Special Article

A History of the American Heart Association’s Council on Clinical Cardiology

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This essay reviews the founding and early history of the Council on Clinical Cardiology of the American Heart Association (AHA), the largest of the AHA’s 14 councils. Based on archival research, it stresses the factors that led to the council’s formation and shaped its agenda. The council was established in the context of the AHA’s transition from a professional society to a voluntary health organization in 1948. But the direct stimulus for its creation was the American College of Cardiology’s (ACC) first membership drive 3 years later. When the AHA’s Section (later Council) on Clinical Cardiology was formally established in 1952, its official purpose was to “facilitate and encourage investigation, prevention, treatment and education in the field of clinical cardiology.” Originally strained, the relations between the AHA and the ACC improved as the organizations came to view each other as potential partners rather than rivals. (Circulation 1993;87:1057-1063)

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This article describes the origins and early history of the Council on Clinical Cardiology (CCC) of the American Heart Association (AHA). Based on archival research, it emphasizes the dynamics that led to the formation of the council and shaped its agenda. Individuals who found professional medical societies often are motivated by specific developments within their specialty. But social, economic, and political factors also influence the formation and character of new societies. That was the case with the CCC. Although it was established in the context of the AHA’s transition from a professional society to a voluntary health organization, the direct stimulus for the creation of the council was the commencement of a membership campaign by the newly formed American College of Cardiology (ACC) in January 1951.

To understand the creation and purpose of the CCC, it is necessary to review the goals and structure of its parent organization, the AHA. In May 1922, 41 physicians met during the annual meeting of the American Medical Association (AMA) to discuss the formation of a national organization for physicians interested in heart disease. Two years later, the AHA was formally incorporated. According to Lewis A. Conner, the association’s first president, the “very widespread interest in circulatory diseases which is now so apparent” resulted from “truly revolutionary advances” in the diagnosis and management of heart disease. The formation of the AHA was also a manifestation of the trend toward specialization and the establishment of professional societies that began during the late 19th century.

The AHA initially focused on collecting, disseminating, and applying knowledge about the causes, prevention, and treatment of heart disease. It also sought to facilitate the rehabilitation or ongoing care of cardiac patients, many of whom had rheumatic heart disease. The association grew steadily; by 1932 it had 1,277 members. In 1935, the programmatic scope of the AHA expanded when a group of physicians led by George Brown of the Mayo Clinic and Irving Wright of New York convinced the organization’s leaders to form a “Section for the Study of the Peripheral Circulation.” This section served as the model for the formation within the AHA of other special interest groups, eventually called “councils.” Wright later recalled, “There were doubts expressed by some of the classical cardiologists regarding the adoption of this upstart, but with the encouragement and guidance of doctors Marvin, White, and others the new and first Council was admitted.” The vascular section members influenced the AHA in another important way. Deeply committed to clinical investigation, they wanted the association to sponsor research. But rhetoric and ambition were not enough to overcome the severe economic conditions of the Great Depression. The AHA did not have enough money to cover its original goals, let alone to subsidize research. In 1939, the association’s board of directors learned that their organization had expenses of $13,327, income of $11,555, and a deficit of $1,772.

The AHA’s tenuous fiscal condition was one factor that led Boston cardiologist Howard Sprague to recommend a dramatic restructuring of the organization in 1939. Three years later, AHA executive director H.M. “Jack” Marvin, a New Haven cardiologist, forwarded to the executive committee an ambitious proposal based on Sprague’s suggestions. The centerpiece was a national fund-raising campaign that would enable the AHA to sponsor research as well as expand its public health and lay education programs. Marvin acknowl-
edged that although the association was supported by “the finest men in the cardiovascular field in the country . . . its limited budget has long been a great handicap.” Marvin knew that many physicians would resist a major fund-raising campaign. He assured the AHA leaders that the public relations firm developing the campaign understood that the association did not want “a lot of ballyhoo and undignified publicity and that no unjustified claims about the cure of heart disease will be permitted.” 8

Marvin and Sprague envisioned a dramatic increase in the scope of AHA activities, but this depended on their ability to attract funds for their cause—heart disease. Initially, they approached the medical directors of major insurance companies for donations. 9 Marvin listed 22 projects that the AHA hoped to undertake in a 1942 letter to the medical director of the Equitable Life Assurance Society. Although some funds were raised, the results of this campaign for corporate support were disappointing. But it was an unsettled time. World War II disrupted the lives of most Americans, and it delayed the reorganization of the AHA that Sprague and Marvin sought.

After the war, the reformers renewed their initiative. As the financial and programmatic implications of the proposed reorganization were delineated, more AHA members embraced the goals and strategy of the reformers. Marvin 11 explained that the AHA board decided in October 1945, after several meetings with “professional fund-raisers, with public relations counselors, with individual members and groups . . . to embark upon a broad expansion of activities and to employ a firm of specialists to outline a fund-raising campaign.” Sprague’s Harvard colleague and AHA founder Paul Dudley White told Marvin, “We must have money to carry on what we want to do. . . . Of course, we have in the past shrunk from all this publicity in keeping the association very scientific and conservative, but obviously we have got to get away from that.” White conceded, “Much as I dislike the thought of all the publicity that is coming, I believe we must undertake it.” 12

The reorganization of the AHA was further catalyzed by the formation, early in 1946, of “The Council on Heart Diseases, Inc.” Informally linked to the New York Heart Association, a powerful AHA affiliate, this corporation alarmed Marvin and his allies. 13,14 Donald Price, incoming executive director of the New York Heart Association, explained that the Council on Heart Diseases, with its influential lay members, could “eventually, by the expansion of its lay and medical boards . . . operate on a national basis, absorbing or being absorbed by the present American Heart Association.”

Marvin 15 complained to Brooklyn physician Edwin P. Maynard Jr., one of the council’s founders: “A new national organization has been formed which must of necessity be in direct competition with, if not in opposition to, the American Heart Association.” Although Maynard reassured Marvin that it was not the council’s intention to compete with the AHA, the reformers were galvanized into action. Sprague told AHA president Roy Scott in 1946: “It is to a degree true, that the stimuli for remaking this Association have come from the formation of the many other organizations, espousing the cause of heart disease, now burgeoning throughout the country.”

In his letter to Scott, Sprague claimed that the AHA included two camps: the “expansionists [who] favor extending the public health, public education, lay representation, federal and large scale features of the program [and] the contractionists [who] desire the emphasis upon the small, strictly scientific, professional and clinical aspects of the Association.” There was also disagreement about the “ideology of research.” Sprague explained that while some still supported the “small investigator, the individual clinic or laboratory,” they were rapidly being overtaken by those who wanted “great central foundations” where “investigative specialists” could work “under one roof [with] our clinicians, biochemists, enzyme biologists, physicists, radiant energists, and the super-priesthood of medicine.” He emphasized that this was the trend in cancer research. Moreover, collaborative ventures during World War II, especially the Manhattan project, demonstrated the potential of federally funded multidisciplinary, multi-institutional research.

But Sprague worried that the expanded agenda of the AHA might be undermined by “sectionalism or local ambition.” That was what was most threatening about the formation of the independent Council for Heart Diseases. Competition among organizations for contributions for heart disease research and education had important implications for the ambitious plans Sprague and the other reformers had for the AHA. He appealed to Scott, “Let us by all means be, first of all, the united and dominant organization in the cardiovascular field in the country.” 17 This statement anticipated the response of Sprague and his circle to the founding of the ACC a few years later.

Sprague’s committee on policies and activities presented a lengthy report to the AHA board of directors at their 1946 annual meeting. This white paper detailed a plan that would transform the AHA into a voluntary health organization within 2 years. The most significant element of the AHA reorganization was the plan to convert it from a professional society into a voluntary health organization. From the start, the AHA was an association of physicians, run by physicians. But this would soon change: under the new plan, the organization would be governed by a board that included 50% lay people. Although they acknowledged that this new structure would surely increase the association’s budget and facilitate expansion of its public health activities, some AHA physicians and scientists worried that the new agenda might “result in a dilution of research activity.” 18 To reassure this influential constituency that their interests would be served, the reformers decided to form a “Scientific Council” (SC) within the AHA.

The council was supposed to maintain “a nucleus within the American Heart Association of scientifically qualified individuals who will be primarily interested in furthering knowledge of cardiovascular disease.” It would be a powerful group responsible for the American Heart Journal (the AHA’s official journal before Circulation was launched in 1950), the annual scientific meeting, the allocation of research funds, and other purely professional activities. All AHA members who were board certified in internal medicine and cardiovascular diseases would automatically become members of
the SC. Other specialists could be elected to the council: “particularly internists, pediatricians, and thoracic surgeons [who] have made major contributions to the knowledge of cardiovascular diseases” and scientists “who have made contributions to cardiovascular research.”19 A committee appointed by AHA president Arlie Barnes in May 1948 invited 676 individuals to join the “founder’s group” of the council. Two months later, a list of 548 founding members was circulated.20

Although it included more than 500 physicians, some viewed the new SC as an elite. William McPeak,21 a social scientist hired to help plan the AHA’s transition to a voluntary health organization, claimed that by making the council “self-electing” and limiting its membership, “a group was formed that tends to be considerably more aristocratic than the American Heart Association previously was.” Although the SC had broad geographic and ethnic representation and included practitioners as well as academic physicians and medical scientists, it did not satisfy all of the association’s physicians. AHA historian and past executive director William Moore2 claimed, “Almost immediately, the structure and restrictions on the membership [in the SC] caused dissatisfaction.”

Among those unhappy with the new orientation of the AHA was New York cardiologist Franz Groedel, the founder of the ACC. Groedel emigrated in 1933 from Germany, where he was a successful physician, prolific author, and productive clinical investigator. An active participant in many European medical societies, he was, with Bruno Kisch, a founding member of the German Society for Cardiovascular Research.223 Groedel spoke excellent English, and shortly after arriving in America he began to participate in the activities of the AHA. He was one of 13 physicians present at the annual AHA business meeting in 1935.4 But Groedel never achieved any stature in the association. And, despite his impressive bibliography, he was not invited to join the SC.

Groedel’s exclusion from the AHA elite is at least partially explained in a letter Paul White wrote to Bruno Kisch, Groedel’s long-time friend and ACC cofounder. One problem was White’s perception—presumably shared by Sprague and other AHA leaders—of Groedel as a clinician and investigator. White told Kisch, “He did not impress a good many of us in the U.S.A. as being a very scientific worker.” But there was more. White revealed an incident that undoubtedly contributed to Groedel’s exclusion from the medical elite of New York City and, for that matter, the Northeast. Groedel’s role in the founding of the ACC—the organization that caused the AHA’s leaders to establish the Section on Clinical Cardiology—justifies an extensive quotation from White’s letter25:

One other early experience antagonized a good many of the doctors in this country including those in New York whom later on he met when he came there. It was his custom on several summers, I think in the late twenties or early thirties, to send printed cards saying that he would be coming to various parts of the U.S.A. and would be in the vicinity of various cities on certain dates. He announced that he would be able to see our patients in consultation with us. Unhappily, but quite naturally, this irritated most of the physicians who received the announcement since the notices seemed patronizing and in poor taste. I’m sure that such experiences with him constituted one of the most important reasons why, when he came to this country, he was not received with open arms right there in New York. I suspect that that early experience of Groedel’s in New York City may have embittered him and stimulated him to establish an organization of his own in competition with the local heart association there in New York and with the mother group, the American Heart Association. At least that is the way the beginning of the American College of Cardiology was viewed by I think almost all of us who did some of the pioneering in the field over here.

The 1948 reorganization of the AHA and the elitist nature of its new SC stimulated Groedel to form the ACC. Shortly after he became president of the New York Cardiological Society (NYCS) in 1949, Groedel proposed that the society expand its geographical scope. He viewed the new AHA as “primarily a lay organization with a few interested physicians participating, interested in obtaining public support in building up funds for cooperative research.” Groedel’s view of the reorganized AHA was not unique. A few years later Paul White26 admitted, “At first there was a tendency of some members to resent the lay membership.” Some physicians who belonged to the AHA, but were not invited to join the SC, doubtless felt disenfranchised. Although Groedel and several other ACC founders were AHA members, they were not affiliated with New York’s elite medical schools or hospitals. Most were immigrants or Jewish. But this was not what mattered: several Jewish immigrants were invited to join the SC, among them Richard Bing, Harry Gold, Louis Katz, Richard Langendorf, and David Scherf. Indeed, Katz was chosen to be AHA president in 1951. But he, like most of the council’s members, was viewed as an academic cardiologist—a scientist.

Groedel argued that the NYCS should assume a national role because there was no “representative national cardiological society at present, which restricts its membership to physicians only, who are interested in the advancement of the study of the heart and circulation.”26 After several weeks of debate, he convinced 13 members of the NYCS to join him in founding the ACC.27 When the college was incorporated in December 1949, Groedel and the founders outlined an ambitious agenda. Their college would seek “to promote and advance the science of cardiology and all its phases; to arrange and conduct an annual Congress of Cardiologists and such other meetings and gatherings from time to time; to edit, print, publish and distribute a Journal of Cardiology and other printed matters relating to the science of cardiology.”28

Sprague, Marvin, and other AHA reformers reacted predictably to the formation of the ACC. They were threatened by the emergence of this new cardiology organization just as they had been by the incorporation of the Council for Heart Disease 4 years earlier. Many physicians were still unsure about the AHA’s new orientation, and the association’s leaders worried that their bold initiative would be thwarted if their ranks were thinned. Moreover, the founding of the ACC jeopardized Sprague’s concept of the AHA as the “dominant organization in the cardiovascular field in the country.”29
T. Duckett Jones, chairman of the recently formed AHA Council on Rheumatic Fever, told Groedel, "I am distressed to hear of the incorporation of your organization for reasons that must be obvious to you." Jones continued, "So far as I am aware, the Scientific Council of the American Heart Association contains and actively works in the realm of scientific interest in the cardiovascular field. . . . I personally feel that to develop competing scientific organizations will serve no useful purpose and probably do little good, if not actual harm, to cardiovascular disease knowledge."

Initially, the AHA leaders hoped to suppress the new organization. Sprague, now AHA president, in a letter to all physician members of the association charged that the ACC "merely duplicates the aims and purposes" of the SC. He announced that it was the AHA's "considered opinion that the establishment of competing scientific associations serves no useful purpose."34 In a letter to former AHA president William Stroud, White revealed that he and others thought the ACC would languish when Groedel died in 1951, just before the college's first national meeting. Much to their dismay, the college thrived. Although 5 years later White still viewed the ACC as "an inferior organization," he acknowledged that it "may now be becoming respectable with time." White35 continued, "This happened, you may remember, with the American College of Physicians. At the beginning it was a society of people who could not get into the Association of American Physicians but it became quite respectable."

Despite the AHA's campaign to discourage physicians from joining the ACC, its membership drive was very successful. By June 1952, the college had nearly 750 members. Many cardiologists and internists thought the new organization offered them something that the AHA, at least in its new form, did not. Earlier, Groedel32 had informed AHA assembly member Edwin P. Maynard Jr. that he founded the ACC "only because of the request of a great number of cardiologists who told me that there is a real need for such a College."

Practitioners were attracted to the college because it was a professional organization devoted solely to continuing education. And, like the American College of Physicians, it offered its members who qualified for "fellowship" the opportunity to distinguish themselves from other doctors.

The postwar era was a dynamic time for cardiology and cardiovascular surgery. Doctors and patients alike were impressed by the dramatic advances in the diagnosis and treatment of heart disease. Cardiac catheterization and innovative surgical approaches to congenital and acquired heart disease proved dramatically that there was more to cardiology than electrocardiography, the technique that for a generation distinguished a "cardiologist" from an "internist." In this context, postgraduate courses held special appeal for physicians—most of them internists and general practitioners—who cared for patients with heart disease.

There were few board-certified cardiologists at the time. Formal training programs in cardiology were virtually nonexistent. In 1947, there were only 15 cardiology training programs, compared with 1,743 residency programs in internal medicine.35 Short courses organized by some medical schools helped fill this void, but most "cardiologists" were self-taught internists.

Groedel and the ACC founders saw postgraduate education as the primary focus of their new society. And they did so at a time that many physicians saw the AHA's commitment to professional education diluted by the organization's new initiatives. At the same time, the ACC was a strictly professional organization that promised to provide doctors with information that would benefit them in their practices. This combination appealed to those physicians who disliked the AHA's new structure and philosophy.

Speaking of the AHA in the early 1950s, William Moore3 claimed, "The cardiologists, although proud of the Association's emphasis on research, could see their influence ebbing within the Association, and their constituency drifting to the American College of Cardiology." It was in this context that the AHA's CCC was formed. As AHA leaders realized that ACC was not only surviving but also thriving, they modified their strategy. To compete with the college, they decided to develop an alternative to it within the AHA framework. Howard Sprague masterminded the transition of the AHA into a voluntary health organization, and, according to AHA executive director Rome Betts,34 he was "very largely responsible for the establishment of the Council on Clinical Cardiology."

In the spring of 1951, Sprague told the AHA and SC executive committees that many members had complained about the "present restricted membership of the Scientific Council."35 To counter the "dissatisfaction with the Scientific Council as presently constituted" among "physicians throughout the country," he suggested that membership in the council be opened to all AHA physicians. As a result, the bylaws were modified and all of the doctors in the AHA were invited to join the formerly elite council.36 Discussing this change, Sprague admitted that "the immediate burr under the saddle was the American College of Cardiology;" Robert Wilkins, chair of the committee on reorganization of the SC, told Marvin, Sprague, Wright, and Jones that AHA president Louis Katz "felt that we should have something to compete with the American College of Cardiology." Irving Wright, AHA president-elect, thought the best way to compete with the college was to "offer more to the doctors—association with a more scientific group of men; the better program." Sprague urged the committee to "set up an 'ideal' Council on Cardiology to be used as a pattern" for other councils.37 As a result of these discussions, the Section on Clinical Cardiology was formally established by the AHA board of directors on June 5, 1952. Its official purpose was to "facilitate and encourage investigation, prevention, treatment and education in the field of clinical cardiology."38

During the next several months, the objectives of the new section were refined in preparation for the group's first formal meeting, scheduled for the AHA's 1953 scientific sessions. Carleton Eustene of the Cleveland Clinic was the first chairman of the Section on Clinical Cardiology. When Ernstene reviewed the section's origins with the group's executive committee, he "discussed the activities of the American College of Cardiology and . . . stressed the importance of initiating, as soon as possible, an active program of professional education."39 To attract physicians seeking practical knowledge, Charles Marple, in 1954, proposed reorga-
nizing the AHA annual scientific meeting to allow concurrent sessions. One series, lasting 3 full days, would be clinically oriented and cover “as broadly as possible the entire cardiovascular field.” Besides “purely clinical papers,” these sessions would include “original papers or selected lecturers and panels on investigative developments, if they apply to the clinical field.”

Concurrent sessions sponsored by other sections of the SC would consist of “the more esoteric aspects of the subject” and “would be designed to attract to them investigators and those clinicians who are interested in the details and technical aspects of current investigations.” Traditionally, many AHA presentations summarized the results of clinical research. But the executive committee of the Section on Clinical Cardiology thought that “the content of such papers, although exceedingly important, is often of very limited interest to the practicing physicians who want practical clinical education.” Their strategy worked. By 1954, the AHA meetings were so popular that it was decided to hold future annual scientific sessions independent of the yearly AMA meeting, a tradition begun in 1924.

As part of a reorganization of the AHA in 1957, the “sections” were elevated to the status of “councils” and were granted representation on the AHA’s board of directors, executive committee, and assembly. This increased the influence of the CCC within the association. The council’s officers continued to lobby for greater control over the content of the annual scientific sessions. Their proposal for a “continuous clinical program during the scientific meeting in the form of papers of general clinical interest, lectures, panels, and symposia throughout the six sessions” was accepted.

Tensions between the AHA and ACC diminished during the late 1950s, and CCC program chairman Lewis January worked with ACC representatives to plan a joint meeting scheduled at the time of the 1959 AHA scientific session. The program included a symposium on cardiac resuscitation and a series of “joint fireside conferences” patterned after evening sessions inaugurated at the 1955 ACC meeting. Although January cooperated with the ACC, he realized it competed with his council for members. He urged the CCC executive committee to hold a “meaningful business meeting” at each annual AHA meeting if they hoped “to attract members to the Council.” The group accepted January’s recommendation, and a business meeting was held during the AHA scientific sessions in 1959. But when the executive committee reflected on the meeting, they concluded that it “followed the type of most business meetings and that nothing could be done at this time to make it more interesting or meaningful.” They were more satisfied with the scientific program and congratulated themselves for achieving their “objective in having a diversified three-day program of clinical sessions.”

Sensitive to their educational mission, the CCC leaders believed that the main audience for the clinical sessions at the annual AHA scientific sessions was “practicing physicians with an interest in cardiology.” They argued that the AHA must appeal to that constituency or it would “lose more and more people to other groups” like the ACC that offered practical educational programs. Their concern was heightened because applications for council membership were “lagging” in 1959.

The success of the joint AHA–ACC meeting, growing acceptance of the college, and lingering concerns about competition led AHA leaders to explore the possibility of an amalgamation of the two organizations in 1960. It was not the first time this possibility was discussed. In November 1952, representatives of the AHA had invited the ACC to “join with us, especially as charter members of the new section on clinical cardiology.” By the fall of 1960, it became apparent the AHA hoped to absorb the ACC into the CCC. ACC president Osler Abbott explained that the AHA wanted the college to “become one of their sub-groups or councils,” but the college’s lawyers thought “that entering their council structure is equivalent to dissolving our corporation.”

Oglesby Paul, an AHA representative in the negotiations, told Paul White in October 1960, “There is an excellent chance for the College to join with the American Heart Association in the next few months. I am greatly heartened by this course of events.” Paul was too optimistic—negotiations broke down by year’s end. The ACC leadership found little enthusiasm among college members for such a merger. Wright Adams, a member of the liaison committee, discussed the situation with the CCC executive committee early in 1961. After his report, the CCC “agreed that the American College of Cardiology, because of its recent growth as a professional society, presents a challenge to the American Heart Association and to the future task of this Council.” In 1961, the ACC had 2,098 members (1,414 fellows, 443 associate fellows, 241 members), and the CCC had 1,350 members. Just as the ACC’s 1951 membership campaign catalyzed the formation of the Section of Clinical Cardiology, the college’s continued success stimulated another response from the AHA.

AHA president-elect Scott Butterworth thought the CCC should be reorganized to “provide for a more select core, composed of those who are certified in the cardiovascular sub-specialty.” This would be analogous to the fellowship category in the college. CCC chairman Wright Adams was opposed to forming such a “super group,” however. He thought the council “should be a rallying point for cardiologists, but at the same time it must keep in mind the interests of the general practitioners and not downgrade them.” AHA executive director Rome Betts agreed: “The reaction would be unfavorable if the Association makes no provision for physicians who are not qualified for the Fellowship.” But the CCC executive committee concluded that unless that AHA began “to move in this direction, physician membership may not carry the prestige that a large national organization should be able to confer on its professional members.” They acknowledged, however, that to exclude from the council physicians who were not board certified “would certainly lessen the chances of further expansion.” In the end, the committee voted unanimously to request AHA approval to establish a fellowship in the CCC.

As these events unfolded, AHA president Oglesby Paul assured Paul White that the association was not indifferent to the ACC and its growing influence. He admitted that the AHA had “been deficient in attracting clinicians” as members because it was “not the usual type of professional organization in that we have such a
large lay representation.” Paul explained that they were considering a plan of “upgrading professional membership... so that it will be competitive with other groups, and offer essentially the type of fellowship given by the American College of Physicians.” But the stimulus for offering fellowships in the CCC was not the American College of Physicians, it was the ACC. Referring to the ACC, Paul claimed, “perhaps this type of competition is healthy for us and maybe it will do the whole field good.”

AHA medical director George Wakerlin shared the CCC leaders’ belief that the addition of a fellowship category would “establish the Council as a rallying point for practicing cardiologists and assure vigorous leadership in clinical cardiology as a primary function of AHA.” When the plan was discussed at the 1962 CCC business meeting, “a number of leading clinicians expressed their enthusiastic support of the proposed reorganization.” The CCC leaders were gaining confidence and influence—their was already the largest of the AHA’s eight councils. In 1963, CCC chairman Lewis January boasted, “The Council has assumed leadership in the field of cardiology, maintains professional standards of training in practice and represents the cardiologists and their interests to other professional groups, to the public and to the government.”

When the fellowship plan won AHA approval, CCC members who served on committees or were board certified in cardiology were invited to become “founding fellows” of the council. Board-certified cardiologists not previously members of the council were asked to apply for fellowship. In addition, the executive committee invited “a group of outstanding cardiologists who were not members of the Council to become Fellows.” Never complacent, the CCC leaders, in another attempt to appeal to practitioners, developed a plan to compete with the ACC’s “workshop program.” Begun as tutorials for small groups of physicians, the college expanded the popular workshop series to a symposium format held at leading medical centers in 1961. Two years later, the CCC began sponsoring “interim courses of the Council” in cities too small for the annual meeting but “where there is a strong medical community.” The first “Three Days of Cardiology” course was held at Emory University in Atlanta, Ga., in March 1963. The program consisted of lectures and panel discussions by Emory physicians and prominent guest speakers. During the next 3 years, similar courses were held at Ohio State University, Duke University, Michael Reese Hospital, New York University, the University of Colorado, Hahnemann Medical College, Wayne State, the University of Alabama, St. Paul Medical Center, Tulane, Columbia-Presbyterian Medical Center, the University of Washington School of Medicine, and Georgetown University.

In addition to offering high-quality educational programs, the CCC addressed other professional concerns of its members. The concept of issuing certificates to CCC members was problematic. When he helped plan the council in 1951, Jack Marvin announced to other AHA leaders: “I am very much against giving out any certificate, placard or diploma.” Howard Sprague, Irving Wright, Rome Betts, and other AHA influencers involved in the reorganization of the SC agreed. But times had changed. When the first group of 301 CCC fellows were elected in May 1963, they received certificates. And, unlike members, fellows could vote at the annual business meeting. The new category of fellowship led to increased responsibilities for the council’s regional representatives. Because only 5% of internists were certified in cardiology at this time, the credentials committee expected the representatives to help them screen candidates for fellowship.

Although these changes—fellowships, interim clinical meetings, and certificates—reflected a pragmatic response to the success of the ACC, they also acknowledged a shift in emphasis within the AHA itself. As the full-time faculty system and clinical research grew dramatically in America, academic physicians and their protégés became more influential within the organization. The program at the annual scientific sessions and the content of Circulation reflected these trends. In this context, Boston cardiologist Harold Levine told former AHA medical director David Rutstein in 1963, “You are aware, as I am, of the growing concern of the American Heart Association regarding the over-emphasis of its publications and its meetings upon the academic and scientific in contrast to the clinical aspects of cardiology.” Levine explained, “As I interpret it, the re-organization of its Council on Clinical Cardiology is an attempt to rectify this over-emphasis.” Levine was right.

The AHA grew remarkably after the 1948 reorganization, and the clinical cardiologists were only one of many constituencies in the organization. Lewis January told the CCC executive committee in 1963 that “problems... had arisen in connection with the Fellowship and Post-Graduate Course Programs initiated a year ago.” He was invited by a panel of the powerful AHA assembly to explain the council’s new programs. The CCC executive committee “agreed that the basic problem was to improve the understanding of Affiliates concerning the place of the Council on Clinical Cardiology as a Professional Society within the program of a Voluntary Health Agency.” Knowing the value of an influential advocate, the committee thanked January for his “enlightening and forceful report to the Assembly panel.” The new structure and agenda of the CC had been established and accepted. As the council received the AHA’s consistent support, its agenda continued to expand, reflecting its important role within the parent organization and its growing influence in American cardiology.

Relations between the AHA and the ACC continued to improve as the organizations began to view each other as potential partners rather than rivals. The acceptance of honorary fellowships in the college by AHA loyalists Paul White and Louis Katz in 1964 was symbolic of the new relation between the two groups. The same year, the CCC and ACC formed a joint study committee “to establish better cooperation in the development of future post-graduate education programs in cardiovascular disease.” Since then, the CCC and ACC have cooperated regularly on issues of mutual interest. Both groups have thrived during the past quarter century, and now many cardiologists belong to both the CCC and the ACC. The fascinating dynamics that led to the establishment of the council and the college have been the focus of this essay.
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