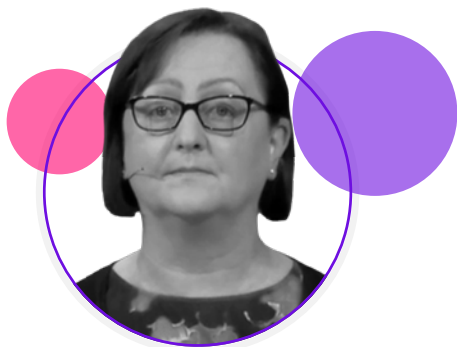




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“The key message is that AI is not itself the objective: better clinical care is”

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Q1 The European Society of Cardiology (ESC) Congress 2026 placed a particular spotlight on AI. What did that focus mean to you, and where do you see the greatest opportunities and the most important challenges as these technologies move increasingly into clinical practice?

For me, the key message is that AI is not itself the objective: better clinical care is. We are already seeing impressive applications in cardiovascular medicine, from ECG and imaging to increasingly sophisticated prediction of risk and clinical trajectory. The real challenge comes as we move from prediction towards action. A model may identify a patient at high risk of deterioration, but that does not necessarily tell us what we should do differently, or whether an intervention will improve that patient's outcome. As AI moves closer to influencing clinical decisions and treatment, I think the evidentiary requirement must rise accordingly. So, I am optimistic, but the important question is no longer simply what AI can do. It is what we should ask it to do, how rigorously we evaluate it, and whether using it actually improves decisions and patient outcomes.

Q2 You serve in several leadership roles across the ESC, including as Secretary-Treasurer and Chair of the Advocacy Committee. What aspects of this work do you find most rewarding, and what continues to motivate you?

What I find most rewarding is the opportunity to work with, and

learn from, extraordinarily talented people across the ESC and beyond. It is a real privilege not only to learn from that breadth of expertise and experience, but also, hopefully, to contribute something myself. The ESC brings together science, guidelines, education, professional communities, policy, and advocacy in a way that creates enormous potential for collective impact.

What continues to motivate me is both inequity and the persistent gap between what we know and what patients actually receive. Good evidence does not implement itself, and access to effective cardiovascular prevention and treatment remains very uneven. For me, the real value of this work is in helping to turn scientific progress into practical change that reaches patients more consistently and more equitably.

Q3 Reflecting on the Congress, what were the most important messages or developments that clinicians should take back to everyday practice? Were there any presentations, sessions, or discussions that stood out as potential practice-changers?

There was an extraordinary amount of high-quality science, including many excellent trials in the Hot Line sessions. TRIC-I-HF was one that particularly stood out, showing for the first time that, in appropriately selected high-risk patients with severe tricuspid regurgitation, transcatheter tricuspid repair could improve hard clinical outcomes, including mortality and heart-failure hospitalisation. Beyond individual trials, two broader

developments will have substantial implications for everyday practice. The new heart-failure guidelines bring important changes in classification and place greater emphasis on disease stage, prevention, and earlier intervention. I was also struck by the Fifth Universal Definition of Myocardial Infarction statement from the ESC, the American College of Cardiology (ACC), the American Heart Association (AHA), and the World Heart Federation (WHF). Moving from the previous numbered classification towards primary, secondary, and procedure-related myocardial infarction feels much closer to clinical reasoning, particularly in critically ill patients where myocardial injury, supply-demand imbalance, and primary coronary pathology can be difficult to disentangle. These developments illustrate the breadth of what a congress can change: treatment, classification, and the way we think about disease.



“**Imaging is most valuable when it helps us understand the physiology well enough to make better decisions**”

Q4 Throughout your career, how has your perspective on the relationship between cardiology and critical care evolved? Additionally, what advances presented at ESC 2026 do you think have the greatest potential to improve outcomes for critically ill cardiovascular patients?

I think the biggest change has been a move from largely reacting to established critical illness towards recognising deterioration earlier, characterising the physiology more precisely, and intervening before potentially reversible cardiovascular failure becomes irreversible multiorgan failure. That was very evident at ESC 2026. In cardiogenic shock, for example, there was a strong focus on better definition and phenotyping, serial assessment of severity and trajectory, and increasingly sophisticated approaches to predicting deterioration. Earlier recognition matters because it creates a therapeutic window, but only if we can then translate it into the right action. That is where the shock team becomes so important as a mechanism for rapid decision-making across imaging, haemodynamics, pharmacological support, revascularisation, mechanical circulatory support, surgery, and advanced heart-failure therapies. The opportunity now is to use earlier recognition and sharper physiological characterisation to decide whom to escalate, to what, and when.

Q5 Echocardiography has also been central to your career. In your experience, how is imaging continuing to transform decision-making in acute and critical care settings?

For me, the real advance is the way imaging is becoming embedded in physiological decision-making. In a critically ill patient, the important question is rarely simply what the heart looks like, but what is limiting the circulation, what might be reversible, what we can change, and how we will know whether an intervention has worked. What is particularly exciting is the increasing cross-talk between advanced echocardiography and the care of the most critically ill patients. Techniques such as strain, detailed Doppler assessment, measures of ventricular-arterial interaction, and serial quantitative imaging can add real physiological insight, while bedside echocardiography allows us to test a hypothesis and reassess immediately after treatment. At the same time, we now have access to an extraordinary range of complementary imaging modalities. The skill is understanding what each can add, when it is needed, and when echo already provides the answer. Ultimately, imaging is most valuable when it helps us understand the physiology well enough to make better decisions.

Q6 Education has been a major part of your work throughout your career. How do you think cardiovascular education and training must evolve to meet the needs of the next generation of clinicians?

The challenge is not simply to keep adding more content. Medicine is already enormously complex, and precision medicine, genomics, AI, and digital technologies will only increase that pressure. We need to be much clearer about what clinicians must know and be able to do independently, what they need to understand, what can safely be retrieved or automated, and where specialist expertise should reside. That probably means less emphasis on factual recall for its own sake, and more on physiology, causal and probabilistic reasoning, uncertainty, critical appraisal, and the ability to recognise when something does not fit. With AI particularly, clinicians will need both independent clinical

reasoning and the ability to use increasingly sophisticated tools safely and critically. Assessment must evolve accordingly. We need to test what clinicians can do independently where that competence is safety-critical, but also how well they use the tools that will form part of real clinical practice. As I mentioned, the curriculum may ultimately place less emphasis on factual recall, but it will likely become more intellectually demanding, with greater emphasis on judgement and decision quality.

Q7 Finally, as an acute cardiovascular care specialist, when you look ahead to the ESC Congress 2027, what developments or conversations would you most like to see progress in the field of prevention?

I would like us to think about prevention as a continuum, and to move the whole cardiovascular disease trajectory to the left. Ideally, we prevent disease before people ever become

critically ill. But prevention also means recognising deterioration early enough to prevent shock, multiorgan failure, or cardiac arrest, and using an index admission as a major opportunity for secondary prevention to reduce recurrent events and disease progression. The other opportunity is to make that prevention increasingly precise. Risk prediction is only the beginning; the more important question is which intervention is most likely to alter this individual patient's trajectory, with what benefit, harm, and burden, and at what point in the disease course. Precision prevention aims to match action more closely to the person. That leftward shift must also be equitable. Earlier diagnosis, precision approaches, digital tools, and better secondary prevention all offer important opportunities; the challenge is to ensure that their benefits are distributed equitably across populations, rather than widening existing inequalities.

