In celebration of our differences

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It is humbling for me to see my name among those of my predecessors in this office. I am grateful to this Association for the honor it has bestowed on me, for the responsibility it has placed on me, and for the unparalleled opportunity it has afforded me to meet, associate with, and work with an array of wonderful surgeons and their families from across Western North America. I am very mindful of the fact that I am only the second Canadian to hold this office, my friend and mentor, John Callaghan being the first.

Dr John C. Callaghan, the ninth president of the Western Thoracic Surgical Association in 1984 and 1985, invited me to come to the University of Alberta in 1974. John was a larger than life, ebullient, gregarious man, a master surgeon who performed Canada's first successful operation on cardiopulmonary bypass. I will always be indebted to him for his unwavering support (Figure 1).

My first medical hero was my uncle, Dr Sidney Gelfand. He was the last of the urban general omni-practitioners who did it all: a family office practice combined with a full range of surgical procedures that would be unthinkable today (Figure 2).

I will be forever grateful to my family for their love and support and understanding. My wife, Dena, our children, Michael, Laurie, and Susie, and their spouses, Bonny, Brian, and Alejandro, and our 6 grandchildren have been a source of inspiration and joy beyond words.

I would like to share with you a comparison of Canadian and US cardiac care. I am going to ask you to consider Canada in a positive frame of mind. All too often, we Canadians are portrayed in a negative light, whether it is as the source of the cold fronts plaguing warmer climes or as a place whose health care system tolerates rampant deaths on interminable waiting lists.

I want you to consider that the specter of a Canadian-style health care plan is not as scary a prospect as perhaps you thought it might be. To that end I will highlight the contrasts that exist between our 2 nations, so I am going to touch on

- the differences generally between us;
- the differences in our health care systems;
- and the differences in provision of cardiac care.

I will share the Canadian model for

- training cardiac and thoracic surgical residents;
- our medical malpractice insurance system;
- and how these differ from our American counterparts.

Our 2 neighboring nations, the United States and Canada, until September 11, 2001, shared the longest unprotected border in the world. John F. Kennedy said of our relationship, "Geography has made us neighbors. History has made us friends."

Canada and the United States have roughly the same land area; however, Canada's population is 33 million, with the United States having more than 300 million

Figure 1. Dr John C. Callaghan.

people. The US infant mortality rate is approximately 1.5 times that of Canada. The birth rate is 23% higher in the United States, as is the death rate by 6%. Life expectancy, however, is 2.9% higher in Canada, currently 80.2 years as opposed to 77.9 years.¹

As a percentage of gross domestic product, health care expenditures are 1.5 times higher in the United States, 15% as opposed to 10%. Canada spent approximately \$140 billion on health care in 2006, which accounts for 70% of all public spending, whereas in the United States, health care spending (\$2 trillion) comprises 57% of public spending. Total per capita government expenditures are 4.6% higher in Canada, reflecting the heavy emphasis on social programs. In both countries, approximately 20% of patients account for 80% of health care costs.¹

Let me tell you a little about the setting where I practice. Edmonton is the most northerly major city in Canada, situated in the province of Alberta, just north of Idaho and Montana, and east of the Rocky Mountains. The province has

Figure 2. Dr A. Sidney Gelfand.

a population of a little more than 3 million people, of which 1 million are in Edmonton, 1 million are in Calgary, and 1 million are in smaller towns and cities in rural Alberta.

Edmonton is the capital of the province, with an economy largely based on the oil industry, agriculture, and forestry. Economically, Alberta is booming because of the high price of oil, with a 12.7% average annual economic growth rate since 2002 (compared with the number 1 economy in the world, China, growing at 14.8%, and averaging 4.6% in the United States since 2003).²

From the standpoint of health care provision, the province is administratively divided into 9 regions, the Capital Health Region around Edmonton being the largest integrated health care region in Canada, serving approximately 2 million people. The provincial government allocates operational funding to each region based on a funding formula, which takes into account

- population;
- age and gender of the population;
- socioeconomic composition of the population;
- and tertiary, quaternary, and province-wide services provided to other health regions.

There are less than 3000 acute care beds in the region. This year's operating budget is \$2.4 billion, and there are \$1.82

billion worth of capital projects under way, the result of which, it is hoped, will provide increased bed capacity and shorter waiting times.

The University of Alberta Hospital (situated on the U of A campus) has 725 beds, including 120 pediatric beds in The Stollery Children's Hospital. With the opening of the new Heart Institute in May of 2008, there will be an additional 124 beds. This \$196 million center will be attached to the University Hospital and will house all cardiac surgical and cardiology services, including operating rooms, catheter laboratories, other diagnostic and imaging facilities, rehabilitation facilities, clinic and office space, and a 2-floor research area.

The University of Alberta Hospital has 8 cardiac surgeons managing 1700+ cases per year and is the only cardiac surgical unit in Northern Alberta. Our case volumes have not shown the dramatic downward trend of many US institutions, due in large part to the lack of emergence of peripheral, small-volume units, as a result of the government philosophy of centralization of cardiac surgical care.

Included in these numbers is Canada's current largest yearly volume of heart and lung transplants at 35 and 31 in 2006, respectively, and Canada's second largest congenital cardiac surgical program, which in 2006 performed 360 open and 246 closed procedures.

Until the early 1960s, Canada and the United States had similar health care systems. Now Canada has one of the most fully socialized health care systems in the world, with few private services and no private insurance available. In contrast, the United States is 1 of only 2 of 30 Organisation for Economic Co-operation and Development countries that does not have some form of guaranteed health insurance for all its citizens.³ In 2005 there were 46.6 million Americans with no health insurance, and approximately another 40 million with inadequate health insurance. Therefore, more than one quarter of all American people have inadequate or no health care insurance. More than one half of all family bankruptcies filed each year in the United States are directly related to medical expenses, and 75% of these are from families *with* health insurance.⁴

Universal health care insurance can take many forms. The philosophic spectrum runs from single-payer systems such as in Canada, Britain, and Sweden, in which governments assume direct responsibility for health insurance, to hybrid systems such as in Germany, where private, nonprofit insurance operates under government regulation, or France, where the insurance is financed through general government revenues rather than premiums and cost-sharing occurs among those who can afford it, except for people with chronic illnesses such as diabetes.

Canadian publicly funded health care was legislated nationwide in 1966 after considerable debate and turmoil. In its final iteration, the Canada Health Act enunciated 5 inviolable principles. These are as follows:

1. It must be publicly administered.

Each province is responsible for administering its services on a nonprofit basis by a public authority, accountable to the provincial government. This is, obviously, a single-payer system.

2. The system is comprehensive.

That is to say, all services deemed medically necessary are insured.

3. Universality.

This means that all residents of the province have access on uniform terms and conditions.

4. Portability.

Provinces must cover health care costs while residents are temporarily absent from their province of residence.

5. Accessibility.

Insured persons must have reasonable and uniform access to insured services, free of financial or other barriers.

A further provision of the Act discourages any financial contributions by patients, either through user fees, extra billing, or private insurers. Privatization is the process by which the government transfers some of its activities or responsibilities to the private sector. Privatization of funding differs from privatization of delivery of services. Privatization of funding implies shifting the burden of funding away from public health insurance plans, toward patients and their insurance companies. This has not occurred to any significant degree. Privatization of delivery, in many respects, already exists—governments deliver few health care services directly. Most health care providers (eg, physicians, physiotherapists, and pharmacists) are in private practice; they are not government employees. Physicians for the most part are paid fee-for-service by the government, the fees having been negotiated between the provincial governments and the provincial medical associations. In academic institutions, physicians may be salaried, although services are still paid for on a fee-for-service basis to the department or division. A new concept is being trialed in some areas, with groups of physicians being paid collectively on a negotiated yearly basis, irrespective of how many services are provided. Although hospitals are funded by provincial governments, they are not owned by these governments, and they are nonprofit.

A major public and political concern with regard to privatization in Canada is that it could lead to a 2-tier system, one in which some patients with financial means may pay privately and receive priority access to health care. In fact, although it does not exist per se, our second tier is the United States, where some patients with financial means choose to go for speedier access. Canada is the only non-third world country I know of with a publicly funded health care system that does not offer a private option.

A recent poll asked Canadians if they support having to pay the full cost for health services if it means speedier

access. Physicians and pharmacists showed the greatest support for a user-pay option, and the public and nurses were the most opposed.⁵

There are many questions still unanswered about Canada's system and whether by any definition, private health care is going to be allowed to emerge. The kind of debate that is occurring, especially in Alberta, is, for example, that private magnetic resonance imaging (MRI) clinics have been allowed to emerge. Patients pay the fee themselves, without the benefit of any insurance, get their MRI performed more quickly, and then enter the public arena for their care, having essentially moved up in the queue by virtue of their ability to pay. The federal and provincial authorities are trying to clarify how this should work. It is a system in evolution.

Another major difference between Canada and the United States has been in the investment in technology and in research and development. With respect to the latter, Canada has to some degree been a follower, benefiting from the research in technology that has mushroomed during the past decades in the United States. In terms of availability of high-tech equipment, we lag behind the United States by a considerable margin. In Canada there are 4.6 MRI scanners per million people, and the United States has 19.5 MRI scanners per million people. Canada has 10.3 computed tomography scanners per million people, and the United States has 29.5 computed tomography scanners per million people.³

I do not pretend to understand all the issues at play in the United States with respect to an all-encompassing scheme of health care insurance; however, I did read a recent editorial⁶ on the various state plans to force people to purchase private insurance. It asks many important questions:

- "Will the state define coverage, routine and catastrophic, in private-sector plans?"
- Will it increase oversight of the insurance industry?
- Will it prohibit price increases by these companies?
- Who defines "affordable insurance?"
- Who qualifies for a public subsidy to purchase insurance, and how will that be financed?"

Most private insurers spend a greater percentage of their dollars on administrative costs than government programs. No public officials in either country are paid \$10 million per year as a US Healthcare Chief Executive Officer was purportedly paid.⁷ In 2004, General Motors estimated that \$1400 for employee health insurance was included in the price of every car it sold.⁸ To many, managed care is more about managing costs than ensuring quality care.

No Canadian is denied care for lack of proof of coverage. How payment for services is going to occur is not a subject that patients or doctors think about. Patients are free to see the physician or physicians of their choice.

From the vantage point of the surgeon, inevitable frustrations arise as a result of waiting lists, and from time to time, the perceived inability to provide timely care espe-

Canadian Benchmarks: Upper limit of wait time

	EMERGENT	URGENT	SEMI-URGENT	NON-URGENT
Initial Consult	24 hours	1 week	4 weeks	6 weeks
Cath (STEMI)	24 hours	3 days	7 days	N/A
Cath (NSTEMACS)	48 hours	3 days	7 days	N/A
PCI (STEMI)	Immediate	Immediate	Immediate	N/A
PCI (NSTEMACS)	Immediate	Immediate	Immediate	N/A
Stable Angina	N/A	7 days	4 weeks	6 weeks
CAB (STEMI)	24 hours	7 days	14 days	N/A
CAB (NSTEMACS)	48 hours	14 days	14 days	6 weeks

Canadian Cardiovascular Society Commentary on Access to Care

Figure 3. STEMI, ST segment elevation myocardial infarction; NSTEMACS, Non ST segment elevation acute coronary syndrome; PCI, percutaneous coronary intervention; CAB, coronary artery bypass.

cially for more elective procedures. On the other hand, the single-payer system means that there are no discussions with insurance companies, no clerks making decisions about who does or does not qualify, and payments in full of the fees occur by electronic bank transfer within 10 days of submitting the bill. Each surgeon at our institution functions with a single clerical staff member. It has been estimated by a study at the University of California San Francisco that the United States would save more than \$161 billion every year in paper work by switching to a single-payer system.⁹

I do not want to paint a picture of perfection, because that is certainly not the case. Recently there has been a shortage of family physicians. Many general practitioners have closed their practices to new patients, and particularly in urban areas, patients are having difficulty accessing a general practitioner. Waiting times for non-urgent consultations in many specialty areas have been increasing. In Canada there are 2.1 physicians per 1000 population, whereas the average for Organisation for Economic Co-operation and Development countries is 2.9.³ Waiting lists do exist for some high-tech services, such as MRI and positron emission tomography scans, joint replacements, and other elective surgery, although in the past 3 years, strides have been made in reducing these waiting times. In some provinces, unacceptable delays have occurred for patients with cancer being seen and treated, necessitating arrangements being made with American institutions or other provincial jurisdictions to achieve more timely care. Canada pays a price for a publicly administered, single-payer system: increased waiting times for some services.

A Canadian federal government initiative has mandated timely access to key medical treatments. Medical panels have established wait-time guidelines (Figure 3), and most provinces have guaranteed their citizens compliance with these targets. Examples of these benchmarks are shown in Figure 3.¹⁰

In most provinces, we are close to meeting these targets for coronary surgery. We are far less successful when it comes to sophisticated diagnostic imaging.¹¹

In the past 12 months, unmet medical needs were reported by 13% of Americans and 11% of Canadians. For Americans the primary barrier was cost in 53%. For Canadians it was waiting for care (32%).¹² There is a tradeoff, it seems, between universal coverage and some delay in accessing services. The United States has rationing of health care related to universality of coverage. We in Canada have rationing by virtue of waiting lists. The question is, “Is there a difference in outcomes?”

Beginning in 1971, overall mortality rates in Canada began to decrease, concurrent with the universal application of publicly funded health care. It also decreased in the United States at that time, although not so precipitously. Today’s mortality rates per 1000 population are 6.5 for Canada and 8.4 for the United States. Even for those considered to be wealthy, the figure is 4.7 in Canada and 5.7 in the United States.¹³

With tight government controls on overspending, redundancies in the Canadian system are rare. A full range of quaternary care services is generally offered in only 1 or 2 institutions in even a city as large as Edmonton with more than 1 million people. In our province of 3 million people, there are only 2 institutions offering adult cardiac surgery, 4 institutions offering sophisticated neurosurgery, 3 catheter laboratories, 1 center offering bone marrow heart transplants, 1 center offering liver transplants, and 2 centers offering bone marrow transplants. This is a conscious effort to concentrate expertise in centers with large volumes. As an example, an arrangement has been reached whereby the University of Alberta’s 2 congenital

Cardiac death rates per 100,000 population

	CANADA	USA
ALL CVD MEN	316.7	364.2
ALL CVD WOMEN	192.7	262.5
ALL CVD OVERALL	245.8	308.8
IHD MEN	188.2	CAUCASIANS 209.2 BLACKS 241.1
IHD WOMEN	97.3	CAUCASIANS 125.1 BLACKS 160.3
IHD OVERALL	136.4	162.6

Canadian Cardiovascular Atlas (Canadian Heart & Stroke Foundation) and Heart Disease & Stroke Statistics 2006 (American Heart Association, American Stroke Foundation)

Figure 4. CVD, Cardiovascular disease; IHD, ischemic heart disease.

Cardiac Procedure Rates per 100,000 population

	Edmonton	Alberta	Canada	USA
CABG Operations	86	73	94	106
Catheterizations	509	515	471	419
PCI	211	204	138	194

Canadian Cardiovascular Atlas (Canadian Heart & Stroke Foundation) and Heart Disease & Stroke Statistics 2006 (American Heart Association, American Stroke Foundation) and APPROACH Database

Figure 5. CABG, Coronary artery bypass grafting; PCI, percutaneous coronary intervention.

cardiac surgeons perform all the pediatric heart surgery for the 3 prairie provinces: Alberta, Saskatchewan, and Manitoba.

In both Canada and the United States, cardiovascular disease is the leading cause of death, comprising an identical 37% of all deaths for the population as a whole. Death rates per 100,000 population differ (Figure 4).^{14,15}

Cardiac intervention rates differ as well between the 2 systems (Figure 5).^{16,17} Patients requiring cardiac surgical procedures are prioritized by perceived urgency for their surgery into categories with target time frames. In Alberta, these priority categories are as follows:

- Emergency: within 24 hours
- Urgent in-hospital: within 7 days
- Urgent out-of-hospital: within 14 days
- Elective: within 60 days

At any one time, there are usually 250 patients on the waiting list at the University of Alberta, and excluding transplant recipients, approximately 40% of the 30 adult patients operated on weekly are patients waiting in hospital for their operation.

Excluding emergencies, in the last 13,180 patients undergoing coronary bypass surgery, the time from cardiac catheterization to surgery was as follows:

- Within 7 days: 1517 (11.5%)
- From 7 to 29 days: 5414 (41.1%)
- From 1 to 6 months: 4828 (36.6%)
- More than 6 months: 1421 (10.8%)

The Alberta data that I am citing are derived from the APPROACH database (personal communication; C Norris, PhD, 2007). The Alberta Provincial Project for Outcome Assessment in Coronary Heart Disease is an ongoing, prospective data collection initiative that began in 1995. It collects data for all patients undergoing cardiac catheterization in Alberta. These patients are followed long term, with subsequent information collected at the time of any interventions and by

subsequent questionnaires. APPROACH is currently following more than 108,000 Alberta patients.

What is the effect of waiting for cardiac surgery?

- Emotional turmoil may occur, particularly among those “type A” personalities who seem prone to this disease.
- There may be negative economic spinoffs, such as lost work days, lost income, and perhaps lost jobs.
- The problem of management of waiting lists and attempting to correctly triage patients for cardiac surgery is real.
- Some mortality occurs on our cardiac surgery waiting list, totaling 1.2% from cardiac causes during the past 10 years, throughout Alberta, and 0.7% in our facility. During this same period, 0.1% of patients died of noncardiac causes, and a further 10% of patients elected not to have surgery or were removed from the list by a physician.
- Operative mortality has not been affected by waiting. Our operative mortality has remained low, irrespective of how long patients wait for surgery, suggesting that we are for the most part able to correctly triage patients (Figure 6).
- Quality of life 1 year after bypass surgery is identical, regardless of how long a patient waits for an operation (Figure 7).

Although our patients, on average, wait longer, particularly in those considered not to be at high risk for waiting, we can achieve excellent results, comparable to most American centers. We have shown that we can safely triage patients waiting out of hospital who clearly would not wait out of hospital in the United States, for example some patients with left main stenosis or critical aortic stenosis.

Medical liability systems in Canada and the United States differ substantially, although both are tort-based compensation systems. This, as you know, means that the claimant is required to prove harm was caused by a breach of the duty of care.

Figure 6. Operative mortality by waiting time to surgery.

Quality of life after bypass surgery

1 Year later

Figure 7. Assessed SAQ, Seattle Angina Questionnaire.

The majority of Canadian physicians are covered by the physician-run Canadian Medical Protective Association. This group has a policy of *never* settling a case for which the expert professional opinion is that there is no physician error involved. Premiums are levied according to geographic locale and type of practice. Generally, awards for pain and suffering are minimal, in contrast with the United States. The intent of the award is to only compensate for loss of income, cost of out-of-hospital care, and the like.

In Canada, all specialty training and accreditation of training programs are under the auspices of the Royal College of Physicians and Surgeons of Canada. In each specialty, a specialty committee with representation from all geographic areas and all training programs is charged with the responsibility for directing training.

In the early 1990s, a close look was taken at the way cardiothoracic surgeons are trained in Canada. At this time the training was similar to that in the United States, with 5 years of general surgery plus 2 years of cardiothoracic surgery. To begin with, it was thought that cardiac and thoracic surgery had different needs, and that different paradigms would be appropriate for the 2 specialties. The stimulus for changing the way cardiac surgery is taught came from a realization that part of the 5 years spent in general surgery, in view of the enormous changes that have occurred in that specialty in the scope of work, and the way in which surgery is done, would be better spent in areas of more relevance to cardiac surgery.

As a result, sweeping changes were made 13 years ago, separating training in cardiac and thoracic surgery. Cardiac surgery in Canada is almost exclusively performed in university

Residency training

Cardiac Surgery

- 6 years – 2 core years
- 3 cardiac years
- 1 academic year
- Thoracic surgery + 30 months
- General surgery + 30 months

Thoracic Surgery

- General surgery + 2 years
- Cardiac surgery + 2 years

Cardiothoracic Surgery

- General surgery + 2 years
- 6 year integrated program

Figure 8. Canada/USA cardiothoracic surgery residency training differences.

centers or university-affiliated hospitals. In most major centers, noncardiac thoracic surgery is performed by pure thoracic surgeons. As a result, there are few centers in Canada where cardiac and thoracic surgery are performed by cardiothoracic surgeons; rather, today, unlike when I began my career, for the most part, cardiac surgery is performed by cardiac surgeons and thoracic surgery is performed by thoracic surgeons.

The recognized modes of training in Canada and the United States are shown in Figure 8. In Canada we have changed our training such that the residency begins directly out of medical school and continues for 6 years. Pilot programs along the same lines have been initiated in the United States as well.

We in Canada are experiencing the same concerns as in the United States with respect to difficulty in attracting the brightest and the best medical students. This is a relatively new phenomenon, one that we are having difficulty coming to grips with. At this year's Thoracic Surgery Directors Association meeting in San Diego, young American cardiothoracic surgeons, in practice for only a short time, were asked to comment on what the major factors were in discouraging the best and brightest from looking at our specialty. Surprisingly, it was *not* the length of training, *not* the perceived nationwide decrease in surgical volumes, and *not* the continuing attack on our compensation. It was, simply, the notion that our specialty's impact on its practitioners' lifestyles would be unacceptable to them. It appears that the choice of careers among young newly graduated MDs today rests less on the challenges and excitement of the specialty than on the ability to have a full and meaningful life outside of that career. We need to recognize this, and address it, or applications to our training programs will continue to decrease and our numbers will continue to dwindle.

I believe that we can and must convey a strong sense of optimism to young people considering a career in our spe-

cialty. We do have the ability to be flexible, to adjust to changing times, and to seriously revamp the way we train residents to support this work/life balance. We must be proactive in our clinical involvement in percutaneous technology and in exposing our trainees to that burgeoning field. We must continue to identify students at an early stage in their careers to interest them in our clinical work, our laboratories, and our clinical research. We must further seek out those who we can encourage as clinician/scientists in basic science and evolving technologies. To do that, we need to be very visible to young medical students and to be involved in their curriculum, their needs, and their progress. They need to be able to look to us as role models, as mentors, and we need to show them, in the strongest way, that it is possible to have a successful and rewarding career in our exciting and evolving specialty, and to lead a balanced life. Perhaps this very special organization of ours should serve as a template for us in how to balance the science of cardiothoracic surgery with the art of living life.

Analysis of recent data and thoughtful reviews of how we treat patients with coronary disease, such as that of Professor Taggart,¹⁸ will, as the information inevitably reaches the public domain, result in a resurgence in bypass surgery and far less confidence in the longevity of percutaneous procedures. Certainly this is being borne out by the release of information from the last American College of Cardiology meeting, in which the use of stenting was thought to be perhaps somewhat indiscriminate. To quote *The New York Times* of March 27, 2007 (Feder BJ. In trial, drugs equal benefits of artery stents. *NY Times*, March 27, 2007;53:1), the debate over the use of angioplasty and stenting should not be "whether to use stents in addition to drugs, but whether stents are used in too many seriously ill patients who might live longer with bypass surgery."

It is estimated that one half of all cardiothoracic surgeons will be leaving practice within the next decade, which has the potential to create a manpower crisis. However, if our next generation operates under a new paradigm, created thoughtfully by us, we may obviate this crisis.

Norman Vincent Peale once said that "the secret in life isn't in what happens to you, but what you do with what happens to you." We need to have the courage of our convictions to pursue these changes. To that end, representatives of our major cardiothoracic surgical societies, the Thoracic Surgery Directors Association, the American Board of Thoracic Surgery, and other interested and relevant participants will be meeting this summer to consider these issues and how to respond to them.

Many brilliant minds in both countries are working diligently to try to answer these questions, but my plea to you today is to ensure that we in the trenches are involved in the decision making, involved in the standard setting, and visibly at the forefront of resolving the issues to sustain the health of our specialty. If we are not involved, the decisions will be made for us.

We as cardiothoracic surgeons understand better than many people the difficulty in establishing the superiority of one technique, one philosophy, one organizational or management style over another. We know we can learn from each other and benefit from our differences. One of the strengths of our training program, for example, lies in the diversity of backgrounds of our attending staff. There is no “University of Alberta” way, rather, our residents benefit from seeing many ways of doing things, and as they carry various techniques from different surgeons forward in their own practices, it is inevitable that improvements will result.

We are among the most privileged people on the planet. Just think about it—we are privileged solely by virtue of where we live. We must never take this privilege for granted. We cardiothoracic surgeons, in particular, are privileged to be entrusted with the lives of our patients and their confidence in us, and we must never forget to shoulder that responsibility with a sense of reverence and awe.

Audrey Lorde, the gifted American poet, teacher, and activist said, “It is not our differences that divide us. It is our inability to recognize, accept and celebrate those differences.”

The means by which we, American and Canadian surgeons, deliver care to our patients may differ, but our objectives do not. On both sides of the border we aspire to provide for the well-being of our patients with compassion and skill, and we do that well. Our outcomes do not differ substantively. Whether our 2 health care systems will continue to move closer together, whether a private tier of health care provision will be allowed to develop in Canada, whether some form of a universal-coverage system will evolve in the United States is open to conjecture. We must encourage the political will on both sides of the border to improve timely accessibility in Canada and to enhance coverage of the populace in the United States. In my view, sophisticated, first-rate cardiac care in North America must be accessible, affordable, and available to all. We, practicing in this magnificent specialty, must be at the forefront of change to make this happen.

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