

# Rhode Island Chapter of the American College of Cardiology

"THE MISSION OF THE RHODE ISLAND CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY IS TO BE AN ADVOCATE FOR ACCESSIBLE, HIGHEST QUALITY, COST EFFECTIVE CARDIOVASCULAR CARE FOR THE PEOPLE OF RHODE ISLAND AND TO ACTIVELY SUPPORT CARDIOLOGISTS IN THEIR EFFORTS TO ACHIEVE THESE GOALS."

Vol. 2 no. 1

Winter 2000

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Office of the A.C.C. Governor for RI  
2 Dudley Street, Suite 360  
Providence, RI 02905  
Phone: (401) 444-3336  
Fax: (401) 444-3327  
e-mail: Fchristian@Lifespan.org

## First Annual Meeting of the Rhode Island Chapter of the ACC

Frederic V. Christian,  
MD FACC, RIACC  
Governor, presents  
National ACC  
President-elect  
George A. Beller, MD  
FACC with a plaque  
expressing the  
Chapter's gratitude for  
delivering the keynote  
address at the RIACC  
First Annual Meeting.



On the evening of October 13, 1999, the Rhode Island Chapter of the American College of Cardiology convened its first annual meeting at Metacomet Country Club in East Providence, Rhode Island. The meeting was an unprecedented event, with representation from cardiologists and fellows of almost every cardiovascular practice in the state.

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# The President's Address at the First Annual Meeting

In March, 1998, when assumed the ACC governorship for Rhode Island, it quickly became clear to me that the ACC members who were in the best position to be an advocate for cardiologists and their patients came from states with active college chapters. These chapter leaders were well informed, articulate and able to participate in dialogue on issues both local and national. The absence of a local chapter clearly placed us at risk of being under-represented on all issues which effect our ability to practice as cardiologists and to be the best advocates for our patients.

Hardly a day goes by without a major health headline:

- United Health mandating hospital-less program
- Fiscal insolvency of Harvard-Pilgrim Health
- Lifespan's looming merger with Care New England and its fiduciary and charitable responsibilities to the community
- South coast hospital's decision not to participate in United Health Medicare Complete
- Blue Cross/Blue Shield's courtship for a fiscally sound partner to alleviate its financial woes

While the list goes on, it is only a continued reminder of our need as cardiologists to be informed, proactive advocates rather than passive and reactionary.

A chapter steering committee was thus formed and a poll of ACC members in Rhode Island demon-

strated enthusiastic support for chapter formation. The Steering Committee then drafted bylaws and an application was made for a Rhode Island chapter which was officially approved just 7 months ago on March 10, 1999 by the ACC Chapter Relations Committee.

Most of our first year goals and objectives as submitted have been completed or are well in progress and include:

1. Appointment of a secretary-treasurer and area councilors with staggered years of office. Half will serve 3 years and half will serve 2 years with an election in 2001. At large councilors will also serve 2 years.
2. The chapter is proceeding with the legal initiatives required to form a 501C6 corporation.
3. Standing committees have been appointed and include: State Government Relations Committee, Third Party and Quality of Patient Care Committee Annual Meeting and Education Committee and Communication and Membership Committee.
4. Quarterly newsletter. The first issue was distributed in the summer and the fall newsletter will be distributed in November.
5. Develop a liaison program with and make application for repre-

sentation on the Rhode Island Medical Society Council.

6. Conduct the chapter's first Annual Meeting.

The Steering Committee gave the chapter mission statement considerable thought and discussion and it is as stated: "To be an advocate for accessible, highest quality, cost effective cardiovascular care for the people of Rhode Island and to actively support cardiologists in their efforts to achieve these goals." For our chapter to be meaningful and successful will require four essential qualities:

leadership, organization, communication and participation.

Most of our first year goals and objectives as submitted have been completed or are well in progress

Leadership. As far as leadership is concerned, the Executive Council has a broad base of representation which recognizes the contribution of both community and academic medical center cardiologists, both adult and pediatric, as well as male and female. I have had enthusiastic and committed support at all our Council meetings which have been monthly except for July and September. The size of our state and the ease of access has served to foster our high attendance at Council meetings.

Our organization has taken shape quickly and we will eventually have a part time executive director whose responsibilities would be defined by the needs of the organization as we move forward.

**As we move forward, your participation as a council or committee member will be essential in sustaining the life and mission of our chapter**

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Communication. Beyond word-of-mouth, which can be quite effective in our state, the Communication Committee, chaired by Bob Schwengel, will continue to publish a quarterly newsletter and is actively building a chapter website with members John Murphy and Joe Spinale and I will soon add a broadcast fax which will allow a more timely communication and response to membership.

Participation. To date, I have had solid support from our council and committee members. As we move forward, your participation as a council or committee member will be essential in sustaining the life and mission of our chapter.

Two recent indices of your support and participation are: 1) chapter dues which are entirely voluntary. 65 out of 86 eligible fellows have submitted their dues for a 76 % response. 2) in a recent ballot for governor-elect for the term 2001-

2004, 71% of eligible fellows responded. This compares to a national average of approximately 50%.

Our chapter has a seat on the local Medicare Advisory Committee. Working through our Third Party Relations and Quality of Care Committee, with Alan Katz

as chairperson, we were able to secure expanded coverage for transthoracic echocardiography. It will be the mission of this committee to establish a dialogue with third party payers on reimbursement and patient access to high quality care. One mission of this dialogue will be to educate insurers. This process will be facilitated by submission to them of updated practice guidelines as is generally promulgated by the ACC and AMA.

State Government Relations Committee, chaired by Pat Brannon, will be the political voice of our chapter. Pat will be a member of the Public Laws Committee of the Rhode Island Medical Society and I will represent the Chapter on the RIMS Council which is the governing and policy making body of RIMS.

I recently participated in the ACC fall legislative meeting which convened over 100 leaders in cardiology (key contacts) who brought the ACC message to Capitol Hill on

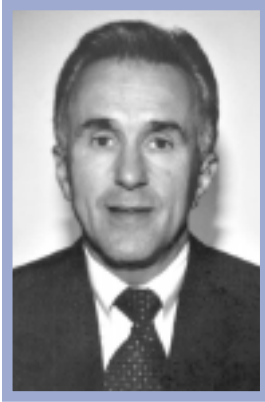
core issues such as patient choice and access, legislation. funding for the NIH and HCVA accountability for resource based practice issues, This type of participation by our local chapter membership at the State House and local government will be an important mission for Dr. Brannon's committee and will be placed in context by Dr. Beller and Mr. DeToy.

If you were in practice in 1900 in Providence, you probably would have made the acquaintance of Dr. Frank Fulton. Dr. Fulton eventually became Director of the Heart Station at the Rhode Island Hospital but came to Providence in 1900. Dr. Fulton trained at Johns Hopkins and came under the influence of celebrated medical figures, especially Willam Osler. Quoting from Dr. Samuel Levine's preface in a monograph entitled "The Story of the Heart Station at the Rhode Island Hospital," Dr. Levine comments that, "the remarkable thing is that he (Dr. Fulton) tried and succeeded in maintaining those high ideals that could more easily be retained in a teaching or university medical clinic although he settled in Providence where there was no medical school. During the first half century, Dr. Fulton, probably more so than any other single person, has been responsible for the high level of medical practice and what is equally important, the high level of medical integrity, that prevails in his community." It is my opinion that this

*continued on page 6*

# The President's Message: Legislative Participation

On September 29<sup>th</sup> and 30<sup>th</sup>, I had the opportunity to participate in the ACO Legislative Conference in Washington, DC. This conference is an opportunity for College leadership, including national officers, board members state governors and members of the government relations committee, to become actively involved in the legislative process.



The Government Relations Committee prepared an agenda for its key contacts to bring to Capitol Hill. This agenda included the three following issues.

**First:** Patient choice and access. For nearly 5 years, the College has worked with more than 130 patient advocacy and provider organizations that comprise the patient access coalition in support of 6 core patient protection principles. The College has endorsed the bipartisan consensus Managed Care Improvement Act of 1999 (HR 2723) cosponsored by Representatives Charles Norwood (R) and John Dingle (D). This bill recently passed on a vote of 275 to 151. This bill holds health plans accountable by allowing patients to sue their health plans in state and federal courts. The stage is now set

for a joint conference committee to hammer out a joint compromise. Our congressional delegation supports this legislation.

**Second:** Medical research funding. The college urged approval of the Senate appropriations committee proposal of \$1763 billion dollars for the NIH and \$2.1 billion for the NI-ILVI. The college also acknowledged Congress past support of increased funding for medical research. The council also urged enactment of the Clinical Research Enhancement Act of 1999 (HR 1978) which would expand clinical research programs. It would also provide grants to support careers in clinical research and clinical investigation.

**Third:** Medical practice expense. College members asked the congressional membership to step in and make certain that HCFA is complying with a mandate that its practice expense payment system reflect the actual cost of running a practice. College members gave actual examples of cardiologists taking their staff to hospitals which need to be cost accounted for the practice expense component.

Our chapters professional and patient advocacy must include a process similar to that described above where our membership visits elected and appointed representative to lobby for the principles and legislation which reflect our mission statement.

This process was the focus of the recent RI ACC Annual Chapter Meeting where we heard of the Virginia ACCs success in working with the Virginia Medical Society for successful passage of the fair business practice act.

The RI ACC Chapter's legislative committee and executive council will be developing an agenda for our chapter. If you are interested in participation, please contact Pat Brannon, MD, chairperson.

—*Frederic V. Christian, MD, FACC*

## Office of the ACC Governor for RI

**Frederic V. Christian, MD, FACC**

(401) 444-3336

Fax (401) 444-3327

*FChristian@lifespan.org*

**Alan Katz, MD, FACC**

Chairman, Third Party and Quality of Patient Care Committee

*AKatz@lifespan.org*

**Pat Brannon, MD, FACC**

Chairman, State Government Relations Committee

*PBrannon@lifespan.org*

**George McKendall, MD, FACC**

Chairman, Education Committee

*GMcKendall@lifespan.org*

**Robert Schwengel, MD, FACC**

Chairman, Communication and Membership Committee

*RSchwengel@HeartRI.com*

The evening was highlighted by a cocktail reception followed by a sit-down dinner, as well as, a keynote speech by the President-elect of the American College of Cardiology, George A. Beller, MD, FACC and informational comments by Steve R. DeToy, Director of Government and Public Affairs at the Rhode Island Medical Society (RIMS). Frederic V. Christian, MD, FACC, the ACC Governor for Rhode Island moderated the evening. The success of this event was also largely due to the efforts of George McKendell, MD, FACC, current chairman of the Chapter's Education Committee and newly elected, Governor-elect of the Rhode Island Chapter.

The event started with an informal cocktail reception, at which time, members and fellows socialized with colleagues, met the keynote speakers and members of the executive council and viewed displays from contributing pharmaceutical and device manufacturers. The program then moved to the main dining hall where Dr. Christian gave welcoming comments and went over the agenda for the evening. A very well received full-course dinner then preceded the official program.

Dr. Christian then called the meeting to order starting with his State of the Chapter Address. This address is reproduced in full in another section of this newsletter (see Rhode Island Chapter ACC President's Address at First Annual Meeting). The highlights of Dr. Christian's address emphasized the need for coalition and cooperation amongst all the cardiologists represented by

the chapter in dealing with quality of care issues, legislative agendas on both a state and national level and issues involving third party payers and reimbursement. Dr. Christian went on to outline the first year goals and objectives that have been accomplished by the chapter and executive council including the establishment of bylaws, obtaining corporate status, appointing committees, publishing the first quarterly newsletter as well as work on a new website, developing relationships

### Dr. Beller emphasized that like accomplishments are within reach of any state chapter given good organization and grass roots efforts

with other medical societies within the state and finally conducting this first annual meeting. Prior to introducing the keynote speakers, Dr. Christian then shared some historical anecdotes of cardiology in Rhode Island and then acknowledged those who contributed to the success of the night's festivities. He then proceeded to introduce the speakers.

George A. Beller, MD, FACC President-elect of the American College of Cardiology then delivered the keynote speech. Dr. Beller's comments revolved around the importance of coalition building of cardiologists and the state medical society. He described the success of the Virginia ACC Chapter in working

with the Virginia Medical Society to obtain passage of the Fair Business Practice Act (FBPA). This act establishes practice standards applicable to the claim reimbursement practices of health insurance carriers, health services, plans and HMOs in the state of Virginia. Dr. Beller emphasized that like accomplishments are within reach of any state chapter given good organization and grass roots efforts. He then congratulated and welcomed the Rhode Island Chapter to the American

College of Cardiology emphasizing the national organization's pleasure with our strong start.

Dr. Christian then introduced Steve R. DeToy who is

the Director of Government and Public Affairs for the Rhode Island Medical Society. Mr. DeToy outlined for the chapter the organization of the Rhode Island Medical Society and its recent successes in lobbying efforts with the state on key points of legislation. He stated that the Society was eager to work with the Rhode Island ACC Chapter cooperatively in joint efforts. Our chapter will have representation on both the Public Laws Committee as well as the Society's General Council.

The evening closed with Dr. Christian bestowing appreciation and gifts to our speakers and wishing the chapter well for another successful year.

—Robert H. Schwengel, MD, FACC

cardiologist has set a standard by which we continue measure ourselves and by which we continue to be successful.

Not only was Dr. Fulton the first cardiologist in Providence but also the first electrophysiologist. He probably didn't know he was an electrophysiologist as he took great interest in electrocardiography, heart rhythm analysis and coronary injections. I guess you might say he Was the first interventional cardiologist in the state as well.

He was fascinated with the discoveries of William Einhoven and Sir Thomas Lewis. As you know, Einhoven discovered the string galvanometer which was the predecessor of the modern electrocardiograph and Thomas Lewis was able to apply this to the study and diagnosis of heart disease. Dr. Fulton spent time in London studying with Dr. Lewis, who was at the time 31, while Dr. Fulton was 45.

Dr. Fulton was fascinated with the heart's pathological anatomy and conduction system. He was able to demonstrated the His-purkinge network by injection of India ink with a hypodermic syringe. To quote Dr. Fulton, "Finally, I purchased at the Providence Public Market, a dozen pig hearts and took them to the hospital to try out this procedure. Ultimately, I got several tolerably good injections—a couple of very good ones, much better than any Lewis had shown us. A photo-

graph of one of these hangs now in the heart station. It was a lot of fun to show these specimens to some of my friends in the pathological laboratory at the Peter Bent Brigham Hospital who had not yet seen the structure demonstrated.

"In the winter of the same year, while in service at the hospital, I discovered on ward A, two cases of auricular flutter which I analyzed and made the subject of a paper that I read at a meeting in Washington, DC in 1913. This was published in the *Archives of Internal Medicine* in October. These were the first cases noted and published in this country."

So Rhode Island has a long history of both pathological and clinical investigation and this is continued in the modern era with our Rhode Island ACC members being leaders in both the clinical trials for thrombolytic therapy and coronary intervention. To continue this tradition of education, the Rhode Island Chapter, beginning in November will cosponsor with the Brown Division of Cardiology. a monthly evening seminar to which all members will be invited. This session will offer CME credits and will be an opportunity to stay informed on

topics which effect our patient care, such as auricular fibrillation. I have asked Peter Tilkmeier and George McKendall to develop a curriculum for this program. There will be 8 or 9 sessions yearly.

Finally, I would like to thank all those who made this evening possible. This includes my co-chair George McKendall and our administrative staff. I would also like to thank my secretary, Helen Hunt, who has provided faithful and timely support of chapter activities. I would also like to thank our spouses who endure our long hours, recognizing that our professional

Rhode Island has a long history of both pathological and clinical investigation...with our Rhode Island ACC members being leaders in both the clinical trials for thrombolytic therapy and coronary intervention

and patient responsibilities are demanding of our time and participation.

I would also like to thank our gold level sponsors who are with us this evening and include representatives from the Guidant Corporation, Medtronic, Merck Pharmaceuticals, Pfizer Pharmaceuticals and St. Jude Medical Cardiac Rhythm Management Division.

*continued next page*

# RIACC Executive Council Meets with Director of DPH Patricia Nolan, MD at November Meeting

On Tuesday November 16, 1999, the Executive Council of the Rhode Island Chapter of the ACC met with Director Patricia Nolan, MD and representatives of the Rhode Island Department of Health (DPH). After general introductions and statements from Chapter President Frederick V. Christian, MD and Dr. Nolan expressing commitments to a long-term working relationship between the two organizations, a number of general and specific issues were discussed candidly.

Dr. Nolan spoke of the Cardiac Services Registry that has been collecting data on coronary angiography and angioplasty outcomes and complications within the state over the past few years. It was felt by the DPH that data regarding coronary angiography probably does not need

to continue to be gathered; whereas, coronary intervention data continues to be helpful. She felt that the ACC should have significant input as to the future collection of this data; perhaps even using the National ACC database to insure quality and competency.

The Executive Council and Dr. Nolan felt that we could significantly work together in the future to enhance cardiac services to citizens of the state of Rhode Island. One area the DPH is interested in pursuing is the prevention of heart disease through an increase in physical fitness education and the establishment of exercise or walking areas throughout the state, as well as, a complimentary nutritional component. The Executive Council expressed great interest in participat-

ing on the front line of the dissemination of valuable prevention information to the communities.

Other discussion revolved around issues of managed care including cost control and the maintenance of value in the market place, payer formulary issues, and the third party payer crisis in the state involving, but not limited to, Harvard Pilgrim of Rhode Island.

The Executive Council was overwhelmingly pleased with the outcome of this meeting and the face-to-face exchange of information with the Director and her department, and looks forward to further an intimate working relationship through this venue.

—Robert H. Schwengel, MD, FACC

## THE PRESIDENT'S ADDRESS *continued from page 6*

Prior to introducing Dr. Beller, I would like to tell you a story. A doctor and an HMO manager died and lined up at The pearly gates for admission to heaven. St. Peter asked them to identify themselves. The doctor stepped forward and said "I was a cardiologist and practiced for over 30 years taking care of patients and their families in a kind and compassionate manner. I came to the hospital at all hours to meet their needs and save their lives. I volunteered for hospital committees, was a member of R I Medical Soci-

ety and contributed to the success of the ACO chapter in Rhode Island. I also endured endless insurance and regulatory forms, delayed reimbursement from insurance companies, preauthorization for patient consultations and endless paperwork" Peter looked at this physician and said, "You may enter and be forever happy.

The second applicant stepped forward and said, "I was an HMO manager. I denied patient choice in access, I took the health out of managed health care, I systemati-

cally denied fair and timely reimbursement to providers, I plotted annual formulary changes to force physicians to rewrite prescriptions and placed patients at increased risk for side effects, I advocated drive by deliveries and same day mastectomies." St. Peter looked at the HMO manager and said, "You can come in too." But as the HMO manager walked by. St. Peter added, "You can stay 23 hours and after that you can go to hell."

—Frederic V. Christian, MD, FACC

# Clinical Briefs from *Journal Watch Cardiology*

*Journal Watch Cardiology has graciously allowed us to reproduce selected articles from their publication that we feel are of special interest. We hope this will be a regular feature, highlighting new and interesting research from the previous quarter.*

## Low-Molecular-Weight Heparin Improves Outcomes in Unstable Coronary Syndromes

Low-molecular-weight heparin (LMWH) offers longer-lasting, more predictable anticoagulation than unfractionated heparin, raising the question of whether it should become the anticoagulant of choice for patients with unstable angina or non-Q-wave myocardial infarction. A recent study and a meta-analysis addressed this question. The first report was a randomized, double-blind, international trial of enoxaparin, an LMWH preparation, which was compared to unfractionated heparin as acute therapy for 3910 patients with unstable ischemic syndromes.

At 8 days, the incidence of death, MI, or urgent revascularization was 12.4% for patients treated with LMWH versus 14.5% for those on unfractionated heparin ( $p < 0.05$ ). In the outpatient phase, the enoxaparin group continued to receive LMWH, while the unfractionated heparin group received placebo. At 43 days, similar differences in complication rates were maintained (17.3% vs. 19.7%). For LMWH, there was no increase in major hemorrhage incidence during the inpatient treatment phase, but the rate of this complication was twice as high during outpatient therapy (2.9% vs. 1.5%).

The meta-analysis combined data from the above study plus a second randomized trial with a similar study design. The meta-analysis found similar outcomes for enoxaparin, with a 20% reduction in odds for mortality versus unfractionated heparin at day 8. LMWH did not increase major hemorrhage but did increase minor hemorrhage (10% vs. 4% for unfractionated heparin).

**Comment:** These studies indicate that LMWH has the potential to reduce mortality and complication rates for patients with unstable ischemic coronary syndromes. A short initial course of a few days seems likely to improve outcomes without increasing major hemorrhage rates. The maker of enoxaparin supported both studies. —TH Lee

*Antman EM et al. Enoxaparin prevents death and cardiac ischemic events in unstable angina/non-Q-wave myocardial infarction: Results of the Thrombolysis In Myocardial Infarction (TIMI) 11B trial. Circulation 1999 Oct 12; 100:1593-601. Antman EM et al. Assessment of the treatment effect of enoxaparin for unstable angina/non-Q-wave myocardial infarction: TIMI 11B-ESSENCE meta-analysis. Circulation 1999 Oct 12; 100:1602-8.*

## Enhanced External Counterpulsation Reduces Angina

Enhanced external counterpulsation (EECP) is a new treatment for chronic angina. This multicenter, prospective, sham-controlled trial evaluated EECP's effectiveness in 139 outpatients with documented coronary artery disease, angina, and a positive exercise treadmill test. EECP was applied via cuffs on both legs for synchronized diastolic, blood pressure augmentation. The sham-treated (control) patients received a lower cuff pressure that did not alter blood pressure. Each patient underwent 35 one-hour treatment sessions over four to seven weeks, with no more than two treatments per day.

Evaluable data for time to at least 1mm ST-segment depression were available for 56 patients in each group, and exercise duration data were available for 57 active EECP patients and 58 sham-treated patients. For patients receiving active EECP, the time to at least 1mm ST-segment depression increased (337 vs. 379 seconds) and the frequency of angina improved; this group also showed a trend toward using less nitroglycerin. Exercise duration increased slightly for both groups.

Device-related adverse events, including leg and back pain and skin abrasion, were more common with active EECP.

**Comment:** This careful study suggests that EECP has a modest, beneficial effect on patients with chronic angina. The cost effectiveness, long-term benefit, effect on clinical events, and role of EECP relative to other treatments remain unknown. —HC Herrmann

*Arora RR et al. The Multicenter Study of Enhanced External Counterpulsation (MUST-EECP): Effect of EECP on exercise-induced myocardial ischemia and anginal episodes. J Am Coll Cardiol 1999 Jun; 33:1833-40.*

## Diuretics and the Risk for Arrhythmic Death Among Patients with LV Dysfunction

Several studies have suggested that diuretics increase the risk for arrhythmic death in hypertensive patients, presumably by altering electrolyte balance. This retrospective analysis of data from the Studies Of Left Ventricular Dysfunction (SOLVD) assessed the association between diuretic use and arrhythmic death in 6,797 patients with left ventricular dysfunction (LV ejection fraction, less than 0.36). Patients were assigned to the prevention or treatment group depending on the absence or presence of heart-failure symptoms (mean follow up, 40 months). For this analysis, patients were classified as receiving no diuretic, a potassium-sparing diuretic, a non-potassium-sparing diuretic, or both types of diuretics at baseline.

Patients who received a diuretic were more likely to have an arrhythmic death than those who did not receive a diuretic (3.1 vs. 1.7 arrhythmic deaths per 100 person-years). Although univariate analysis revealed an association between diuretic use and increased risk for arrhythmic death, only non-potassium-sparing diuretic use was independently associated with arrhythmic death after controlling for covariates. The use of a potassium sparing diuretic, alone or with a

non-potassium-sparing diuretic, was not independently associated with an increased risk for arrhythmic death.

**Comment:** This large retrospective study provides compelling evidence that non-potassium-sparing diuretics are associated with increased risk for arrhythmic death in heart-failure patients. The absence of an association between increased risk for arrhythmic death and the use of a potassium-sparing diuretic suggests that the mechanism of action may be potassium depletion. Despite the nonrandomized, retrospective study design, it seems prudent to include a potassium-sparing diuretic for heart-failure patients when diuretic therapy is required, particularly if the patient has normal renal function. —H Calkins

Cooper HA et al. *Diuretics and risk of arrhythmic death in patients with left ventricular dysfunction. Circulation* 1999 Sep 21; 100:13115.

### Benefits of Walking to Work

Although increased physical activity is often recommended for persons with hypertension, the importance of physical activity as a

risk factor for the development of hypertension has not been thoroughly explored.

For 10 years, investigators in Osaka, Japan, followed 6,017 normotensive, nondiabetic Japanese men; 626 members of the cohort developed hypertension.

In Japan, physicians routinely advise male patients to walk to work. In this population-based cohort, 39% regularly walked to work for a duration of 11 to 20 minutes, whereas 10% walked for more than 20 minutes.

After adjustment for age, blood glucose level, blood pressure, amount of leisure-time physical activity, body mass index, smoking status, and alcohol consumption, men who walked for more than 20 minutes to work had a markedly reduced risk for developing hypertension (relative risk, 0.71). Leisure-time physical activity was also independently associated with lower risk for developing hypertension (RR, 0.70 for those who exercised at least once a week). **Comment:** This well-organized, population-based study suggests that regular mild exercise, such as walking to work, may significantly protect men from developing hypertension.

The authors suggest that people who drive to work may benefit from regularly parking more than a 20-minute walk away from their workplace. —MS Lauer

Hayashi T et al. *Walking to work and the risk for hypertension in men: The Osaka Health Survey. Ann Intern Med* 1999 Jul 6; 131:21-6.

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A subscription to *Journal Watch Cardiology* (12 issues per year) is \$89 for physicians and \$59 for residents. To order call: 1-800-843-6356.

Massachusetts Medical Society  
860 Winter Street  
Waltham, MA 02451-1413

## RIACC Chapter Takes Seat on RIMS Council

The newest constituent member of the Rhode Island Medical Society Council is the Rhode Island Chapter of the American College of Cardiology. Fredric V. Christian, MD represented the chapter at its October 12<sup>th</sup> meeting

A medical specialty organization is eligible to apply for a seat on the RIMS Council if it meets all the following criteria: 1) a minimum membership of 25 Rhode Island physicians, at least 50% of whom must also be members of RIMS, 2) bonafide status in statewide organizations and 3) demonstrated activity and ability to communicate with its own members.

The RIMS Council, which is the supreme governing and policy making body of the Rhode Island Medical Society, now has a total of 44 members. It meets 6 times/year in the even numbered months. Most members of RIMS are represented on the council in multiple ways: by geography through their district and county medical societies by medical specialty through their specialty societies, and by the officers, delegates and counselors at large, all of whom are charged to represent the membership in general.

THE RHODE ISLAND CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY GRATEFULLY ACKNOWLEDGES FINANCIAL SUPPORT FOR THE 1999 FIRST ANNUAL MEETING FROM THE FOLLOWING CORPORATIONS:

GENENTECH, INC.

GUIDANT CORPORATION

MEDTRONIC, INC.

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# Local and National ACC News Briefs

## How can physicians fight back?

The College is poised to assist members in combating arbitrary down coding activities designed to slow or limit payments rightfully due physicians. Please contact RIACC Third Party and Quality of Patient Care Committee Chairman Alan Katz, MD FACC at e-mail, [Akatz@lifespan.org](mailto:Akatz@lifespan.org), or Jeff Gorke, ACC National Director of Practice Organization and Management, at e-mail, [jgorke@acc.org](mailto:jgorke@acc.org), or phone 800-435-9203, if you have concerns regarding arbitrary payment practices of payers in your community. Your issue might not be limited to your region!

## ACC Forum on the Future

On December 3, 1999, RIACC Governor Frederic V. Christian, MD FACC participated in the ACC Forum on the Future as a member of the Board of Governors. This was held in conjunction with the 50 Anniversary of the founding of the ACC. The purpose of this forum was to focus on ways to deliver quality cardiovascular care in the 21st century. Reports from five subcommittees were presented with a following brief discussion period. Participants were divided into breakout groups to discuss these reports more thoroughly and to offer further recommendations and comments. The topics included the history and present role of the ACC, changing

demographics, technological developments and expected developments in health care cost structures and their effect on the future delivery of cardiovascular care. The fifth paper discussed the role of the ACC in promoting and maintaining the delivery of quality cardiovascular care in the future. The final report will be published in the March 2000 issue of JACC and will be presented at ACC 2000 in Anaheim.

## ACC and State Government Affairs

Recognizing that members and chapters need to be involved on the local level, the ACC Government Relations committee has asked the Board of Governors (BOG) to assume responsibility for coordinating ACC interaction with state governments. To carry out this task the BOG will form a large committee consisting of representatives of every state and chapter. This committee will meet electronically with a special e-mail list server and in person annually at the ACC annual meeting. Patrick Brannon, MD FACC, Chairman, State Government Relations Committee will serve as the Rhode Island ACC Chapter representative.

## ACC Appoints New State Legislators Affairs Advocate

Enzo Pastore has been appointed as the Assistant director for State Legislative Affairs at

the ACC. The ACC recognizes the importance of a proactive stance in advancing state legislation that benefits ACC members and the patients in their care. Mr. Pastore will work with the chapter's Executive council and Legislative Affairs Committee to organize an agenda of bills in progress which we support, those which we oppose and also bills and proposals we would like to see introduced. Mr. Pastore was very active in Rhode Island in his recent work with the National Committee to Preserve Social Security and Medicare. Chairman, State Government Relations Committee will serve as the Rhode Island ACC Chapter representative.

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SUBMISSIONS, SUGGESTIONS OR COMMENTS REGARDING THE RIACC CHAPTER NEWSLETTER SHOULD BE E-MAILED TO ROBERT H. SCHWENDEL, MD FACC AT [RSCHWENDEL@HEARTRI.COM](mailto:RSCHWENDEL@HEARTRI.COM)

Office of the A.C.C. Governor for Rhode Island  
2 Dudley Street, Suite 360  
Providence, RI 02905