

To all *European Heart Journal* and CardioPulse readers.



Wishing you and your families all the best for a Festive Holiday Season

This second year of CardioPulse's existence is drawing to a close, and I thank all contributors and valuable readers for their efforts and attention that has made CardioPulse successful.

I wish all readers relaxed and cheerful days for the coming **Holiday** season, and a very **Happy New Year**.

Andros Tofield, Managing Editor CardioPulse

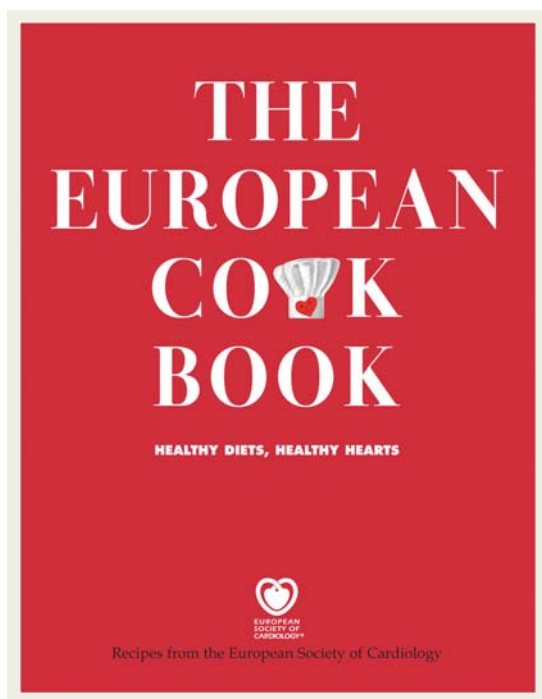
People's corner

CardioPulse announces a new Series: *The Personal Experiences of émigré cardiologists*

CardioPulse is starting a new series about the personal experiences of cardiologists who have moved to practice in another country/culture. Their views and feelings on confronting another language, another healthcare system, different lifestyle habits, how their families cope, and adjust to the new environment.

Should you wish to contribute please contact Dr Andros Tofield at docandros@bluewin.ch

A new tool to fight coronary artery disease: The European Cook Book



As well as having a hugely innovative medical research community, Europe has a culture of food second to none and should use it, together with all the tools of medicine, to fight cardiovascular disease... and have fun, Professor Roberto Ferrari, Past-President of the European Society of Cardiology tells Barry Shurlock, PhD

It is widely believed that if only people ate more healthily, the current pandemic of coronary artery disease would be much reduced. But how can this relatively simple message be got across? If proof were needed that there is still much to do, just take half-a-dozen cardiologists out to lunch and see what they choose from the menu! Someone who thinks he knows part of the answer is Prof. Roberto Ferrari, from Ferrara, in northern Italy, Past-President of the European Society of Cardiology (ESC). He believes that much dietary advice is far too solemn and the cardiovascular community needs to loosen up and make the business of healthy eating much more fun. He comments: 'Dieting is generally linked with unhappiness, and that is what we should avoid. If we can achieve the "happy diet" people will be much more willing to keep to it'.

Ferrari is passionate about the central role of food in human culture. He points out that the history of medicine shows that although evidence-based, scientific medicine ameliorates disease, major socioeconomic changes can have a much larger effect. In short, the culture of food in the twenty-first century should be regarded like fresh water was in the nineteenth century. And where better to reap benefits from that culture than Europe, which has a huge diversity of culinary traditions? To prove the

point, he and his wife, film director Claudia Florio Ferrari, have recently published with the ESC *The European Cook Book: Healthy Hearts, Healthy Diets*, which presents a panoramic view of European cooking, arranged in menu form, with each meal tailored for healthy eating.

The recipes were contributed by 44 of the 52 national cardiac societies of the ESC. Mouth-watering photographs by celebrity photographer Paolo Zappaterra and the skills of master chef Gabriele Romagnoli make this book a must-have for every kitchen bench and coffee table. More than that, every recipe has been subjected to the dietary analysis of Emeritus Professor Giovanni Cassani, formerly of the Department of Biochemistry, University of Milan, to ensure that it is fit for consumption by anyone with cardiovascular disease and/or diabetes.

Ferrari's crusade to persuade people to eat more healthily started with two cookery books he produced for the Italian Society of Cardiology, *Il Cuore nel Piatto (The Heart of the Dish)*, published in 2001, and *La Cucina del Cuore (Cooking for the Heart)* published 2 years ago (2008). He explains: 'Very often in the hospital we tell patients they should eat in a different way, but it is usually very difficult for them to know what we mean. Nurses used to give them a piece of paper with the information photocopied in black and white—it looked horrible and was very depressing for them. So I decided to produce some nice looking books—one for those with high cholesterol and another for those with diabetes. They were a huge success. So, when I became President of the ESC, with its 52 national societies, I had this idea to help to bring them together, and at the Barcelona meeting [in 2009] I asked them to submit some healthy menus to put in a book. I really thought that no-one would do it, but we got 44 replies. These have all gone into the book, though we had to modify some of them as they were really not that healthy!'.

Particularly useful for those who take their diet seriously is a 24-page table of nutritional values for a vast range of foodstuffs, which was specifically compiled for the book by hospital nutritionist Isabelle Zucchi from Ferrara, who also calculated the basic nutritional information given with each recipe. Did you know, for example, that a 100 g portion of squid delivers 81 kcal, has 1.7 g total fat (35% polyunsaturated, 12% monounsaturated, 24% saturates), contains a whopping 225 mg of cholesterol and 1.2 g of carbohydrates, and is a source of vitamins B6, B12, and E? The book also contains a useful patient-oriented introduction to cardiovascular disease and the essentials of dietetics, and a four-page table lists foods with high and low values of the glycaemic index.

As the new project gained momentum, the home of Ferrari in Ferrara was transformed into the sort of production set that his wife is used to. She directed the operation and the cast played their parts. Once the basic recipe had the green light from Prof. Cassani, it passed to Gabriele Romagnoli, who took time out of his restaurant *Quel Fantastico Giovedì (What a Fantastic*

Thursday), which is a gourmet destination in the city of Ferrara. He cooked each dish and made it ready for the camera of Paolo Zappaterra. Then, it was subjected to the discerning palates of the Ferrari family and crew.

Ferrari comments: 'It was all done in a "family way"—we all decided what to do together. For 2–3 months in the afternoon our kitchen was a hive of industry! I was there occasionally, and even cooked some of the simple recipes! Sometimes we cooked too much, so we had a lot to eat—and there is still a lot more in my freezer. It was a marvellous experience and I learnt a lot. The book taught me that we do not have a single European cuisine, but food is the identity of each country, each region, and even each person. There are two main cultures, the southern European—a legacy of the Romans and the Greeks—which is a cuisine based on wine, fruit and vegetables and olive oil, and a Nordic-Viking culture based on beer, butter and meat. And the fusion of the two cultures has produced the sandwich [said to have been invented by the gambling Englishman, the Earl of Sandwich]. Of course, European cuisine is not static and there is a continual fusion of lots of identities to produce new ones'.

The whole exercise has been conducted with the panache that one would expect of the former President of the ESC, who launched the book at the annual meeting held in Stockholm earlier this year [2010]. The beautifully printed volume has already started to make profits, all of which will be contributed to the European Heart for Children (EHC), the foundation created by Claudia Florio Ferrari to improve the treatment of congenital heart disease in disadvantaged parts of the world. He comments: 'The book was financed by the ESC and we had to sell 7000 copies to break even—and we have already done that. So now it's all profit, which will go to the EHC. We sold over 500 copies on site at Stockholm and we are hoping that Amazon.com will take the book and sell it for about 23 Euros. We have also made arrangements with several national societies to translate the book for their own use'.

The European Cook Book is an excellent starting point for an adventure. Recently, my wife and I had some friends to dinner and decided to give the book a field test. First, we served a dish contributed by the Georgian Society of Cardiology (who are planning to translate the book), namely Aubergines with Walnuts (see below).

The little rolls of thinly sliced aubergine looked very stylish on the plates—and were very tasty! Having eaten a dish with no cholesterol whatsoever, we moved on to Fish in Paprika Sauce, containing a modest 73 mg of cholesterol, a contribution from the Hungarian Society of Cardiology. We chose cod as the low-fat fish base and, as recommended, substituted yoghurt for the sour cream traditionally used in this dish.

After a successful surf on the Internet, we toyed with the idea of cooking the small Hungarian dumplings called galuskas, but lacked the 'colander with big holes' that is needed to squeeze the dough mix into the boiling salted water, so opted instead for pasta. Even so, our friends were hugely impressed by the new dimension we had given to our culinary endeavours. We were tempted to finish with the traditional English Summer Pudding (another zero cholesterol dish), contributed by the British Cardiovascular

Society, but opted instead for Bourdaloue Pear Tart, a suggestion from the French Society of Cardiology. After all, as the French playwright Henri de Bornier wrote in 1875: '*Tout homme a deux pays, le sien et puis la France*' ('Every man has two countries, his own and then France', a quote frequently misattributed to one of the Founding Fathers of the United States, Benjamin Franklin!) . . . and he might have added, Malta, Cyprus, Belarus, The Netherlands, Finland . . . and many others.

Dishes submitted by National Cardiology Societies



Aubergines with walnuts, Georgian Society of Cardiology



Forester's salad, Hungarian Society of Cardiology



Mar y Montana, Spanish Society of Cardiology



Orange Ice, Saudi Heart Association



Valahian papanasi with sour cherries, Romanian Society of Cardiology

Verdi is in tune when it comes to blood pressure control

What do a Verdi aria; a yoga mantra and a Latin prayer have in common? They all follow the same 10 second rhythm which matches the innate cardiovascular rhythm of the human body (Mayer waves). As a result, they all have the ability to reduce blood pressure and heart rate, Prof Peter Sleight, MD, tells Ingrid Torjesen



P. Sleight, centre, receiving honorary MD from Gdansk University 2001

In 1992 Peter Sleight went on a sabbatical for 8 months to Pavia in Italy to study circulatory rhythms with a Dr Luciano Bernardi, MD—a man he had never met. 'My wife was worried that I was working too hard, and she said isn't it time you had a sabbatical', he explains, 'So I decided to take one'. The two men got on

very well and published four papers about circulatory control in normal people in 8 months.

After Sleight returned to the John Radcliffe in Oxford, where he was a professor of cardiovascular medicine, he received a letter from Bernardi, a lecturer in medicine at Pavia University, asking whether he would be interested in returning to Italy on a semi-regular basis to continue the work. Sleight astounded his wife by telling her that he intended to retire 2 years early to do just this, and he has been going to Pavia twice a year ever since.

Music and the circulation

For the last 5 years, the two men have been looking specifically at the effects of music on the circulation. While other researchers have found that music can have a beneficial effect on patients with cardiovascular disease,¹ Sleight and (now) Prof. Bernardi have shown that certain music has a calming impact on the blood pressure and heart rate of young healthy individuals. What is more, while in other research, a person's personal taste in music has been shown to have a bearing on response, they have found that certain types of music have an impact on the blood pressure and heart rate in all individuals, regardless of their musical preferences.

In one study, six sample musical tracks, including reggae, classical, techno, and rap, plus a silent track were played randomly to 24 people—12 musicians and 12 non-musicians. Music with a faster tempo induced arousal and was associated with faster breathing, whereas listening to music with a slow or meditative tempo had a relaxing effect, slowing breathing and heart rate.

The specific effects of different types of fuller examples of classical music were then looked at. Again 24 people—12 musicians and 12 non-musicians—were played six different tracks in a random order: silence, ‘Nessun Dorma’ from Puccini’s *Turandot* (music with vocal), Beethoven’s 9th Symphony adagio (music with orchestral progressive crescendos), Bach cantata (more uniform emphasis), Giuseppe Verdi’s arias ‘Va pensiero’ from *Nabucco*, and ‘Libiam nei lieti calici’ from *La Traviata*, which both have the 10 s rhythmic phrases of Mayer waves. Heart rate, respiration, blood pressures, middle cerebral artery flow velocity, and skin vasomotion were recorded.²

The vocal and orchestral crescendos, characteristic of the Puccini and Beethoven pieces, induced moderate arousal with progressive skin vasoconstriction along with increases in blood pressure, heart rate, and respiratory amplitude proportional to the crescendo. In contrast, decrescendos, and the uniform emphasis of the Bach cantata induced relaxation, characterized by skin vasodilation and reduction in blood pressure. However, a particularly profound effect was observed when a Verdi aria was listened to. Phrases by Verdi at 10 s periods entrained the cardiovascular autonomic variables.



Don Carlo Opera, and credit The Royal Opera House, London, and photographer Catherine Ashmore

The effect of Verdi arias

The reason for this is linked to the way that blood pressure is controlled. There is a special sensing mechanism in the arteries in the neck to control the pressure of blood entering the brain, and this sends extremely accurate information about the pulse, blood pressure, and variations in the pulse to the brain. When blood pressure is high, the brain sends out two signals to control it. One signal goes down the vagus nerve to the heart and its main function is to alter the heart rate. This response is very fast, it happens within one beat; the result being that if blood pressure rises, the heart beat will be slowed by the next beat. The other mechanism—the

sympathetic vascular response—is much slower; if blood pressure is high, it takes 2–3 s before arterial vasodilation is achieved.

Sleight says: ‘You can never get perfect blood pressure control with such a mechanism, because they obviously interfere with each other’. As a result, rather than being steady, blood pressure humps up and down with a rhythm of six cycles per minute. These 10 s waves are known as the Mayer waves of blood pressure, they result from this imperfect baroflex control caused by the interaction between a fast (vagal) response in heart rate and a slow (sympathetic) vascular response.

Some music, including several famous operatic arias, particularly those by Giuseppe Verdi, contains phrases close to six cycles per minute. For example, ‘Va pensiero’ from the slaves’ chorus in *Nabucco*, which is used in the British Airways television advertisements and the drinking song ‘Libiam nei lieti calici’ from Verdi’s *La Traviata*.

‘These operatic arias use the same exact phraseology, the same rhythm, which is remarkable. I don’t know how Verdi got on to it’, Sleight explains. ‘If you listen to a Verdi aria with a 10 sec rhythm, it coincides with the normal fluctuation in blood pressure increases, and exaggerates the swings up and down in blood pressure; this stimulates the vagus nerve to slow your heart rate down. If you play Bach it doesn’t coincide with this rhythm; Bach Cantatas don’t have these 10 sec phrases’. He emphasizes: ‘When you are listening to a Verdi aria and you have a tremendous crescendo at the end, your circulation is more relaxed after that finish than after 20 minutes of resting, lying in bed, beforehand. It looks as if this arousal and the 10 sec entrainment have a really profound effect in lowering your blood pressure and heart rate temporarily’.



Don Carlo Opera, credit The Royal Opera House, London and photographer Catherine Ashmore

Yoga and prayer

Yoga mantras, which are also able to slow down the pace of a person’s breathing, also follow a 10 s rhythm. ‘This had been discovered empirically by the monks’, Sleight adds, speculating that the induction of slow breathing or increased vagal tone could induce calm and more ‘receptiveness’ in the subject.

Interestingly, the Ave Maria prayer also follows this 10 s rhythm when said in Latin. However, the rhythm is different if the prayer is said in Italian or English.

‘This may be why some people objected to the changes in the liturgy,’ he speculates. ‘Some priests thought they would be

trendy and instead of doing it in Latin they would do it in the local language—and a lot of the parishioners didn't like it. They didn't feel as good with it; maybe this is one of the reasons?'

Clinical applications

Music is already used in medicine. It has been found that people with an injury or disease of the brain, or other disability, perform better if music is played. Music is also frequently played in coronary care units and in operating theatres because it is believed that it has a beneficial effect.

So, could there be clinical applications for the effect seen on the blood pressure and heart rate of people listening to Verdi arias? Sleight points out that there is already a machine—RESPeRATE produced by InterCure—that produces a tone to which the patient tries to match the rhythm of their breathing. The tone gradually slows to reduce breathing to <10 bpm (an effect similar to yoga breathing

exercises) and this reduces blood pressure.³ He believes that there is potential for other clinical applications that build on the 10 s rhythm of Mayer waves which is seen in music such as the Verdi arias to modulate blood pressure.

'Music is unique to humans and is extremely old in all cultures. Maybe one of the reasons for this is that it hooks up with this ingrained rhythm we have for control of blood pressure and heart rate', he concludes.

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Sustained benefits of a health project for middle-aged football supporters, at Glasgow Celtic and Glasgow Rangers Football Clubs

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Introduction

Middle-aged men in the West of Scotland are at high risk of cardiovascular and other diseases. The average life expectancy in parts of Glasgow for men is 64 years, >10 years fewer than affluent parts of England.¹ It is well known that men from this age group are difficult to attract to health programmes, and rarely comply with and continue health-modifying behaviour.^{2,3} At a meeting between the Royal College of Physicians and Surgeons of Glasgow (RCPSG), and Celtic and Rangers Football Clubs, it was agreed that a pilot study would be undertaken to examine whether this most difficult social group could be addressed in a health programme based at the main Glasgow football clubs. The hypothesis was that the life-long devotion and involvement with the individual's club could be harnessed to effect the real change in lifestyle and health choices.

The fundamentals of the programme were to develop and to sustain change in the basics of health—diet and exercise. The programme would be based at Ibrox Stadium for Rangers sup-

porters and at Celtic Park for Celtic followers. Obesity, lack of exercise, and poor diet were identified as principal targets for intervention.



Glasgow Rangers

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Glasgow Celtics

Methods

Men aged 40–60 were invited using the Rangers and Celtic season ticket holders' databases. They were requested to provide their height, weight, general level of fitness, and approximate level of general health. They were graded according to body mass index (BMI), and those with the greatest BMI were selected first. Interestingly, almost all men underestimated their true weight, and overestimated their height. The only exclusions were an inability to perform exercise, and overt cardiovascular or other disease that would preclude participation.

Twenty men were invited to each club for the first cycle of the programme. There were two early withdrawals prior to the initial assessment, and these places were readily filled by others.

Principal measures

The principal endpoint set for the programme was: sustained improvement in body weight. Changes in blood pressure and cholesterol were also measured. It was originally planned to include measures of fitness using the Bruce exercise protocol, but in practice this was difficult to standardize on a large scale inside a football stadium, and so was dropped. Indeed, carrying out clinical research at a football ground did place challenges on logistics, but simple measures were determined. Random blood glucose was also measured. There were five men with type II diabetes. Baseline control was reasonable, and diabetic control was not an endpoint.

The exercise programme was designed for each individual participant. A safe zone of heart rate for the exercise programme was determined using the formula:

60–80% of maximum predicted heart rate.

Maximum heart rate = $220 - \text{age}$.

Polar heart rate monitors were issued (minimum chest strap size, XXL) and the safe zone of aerobic exercise determined for each man. The participants were instructed to exercise for 20 min at the appropriate heart rate if they could sustain this, three or four times per week. Each Friday afternoon for 10 weeks, the Celtic participants would attend Celtic Stadium, and the Rangers participants would meet at Ibrox stadium for a 2 h session. The first hour consisted of a health discussion. The subjects covered cardiovascular health, alcohol, obesity, dental health, diabetes, urological and prostatic disease, stress management, and diet. The second hour of the programme had a rotation between 20 min pitch side exercise; 20 min

cardiovascular workout using treadmills and other aerobic equipment, and 20 min dietary advice and discussion.

The exercise programmes were run by the professional coaching staff at Rangers and Celtic. The health lectures were delivered by physicians from Glasgow Hospitals. Dietary advice was provided by research dietitians and nurses. Administrative matters and data collection were coordinated by RCPSCG.

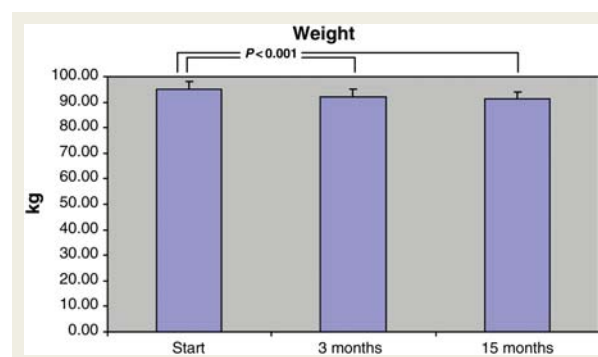
The dietary adjustments were based on adoption of a Mediterranean-style diet, with less red meat, dairy products, and moderation of alcohol. The emphasis was placed on reduction in saturated fat and salt, together with calorie restriction where required. The exercise programme was easy to adhere to, and the participants quickly understood the implementation of heart rate monitors, with exercise carried out in the safe zone of 60–80% of maximum predicted heart rate.

All men gave informed consent and were provided with their own baseline data, together with the results at the end of the 10 week programme. Any health issues, for example, undetected hypertension, were explained to the individual and a written summary prepared for their own general practitioner. The project was approved by an independent research ethics committee set up by the Royal College.

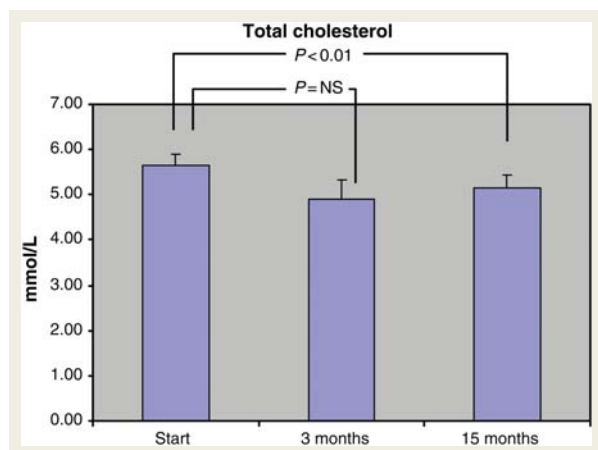
Results

Over the first 10 weeks of the programme, there were significant improvements in measures of cardiovascular health. Mean body weight fell by 2.73 kg (4% reduction, $P < 0.001$, 95% CI 1.54–3.92). There was an 8% fall in cholesterol, from 5.66 to 4.91 mmol/L (95% CI 0.28–0.86, $P < 0.001$). Systolic blood pressure fell slightly from 136.6 to 134.1 mmHg ($P = \text{NS}$) and diastolic blood pressure likewise was unchanged (1 mmHg fall, $P = \text{NS}$). These benefits were achieved with lifestyle change, exercise, and weight loss. No pharmacological agents were employed.

The pilot group of 40 men attended for review 15 months after cessation of their programme. Data from 36 of the original 40 men were available for analysis, apart from some cholesterol samples which were damaged in transit. Crucially, the weight loss had been maintained over 1 year, even though the attendance at the football club programme had finished. In fact, mean weight fell a further 1.05 kg (95% CI -0.89 to 2.99 kg, NS) during the year following the pilot study.



Cholesterol fell by 0.49 mmol/L (95% CI -0.18 to -0.8 , $P = 0.01$) over the 15 months. Systolic and diastolic blood pressure levels were not significantly different over the duration of the programme or follow-up.



Exercise capacity was not formally measured. But at the start of the programme only six men could jog around the perimeter of the pitch without stopping, a distance of ~350 m. Many walked the whole way. After 10 weeks' training, all the men easily managed the 350 m run, some for many laps.

Discussion

Diet and exercise programmes among middle-aged men usually fail. Middle-aged men in the West of Scotland and indeed elsewhere are notorious for ignoring their own health, and the challenge set was to examine whether real change could be made and sustained. This pilot study recruited 40 men with a passion for their football team. This was intentional bias, to try to ensure that subjects attended the course in full. There was 100% attendance during the health programme, a finding astonishing and unmatched among other health programmes for middle-aged men. The participants ranged from manual workers and office workers to a company director. They all had the same common feature—a passion for their club.

The principal goal of the health programme was to change lifestyle and healthy behaviour for the participants and their families. The 100% attendance and the unanimous verdict by every participant, that their involvement in the health programme was one of the most rewarding experiences of their lives, underpinned the value of the project.

The key factor in the whole study was: would these benefits be sustained over time, after the men finished the course. In fact, average weight and total cholesterol fell slightly further, with continued diet and exercise over 12 months in an unsupervised capacity. Some of the men had grouped themselves together in small numbers, to provide support groups for their own exercise programmes. Others, encouraged exercise programmes at the

workplace, a change in behaviour unimaginable before participation in the programme.

Involvement of Celtic and Rangers Football Clubs

It seems absolutely clear that hosting the health programmes at the major football clubs was the key to success. Participants were operating within an environment they adored, surrounded by professional coaches, together with the advocacy of current and former players. A simpler, leaner programme is now being developed and is planned to be extended to all 12 Scottish Premier League football clubs, to train the coaching staff in the delivery of health education and exercise programmes to football fans.

Conclusions

A health programme devised at improving the health of overweight sedentary middle-aged male football supporters was devised in Glasgow involving the Royal College, and Celtic and Rangers Football Clubs. The attendance was 100% and the improvements were significant and sustained. The authors believe that harnessing an individual's love for their chosen sport as an avid supporter can be channelled into sufficient devotion to an exercise and lifestyle programme, so that meaningful results and benefits are obtained in the long term. Such a programme could be undertaken at many venues, and many sports.

Acknowledgements

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Conflict of interest: none declared.

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Personal experiences of émigré cardiologist: Kenneth Dickstein MD, PhD, FESC

A tale of enchantment

Philadelphia born Kenneth Dickstein first fell in love with Europe as a child and has since carved a successful career as a research and clinical cardiologist in Norway. Helen Jaques finds out about his practice and why he enjoys life in Scandinavia



It all started at age 12. Kenneth Dickstein's father had travelled extensively in Europe as an air force surgeon in the Second World War and took his young family on a long trip around the continent. Kenneth in particular was deeply affected by the lifestyle and culture he saw. He became infatuated with Europe, first with the UK and later with Norway, where he is now the professor of medicine at the University of Bergen and Stavanger University Hospital. 'I've often tried to think about what it was that happened on that trip when I was 12', says Dickstein. 'I somehow felt at home in Europe, especially with the history, the pace, and the style in Britain'.

After completing his undergraduate studies at the University of Pennsylvania, Dickstein went to study medicine at the University of London and the Royal College of Surgeons in Dublin. By the time Dickstein graduated, he had become, in his own words, 'a serious anglophile'.

But another country had already begun competing for his affections. During medical school, he had met several Norwegians and had been on trips with them to their home country, where he was struck by the untamed beauty of Norway. He was also intrigued by the efficiently delivered socialized health system in Norway.

Healthcare home and abroad

After completing medical school, Dickstein left the UK and made the move to Norway. 'I tackled the language barrier head on and studied Norwegian at the University of Oslo, then took a job in the far north of Norway, where few patients spoke English', he says. 'My accent is a bit funny but my grammar is great'.

Later, he returned to the USA for 2 years to work as a research Fellow at Harvard Medical School's Brigham and Women's Hospital in Boston. Although this experience gave him a 'tantalizing' taste of competitive clinical research, it also confirmed that practice in the USA can be complex. 'The healthcare system in the USA involves financial and legal concerns shared by both the doctor and the patient that can cast a cloud over practice and research', he says.

And, to a degree, it was the 'smooth, well functioning, socialized system' that drew him back to Norway. In the early 1990s, Kenneth returned to the country to complete a PhD in exercise physiology at the University of Bergen. During this time, he fell for a South African who had moved to Norway in the early days of the North Sea oil adventure. They have two sons aged 21 and 18 years.

Clinical practice

Professor Dickstein now runs the 24-bed coronary/intensive care unit at Stavanger University Hospital, where his clinical practice includes teaching medical students. Teaching is 'a passion and a privilege', he emphasizes. He is a coordinator for the medical student teaching programme at the hospital, where he has responsibility for 80 medical students and 31 academic positions.

Dickstein considers himself an echocardiographer, but he works very closely with interventionalists. He has become especially interested in devices for heart failure, particularly cardiac resynchronization therapy. 'The atmosphere at the cardiology department is good and we try to encourage and support each other's research initiatives', he says.

Clinical research

In addition to his clinical responsibilities, Dickstein conducts clinical research in heart failure. During his career, he has been involved in many large multicentre trials, not least, as a principal investigator of the influential Optimal Therapy in Myocardial Infarction with the Angiotensin II Antagonist Losartan (OPTIMAAL) study. This trial, which took place in six western European countries, had a neutral result and confirmed Albert Einstein's statement: 'In theory, theory and practice are the same. But in practice, they are not'.

'Conducting clinical trials in Europe has advantages,' says Dickstein. 'In Europe there is a culture of cooperation between countries. Patients still trust doctors and participation in a clinical trial is seen as an opportunity to improve their care'. Furthermore,

'the infrastructure functions smoothly in Scandinavia. Discontinuation rates are low and patients are rarely lost to follow-up'.

European Society of Cardiology

On top of his clinical and research responsibilities, Dickstein is actively involved with the European Society of Cardiology (ESC). He previously held the position of president of the Heart Failure Association and is currently on the board of the ESC. Notably, he was Chairman of the task force for the 2008 ESC guidelines on heart failure as well as the 2010 device update in heart failure, presented at the ESC annual congress in Stockholm.

'The ESC provides a broad platform for academic cardiologists to thrive and establish a multinational network within their field of expertise', he says. 'The associations and working groups offer superb opportunities and the Heart House in Nice, France, is a very sophisticated organisation with staff dedicated to detail. Certainly my involvement in the ESC opened doors and shaped my career'.

He cites being an American in Norway as quite advantageous when dealing with ESC matters. 'Nobody dislikes Norwegians', he points out. Having an easily understood accent means Dickstein is able to diplomatically summarize the discussions at international meetings.

Lifestyle

It's not just the career opportunities in Scandinavia that attracted Dickstein. 'The lifestyle in Norway is also appealing'. During the long dark and cold winters, he focuses on his work, but takes advantage of July when the country slows down and everyone takes time off to enjoy the short summer.

In particular, Kenneth is a keen fisherman and never leaves the country during the trout and salmon season. The family has a country home in a valley surrounded by high mountains and a salmon river only 1 minute from the house. 'There is a rich quality of life in Norway and a favourable work-life balance. Free time is protected passionately', he says. 'When my American friends come to visit, they are envious'.

Advice

So what advice would Dickstein give to a young American who was considering making the same leap across the pond? 'If you're moving to another country, you have to really prepare yourself well, especially in medicine', he says. 'And test the waters before

you jump in. It's less of a culture shock to move within Europe'. Of course, family considerations are essential. 'I established my family after I made the move to Norway', he points out.



Also make sure you consider all the various aspects of the country you are heading for and are going there for the right reasons. 'If you move somewhere it has to be because you're attracted to the place, not because you're trying to escape something. There's got to be a real interest in the culture', he says. 'It can't be a place you go to because you don't like your current situation. That's not what I did'. One should also take the language seriously. 'You can't really enter the culture if you're not fluent', he points out.

Dickstein certainly feels that he made the right decision. 'I can't think of any regrets', he says. 'I didn't feel like I was sacrificing anything when I left the USA. I was attracted to Europe and I just did what I had to do to make it happen. But in the end, it's fate. As my father told me, in life doors open and doors close. Recognise and seize the opportunities'.

Helen Jaques, a British freelance medical writer and editor.

People's corner

The People's Corner Box is about cardiologists: promotions, new positions, prizes won, awards given, retirements and obituaries. Please submit news of yourself or of a colleague (maximum 400 words) to Dr Andros Tofield at docandros@bluewin.ch