation and practice expense.

We will inaugurate a member relations task force, chaired by Spencer King. This task force will work with the Board of Governors to increase involvement in chapters and chapter input at the national level. To make sure we know what you want, we will be calling a large number of members each month to ensure a direct dialogue. I will personally be making more than 100 of these calls because I want to hear what you have to say. It’s also important to involve more members in ACC activities. I made the first step toward this goal when appointing members to committees; more than half of committee openings for this year were filled by members.
who had never before served on an ACC committee.

We will work closely with the cardiovascular subspecialty societies and the American Heart Association for the mutual benefit of our members.

2. ACC 2000. As part of increasing the value of the ACC to its members, the Annual Scientific Session in March of 2000 will undergo significant changes to provide an even better educational experience. For example, on Sunday, the entire day will be devoted to single-subspecialty tracks—interventional cath or echo—developed with the subspecialty societies. We will also have a separate Sunday track entirely for the clinical cardiologist. ACC 2001 will have even more.

3. The great circle. We will put the pieces together for a structure—that I refer to as the “great circle”—to help cardiovascular specialists to produce the most cost-effective care for patients. This circle links four processes: practice guidelines, performance measures, outcomes data through our National Cardiovascular Data Registry™ and education.

4. Personalized CME. We’re going to bring continuing medical education closer to the membership. The ACC has created a new task force whose aim will be personalized CME—helping individual physicians determine what they need and how they want to receive it. One thought is to have real-time CME that can be obtained during patient visits. We’re really looking forward to great ideas and great operational strategies coming out of this process.

5. Better health care system. Finally, we must strive for universal coverage. For the next year, it appears that incremental steps will be necessary. One group particularly hard hit is adults with congenital heart disease. You may not know that when you turn 19 years old in the U.S.—no matter how poor you are—unless you are completely disabled, there is no health care coverage. For example, you can get a pacemaker at age 15 and be covered by Medicaid. However, if you require a pacemaker change at age 23, there is no funding to pay for that pacemaker. This is one area in which the ACC is—at least in one way—going to try to create universal coverage. We are spearheading a national funding program for adults with childhood disease. This effort is not just about cardiovascular disease. It is about childhood cystic fibrosis, cancer survivors, seizures and more. The ACC is taking the lead in a “House of Medicine” issue.

Thank you. Before closing, I want to take the time to say thanks. Thank you to all who got me interested in the ACC, teaching at Heart House, the broad spectrum of education, and health policy. Becoming the ACC president is indeed a signal honor.

I also want to thank Bill Winters and Paul Gillette in addition to Spencer King and Richard Popp, the ACC’s most immediate past presidents, who have truly been mentors. Thanks to the staff at the ACC, led so wonderfully by Chris McEntee, who are truly the best in the world. To the people in this room—the new ACC Fellows—thanks in advance for teaching us more than we teach you.

I also want to thank my family, not just for their incredible support but for being my greatest teachers. Another key to continued learning is humor. With all the candor and honesty that only a child can bring, one of my daughter’s friends recently asked me when I was being indicted as president of the ACC. This is probably the most pleasant kind of “indictment” I can imagine, and I thank you.

Accountability. Finally, I pledge to this group to come back next March and hold myself accountable for the goals. As I look toward the year ahead and as our new Fellows look toward the future, Ralph Waldo Emerson’s definition of success may be helpful to reflect upon:

“To laugh often and much; to win the respect of intelligent people and affection of children; to earn the appreciation of honest critics and endure the betrayal of false friends; to appreciate beauty, to find the best in others; to leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition; to know that even one life has breathed easier because you have lived. This is to have succeeded.”

Thank you.

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