The American Heart Association is challenging every woman to put her heart health first by choosing to move. Choose To Move is a free 12-week physical activity program that helps busy women increase their exercise levels and build healthy habits into their daily lives. As part of the association’s Go Red For Women movement, the program provides women with practical solutions to lower their risk for heart disease, today’s No. 1 killer. To date, over 200,000 women have enrolled.

A recent Choose To Move survey found that 98 percent of women believe physical activity impacts their health, yet only one in 10 women includes adequate physical activity in her weekly routine. That's why Choose To Move took a different route this year and sought real-life, busy women to show that moving is attainable and can be fun.

In a nationwide search, we found seven women with varied backgrounds to take the Choose To Move Challenge. In January, the women gathered at the Cooper Institute in Dallas, Texas, for a comprehensive physical evaluation consisting of blood and cholesterol screenings, treadmill stress tests, diet analysis and physician consultations.

Throughout the 12 weeks, these women documented their successes and challenges via online blogs and video diaries (www.choosetomoveblog.org). At the end of the challenge, the women returned to Dallas for a final physical evaluation. Results were broadcast nationally during a satellite broadcast.

Choose To Move (CTM)

Jennifer Mieres, MD, FACC, FAHA
Director of Nuclear Cardiology and Associate Professor of Medicine at NYU School of Medicine

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media tour in June that included the seven women, celebrity spokesperson Marie Osmond, and myself.

These seven women were a source of inspiration to me. In fact, upon my return to the stress lab from Dallas, I encouraged two female medical assistants and several female patients to join Choose To Move. These women are truly motivated and have inspired each other to keep going. Small steps truly make a difference in the fight against heart disease.

Learn more about our real women, their results, and how you can encourage the women in your life to join Choose To Move. Call 1-800-AHA-USA1 or visit choosetomove.org.

The American Stroke Association and Bugher Foundation Announce Three Centers for Stroke Prevention Research

The American Stroke Association and the Henrietta B. and Frederick H. Bugher Foundation are excited to announce the award recipients for the American Stroke Association/Bugher Foundation Centers for Stroke Prevention Research. These three centers will form a research and research training network to advance stroke prevention:

- Duke University, Durham, N.C; Center Director — Larry Goldstein, MD
- Massachusetts General Hospital, Boston, Mass.; Center Director — Karen Furie, MD, MPH
- University of California, Davis; Center Director — Frank Sharp, MD

These awards became effective July 1, 2007, and will be funded through June 30, 2011, with a total commitment of $7.5 million.

The Bugher Foundation was established in 1961 by Frederick McLean Bugher in honor of his parents, Henrietta B. and Frederick H. Bugher. The foundation’s mission is to advance cardiovascular research. The American Stroke Association is a division of the American Heart Association, whose mission is “Building healthier lives, free of cardiovascular disease and stroke.”

A Different Approach to Mortality Measures

The CMS report is based upon administrative data rather than chart-abstracted information. The methods used by CMS in this effort have been validated against clinical, chart-abstracted data, and the output of the CMS approach has been shown to be a reasonable surrogate for chart-based methods with respect to profiling hospital performance.

The risk-standardized mortality rates provided by the CMS report will be derived from administrative data for Medicare patients with a principal discharge diagnosis of MI and HF from all acute care and critical access hospitals in the nation. The intent of these measures is to draw attention to the outcome of hospitalization in an effort to recognize quality improvement efforts made by hospitals. CMS will provide all hospitals detailed reports (with numerical rates) that describe their performance, the performance of other hospitals in the state and patient-level data for use in quality improvement. For the public, CMS will describe hospital performance relative to U.S. national rates on Hospital Compare, as “better than...,” “no different than...,” and “worse than...” those national rates. Actual numerical rates will not be released. Almost all hospitals will fall in the middle category, “no different than...”

In early 2007, “dry run” reports based on 2003 data were made available to hospitals in preparation for the formal 2005 and 2006 reports to be publicly released in 2007.

Coming to You, Your Hospital and Your Patients: New CMS Report on Mortality Rates for MI and HF

Evaluation and transparent reporting of patient outcomes is an essential component of efforts to improve the quality of patient care. In June 2007, the Centers for Medicare & Medicaid Services (CMS) and Hospital Quality Alliance (HQA) began annual reporting of 30-day mortality measures for acute myocardial infarction (MI) and heart failure (HF) on the Hospital Compare Web site (www.hospitalcompare.hhs.gov). The mortality rates will be derived from administrative data using new measures, methods and ratings. The AHA is committed to improving public health by supporting quality improvement, education and science in heart disease and stroke. In order to help physicians, hospitals and communities understand the results and to take full advantage of this opportunity to improve patient outcomes, important information regarding the process and best use of these new data are summarized here.
Commerce, a leading business lobby.

The bill was first introduced in Congress 12 years ago. It was approved twice in the Senate by unanimous votes, the last time in 2005, but had never previously cleared the House. It would ban group health plans and health insurers from denying coverage to a healthy person or charging higher premiums based solely on a genetic predisposition to a disease. It also would prohibit employers from using genetic information in hiring, firing, job placement or promotion decisions.

New York Democratic Rep. Louise Slaughter, who sponsored the bill with Illinois Republican Rep. Judy Biggert, said it will eliminate a new form of discrimination and remove people’s reluctance to take part in genetic research and testing. Scientists are learning more and more about the genetic underpinnings of a variety of illnesses such as breast cancer and heart disease, and tests are being developed to determine a person’s predisposition to various ailments.

Supporters of the bill worry that results of genetic tests could be used against people by employers or insurers loath to assume the financial burden of treating costly illnesses. They also argued that without such legislation, people might be reluctant to get genetic testing that could be extremely beneficial — for example in allowing them to get early treatment for a disease — out of fear the results could harm them in hiring, promotion or insurance decisions.

‘WE ARE ALL VULNERABLE’

“There is not a single person on this planet that carries with them perfect genes — every one of us carries a predisposition to illnesses — and therefore we are all vulnerable to genetic discrimination,” Slaughter said during House debate.

While the bill has attracted the support of some businesses such as IBM and influential conservative former House speaker Newt Gingrich, the Chamber of Commerce is fighting it.

Eastman said the bill would impose a new layer of medical privacy regulations inconsistent with existing law, would permit states to set their own perhaps different rules and would allow for excessive lawsuit damages.

The White House issued a statement supporting passage of the bill.

“‘The administration wants to work with Congress to further perfect this legislation and to make genetic discrimination illegal and provide individuals with fair, reasonable protections against improper use of their genetic information,’” the White House said.
On May 9–11, 2007, the 8th Annual Scientific Forum on Quality of Care and Outcomes Research was held in Washington, DC. By all accounts, it was the most successful conference ever. Over 600 participants shared in presentations of novel discoveries about quality improvement and outcomes research. The presentation of cutting edge science, methodological approaches to investigating patient outcomes and demonstrations of improved techniques to elevate patient care were not the only important aspects of the meeting. The ability to interact and network with colleagues resounded as the most important lasting impact of the conference.

Prior to the conference, the ACC-NCDR held its national users’ group meeting and workshops on advanced statistical techniques, nursing research, provider profiling, implementation research and business approaches to quality. The conference opened with a plenary session moderated by Rob Califf on translational research that was highlighted by a presentation from Betsy Nabel, Director of the National Heart Lung and Blood Institute. Throughout the meeting, there were tracks in quality assessment/improvement, stroke, and outcomes/T2 research. Two poster sessions provided over 200 research projects that will form the foundation of scientific literature for the next 2 years. The meeting ended with a plenary session on Conflicts of Interest that included highly interactive and stimulating presentations by Catherine deAngelis and Robert Steinbrook, editors of JAMA and the New England Journal of Medicine, the presidents of the ACC and AHA, Steve Nissen and Dan Jones, and Barry Meier, a New York Times reporter who has been a leader in disclosing conflicts of interest in medicine. The energy and enthusiasm of participants was palpable throughout the meeting.

Since its inception, the Outcomes Conference has been a nurturing environment for new investigators. An opening lunch on career development, supplemented with a mid-conference ‘Meet the Experts’ lunch and the highly interactive posters sessions have allowed new investigators to present their work, obtain valuable feedback and create new collaborations to extend their projects. Thus, the major outcomes of the conference are the evolution of young investigators into active participants in the outcomes and translational research community. Next year’s conference will be held in Baltimore, MD between April 30 and May 2, 2008. Planning is already underway and those interested in participating in the design of the conference should contact Chair John Rumsfeld (john.rumsfeld@med.va.gov) or Stephanie Wurtz (stephanie.wurtz@heart.org), AHA staff. More importantly, those interested in learning about state-of-the-art outcomes research and quality assessment/improvement should plan on attending. For more information, go to my.americanheart.org, Scientific Conferences.

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### Interdisciplinary Working Groups

#### Quality of Care and Outcomes Research

**2007-08 Steering Committee**

- Eric Peterson, MD, MPH, Chair
- John Spertus, MD, MPH, FACC, Vice Chair
- David Goff, MD, PhD, FAHA, Immediate Past Chair

**Members**

- Karen Alexander, MD, FACC
- Hector Bueno, MD, PhD, FESC
- Joanne Foy, MD, FACC, FAHA
- Paul Heidenreich, MD, MS
- Judyinchey, MD, FAHA
- Corrine Jurgens, PhD, RN, CS, ANP
- J ohn Rumsfeld, MD, PhD
- Lee Schwamm, MD, FAHA
- Jack Tu, MD, PhD

**Liaisons**

- Lawrence Fine, MD, DPh
- Gregg Fonarow, MD, FAHA, FACC
- Darryl Gray, MD
- J ohn Marler, MD, FAHA
- Frederick Masoudi, MD, MPH
- Mary Ann Peberdy, MD
- Ileana Pina, MD, FAHA
- David Shore, PhD
- William Weintraub, MD, FAHA

#### Atherosclerotic Peripheral Vascular Disease

**2007-08 Steering Committee**

- Christopher J. White, MD, Chair
- William R. Hiatt, MD, Vice Chair

**Members**

- Joshua Beckman, MD, MD
- Sharon Kay Christman, RN, PhD
- Mark A. Creager, MD, FAHA
- Francis G. R. Fowkes, MD
- J erry Goldstone, MD, FAHA
- Heather Gornik, MD

**Liaisons**

- Abby Ershow, SCD, NHLBI
- J ohn A. Kaufman, MD, FAHA, Society of Interventional Radiology
- Martha Cathcart, PhD, FAHA, Research Committee
- H. Eser Tolunay, PhD, NHLBI

**Current Activities**

- Preparing scientific statements on peripheral vascular disease.
- Sponsoring the Atherosclerotic Peripheral Vascular Disease Symposium and the Vascular Disease Fellows Workshop
- Developing Patient Education materials on PVD
- Contribute content, presenters and moderators to Scientific Sessions
- Grading abstracts for Scientific Sessions

**Mission Statement**

The mission of the Atherosclerotic Peripheral Vascular Disease Interdisciplinary Working Group is to provide input into the AHA’s science position as they relate to peripheral vascular disease.
A Different Approach to Mortality Measures
Continued from page 2

A Call to Action: Responding to the CMS Report

The hospital and public CMS reports will display the levels of hospital success in achieving good patient outcomes to professional and lay audiences, and hopefully serve as a driving force for improvement. However, it is important to understand what these reports are not. These ratings should not be an invitation to complacency. The benchmark of the national rate for MI and HF mortality is not the same as the best possible outcome for which we all must strive. Even hospitals with a “better than” rating will continue to have significant opportunity to improve, and these outcomes results can serve as a catalyst and indicator for those efforts. We should all strive to improve, to achieve and keep pace with a rising benchmark for national cardiovascular care performance.

These ratings are based on national Medicare data and must not be viewed as a head-to-head comparison between hospital systems. While these methods are robust, they do not reflect patients in HMOs or those younger than 65.

It is also important for patients and communities to understand that these ratings should not be used to differentiate regional options for emergency cardiac care, where rapid access is foremost in importance.

These reports emphasize the need for providers to recognize improved patient outcome as the “end game” of all efforts to improve quality of care. Institutions which have limited their scope of quality improvement efforts to the narrow spectrum of performance metrics set forth by CMS or Joint Commission will see a need to broaden their scope of interest. While performing well on these test indicators is important, it is likely that more fundamental changes are needed to truly effect outcomes.

We encourage all hospitals to carefully review and respond to the CMS report. It can be anticipated that patients and communities will also expect a local plan of action.

Suggestions include:

• Create a multidisciplinary team to review the data and develop plans to improve outcomes for patients with MI and HF. The designated team should:

  A. Perform an ongoing review of the causes of death for MI and HF patients and determine how many deaths were fully anticipated (patients admitted with “comfort measures only” orders) versus predictable but perhaps preventable (e.g., severely ill on admission) versus unanticipated (generally well but suffered complications or sudden death).

  B. Review current care process information. All hospitals should have process performance measures required by CMS/JCAHO and many others will have more detailed clinical information available from participation in other clinical data registries.

• These teams should broadly consider all means to improve outcomes, including structure and process, as well as culture and interpersonal interactions. Many factors may influence effectiveness and safety, e.g., clear communication and coordination between departments and caregivers, infection control, accurate medication administration, early and appropriate interventions for signs of a change in clinical condition, and systems which foster quality control and a spirit of commitment to the patient.

• For each opportunity for optimization, the team should develop an action plan for improvement (including defined clinician champions, an intervention plan and a timeline). Action plans need downstream monitoring to determine whether they were implemented, whether the intervention was successful and the outcomes improved.

This cycle of review, reflection, quality improvements and monitoring should be continuous and carried out with an ambitious end-goal in mind such as “we are committed to having no preventable deaths related to our institution’s care.”

Several programs for improving compliance with evidence-based treatments and improving care are available, including the AHA’s Get With The Guidelines® programs for coronary artery disease, heart failure and stroke. These programs not only can provide institutions with in-depth feedback on care processes but also work to assist sites in their quality improvement efforts.

References


**International News and Highlights**

**ECC Around the World**

The AHA’s reach and influence truly spans the globe. A notable example of this is ECC, which began to establish itself internationally in 1998 through its first International Training Organizations in countries including Italy, Ireland, Brazil and South Africa. Today, ECC has 93 International Training Centers (ITCs) in 43 countries, and has offered training in more than 40 additional countries. Between FY 2004 and FY 2006, the number of people receiving ITC-led training grew from 148,000 to 304,000. The road leading to status as an AHA ITC starts in several different places, with AHA volunteers playing a role in all. In some cases, visiting professionals have been trained in the United States, then returned home to establish ITCs in countries including Lebanon, Russia, Mexico and Spain. ECC training has also been introduced overseas through humanitarian and faith-based missions such as Operation Smile, Project Hope and Christian Medical/Dental Association. Other training initiatives have been established through the personal efforts of AHA volunteers and instructors. Leaders in this area included Drs. Vinay Nadkarni, Bob Berg and Leon Chameides.

The quality and credibility of ECC programs and training is recognized throughout the world as a standard to be initiated. That’s why organizations worldwide continue to contact the AHA seeking to become ITCs.

**Not Just in English**

ECC materials are available in several languages. The 2005 materials are being translated in four core languages: Spanish, German, Portuguese and Japanese. Selected materials are also being translated into six other languages, and that number is expected to increase. The Winter 2005 edition of Currents, which summarized the 2005 guidelines changes, was translated into 17 languages. These are still available on the ECC Web site. The interests of our international colleagues are not limited to ECC training. They also seek information on other areas of the AHA including research, involvement in guidelines development and membership in Councils.


**Top Scientists and Physicians in Cardiovascular Disease & Stroke are Looking for International Mentors**

To show our support for young physicians and scientists outside the United States, the American Heart Association has established an International Mentoring Program. This program provides international members with networking opportunities, advice and advocacy that’s meaningful in their professional development, as well as,

- promote the highest possible quality of science and practice in cardiovascular and cerebrovascular disease
- increase international collaboration in basic and clinical research in cardiovascular and cerebrovascular disease.

The AHA will match each mentee by area of interest with a mentor from a pool of volunteers. The selected mentor will receive information about their assigned mentee and will contact them by e-mail. The program features an opportunity to meet face-to-face at Scientific Sessions and/or the International Stroke Conference.

Becoming a mentor or mentee is easy. To register for the program, you must be an AHA Professional Member to apply. Visit [http://my.americanheart.org/portal/professional/memberservices to join AHA/ASA Professional Membership.](http://my.americanheart.org/portal/professional/memberservices)

To submit mentee’s name, please contact mentor@heart.org/. For more detailed information, visit [http://www.americanheart.org/prese nter.jhtml?identifier=3040709](http://www.americanheart.org/prese nter.jhtml?identifier=3040709).
Greetings from the Chair
Alan Daugherty, PhD, DSc, FAHA

The ATVB Council is extending additional efforts to reach out to two important groups of our members. The first is our Early Career Investigators, who can become members of our Council under the designation of “Early Career” or “Student/Trainee”. This status affords many benefits of AHA membership. The Council is also developing approaches to engage these members in our activities. The ATVB Early Career Representative on the Leadership Committee, Muredach Reilly, is extending considerable time and energy in forming an Early Career Committee and planning events. There is more information on this initiative in this newsletter. Further information will also be posted on our Web site. To promote interactions between Early Career Investigators and the rest of the membership, ATVB will be hosting a Networking Reception on Tuesday night at the 2007 Scientific Sessions in Orlando. We hope to see you there!

The Council is also recognizing our International members, who represent almost 30 percent of our membership. In recognition of this contribution, we have added two International members-at-large to the Leadership Committee. Their role will be to advise on how the ATVB Council can best serve our large International contingent.

If anyone has any thoughts on how the Council could enhance the benefits for our Early Career and International members, please feel free to contact me at alan.daugherty@uky.edu.

Report from the ATVB Spring Meeting in Chicago

The 8th Annual Conference on Arteriosclerosis, Thrombosis and Vascular Biology was a tremendous success. Held at the Palmer House Hilton in Chicago, this meeting had the highest attendance rate to date with 950 participants and 553 abstracts. The Spring Meeting has become an outstanding forum for the exchange of scientific information on emerging research in lipids and lipoproteins, arteriosclerosis, thrombosis and vascular biology. In particular, this meeting is known for providing ample opportunities for young scientists to interact with more senior scientists in their research area. A special thanks to Conference Chair Martha Cathcart, PhD, FAHA, and the Program Committee for putting together such a successful meeting.

Call for Nominations for The Early Career Committee of the ATVB Council

An Early Career committee of the AHA Arteriosclerosis, Thrombosis and Vascular Biology Council was approved by the Leadership Committee at the spring 2007 ATVB Conference and will be inviting applications for one- or two-year member appointments (a total of 8 to 10 appointments) to this committee beginning this fall. We would like to encourage members at the trainee or early career level to apply for membership.

The goals of the Early Career Committee are to involve early career individuals in the Council’s activities, to allow members to reinforce their interest in CVD and to enhance career development of the Council membership. Proposed activities include establishment of an early career ATVB networking evening event at Scientific Sessions, Web site development, and participation in AHA Lobby Day in Washington, D.C. Each committee member will serve on another ATVB Council committee, such as the Leadership, Spring and Fall Conference Programs, and Membership and Minorities committees. Eligible candidates should be in training (predoctoral or postdoctoral) or within the first four years of completion of training at the time of their appointment to the committee. The duration of committee appointment is two years.

If you would like to be considered for a position on the Early Career Committee, you must be a member of the Arteriosclerosis, Thrombosis and Vascular Biology Council. Please submit a letter of intent, one letter of recommendation and a CV to Dena Looper (dena.looper@heart.org). Questions may also be directed to Muredach Reilly (muredach@spirit.gcrc.upenn.edu).

Thank you for your interest in this new and exciting committee!
Muredach Reilly (Early Career Representative, ATVB Leadership Council)
Kathryn Moore (Chair, ATVB Membership & Communications Committee)
Alan Daugherty (Chair, ATVB Leadership Council)
Congressional Heart Disease and Stroke Lobby Day

More than 600 heart disease and stroke survivors and volunteers converged on Capitol Hill for the Congressional Lobby Day to urge Congress to support policies to help fight heart disease and stroke. The ATVB Council sponsored the attendance of Julie Jensen of San Francisco, Calif., and Denise Rubin of York Harbor, Maine, who joined Alan Daugherty, PhD, FAHA, to advocate for vital research funding and public policies to advance the fight against this deadly disease.

**Julie Jensen — San Francisco, CA**

At the age of 26, Julie suffered a major ischemic stroke to the right carotid artery. Recognizing her symptoms, the paramedics opted to take her to a hospital with stroke center certification, even though that meant traveling beyond her local hospital. The receiving hospital’s ER team used the AHA/ASA “Get With The Guidelines” program to help her. Doctors discovered it was a PFO that allowed the clot to flow to her brain. Thanks to the actions of the medical professionals that day, she is a proud survivor with no discernible effects of her life-threatening stroke.

**Denise Rubin — York Harbor, ME**

After being misdiagnosed at the age of 40, Denise suffered a pulmonary embolism. Today, she shares her story of survival and serves as a member of the Northeast Affiliate Women and Heart Disease Committee. She knows the importance of taking control of one’s health and encourages all women to know the signs of a heart attack and to continue questioning until they get the treatment they need.
2007–08 Leadership Committee

Richard Kitsis, MD, FAHA, Chair
Steven Houser, PhD, FAHA, Vice-Chair
Roberto Bollt, MD, FAHA, Immediate Past Chair

MEMBERS
Piero Anversa, MD, FAHA, Member at Large
Hossein Ardehali, MD, PhD, Member at Large; Early Career Liaison
Xiongwen Chen, PhD, MS, Early Career Representative (Marcus Award)
Glen Fishman, MD, FAHA, FACC, Co-Chair, Sessions Program
Thomas Hintze, PhD, FAHA, Advocacy Ambassador
Daniel Kelly, MD, FAHA, Chair, Katz Prize Selection Committee
Walter Koch, PhD, FAHA, Research Committee Representative
David Lefer, PhD, FAHA, Member at Large
Annarosa Leri, MD, FAHA, Chair, Program Committee
Ivan Moskowiz, MD, PhD, Early Career Representative (Katz Prize)
Elizabeth Murphy, PhD, FAHA, Chair, Communications Committee
Mark Sussman, PhD, Chair, Marcus Prize Selection Committee
Jennifer Van Eyk, PhD, FAHA, Member at Large

AHA
Anthony Ron White, PhD, Science and Medicine Advisor
Sabrina Simmons, Program Manager, Professional Memberships
Lonnie Willis, Director, Professional Memberships

How does the BCVS Program Committee Work?

One of the major functions of the Council on Basic Cardiovascular Sciences is to contribute to the annual Scientific Sessions program. This is not a simple task; it requires several face-to-face meetings, conference calls, and an enormous amount of e-mail correspondence. It may come as a surprise, but the first face-to-face meeting of Council members involved in the organization of Scientific Sessions 2007 took place in Chicago in November 2006. In fact, the annual meeting offers a good opportunity for a direct interaction among Council members and the identification of new directions in the cardiovascular field and their popularity level. A successful meeting is based on the quality of the science presented and the interest of the audience. During this initial phase, numerous suggestions are made to the Council Representatives of the Committee on Scientific Sessions Program (CSSP), who then submit these proposals to the entire committee at the January CSSP meeting in Dallas. We are pleased that our Council members have taken strong initiative. Numerous proposals were received for Plenary and Special Sessions, Sunday Morning Programs, Cardiovascular Seminars, How-to-Sessions and Ask the Experts Sessions.

CSSP Chair Gordon F. Tomaselli has taken important steps to enhance Sessions by adding the first International Symposium on Myocardial Regeneration and nominating an International Program Subcommittee composed of leading scientists in Asia, Europe and the United States. The objective is to emphasize current understanding of stem cell behavior and the role that they may have in cardiac repair. Numerous experimental studies and clinical trials have been conducted, but the search for the most appropriate progenitor cell for the reconstitution of the damaged myocardium continues. The program will cover the entire spectrum of knowledge from basic mechanisms of stem cell engraftment, growth and differentiation to the clinical use of different cell types, mostly of bone marrow origin. Whether resident cardiac progenitor cells constitute a novel strategy for the regeneration of the infarcted myocardium will be extensively discussed. The symposium will begin on the afternoon of Saturday, Nov. 3, and end Wednesday, Nov. 7, concurrently with Scientific Sessions in Orlando.
Council on Cardiopulmonary Perioperative and Critical Care

Updates on the Resuscitation Science Symposium (ReSS)

C PCC members should mark their calendars for ReSS, the premier annual conference on resuscitation science, to be held Nov. 3 and 4, 2007, at the Orlando Convention Center, immediately preceding Scientific Sessions. Planning for ReSS is well underway, and the program will be notable for a number of wide-ranging topics, including “Metabolic Resuscitation: Hibernation, Hypothermia and Metabolic Control,” “International Advances in Resuscitation Training,” and “Cardiocerebral Resuscitation: Ventilation Not Necessary in Cardiac Arrest?” ReSS is unique in its goal of bringing together experts in trauma, emergency medicine, critical care, cardiology and other traditional disciplines all under the focus of resuscitation.

ReSS has grown rapidly over the past few years. In 2006, 390 abstracts were submitted, with approximately 25 percent accepted as posters or oral presentations. This year, abstract submission has nearly doubled, with 799 abstracts submitted for review. In 2006, over 350 people attended ReSS, and this year’s attendance is anticipated to grow as well.

An important goal at this year’s ReSS is to build on the recruitment and development of new young investigators to resuscitation science. On Friday, Nov. 2, there will be a dinner program for resident physicians, graduate students, fellows and early career faculty members who will be attending the symposium. Inquiries regarding this new program should be directed to Dr. Benjamin Abella, benjamin.abella@uphs.upenn.edu. In addition to this program, a number of travel awards will be granted for young investigators to attend ReSS.

Further information can be found through the Scientific Sessions 2007 Internet portal at http://scientificsessions.americanheart.org, or through the Council leadership. The co-chairs of ReSS 2007 are longstanding CPCC members Graham Nichol, MD, FAHA (University of Washington), and Lance Becker, MD, FAHA (University of Pennsylvania).

Meet the New CPCC Chair

Dr. Stephen Archer has assumed the role of Chair of the Council, following after the leadership of Dr. Mary Townsley. Dr. Archer trained in both internal medicine and cardiology at the University of Minnesota, and has recently joined the faculty at University of Chicago as Professor of Medicine and Chief, Section of Cardiology. His research program explores the molecular basis for oxygen-sensing in the ductus arteriosus and pulmonary arterial system. In his recent move to Chicago, Dr. Archer has moved his research group from the University of Alberta, Canada, where he was Professor of Medicine and Physiology. The CPCC welcomes Dr. Archer and looks forward to his leadership for the next two years. Dr. Archer will be joined by Dr. Kenneth Bloch (Associate Professor of Anesthesiology, Massachusetts General Hospital and Harvard Medical School) who will serve as Co-chair of the Council, also for a two-year term.

AHA Research Grant Programs

CPCC members should be aware of AHA funding opportunities for both junior and established investigators. Such grant awards include Fellow-to-Faculty Transition Awards, Beginning Grant-In-Aid Awards, and Scientist Development Grants, among other programs. The AHA has highlighted resuscitation science as one various funding priorities for upcoming cycles, and CPCC members interested in resuscitation topics are therefore especially encouraged to apply. More information can be found at the AHA Web site or through your regional affiliate office.

CPCC events at Scientific Sessions

As in the past, CPCC will sponsor a number of events at Scientific Sessions, including the Cournand and Comroe Young Investigator competition, several program blocks dedicated to pulmonary biology and resuscitation science, as well as the CPCC Council dinner program on Thursday, Nov. 6. All CPCC members are encouraged to attend the scientific programs and Council dinner. The Cournand and Comroe competition, won last year by Dr. Georg Hansmann (Stanford University), showcases a high caliber of young scientific talent and is an event not to be missed.
Dear Colleagues:

It is my honor to serve as the Chair of the Cardiopulmonary, Perioperative and Critical Care Council (CPCC). The CPCC began as the Cardiopulmonary Council in 1973 and was chaired by Dr. Al Fishman. I am honored to follow a series of effective and committed predecessors, including Drs. E. Kenneth Weir, Michael Wolin, Lance Becker and our recent past Chair, Dr. Mary Townsley. After briefly introducing myself, I will offer some thoughts on the mission of the CPCC and why you and your trainees will benefit by being active members and participants.

Biosketch: I am a cardiologist and translational physician-scientist. I have been a committed AHA volunteer since the 1980s, chairing the peer review committees for Minnesota and then the first Midwest Consortium Peer Review Committee before a term as CPCC’s representative on the Fall Meeting Program Committee. In my clinical life, I attend on the wards and see patients in clinics. My clinical interests include pulmonary hypertension and developing strategies to improve cardiovascular care. I am committed to training the next generation of physician-scientists. Currently, I am the Chief of Cardiology and Harold Hines Jr. Professor of Medicine at the University of Chicago, where my major goal is the creation of a transdepartmental Heart and Vascular Institute, to enhance patient care, research and education. I am a native of Canada, and prior to relocating to Chicago, I served as Heart and Stroke Chair and Director of the Cardiology Division at the University of Alberta. My Translational Cardiovascular Research program has two aims:

1) Defining the molecular basis of oxygen sensing: (relevant to hypoxic pulmonary vasoconstriction and oxygen-induced ductus constriction)

2) Identifying experimental therapies for vascular diseases: (i.e., notably persistent ductus arteriosus and pulmonary arterial hypertension).

Thoughts on the CPCC: A Council provides a “home” for like-minded scientists, practitioners and students within the large organization that is the American Heart Association. Councils are your peers, people who care about the issues that are near and dear to your heart. A Council, by addressing the interests of its members, elevates the profile of the Science and provides a forum for presentation and advancement of the discipline. Reflecting on the mission of the Council, I am struck by the success of the CPCC in simultaneously and equitably advancing two rather distinct disciplines, the cardio-pulmonary circulation and resuscitation science. The Council is the home to research on hemodynamics, pulmonary hypertension, oxygen sensing, resuscitation and more recently, perioperative care and anesthesia. Through our resuscitation members, our Council has a leadership role in determining guidelines for CPR and ACLS. Our members are an eclectic group, including basic researchers, physician scientists, clinical trialists, outcomes researchers, nurses, paramedics and students.

Ten Reasons You Should Join the CPCC and Participate in our Mission: There are many Council activities that take place, often unrecognized by AHA members, but which benefit us all. These are some of the benefits of becoming an AHA volunteer by joining the CPCC.

1) Promoting Your Research Through Design of the Program at Scientific Sessions

2) Appearing on the Scientific Sessions Program

3) Engaging Trainees

4) Representing Your Interests to AHA National

5) AHA Position Papers to Address Important Areas of Cardiology or Resuscitation Medicine

6) Advocacy

7) Awards — the Dickinson W. Richards Lecture and Cournand and Comroe Prize

8) Meetings

9) Our Newsletter — Dr. Benjamin Abella, newsletter editor

10) Networking with Old Friends and Making New Friends — The Council becomes our home within AHA

I look forward to working with you over the next two years and representing your interests.

Stephen L. Archer, MD, FRCP(C), FAHA, FACC
Harold Hines Jr. Professor of Medicine
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See expanded newsletter on the CPCC Website at:
Identifying a Mentor
Shelley Miyamoto, MD

A career in medicine is a decades-long journey that can seem overwhelming at times. Fortunately, we are surrounded by individuals who can offer experience and guidance along the way. We are encouraged early in our education to identify a mentor, but often that is easier said than done. Not only are there many important factors to consider when finding a mentor, but what you need from a mentor changes as your career progresses.

There are several characteristics that one might look for in a potential mentor. The mentor should be someone who you believe can give you unbiased career advice. For example, a mentor needs to be willing to lead you in the direction that will allow you to achieve your personal and career goals, even if that means accepting a position at another institution. In addition, one should look at how successful a mentor has been in the past in assisting trainees. Have they helped their trainees by: 1) nominating them for committee positions, 2) suggesting them for speaking or moderating roles at national meetings, or 3) introducing them to prominent cardiologists, i.e., networking? Many of these intangible aspects go a long way in developing the career of a new pediatric cardiologist.

One of the most important aspects in identifying a mentor is ensuring that they can promise the gift of time. Trainees and faculty members alike are busy trying to balance clinical duties, research, education and personal lives outside of the hospital. You must ensure that a mentor is able to commit time, thought and energy to your future career and needs. Your favorite attending may not be the best mentor if they are overextended already. Many faculty will not readily admit or even realize that they do not have the time to be a mentor; consulting those who have preceded you regarding past mentoring successes (and failures) may serve you well.

A mentor should be able to provide both formal and informal feedback. Most successful relationships with a mentor include regularly scheduled evaluations that highlight personal strengths and areas that need improvement. These meetings can also provide time to develop a career timeline with tentative dates for completing projects, grant submissions and applications for further training or career placement. It is important to clearly establish your expectations as the mentee, but mentorship is not a one-way street. You have a responsibility to ensure that your relationship with your mentor is a success. As the mentee, you must remain accountable for your actions, respectful of the advice administered and receptive and responsive to constructive criticism. A good mentor is empathetic and a good listener, but must also remain objective and critical when necessary.

It is advantageous to have more than one mentor at a given time; different aspects of your career will require different kinds of guidance and it is unlikely any one individual will have all of the answers all of the time. For example, a clinical mentor can offer career guidance and knowledge about your potential field of interest, while a research mentor can counsel you on how to successfully balance and manage your time to maximize productivity. Of course, mentorship is not isolated to the realm of academic medicine. Transitioning to a private practice either from fellowship or even as an experienced cardiologist presents additional unique challenges and is a complex endeavor. A private practice mentor could discuss the practice’s business model, offer advice on how to stay current with medical literature and help answer clinical questions that arise. All mentors will offer you insight into the challenges they face while balancing a demanding career, family or other outside interests.

The need for a good mentor does not disappear once fellowship is completed, as different and new challenges are certain to arise at the junior faculty level and beyond. Medicine is a field of lifelong learning, so lifelong mentorship should be sought — as mentors will serve as a valuable resource throughout your career.
Report From the Chair
Catherine L. Webb, MD, Chair

Many CVDY members participated in AHA Lobby Day on April 24 on Capitol Hill. It is always an exciting experience to see democracy in action. We lobbied our state senators and representatives for increased funding for heart and stroke research. A number of children with congenital heart disease or stroke also participated, and it is clear that our pediatric patients have a major impact when we meet our legislators and their staff. I encourage all of you to make plans to participate in next year’s Lobby Day in April. It really does make a difference and is one of the AHA’s most important activities.

Membership in the CVDY Council is important and I would encourage your help in recruiting new members. It is an exciting time to share in the Council’s mission for research and advocacy not only for congenital and acquired heart disease in children but also as advocates for prevention of heart disease beginning in childhood. Again, I would encourage you to join the CVDY at the premium professional level. There are many benefits of becoming a premium professional member, which are listed on the Member Services Web site (http://www.americanheart.org/presenter.jhtml?identifier=3004002).

Collaboration with colleagues from across the nation and from abroad is particularly rewarding and satisfying. I would encourage all from the U.S. and particularly our international colleagues to join.

If you are a premium professional member of the CVDY Council, I encourage you to consider becoming a Fellow of the American Heart Association (FAHA). This designation is an honor awarded to those individuals who have careers in or expertise in advocacy for cardiovascular disease, who are board certified, and who are recognized for competence and the highest ethical standards of professional behavior in their field. An important component of Fellowship is demonstrated involvement in activities that reflect significant and current service to the AHA. Details of qualifications for FAHA status can be found on the application Web site at www.americanheart.org/cvdy. In the left-hand navigation menu, click on Fellowships. The process has recently been reworked so that it will now be entirely Web based, making it easier to complete the application. Part of the application process is to obtain a Proposer and Seconder to write letters of recommendation for you. Both these individuals must be premium professional members and one must be a current FAHA. To help you in identifying fellows who are happy to write letters for you, please access this link: www.americanheart.org/cvdy. In the left-hand navigation menu, click on Fellowships.

Under Eligibility, click on CVDY Active Fellowship Roster. To help you identify general members who could write letters for you, please access this link (you must be an AHA member to get to this link): http://my.americanheart.org/portal/professional/membershipdirectory?paf_dm=shared&paf_gear_id=2300001&councilCode=CVDY COUNCIL&eventType=viewCouncilCommittees. The CVDY Leadership Committee votes to admit new FAHAS twice a year at the November and April meetings.

The CVDY Council has nominated a number of our members for AHA and CVDY awards at Sessions in the fall. We are waiting for the awards committees to make decisions, but we hope that CVDY will be prominently represented again this year. The CVDY Council continues to enjoy the enthusiastic participation of many important and expert volunteers who are busy and actively engaged in a great number of significant projects through their committee work and writing activities. Our Mentorship and Early Career Committee has launched a very popular visiting lectureship series, and also is encouraging CVDY membership and participation by individuals relatively new in their fields, and advocacy for adults with congenital heart disease. Revised AHA guidelines for bacterial endocarditis prophylaxis have been jointly completed by multiple AHA Councils. Please be sure to review this document, as major changes have been recommended. CVDY papers on genetics of congenital heart disease and non-inherited risk factors for congenital heart disease were also recently published. The CVDY has partnered with Clinical Cardiology by forming a joint Adult Congenital Heart Disease Committee. Collaborative efforts are aimed at advocacy for these patients, particularly by improving education for pediatric and adult cardiologists as well as for the general public. Look for a number of important presentations at Sessions. Drs. Craig Sable (CVDY) and Elyse Foster (Clinical Cardiology) will be co-chairing a Sunday Morning session on long-term outlooks for tetralogy of Fallot. The committee is also working on several educational initiatives including updating the Web site section and revising the booklet on adult congenital heart disease for patients and families.

Important research advances and advocacy for prevention of acquired heart disease beginning in childhood continue to be a primary focus of the CVDY. A number of papers defining and assessing risk for this important problem as well as outlining how to implement healthcare reforms in this area have been published recently or are in the works. This effort also includes important collaborations with private institutions such as the Clinton Foundation. California Gov. Arnold Schwarzenegger has recently joined former President Clinton and the AHA in this important effort. Additional topics currently with writing groups include the use of pulse oximetry for congenital heart disease screening in neonates, the use of stimulant drugs in pediatric cardiology, and thrombosis in congenital heart disease.

The CVDY continues to be an important AHA Council. Although we are small in numbers, we have a significant impact on the activities of the Association. We encourage you to become a part of this essential and exciting Council. Please contact a member of the CVDY Leadership Committee or a member of one of the other CVDY Committees if you have an interest in joining us in our research, writing or advocacy roles. For a list of committee members, visit www.americanheart.org/cvdy. In the left-hand navigation menu, click on Council Committees.
Chair's Report
Dorothy M. Lanuza, PhD, RN, FAHA, FAAN

It is hard to believe that my two-year term as Chair of the Council is over. I am grateful for having had the opportunity to serve in this position and get to know the many talented and committed members of AHA/ASA, and especially the members of this Council. This has been a very positive, interesting and challenging experience. Thank you!

Council on Cardiovascular Nursing (CVN) Update

1. Strategic Plan — The Leadership Committee is revising the CVN Strategic Plan so that its goals include strategies to increase membership (national and international), mentorship of early career investigators and clinical leaders (national and international), addressing health disparities, and increasing membership diversity.

2. Possible Council Name Change — One topic of discussion at the April Leadership Meeting was whether or not we should change our Council's name to be more inclusive. Choices discussed included to keep the current name, Council on Cardiovascular Nursing; change the name to the Council on Cardiovascular and Stroke Nursing, or change the name to Council on Nursing.

3. Possible New Clinical Subcommittee — A task force has been formed to explore whether there exists both a need and support for an additional clinical science subcommittee related to advanced acute and long-term cardiovascular care. Our current Clinical Science Subcommittees are focused on Prevention, Stroke, and Pediatrics.

4. CVN Book — Other AHA/ASA Councils have published books to raise money for their respective Councils. A task force has been formed to explore the need for and the topic of a potential CVN book.

5. International Fellowship Mentoring Program — The AHA/ASA Council on Cardiovascular Nursing (CVN) and the European Society of Cardiology, Nursing (ESC) have collaborated to fund and evaluate a one-year pilot International Postdoctoral Mentoring Program to assist with postdoctoral training of European and/or American early investigators. The program aims to assist in strengthening the selected individuals’ research knowledge, skills and collaborative network. Information about the program and the application process can be found on the CVN Web site (http://www.americanheart.org/presenter.jhtml?identifier=1148).

6. Scope and Standards of Cardiovascular Nursing — The 1st Scope and Standards for Cardiovascular Nursing was developed and published in 1975 in collaboration with AHA, and revised in 1981. The new Scope and Standards of Cardiovascular Nursing, a collaborative writing effort of nurse representatives from about 17 cardiovascular nursing organizations, has been approved for endorsement by the AHA. Drs. Nancy Albert and Barbara Riegel were the CVN representatives for this project.

7. Heart Failure, State of the Science — This preconference was held on May 9th just prior to the AHA Quality of Care and Outcomes Research Conference (May 9–11).

8. Council Awards — There have been many changes to the Council Awards so please be sure to check the CVN Web site for specifics. The most notable change is the elimination of the Manuscript of the Year awards.

AHA National/ASA Update

1. New AHA/Stroke Mission Statement — At the April AHA/ASA Annual Meeting, the proposal to change the mission statement was approved. The new mission statement is “Building healthier lives, free of cardiovascular diseases and stroke.”

   Chairman of the Board: Gary L. Ellis
   Chairman-elect: David A. J osserand
   Immediate Past Chairman: Andrew B. Buroker, Esq.
   President:Daniel W. J ones, MD, FAHA
   President-elect: Timothy J. Gardner, MD, FAHA
   Immediate Past President: Raymond J. Gibbons, MD, FAHA
   Secretary-Treasurer: Debra W. Lockwood, CPA

3. AHA/ASA 2006–10 Research Strategic Plan — This is in its final stages of approval.

4. Impact of HIPAA on Clinical Research — AHA/ASA is interested in the “impact of HIPAA on clinical research,” so do not be surprised if you receive a survey on this topic, as a questionnaire will be sent to a random sample of members.

5. Sites of Future AHA meetings — Future AHA/ASA conferences, including Scientific Sessions, will be held only in cities with smoke-free workplace laws.

6. The Next Scientific Sessions — In 2007, Scientific Sessions will be held Nov. 3–7 in Orlando, Fla. The Saturday afternoon pre-session registration fee will be rolled into the Scientific Sessions registration so there is no additional registration fee. How-to-Sessions and Ask the Experts will be moved to the morning from 7:45 to 8:45 a.m. to allow more time for visiting posters and exhibits. (Chicago 2006 Scientific Sessions attendance was 26,878 and approximately 44 percent were international attendees.)

7. Stop Stroke Act — Representatives Lois Capps (D-CA) and Chip Pickering (R-MS) introduced to the House of Representatives the Stop Stroke Act (“Stroke Treatment and Ongoing Prevention Act) of 2007. More information can be found at http://www.americanheart.org/presenter.jhtml?identifier=2945

Dorothy M. Lanuza, PhD, RN, FAHA, FAAN
Chair's Report

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Because feedback was positive regarding the new programming format we pilot tested at Scientific Sessions 2006, we will use it again for Scientific Sessions 2007 in Orlando, Fla. Once again clinically-focused invited presentations will be combined with oral research abstract presentations. The purpose of this new format is to enhance the translational aspects of our research and the evidence base of our invited sessions, and to bring clinicians and researchers together. Topics of these sessions will be finalized after abstracts are accepted. As in the past, we will also have poster sessions.

In addition to the combined sessions, we will sponsor seven traditional How To Sessions and two traditional Cardiovascular Seminars. The How To Sessions will be moved from noontime to early morning this year. Tentatively scheduled sessions include assessing and promoting cognitive and psychosocial functioning in children with congenital heart disease, promoting full school participation for children with heart disease, assessing risk and causality, counseling patients on weight management, managing in-flight medical emergencies, enhancing accuracy in intervention research, and discontinuing cardiac devices at the end of life. The two scheduled Cardiovascular Seminars, which will be held in the early evening, are on sexual dysfunction and gene and lifestyle interaction.

The Ask the Expert Sessions have also been moved to early morning. The session sponsored by CVN will address developing a successful research grant proposal.

Our Sunday Morning Program is entitled “First Do No Harm: Cardiovascular Patient Safety,” and will include presentations on what cardiovascular clinicians can do to reduce harm, decreasing time to treatment in ST-elevation MI, rapid response teams, reducing errors in the cath lab and managing post-PCI complications, medication reconciliation, the role of anticoagulation clinics in enhancing safety, improving adherence to prevent hospitalization for heart failure, and future cardiovascular quality initiatives.

Our Pre-Conference Symposium on Advances in the Care of the Hospitalized Cardiac Patient: Second Annual Cardiovascular Nursing Symposium will be held on Saturday, Nov. 3, 2007. This program is targeted toward advanced practice nurses in the acute care setting, although others will find it relevant. Presentations have been confirmed on these topics: stem cell therapy, devices in heart failure, glucose regulation, managing supraventricular tachycardias, and promoting sleep in the hospitalized cardiac patient.

For the first time this year, the AHA will offer interactive learning sessions using an audience response system in a special classroom-style room designed for that purpose. CVN will sponsor one of these sessions; the tentative topic is “Case Studies in ECG Monitoring.”

We are also cosponsoring some sessions with other Councils and working groups that will be of interest to CVN members.

The February 2007 State-of-the-Art Stroke Nursing Symposium, a regular preconference event of the International Stroke Conference, included paper and poster presentations and had an attendance of 845 healthcare professionals. Once again, this very successful symposium covered a wide range of topics, with a focus on important advances such as assessment/management of intracranial hemodynamics, translation of prevention strategies into practice, strategies to improve the outcomes of survivors and their families, and recertification for JCAHO Primary Stroke Centers.

Program planning is currently underway for the State of the Art Stroke Nursing Symposium to be held Feb. 19, 2008. Abstract submission for the symposium began on June 11 and closes on Aug. 27.
Report on State of the Science: Promoting Patient Self-Care in Heart Failure

On May 9th, the CVN sponsored a State-of-the-Science Preconference of the AHA Quality of Care and Outcomes Research Conference in Washington, DC. The preconference, which was also sponsored by the American Association of Heart Failure Nurses, focused on presenting the state of the science related to patient self-care in heart failure. Conference organizers are planning a special issue of The Journal of Cardiovascular Nursing with individual articles by each of the presenters on their topic.

Conference Overview: Despite recent advances in heart failure science and care, the disorder remains a significant burden for patients and families. The complexity of heart failure necessitates a patient-focused, interdisciplinary approach to treatment and care. Ultimately, most care is done in the home by patients and their families or other caregivers, yet the promotion of patient self-care has received relatively little systematic attention from researchers.

The foundation for self-care is comprehensive patient/family education and counseling that includes skill building, behavioral strategies to increase adherence, and alterations to the structure of healthcare delivery. In 2000, Grady and colleagues published “Team Management of Patients with Heart Failure: A Statement for Healthcare Professionals from the Cardiovascular Nursing Council of the American Heart Association,” which identified best practices based on evidence and expert opinion. The newly revised Heart Failure Society of America guidelines address disease management strategies that incorporate patient education, counseling and follow-up care. However, there has not been a coordinated, systematic effort to review the existing state of the science in patient/family self-care in order to determine priorities for future research. Moreover, research efforts to date have been conducted in relative isolation, which has resulted in parallel lines of discovery that have failed to build upon each other. Thus, a systematic review is critical if we are to meet the challenges resulting from the rising numbers of heart failure patients who will need care in the next decade.

The objectives of this conference were to:
1. synthesize the state of the science of heart failure patient self-care, and
2. determine priorities for future research in this area.

Specific outcomes:
1. synthesis document to be published in peer-reviewed journal, and
2. specific strategies for moving priorities forward.

Topics and speakers

Introduction and state of clinical practice: **Robin Trupp** and **Nancy Albert**
1. Self-care theory: **Barbara Riegel**
2. Family-focused interventions to promote self-care: **Sandi Dunbar**
3. Self-care and nutrition: **Terry Lennie**
4. Influence of cognitive function on self-care: **Susan Pressler**
5. Exercise and self-care: **Kathy Dracup**
6. Quality of life and self-care: **Kathy Grady**
7. What do we know about adherence and self-care: **Lorraine Evangelista**
8. Difficulty assuming self-care: vulnerabilities of patients that interfere with self-care: **Debra Moser**.
9. Influence of sleep disturbances on self-care: **Nancy Redeker**
10. Self-care at the end-of-life: **Cheryl Zambroski**
11. It’s all in your mind: a new paradigm for heart failure: **Mary Woo**

In addition, invited guests from the NIH, National Heart, Lung, and Blood Institute and National Institute of Nursing Research discussed funding opportunities in this area of research.

E-mail Debra Moser at dmoser@uky.edu for further information.
CHAIR’S MESSAGE
Randall T. Higashida, MD, FAHA, Chair

In the past two years, the Cardiovascular Radiology & Intervention Council has achieved several outstanding accomplishments, thanks to the dedication of our Leadership Committee and our many contributing members. Dr. Antoinette Gomes, as Vice-Chair, did a wonderful job working on recruitment as well as completing a membership color brochure to be sent to national and international societies to increase awareness of our activities. Our membership now stands at more than 1500, and interest in and awareness of cardiovascular imaging involving new techniques and applications has drawn great interest at Scientific Sessions. Dr. Gomes, as the incoming Chair of our Council, will continue to be instrumental in attaining our long-term goals.

Drs. Pamela Woodward and Arthur Stillman were outstanding as program directors for Scientific Sessions, putting together outstanding workshops and “how to sessions,” and planning for the main plenary sessions. Their tireless effort at bringing in well-respected speakers and nationally recognized faculty was reflected in the excellent attendance at all of the sessions sponsored by our Council.

Dr. Richard White was honored as this past year’s Charles T. Dotter Memorial Lecturer, and he continues to provide service as our Advocacy Ambassador. Dr. John Kaufman served as Chair of our Nominations Committee, and was instrumental in placing a number of CVRI representatives into key positions within the AHA. Dr. Zahi Fayad served as our Research Committee Representative, and Drs. Curtis Bakal and Anne Roberts were our Member-At-Large Representatives. Dr. Patricia Cole was liaison to the SIR, Dr. Philip Meyers was Chair of the Cerebrovascular Imaging and Interventions Committee, Dr. Timothy Murphy was our Early Career Representative, Ms. Patricia Doolan was liaison to the ARNA, and Ms. Lois Jean Layne was liaison to the ASRT.

Lastly, I would like to acknowledge the ongoing work and effort of Ms. Navida Virani, our AHA Program Manager, and Dr. Kathryn Taubert, Senior Scientist and Special Assistant to the CSO, who were both instrumental in organizing and tracking all of our activities, finances, writing groups, political activities and meetings, and whose dedication was instrumental in advancing our activities. It was a pleasure to serve these past two years as Chair, and I look forward to the ongoing activities and future achievements of the CVRI!!

**2007-08 Leadership Committee**

- Antoinette S. Gomes, MD, FAHA, Chair; Chair, Membership
- Arthur E. Stillman, MD, PhD, Vice Chair; Liaison, NASCI
- Randall Higashida, MD, FAHA, Immediate Past Chair; Chair, Nominating

**Members**
- Michael Bettmann, MD, FAHA, Vice Chair, Membership
- Patricia Cole, MD, PhD, Chair, Communications/Newsletter
- Zahi Fayad, PhD, FAHA, Liaison, SAIP: Research Committee Representative
- Timothy Murphy, MD, FAHA, Early Career Representative
- Richard D. White, MD, Advocacy Ambassador; Chair, Cardiovascular Imaging & Intervention
- Pamela Woodward, MD, FAHA, Chair, Program

**Members-At-Large**
- Curtis Bakal, MD, MPH, FAHA
- David Bluemke, MD, PhD, MsB, FAHA
- Ziv Haskal, MD, FAHA
- Sanjay Misra, MD

**Liaisons**
- Patricia Doolan, RN, Liaison, ARNA
- John Kaufman, MD, FAHA, Liaison, SIR
- Lois J. van Layne, BS, RTR (CV), Liaison, ASRT

**AHA**
- Navida Virani, Program Mgr., Professional Memberships
- Angela Johnson, Senior Mgr., Professional Memberships
- Anne Leonard, RN, MPH, Science & Medicine Advisor
- Kathryn Taubert, PhD, FAHA, Sr. Scientist & Special Assistant to CSO
- Lonnie Willis, Director, Professional Memberships

Please encourage your colleagues to join online at my.americanheart.org or by phone at 1-800-787-8984.
Greetings to all of our Council’s members.
This is my final opportunity to address you as Council Chair. It has been my distinct honor and privilege to serve in this role for the past two years.

During my tenure, I have been most pleased to see a greater involvement of our Council’s representatives in all facets of the AHA. We have had representation on a wide variety of AHA-sponsored publications including practice guidelines, science advisories and scientific alerts. We have had Council-sponsored publications including the OPCAB review and an update on cardiac valve surgery and interventional approaches. I have been very pleased to see an increased participation by our cardiovascular anesthesiology community at all levels. In particular, we should look forward to the opportunity to support the new AHA President-Elect, our past Chair, Tim Gardner.

Council activities and interests tend to focus upon the scientific, research and educational missions of the AHA. I would like to take a moment to ask you each to take notice of the high level of talent, enthusiasm and passion exhibited by the lay volunteer leadership of the AHA. Those who serve as Chairman of the Board and on the Board of Directors — on the national, affiliate and local division levels — are true business and community leaders with resumes that could at times exceed the depth and breadth of those of any of our own scientists. For all of the right reasons, these individuals devote considerable time and financial resources to fulfill the AHA mission. It is these individuals, as well as national, affiliate and local division staff, who raise the funds which fuel the engine of the AHA’s scientific, research and educational programs. We as physician/scientists need to understand that the research funding, in particular, which the scientific community requires, is generated by the efforts of these people. It is incumbent upon all of us to join this effort on a local basis to raise awareness of AHA initiatives such as “Go Red For Women,” “The Alliance for a Healthier Generation,” “Power to End Stroke,” “Get With The Guidelines” and “Start!”; to participate in local fund-raising activities; and to help lay volunteers understand the true importance of their efforts by telling your “science and research story” to them in lay terms.

I am pleased to turn over the reins of the Chair to Bobby Robbins and look forward to even more success stories from our Council membership.

Best regards to all, and thank you for the opportunity to serve as your Chair.

CHAIRMAN’S REPORT
Loren F. Hiratzka, MD
E-mail: lfhcvt@aol.com

2007–08 Leadership Committee

Robert Robbins, MD, FAHA, Chair; COC Representative
Frank Sellke, MD, FAHA, Vice Chair
Loren Hiratzka, MD, FAHA, Immediate Past Chair; Chair, Nominating Committee; Advocacy Ambassador

Members
Paul W.M. Fedak, MD, PhD, Young Investigator
John Ikonomidis, MD, PhD, FAHA, Chair, Program Committee
Y Joseph Woo, MD, FAHA, Vice Chair, Program Committee

Members at Large
Richard P. Cambria, MD
Ronald L. Dalman, MD
Jerrold H. Levy, MD
Marc R. Moon, MD
Nancy Nussmeier, MD
Frank Pagani, MD, PhD, FAHA

Liaisons
Elliot Chaikof, MD, PhD, Society for Vascular Surgery; Co-Chair, Membership/Communications Committee
Christine Mora Mangano, MD, FAHA, Society of Cardiovascular Anesthesiologists; Co-Chair, Membership/Communications Committee
Richard Weisel, MD, FAHA, Research Committee

AHA
Shana K. Batten, MD, Senior Manager, Professional Memberships
Gayle Whitman, PhD, RN, FAAN, FAHA, Vice President, Science Operations
Lonnie Willis, Director, Professional Memberships
FROM THE CHAIR
Gerald F. Fletcher, MD
Chair, Council on Clinical Cardiology

REFLECTIONS ON THE HISTORY OF THE COUNCIL ON CLINICAL CARDIOLOGY

Our Council on Clinical Cardiology has a rich and important history dating back many years (Circulation 1993; 87:1057). In 1922, at the meeting of the American Medical Association, 41 physicians convened and formed a “group” on heart disease.

Two years later (1924), the American Heart Association (AHA) was formed to address the causes, prevention, treatment and rehabilitation of CVD.

In 1935 a section on Peripheral Arterial Disease was established within the AHA; this became the “basis” for the Councils. In 1948, the Council on Clinical Cardiology was established as a section of the AHA, at the very time the Association was transitioning from a professional to a volunteer organization. In 1952, the Council on Clinical Cardiology was formally established to address investigation, prevention, treatment and education with regard to CVD.

Our Council has now reached its 55th birthday as a strong and vital part of the AHA. A growing number of Premium Members and Fellows now provide a firm base of scientific talent for our activities in research, teaching and in developing guidelines for improved patient care and outcomes. Our 16 Council subcommittees with diverse membership are most vital in the implementation of our activities and in fulfilling the AHA mission.

The future of the Council on Clinical Cardiology and our “partner” AHA Councils is bright but will involve different strategies as we move forward. These efforts will include, but are not limited to, closer relationships with affiliates and community boards and their volunteer bases, “partnering” with other healthcare organizations and improving relationships with other professional cardiovascular societies. The Councils are indeed a strong and integral part of the AHA and make our organization unique in many respects.

We in the Council on Clinical Cardiology are poised to accept and face new challenges, to work closely with the AHA’s many scientists and volunteers, and with our excellent staff around the nation and at the National Center, and to achieve our mission of “building healthier lives, free of CVD and stroke.”

2007–08 LEADERSHIP COMMITTEE

| Gerald Fletcher, MD, FAHA, Council Chair |
| N.A. Mark Estes, MD, Council Vice-Chair; Chair, Long Range Planning/Budget Committee; Chair, Samuel Levine Award Committee |
| MEMBERS |
| C. Noel Bairey Merz, MD, FAHA, Chair, Women in Cardiology Committee |
| Ann Bolger, MD, FAHA, Chair, Nominating Committee; Immediate Past Chair |
| W. Brian Gibler, MD, FAHA, Chair, Acute Cardiac Care Committee |
| Brian Griffin, MB, ChB, FACC, FAHA, Chair, Laennec Post Graduate Education Committee |
| Joshua Hare, MD, FAHA, Chair, Heart Failure & Transplantation Committee |
| Alan H. Kadish, MD, FAHA, Chair, Program Committee |
| Edward Kasper, MD, Chair, Young Clinicians & Investigators Committee |
| Bradley Knight, MD, FAHA, Chair, Electrocardiography and Arrhythmias Committee |
| Glenn Levine, MD, FAHA, Advocacy Ambassador |
| Jennifer H. Mieres, MD, FAHA, Chair, Cardiac Imaging Committee |
| Todd D. Miller, MD, FAHA, Chair, Exercise, Cardiac Rehabilitation Secondary Prevention Committee |
| S.K. Rao Musunuru, MD, FACC, FAHA, Chair, Membership/ Communications Committee MMCC Representative |
| Kenneth Rosenfield, MD, FAHA, Chair, Diagnostic & Interventional Cardiac Catheterization Committee |
| MEMBERS AT LARGE |
| Gordon Fung, MD, FAHA |
| Jagat Narula, MD, DM, PhD, FACC, FAHA |
| John (Ian) Nixon, MD, FAHA |
| Hani Jneid, MD |
| Laura F. Wexler, MD, FAHA |
| Kristin L. Newby, MD, MHS |
| LIAISONS |
| Patrice Desvigne-Nickens, MD, Liaison, NHLBI |
| Wilson Colucci, MD, FAHA, Research Committee Liaison |
| Ileana Pina, MD, FAHA |
| AHA STAFF |
| Shana Batten, MS, Senior Manager |
| Lonnie Willis, Director, Professional Memberships |
Urgent and Important Message to Members

Rao Musunuru, MD, FAHA
Chairman, Membership/Communications Committee

If you are not yet a Fellow of the American Heart Association (FAHA), I would like to strongly encourage you to become one. As you probably know, the FAHA designation is reserved for healthcare professionals who have made significant contributions in the field of cardiovascular research and/or clinical cardiology, like yourself. I personally receive a lot of positive comments from patients and scientific colleagues about the FAHA designation.

If you are an FAHA, we recognize and appreciate your leadership. As a Council, we do rely on current Fellows to help maintain a dynamic membership by recruiting new Fellows interested in networking with like-minded professionals and advancing our understanding of cardiovascular disease. I am certain that you have colleagues who should also be recognized as Fellows of the American Heart Association. Please invite them to apply as a FAHA through the Council of Clinical Cardiology.

You can obtain the application and the appropriate information from americanheart.org/fellowship, and click on the “Council on Clinical Cardiology.” I am proud to be a Fellow and I hope your experience will be the same.

HEART INSIGHT
Healthy Living for Patients, Their Families & Caregivers

Heart Insight is the American Heart Association’s FREE quarterly magazine for patients, families, and caregivers, which focuses on the prevention and management of cardiovascular disease and related conditions. Heart Insight covers a variety of topics including:

- Nutrition tips for preventing and managing heart disease, complete with heart-healthy recipes in every issue
- The latest news on medications and treatments
- Profiles of people surviving — and thriving — with heart disease
- Quizzes and tools to help you manage your risk for heart disease and stroke

This publication is available in many cardiologists’ offices for people to read and take home. FREE bulk copies may be ordered by healthcare providers interested in making Heart Insight available in their waiting rooms by visiting www.HeartInsight.com or by calling 866-440-7557. Individuals may order their free subscription for home delivery, by filling out a subscription card, or by visiting www.HeartInsight.com.
Since this is the summer issue, I will start by saying that I hope everyone is having a great summer. I hope you get a chance to relax and recharge at least for a bit.

Certainly, the current dearth of NIH funds for our research is adding to the stress load for many of us. The most recent column by Dr. Elias Zerhouni in the NIH newsletter (http://www.nih.gov/about/director/newsletter/Spring2007.htm) contains some remarks of interest to members of the Epidemiology and Prevention Council, particularly with respect to his March testimony before the House Appropriations Subcommittee on Labor, Health and Human Services, and Education, and the corresponding Senate Subcommittee. In his testimony, Dr. Zerhouni said that the “21st century will be for the life sciences what the past century had been for the physical sciences.” He stressed the importance of meeting the “challenge of the unsustainable growth rate of health expenditures.” He said he believes we will soon enter a new era where fundamental understanding of disease processes will allow unprecedented opportunities for prevention: the three P’s of predictive, personalized and preemptive medicine.

The scientific interest areas of our Council members are integral to this NIH core strategic vision. We need to persever with our science, and stress to Congress how important research is to the nation’s health and competitiveness in the global economy. We all have a role to play. Joining the “You’re the Cure” network, working with local affiliates, and interacting with our congressional delegation can all help.

Given the importance of these communications, the AHA has developed the Advocacy Ambassador program to synchronize all the advocacy efforts of the Councils. Our Ambassador, David Goff, will lead and coordinate our Council efforts, and the Leadership Committee will devote more time to discussing, implementing and providing feedback on the advocacy agenda.

One of our key Council activities has always been mentoring new investigators. Our recently developed Early Career Committee has already been a big hit. We appreciate the
This was my second Lobby Day, and this year’s event confirmed my positive previous experience. For me, the best part about Lobby Day was interacting with the real heroes — survivors of heart disease and stroke who attended to tell their stories to their representatives and senators. Their stories are highly inspirational and put our work in a very real light. You can’t help but leave rededicated to doing the very best research you can to help eliminate heart disease and stroke. What a refreshing change from the typical daily experience we have that can sometimes seem routine.

Interacting with your representatives and senators and their staffs can also be a rewarding experience. I enjoyed giving back to the AHA, NIH and CDC. I have been very fortunate to benefit from the good work of the AHA and the resources available through the NIH and CDC. I felt good that I was able to speak up for better funding for NIH and CDC and in support of other initiatives that AHA supports, like HEART for Women. The presence of a scientist to provide data to complement the personal stories of the survivors is very effective. It is well worth your time to attend.

As we attempt to eliminate heart disease and stroke through research, clinical and public health practices, we should remember that we benefit from the AHA’s efforts to support our fields and from NIH and CDC funding. Giving a little back by attending Lobby Day will provide you with rewards that are difficult to believe and express. But just ask anyone who has attended. I am sure you will hear a similar story. I look forward to seeing you there some year.

Consider Nominating a Colleague for Fellowship in the Council on Epidemiology and Prevention

Fellowship is reserved for Council members who have been actively involved in the field of cardiovascular disease (CVD) epidemiology or CVD prevention for at least five years and who have made substantial contributions to the field. Fellowship criteria include publishing in peer-reviewed journals in CVD epidemiology or prevention; participation and leadership in American Heart Association national or local activities; and clinical or community service in CVD epidemiology or prevention OR teaching in the field of CVD epidemiology or prevention.

Benefits of Fellowship include:

• Council newsletter and other mailings relevant to the Council’s affairs.
• Reduced registration fee to the AHA’s Scientific Sessions, Annual Conference on CVD Epidemiology and Prevention, and other AHA-sponsored conferences.
• Eligibility to serve in leadership roles and on Council committees. (Associate Fellows are not eligible for election to office.)

For more information about applying for Fellowship in the AHA’s Epi Council, go to the Council of Epidemiology and Prevention Web site: http://www.americanheart.org/presenter.jhtml?identifier=1247 and click on Fellowships (left side of Web page); page down and click on Criteria, Instruction, and Application.
Council on High Blood Pressure Research

Message from the Chair
L. Gabriel Navar, PhD, FAHA

As we go to press for this newsletter, I am pleased to report that there has been a great deal of activity on the part of your Leadership Committee and the Fall Conference Program Committee.

The Fall Conference Program Committee has been busy reviewing abstracts and planning for the Fall Conference to be held in Tucson, Ariz., Sept. 26–29. Under the able leadership of Clinton Webb, the abstracts were graded and scheduled for posters and oral sessions. A unique aspect of the Fall Meeting is that it is driven primarily by the abstracts submitted by you and the rest of the constituency of the Council on High Blood Pressure Research. About 300 abstracts will be selected for presentation as oral communications or posters. We will also have select state-of-the-art lectures and the presentations by the recipients of the Novartis Award, Corcoran Award, Dahl Award and Lifetime Achievement Award, plus the three Goldblatt New Investigator Award finalists. Award recipients and finalists were selected by the Awards Committee chaired by Clinton Webb. From now on, the Dahl Lecture will be presented at our Fall Conference rather than at Scientific Sessions. This change was made at the request of many Council members.

At the Experimental Biology Meeting in Washington, D.C., the Council co-sponsored a session on “Hypertension: Integrated Mechanisms and Sequelae” with the Water and Electrolyte Section of the American Physiology Society, which was chaired by J. oey Granger and Gabe Navar. The session included a state-of-the-art lecture by Mark Chappell from Wake Forrest University and five free communications on hypertension-related topics. This outreach effort allowed us to highlight the activities of our Council and encourage interested members of the American Physiological Society to join the Council on High Blood Pressure Research.

This spring our Council also supported the very successful meeting of the InterAmerican Society of Hypertension (IASH). As most of you know, our Council is closely associated with the IASH, which was founded to encourage greater interactions among scientists in hypertension research from the Americas. The 2007 IASH meeting was held in Miami Beach, Fla., and was chaired by Carlos Ferrario and Leopoldo Raji. A more detailed report is provided in this newsletter. The 2009 IASH Meeting will be held in Brazil so make plans now to attend.

The Spring Leadership Committee Meeting was held in Miami Beach right after the IASH Meeting. We discussed many topics of importance to our Council members. An important area of emphasis is the need to markedly increase our membership numbers. Under the able leadership of David Calhoun, we are making a major effort to recruit new members and, above all, we need your support. Make a pledge now to recruit at least one new member to our Council. The Leadership Committee heard reports on the many activities going on with AHA. J. R. Haywood represented our Council at Lobby Day and is providing a separate report. This year, we elected two new members to the Leadership Committee: Kathryn Sandberg from Georgetown University and Tom Coffman from Duke University. In view of our Council’s growing international presence, we decided to have at least one designated international member on the Leadership Committee. We elected Toshiro Fujita from Tokyo, Japan, to fill this position.

The Awards Committee reported on the designated recipients of awards made by our Council. This year’s awardees are:

**Corcoran Lectureship Award:** Curt Sigmund, University of Iowa, Iowa; **Dahl Lectureship Award:** Debra Diz, Wake Forest University, North Carolina; **Irvine Page-Alva Bradley Lifetime Achievement Award:** Ernesto Schiffrin, Jewish General Hospital and McGill University, Montreal, Canada. The winner of the Novartis Award will be announced at a special press conference at a later date. These awards will be presented at the Fall Conference in Tucson.

The Research Committee reported that the National Office approved funding of 91 Scientist Development Grants and 25 Established Investigator Awards for next year. There was considerable discussion about how to increase the amount of AHA funds allocated for research grants. We are pleased to report that the High Blood Pressure Council has benefited greatly from the production of the Hypertension Primer. We thank editors Joe Izzo and Henry Black for their diligent work in keeping the primer updated. The revenue it generated will help ensure that our special programs and meetings are properly supported.

In summary, I am very pleased to report to our membership that your Council is financially sound and very actively involved in numerous exciting projects and ventures. Most importantly, we are very excited about our upcoming Fall Conference in Tucson, Ariz. We encourage you to make plans now to attend the workshop and conference. Please feel free to contact me by e-mail (navar@tulane.edu) with your ideas and suggestions as to how your Leadership Committee can be more responsive to your needs. Thank you for your loyalty and continuing support.
Lobby Day

On Lobby Day (April 24, 2007), thousands of volunteers, survivors and scientists blanketed Capitol Hill to advocate for help from Congress to reduce the occurrence of cardiovascular disease. After a day of preparation, AHA volunteers met with and encouraged members of Congress and their staff to: 1) significantly increase NIH funding, 2) significantly increase funding for the CDC’s Heart Disease and Stroke Prevention Program, 3) co-sponsor the HEART for Women Act aimed at improving the prevention, diagnosis and treatment of cardiovascular disease in women, and 4) co-sponsor the Family Smoking Prevention and Tobacco Control Act.

A Lobby Day highlight was the Heart for Women rally on the National Mall. Several hundred supporters looked on as American Heart Association volunteers presented a Red Dress Paper Doll chain of 20,000 paper dolls to Congressional sponsors, to show support for the HEART for Women Act. Sens. Debbie Stabenow (D-MI) and Lisa Murkowski (R-AK) and Rep. Lois Capps (D-CA) informed the gathering that all the women in the House and Senate had signed on as co-sponsors of the bill.

High Blood Pressure Research Council Fellows J.R. Haywood and Dan Lackland, as well as AHA President and HBPR Fellow Dan Jones, helped garner support for a “Dear Colleague” letter circulated by Rep. Edward Markey (D-MA) requesting a 6.7 percent increase in NIH funding. The initiative is part of a three-year campaign to get NIH appropriations “Back on Track” to where funding was after the doubling of the NIH budget in 2003. A record 176 members of the House of Representatives have signed the letter already. A similar letter has been introduced in the Senate. The scientific community must keep pressure on their representatives in both the House and Senate about the importance of returning the NIH budget to its critically needed level.

National Research Program
New Award Commitments
Approved for 2006–07

November 2006

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<tr>
<th>Program</th>
<th>Number Funded</th>
<th>Percentile Rank</th>
<th>Dollar Amount</th>
<th>Success Rate</th>
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<td>25</td>
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May 2007

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Funding to underrepresented minorities equaled 5 percent of national unrestricted research allocations for the year (goal rate is 6 percent).

The Research Committee also advocated an increase in the National Research Program budget as critical for developing the new strategic research initiatives.

AHA Research Committee Report

The Research Strategic Plan, in development since 2005, has been finalized for submission to SACC and the Board. Major plan components are highlighted in the Research Vision Statement: The American Heart Association will be the premiere cardiovascular and stroke influencing agent for developing and funding early career investigators, including high school and undergraduate students. The Association will endorse and support multidisciplinary and collaborative models; undertake high-risk, high-reward research; actively balance basic, clinical, population, and translational research; and expand its international scope.

A recent funds allocation exercise yielded a research balance target of 56 percent basic and 44 percent clinical/population by 2010. Currently, the distribution is about 66/34 percent. Increased clinical and population research funding will be achieved through the development and implementation of new programs, including the newly approved Clinical Research Program and potential outcomes research programs.

Other proposals included:

- Striving to more effectively communicate our support of increased clinical, population and translational research and
- Better targeting of grants to appropriate review committees, including new mechanisms to classify applications as basic, clinical, population and translational.
F ollowing in the fine tradition of previous biennial meetings, the XVIIth Meeting of the Inter-American Society of Hypertension (IASH) was held May 6–10, 2007, in Miami, Fla. The meeting provided a forum for the presentation of scientific work related to hypertension, atherosclerosis, the metabolic syndrome and obesity. Participants presented both basic and clinically related work in the form of posters, oral presentations, and invited lectures and symposia.

The IASH was founded by the Council on High Blood Pressure Research in association with scientists from Latin America to promote collaboration and interaction among scientists involved in hypertension-related research throughout the Americas. Since then, IASH has held meetings every two years. With 503 registrants — including experts in hypertension, vascular disease and related areas, and 156 faculty — the Miami gathering was one of the most successful to date.

Special clinical symposia focused on updating clinical guidelines for management of global risk factors, epidemiology of hypertension in Latin American countries, and new insights into the role of hypertension in diabetes, dyslipidemia, the metabolic syndrome and obesity. Complementary sessions addressed new aspects of clinical hypertension research on genetics, the role of prostanoids in the inflammatory processes associated with hypertensive vascular disease and atherosclerosis, and newer insights into the role of the renin angiotensin system in the pathogenesis of hypertension and vascular disease. Additional research symposia focused on the emerging role of renin inhibitors in the management of hypertension, renal disease, and heart failure. Sessions on hypertension-related target organ damage provided an update on aspects of the problem throughout the Americas.

This year’s meeting was unique in that it was co-sponsored by COSEHC (The Consortium for Southeastern Hypertension Control), a nonprofit organization formed in 1992. COSEHC’s mission is to reduce hypertension and hypertension-related risk factors through education, research, publication and quality improvement. The Council on High Blood Pressure Research (Silver sponsors) supported the meeting with a grant of $25,000, which was used for 35 merit-based young investigator travel awards. IASH provided travel support for another 11 young investigators, and COSEHC provided in-kind funding in program development and CME accreditation. The winners of the IASH Young Investigator Awards were Vera de Moura Azevedo Farah and Katie DeAngelis, both from Sao Paulo, Brazil. The IASH Lifetime Achievement Award was presented to Alberto Nasjletti, MD, from New York. The Council on High Blood Pressure Research (Silver sponsors) supported the meeting with a grant of $25,000, which was used for 35 merit-based young investigator travel awards. IASH provided travel support for another 11 young investigators, and COSEHC provided in-kind funding in program development and CME accreditation. The winners of the IASH Young Investigator Awards were Vera de Moura Azevedo Farah and Katie DeAngelis, both from Sao Paulo, Brazil. The IASH Lifetime Achievement Award was presented to Alberto Nasjletti, MD, from New York.

Other corporate sponsors include Merck, Daiichi-Sankyo, Pfizer (Platinum sponsors); Abbott Cardiovascular (Gold sponsors); Boehringer-Ingelheim, Forest Laboritories, and Takeda (Silver sponsors); and Astellas Pharma, Astra Zeneca, Bristol Myers Squibb, CardioDynamics, Eli Lilly, National Lipid Association, Sanofi Aventis, and Schering Plough (Bronze sponsors). We thank all sponsors for their generous support.

Abstracts submitted: 336 (Poster Presentations, 293; Oral Presentations, 43)

VACANCIES AT NATIONAL HEART, LUNG AND BLOOD INSTITUTE (NHLBI)

Vascular Biology/Hypertension

The Vascular Biology and Hypertension Branch (VBHB) in the Division of Cardiovascular Diseases of the NHLBI, at the National Institutes of Health (NIH), is seeking two biomedical scientists to administer extramural programs of basic, translational and clinical research. The VBHB supports and manages integrated basic and clinical extramural research programs in vascular biology, hypertension, and peripheral vascular diseases.

BRANCH CHIEF

The Branch Chief, with the assistance of the Deputy Branch Chief, would provide leadership and strategic vision in designing, implementing and managing a national research agenda on basic, translational, and clinical aspects of vascular disease and hypertension. This individual is expected to be a physician scientist with experience in clinical trials and clinical studies, and expertise in either hypertension or vascular diseases.

PROGRAM DIRECTOR

The Program Director would work closely with the scientific community and Institute staff to identify new directions for vascular biology and hypertension research for the nation, and to manage the NHLBI’s research portfolio in these areas. Expertise is desired in one or more of the following areas as they relate to vascular biology and hypertension: inflammation, oxidative stress, angiogenesis, endothelial and smooth muscle biology, flow mechanics, signal transduction, molecular genetics, genomics and proteomics. Research experience with systems or integrative physiological approaches is also desirable.

Both positions provide excellent health, life, investment, and personal leave benefits.

For more information, please contact Eser Tolunay, Acting Branch Chief, Vascular Biology and Hypertension Branch, by email (tolunaye@nhlbi.nih.gov) or call (301-435-0560).
The two-and-a-half day scientific program gives physicians and research investigators the opportunities to enhance their knowledge, advance their skills, and learn about the latest developments in research pertaining to:

- Hypertension
- Stroke
- Kidney function
- Obesity
- Genetics

The program will include state-of-the-art lectures and more than 350 oral and poster abstract presentations and discussions led by authorities.

CME/CE
CME credit will be offered.

American Society of Nephrology Annual Meeting

The ASN will meet in San Francisco this year from Oct. 31-Nov. 5. The Kidney Council will sponsor a post-graduate education course, "CKD and CVD from the Vascular Viewpoint: Merging Basic and Clinical Sciences to Optimize Treatment," Oct. 31-Nov. 1. Current basic and clinical research findings will be applied to the understanding of vascular adaptation in health and disease. The Council will also sponsor a symposium on Nov. 4, "Basic Science for Clinicians: Cardiovascular Disease for the Nephrologist."

Speakers at this session will address the latest basic science findings on endothelial dysfunction in relationship to chronic kidney disease.

More information about the ASN meeting will be available at http://asn-online.org/education_and_meetings/Renal%20Week/renal_week.aspx.

American Heart Association Scientific Sessions

The annual meeting will be held in Orlando, Fla., Nov. 4-7. The Kidney Council will cosponsor two sessions. On Nov. 4, "Chronic Kidney Disease as a Cardiovascular Risk: Implications for Screening and Treatment" will be presented. "How to Treat Coronary Disease in Patients with CKD" will be on Nov. 5. More information about these sessions will be available at http://my.americanheart.org.

Sponsored Lectureship for the Council on the Kidney in Cardiovascular Disease: The Donald Seldin Lecture

Dr. Donald Seldin has been a pioneer and leader in the field of cardiovascular disease as it relates to kidney failure. Dr. Seldin, a member of the American Heart Association, has made seminal observations relating to sodium and potassium transport in the kidney and their effects on blood pressure and cardiovascular homeostasis.

This lecture will continue to enhance awareness among AHA attendees concerning the rising epidemic of cardiovascular disease and mortality in patients with chronic kidney disease. Cardiovascular mortality is occurring early in the course of chronic kidney disease, prior to ESRD, affecting millions of Americans. This lecture will allow experts in the field to bring the latest basic, translational or clinical information to the AHA meeting.

The 2007 Donald Seldin Lecturer is Richard Johnson, MD, FAHA, Professor of Medicine at the University of Florida. Dr. Johnson is scheduled to give his lecture at Scientific Sessions in Orlando, Fla., in November.
The Council on Nutrition, Physical Activity and Metabolism (NPAM) is the newest of the AHA councils, but we believe its activities — which focus on lifestyle and prevention — are important for all researchers and clinicians concerned with cardiovascular diseases. Our mission is to promote the expansion and exchange of knowledge of nutrition, physical activity and metabolism as it relates to CHD and stroke, and also to assist the AHA in promoting healthy lifestyles and behaviors (including, physical activity and weight control) in the prevention of CHD and stroke and their associated risk factors.

The Council has several active committees, including:

- The Nutrition Committee, which focuses on expanding the knowledge base on nutritional issues and producing advisories and educational materials to promote healthy eating.
- The Physical Activity Committee, which promotes research on the effects of physical activity on the cardiovascular system and develops guidelines for physical activity in persons with and without CVD.
- The Obesity Committee, which focuses on expanding research in obesity and its effects on CVD, and planning advisories and conferences in this area.
- The Diabetes Committee, which covers the impact of diabetes on all facets of CVD. It currently is focusing on the role of PPARs in diabetic vascular disease, and on defining strategies for prevention of CVD in diabetic patients.
- The Clinical Affairs Committee, which is focused on producing prevention materials that can be applied in busy clinical settings.
- The Membership/PR Committee, which is working to expand our membership and promote the inclusion of early-career members and members from outside the U.S.

NPAM also works with other groups to further the overall mission of AHA through advocacy activities and participation in community based prevention and education initiatives.

We are actively seeking and welcome input from all AHA Council members. Please feel free to contact me or any of the members of the Leadership Committee.

The American Heart Association launched the “Face the Fats” national consumer education campaign in April 2007 to raise consumers’ awareness and understanding of trans fats and other fats in the context of an overall healthy diet. The key campaign messages to consumers are:

- Both saturated fats and trans fats are bad.
- Replace saturated fats and trans fats with mono- or polyunsaturated fats.
- “Trans fat-free” does not necessarily mean “healthy.”

A top campaign priority is to highlight the need to avoid the unintended consequence of increasing saturated fat consumption as the nation moves to minimize trans fats. This is reported in the proceedings of a trans fat conference convened by the AHA to better understand the complexity of trans fat reduction in the American diet (http://circ.ahajournals.org/cgi/reprint/CIRCULATION.AHA.106.181947).

The campaign’s main Web site (www.americanheart.org/FaceTheFats) helps consumers learn about fats and eating sensibly. It includes My Fats Translator, an interactive calculator that provides personalized daily calorie and fat limits based on the user’s age, gender, height, weight and physical activity level.

Face the Fats also introduces two cartoon characters — the Bad Fats Brothers, named Sat and Trans. These two heartbreakers come to life in their debut Webisode within their own virtual “edutainment” center, at www.BadFatsBrothers.com. This Web site also includes “meet me” profiles of each brother.

The “Face the Fats” campaign launch received extensive media coverage, including articles in the Washington Post and the Associated Press, which were printed in newspapers nationwide; coverage on CBS Early Show and CNN Headline News; and more than 80 broadcasts of media segments with past AHA President Dr. Bob Eckel and celebrity chef Alton Brown. The “Face the Fats” Web section received more visitors than any other Association Web section during the two-week launch period.

The AHA Council on Cardiovascular Disease Epidemiology and Prevention and the Council on Nutrition, Physical Activity, and Metabolism will present joint conferences.

**Face the Fats**

The AHA Council on Cardiovascular Disease Epidemiology and Prevention and the Council on Nutrition, Physical Activity, and Metabolism will present joint conferences.

**Nutrition, Physical Activity, and Metabolism Conference 2008** — March 11-13, 2008

**48th Cardiovascular Disease Epidemiology and Prevention** — March 13-15, 2008

The Broadmoor Hotel, Colorado Springs, Colorado

**Abstract Submission Deadline** — Oct 1, 2007

**Advance Registration Deadline** — Feb 18, 2008

**General Information**

E-Mail: scientificconferences@heart.org

Phone: 888-242-2453 (inside U.S.)

214-470-5935 (outside U.S.)
As the Advocacy Ambassador to the Stroke Council, I serve as the Council’s liaison to the American Stroke Association’s Advocacy Department. It is my pleasure to share with you the following report on four stroke-related advocacy efforts of the American Heart Association/American Stroke Association. To learn more about these and other related initiatives, please visit our new stroke advocacy Web site at www.strokeassociation.org/ yourethecure!

You're the Cure

The Stroke Treatment and Ongoing Prevention (STOP) Act is bipartisan, bicameral legislation introduced by Reps. Lois Capps (D-CA) and Chip Pickering (R-MS) and by Sens. Thad Cochran (R-MS) and Edward Kennedy (D-MA). This legislation aims to help ensure that stroke is more widely recognized by the public and treated more effectively by healthcare providers.

I am excited to report that on March 27, the House of Representatives passed its version of the STOP Stroke Act (HR 477) by voice vote. Also on March 27, Sens. Cochran and Kennedy reintroduced the act (S 999) in the Senate. As of May 10, the STOP Stroke Act has 20 co-sponsors in the Senate.

Now, the American Stroke Association is making a major effort to get the Senate to act on the bill before the end of this session. Largely as a result of the American Heart Association’s Congressional Heart and Stroke Lobby Day, nine additional co-sponsors have been added to the STOP Stroke Act since mid-April. Several members of the Stroke Council Leadership Committee attended Lobby Day and the Stroke Council also helped fund stipends to bring stroke survivors to Lobby Day.

As Stroke Council members, you should have also received an e-mail on May 1 from our Council Chair, Dr. Larry Goldstein, and myself urging you to contact your senators to co-sponsor the STOP Stroke Act. If you didn’t respond, it’s not too late to contact your senators! Contacting your senator takes just a minute — go to www.heartassociation.org/yourethecure! (If you’re already a member of the You’re the Cure network, you’ll need to sign in and then click on the “Take Action” button to send a STOP Stroke e-mail to your senators. If you’re not a current member of You’re the Cure, you’ll need to register first so we’ll know who your lawmakers are, then click on “Take Action.”)

On May 15, the American Stroke Association sponsored a Congressional briefing about stroke, featuring New England Patriot football player and stroke survivor Tedy Bruschi. Dr. J de Broderick, professor and chairperson of neurology at the University of Cincinnati, and Dr. Ed Capparelli, practicing family physician and American Stroke Association volunteer, also spoke.

Medicare Therapy Caps

The American Stroke Association also continues to work to protect Medicare stroke patients from arbitrary limits on outpatient therapy services. For 2007, Medicare Part B beneficiaries are subject to an annual therapy cap ($1,780) on combined physical therapy and speech therapy and a separate $1,780 cap on occupational therapy. The American Heart Association and the American Stroke Association have endorsed legislation in the current Congress to repeal the caps, but due to budget constraints, Congress has been reluctant to do so.

However, the American Stroke Association and other interested organizations worked with Congress to implement a process by which Medicare patients who need additional, medically necessary therapy can receive an exception to the caps. This “exceptions process” was extended by Congress for an additional year (FY 2007) as part of the Tax Relief and Health Care Act of 2006, which Congress passed in December 2006. Stroke continues to be included on the list of conditions that qualify for an automatic exception, provided that the additional therapy services are medically necessary.

Given that the most recent extension of the exceptions process is only for one year, the American Stroke Association expects to continue to be involved on this issue in 2007.

NIH and CDC Funding for Stroke Research and Prevention

Securing increased funding for NIH-supported stroke research and for CDC’s Heart Disease and Stroke Prevention Program continues to be a top priority for the American Heart Association and American Stroke Association.

As those of us involved in research know all too well, the NIH budget has failed to keep pace with medical research inflation since the end of the doubling of the NIH budget in FY 2003. For FY 2007, Congress did provide an increase of $620 million for the NIH as part of the “FY 2007 Joint Funding Resolution” — a significant increase in a tight budget environment. According to the report accompanying the measure, these resources will be used to allow NIH to award an additional 500 research grants in areas such as cancer, heart disease and diabetes. It will also create a new $40 million program to support innovative, thinking-outside-the-box research and provide $91 million for grants to first-time investigators.

Unfortunately, however, the President’s budget request for FY 2008 would widen the NIH shortfall (the gap between the level of funding achieved at the peak of the NIH doubling and proposed funding) to 13.3 percent. The American Heart Association has joined the research community in a campaign to get NIH funding “Back-on-Track” by advocating for a 6.7 percent increase in each of the next three years.

With respect to the CDC, heart disease and stroke prevention was level funded at $44 million for FY 2007, and the President’s budget recommended level funding (no increase) for FY 2008.

The American Heart Association is advocating for a $20 million increase for the CDC Division for Heart and Stroke Prevention. An increase of this amount will allow CDC to support the 32 states and the District of Columbia that currently have grants under the State Heart Disease and Stroke Prevention Program, fund additional states for basic program implementation, and add more states to begin planning for the State Heart Disease and Stroke Prevention Program.

Open competition for this lifesaving program started in January 2007, allowing unfunded states to apply for funding for the first time since 2002. This increase will maintain the Paul Coverdell National Acute Stroke Registry, support development of a state-based sudden cardiac arrest registry, and enable CDC to explore establishment of a National Heart Disease and Stroke Surveillance Unit to monitor existing relevant data.

During Lobby Day 2007, AHA You’re the Cure advocates urged their lawmakers to sign the Dear Colleague letter circulated by the co-chairs of the Congressional Heart and Stroke Coalition, Sens. Byron Dorgan (D-ND) and Mike Crapo (R-ID) and Reps. Lois Capps (D-CA) and Chip Pickering (R-MS) to increase funding for NIH and CDC heart disease and stroke research and prevention programs. Thirty-eight senators and 72 representatives signed letters.

75 Percent Rule

The American Stroke Association continues to monitor regulatory and legislative action with respect to Medicare’s “75 percent” rule for Inpatient Rehabilitation Facilities (IRFs). The 75 percent rule is the criterion that the Centers for Medicare and Medicaid Services uses to determine whether a facility classifies as an IRF and therefore qualifies for the higher Medicare payments that IRF designation provides. Under this rule, a facility may be classified as an IRF if at least 75 percent of its patients in a year, including Medicare patients, require intensive rehabilitation for at least one of 13 specific, listed conditions (stroke is one of the 13 conditions). The concern is that inpatient rehabilitation facilities may close because they are unable to meet this requirement.

This rule is being phased in over a period of three years; currently, at least 60 percent of a facility’s patients must have one of the 13 conditions to be classified as an IRF. This threshold increased to 65 percent in July 2007 and to 75 percent in July 2008.

New legislation, the “Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007” (S 543/HR 1459), has been introduced in Congress, which would permanently freeze the threshold for the IRF qualification at the current 60 percent level.

The Stroke Council

Stroke Advocacy Update

Maggie Kelly-Hayes, RN, EdD, FAHA

Stroke Council Advocacy Ambassador
An Interview With Pamela Douglas, MD, FAHA
By Patricia Pellikka, MD, FAHA

Dr. Pellikka: Thank you very much for this interview. How did you decide on a career in medicine?

Dr. Douglas: I was always attracted to the biological sciences. I was kind of on the fence of about whether to go to graduate school or medical school. I did not have anybody in my family that had been a physician or in health care. So I applied to both graduate school and medical school and in the end, decided that going to medical school provided more options.

Dr. Pellikka: What was your major at Princeton?

Dr. Douglas: I had an independent concentration in neurosciences and behavior. This was called an independent major which meant that you didn’t follow any specific set of preordained classes, but instead devised your own curriculum.

Dr. Pellikka: That took a lot of foresight. Then you went to the Medical College of Virginia. When did you decide on cardiology as a specialty?

Dr. Douglas: I initially thought I was going into neurology on the basis of what I had done in college, but then neurology seemed like a specialty where there was not really a lot that you could do for patients. I thought about OB/GYN in my medical school rotation. There were very few women in OB at that time and the specialty did not seem to be particularly celebrating of women’s health. I ended up in medicine in part because I really enjoyed the thought process of internal medicine with the diagnostic puzzles and the variety. When it came time to finish internal medicine, I had really enjoyed my time in the Intensive Care Unit. We had a joint medical and cardiology intensive care and Mark Josephson had been my attending and is still a mentor. I thought about cardiology and considered anesthesiology, critical care and rheumatology. I had spent two months at NIH during medical school and really enjoyed collagen vascular disease. But in the end, I decided to do cardiology and asked Dr. John Kastor, who was chief at Penn at that time, if I could stay on and do cardiology and actually never even applied for fellowship.

Dr. Pellikka: Very efficient. Were there others who were important mentors for you?

Dr. Douglas: Martin St. John Sutton was very important during my fellowship program. Afterwards, other folks have included Val Fuster, Rich Popp, and Tony DeMaria.

Dr. Pellikka: Seems like an echo influence.

Dr. Douglas: I actually got interested in echo because I just thought it was very cool. You could actually see the heart beat. It is sort of corny and we take imaging for granted so much now but the idea that you could actually see inside the human body with no damage or injury was just fascinating.

Dr. Pellikka: It still is amazing.

Dr. Douglas: I finished fellowship in 1984. I came into my residency when 2D echo was just coming out. I finished my fellowship right when Doppler was coming out. It was just exploding and you could learn so much.

Dr. Pellikka: You also became interested in gender differences in heart disease and delivery of care well before that become a hot topic. I noticed your 1986 editorial in Circulation.

Dr. Douglas: Which I wrote as a fellow! I was asked to write a book chapter on exercise in women. I realized as I was doing it that there was a tremendous difference in predictive accuracy of stress testing between men and women which we all know and take for granted now. At that time I was finishing up a very excellent fellowship program. There were just a handful of articles (3–4 articles) about this and I was just amazed that we never talked about. It was not part of education or we did not take differences into consideration when making decisions about whether to send our female patients to cath. So I got fired up that we really did not have the information we needed in half of our patients and that we were operating in the dark really on how to care for women and that it was never recognized as a problem. I sat down and wrote what I thought was just sort of a perspective for an essay and fired it off to Circ and they published it.

Dr. Pellikka: That is remarkable. Not surprising now though.

Dr. Douglas: It is a very empowering message for people that if you keep your mind open and look at the world around you and the paradoxes that you see and the opportunities, you can make a difference. If you decide to do something you actually can.

Dr. Pellikka: You have been active in the American Society of Echocardiography and the American College of Cardiology and recently served as president of each organization. How did you become involved in these organizations?

Dr. Douglas: For ASE, I was asked to serve on committees, then served on the Board and then was asked to run Scientific Sessions which I did in 1999. The progression is to transition to the executive if you do a good job with all of those preliminary tests. Regarding ACC, in the early ‘90s, Merck funded an exchange program between ACC and the European Society of Cardiology whereby new faculty, accompanied by a senior faculty member, would spend three weeks traveling around visiting academic medical centers on the other continent. The first one of these was in 1992 and I thought it sounded really cool and I wanted to go to Europe and learn what academic medicine there was about. I have always loved to travel and so I applied. My chief, Dr. Bill Grossman, needed to write an important letter. He said, “Are you really wanting to do this? Three weeks away from home is really a long time.” I said, “Yes, I think it would be fun and exciting.” It was fun, exciting and eye opening. I had a particularly wonderful two to three days at the Thoraxcenter, made some very good friends on that travel and then came back and ACC asked me to serve on the committee for the exchange award. I subsequently chaired that committee. At that time (in 1995), Rita Redberg and Elyse Foster decided that more women were needed on the ACC Board. They decided that as ACC members and women they would take it upon themselves to figure out who were senior women who had a chance of being nominated, and would write the nomination letters, solicit them and put
somebody into the position. They called me and asked if I would be willing to do that and I said sure I would be happy to. I was not sure that I was senior enough, but I would be happy to try and that is exactly what they did and that is how I got on the Board. Simply playing the game, and deciding they wanted to make a difference in doing it.

Dr. Pellikka: That is great. How did you find your terms as president?

Dr. Douglas: ASE was favorable and very challenging but for very different reasons. I took over ASE at the exact time when the founding Executive Director was stepping down for personal reasons. Robin Wiegerink was on the staff but fairly junior. After the ASE meeting when she became the Executive Director and I became president I remember many phone calls when one of us would say, “What do we do now?” and the other one would say, “I don’t know. I have never done this before.” So we decided to make a huge opportunity of it and completely rethink the structure of the organization and the committee and staff structure and organize it in a way that made sense to us. We actually retired every single one of the committees and every single one of the committee members over the first two months. We reduced 37 committees to 16. With Executive Committee approval, we recharged all of the committees. We charged them with what needed to be done and appointed new chairs and new members while preserving some continuity. Robin reorganized the ASE staff, assigning somebody to education, research, external affairs and internal affairs. We paired those mission areas with each member of the Executive Committee so each member would have responsibility for a set of committees. That has served the organization extremely well over the four years since I stepped down. The membership has grown 30–40 percent with that revitalized foundation in internal operations.

Dr. Pellikka: A complete overhaul!

Dr. Douglas: It was. We did a lot of fun things. We set up a lot of Web sites, SeeMyHeart.Org, digitalzone.com, ASE marketplace; a bunch of very fun new initiatives to increase the value to members and create more of an echo community and bring people into that community.

ACC had its challenges for different reasons. When I became president there was tension between the senior level of staff and the presidential and executive committees that had been brewing for some years. We ended up doing a very profound examination of the role of staff versus the board and the executive and what it means to be a member-driven organization. It means that the members have to pay attention and be engaged and involved in what they do. Staff need to defer to members for strategic decisions and everybody needs to work together to execute on those decisions. We did a lot of soul searching about what our values were and what the best structure and governance would be for the organization going forward and made a decision that we would stay member driven. It was a very important, intense time but the organization has really moved forward with its dynamic staff leadership and a much more engaged volunteer leadership than we had before.

Dr. Pellikka: Excellent. You are an obviously very talented leader and administrator, serving as Chief of Cardiovascular Medicine at the University of Wisconsin and then at Duke University.

Dr. Douglas: I am not afraid of change and really not afraid to look under the hood!

Dr. Pellikka: What are some of the greatest challenges you have faced?

Dr. Douglas: With reimbursement and NIH funding going down, it becomes hard to figure out how to make ends meet and how to do so in a manner that preserves what we value most about our academic environment: namely the freedom, the ability to inquire about our world, and to try to change the world rather than just crank out clinical work. Those are really the challenges and I think those are the challenges that I faced in Wisconsin and at Duke, and which every leader in cardiology faces.

Dr. Pellikka: Do you have any advice for women early in the cardiovascular careers?

Dr. Douglas: Women in particular need to take charge of their career and think hard about what it is that they want to do and want to accomplish. This is not a one-time event, this is something that is an ongoing process and it something that we all need to think about and ask ourselves regularly: what do we truly love doing? No cardiologist works a short day. We work very intensely. The way to have the energy to get through those days is to really love what you do. It also has to be something that you are good at and that you have the talent to do. So, it needs to be realistic given your skills and possible in your environment. It needs to be meaningful not just to you but to the outside world. So you must find where is there opportunity, where is your passion, where you have skills and find the sweet spot in the middle of that and then really go for it and figure out what you need to do to make it happen. If you want it, go for it!

Dr. Pellikka: Your accomplishments and career have really been brilliant. Is there anything that you would do differently if you did it again?

Dr. Douglas: No — actually not. Medicine is a very, very special profession where we can be intellectually stimulated and help people at the same time. I love the academic environment and am very committed to the academic missions. The variety is great to keep you interested and there is a synergy between the different missions and this is really important. You do better care when you do research and when you teach and vice versa. I have enjoyed my administrative roles and the opportunity to lead very, very talented people and to make a difference in the world around me.

Dr. Pellikka: So what is next on your list of accomplishments?

Dr. Douglas: I am really enthusiastic about being able to return to research interests, including novel applications of echo and ultrasound as well as imaging and health services, quality utilization and appropriateness. We need to address gaps in women’s health and improve quality of care for women.

Dr. Pellikka: Is there anything else you wanted to talk about?

Dr. Douglas: I have a wonderful husband. When you think of what enables you in your career, a fabulous home life and an incredibly supportive staff and family are really important. Make sure that you work equally hard on all of those things outside of work, because they are more important than anything you do in work as well as being incredibly rewarding.

Dr. Pellikka: I completely agree. Thanks for talking to me. I have thoroughly enjoyed it.
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