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Medical Staff
PROGRESS NOTES

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LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

Remembering C.D. Schaeffer — A Quiet Giant

by Pam Maurer, Public Affairs

When C.D. Schaeffer, MD, was just a boy in the 1930s, he and his father would load instruments onto the family farm's pickup truck and road trip around the community with friends.

"We would stop at all the hospital board members' homes and play a selection to conjure up support for the hospital," Dr. Schaeffer recalled in a 1999 interview. "We had a whole band—violins, trombones, and I played the coronet. Boy, we had good times."

This was only the beginning of Dr. Schaeffer's lifetime of support to the hospital. He later served on the medical staff for 50 years, and today, colleagues remember Dr. Schaeffer, who passed away at age 83 on December 7, as an educator, surgeon and most of all, devoted friend.

"C.D. taught me what it means to be a doctor, that a patient's needs and wishes always come first—but he also taught what it means to be a friend," says Charles J. Scagliotti, MD, a resident under Dr. Schaeffer's tutelage in the 1970s. "When my wife and I were newly married and in our first house, we were short on a few necessary items. Suddenly, just when the grass started to overgrow, C.D. drove up with a new lawnmower."

That was the spirit of the Schaeffer family, their legacy dating back to 1899 when cousin C.D. Schaeffer, MD, became a trustee and the first chief surgeon at Allentown Hospital. His partner was the younger C.D.'s "Pop," Robert Schaeffer, MD, endearingly known as "Dr. Bob" throughout the Lehigh Valley.

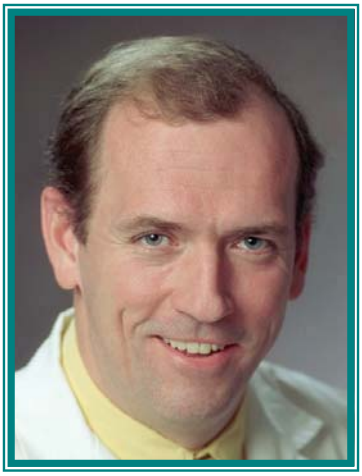
As the saying goes, "the apple doesn't fall far from the tree." The younger C.D. went on to become chief of surgery and thoracic surgery and medical staff president. "It was an understatement to say his patients loved him," Dr. Scagliotti says. "His office was often overflowing with cards and baked goods as gifts of respect and gratitude."

Dr. Schaeffer's patients inspired him to always take care to the next level. He was instrumental in developing a strong surgery residency program and was on the team that performed the first emergency heart surgery here. The patient was a woman who was stabbed in the chest. "The surgery was intense, but it's the chance we had to take," Dr. Schaeffer recalled in 1999. "And by God, we saved her life."

Bernadette Kratzer, RN, former operating room nurse, remembers Dr. Schaeffer as a "quiet giant." "He was an excellent surgeon and a good man," she says. "He was always whistling and singing Hello Dolly, and doing needlework for his friends and patients," a hobby that kept his surgical skills sharp.

You could say the hospital was his life. He even met his wife, Sallie, here, who was working in a pathologist's office. "I was Christmas caroling at his relatives' home one day and saw his photograph on the mantle," Sallie Schaeffer recalled in 1999. "I couldn't help but ask 'Who is that?' Little did I know…"

A marriage of love and partnership ensued. While Sallie and C.D.'s mother collaborated as members of the Allentown Hospital Auxiliary, C.D. worked diligently in the OR and the boardroom. "No one loved our hospital more than C.D. Schaeffer," Dr. Scagliotti says. "Without him, it would not be what it is today. He will be greatly missed."



From the President

Culture of Delight Redux: Life outside the plastic bubble

There's a theme that's worth returning to time and time again, and I'd like to bring us back to that theme. It's a theme that plays out all around us every day, and one that becomes like background noise. We don't often pay attention to it any more, it's that automatic and routine. The theme? The atmosphere of care that we develop while we go about our day to day work. It's a theme that has been discussed in the past, but still is just as important as it was a hundred years ago. Since it's central to our mission of care, it's worth a second look. Maybe a third, even.

Sometimes it's easy to externalize the provision of health care. By this I mean, acting as if what goes on in a patient's care has nothing to do with us. It's all them; that's the externalization. It's as if you went around in a plastic bubble, so that nothing you did had an effect on the environment of care or the people around you. People in a plastic bubble don't affect the quality of care because they are cut off, removed from everyone else, hermetically sealed. Thing is, I haven't seen anyone wearing a plastic bubble lately. No one does rounds as a disembodied voice. Everyone must be present to provide care. So they, by their presence, affect the environment around them.

Walk onto the floors some time and just observe what goes on. People around you notice you, and are affected by how you act. If you rush to the charts and angrily open them with a snap, how likely do you think others will be to come up to you to discuss Mrs. Stentson's med orders or tell you about how Mr. Johnson seems to be confused today? Or if you come onto the floor with a smile and nod to those around you, from the gentleman who buffs the floor to the nurses and nursing supervisors, and inquire how your patients are doing, what kind of response do you think you will get? You (and I address physicians here, but this is shared by everyone on the floor) affect those around you by your actions. Are you on the phone berating your office staff, giving your broker stock tips, telling your wife you'll be late again because of every one at that damn hospital? Would you like to work in an environment where next to you people are complaining or yelling or stamping their feet? Neither would I.

Ok, so let's move into the patient's room. Do you knock? When you visit a friend's house, do you knock? Should you? If the curtains are closed, do you inquire if Mrs. Smith is decent? No one feels comfortable talking to anyone while sitting on the bedpan. Clinical studies show that people have a 68% hearing loss when being interviewed naked. Do you notice?

When your patients are eating a meal, do you interrupt and push the tray to one side so that the food can achieve that tasty lukewarm heat we all like so much? Do you like to be interrupted when eating your lunch? Do you come to the bedside without introducing yourself, not telling the patient why you are there? Do you explain what you are about to do, or do you attack the patient with your chilly stethoscope which has been sitting outside in your car all night? Do you tell the patient what the plan for the day is and explain what is going on? Do you ignore the family members sitting at the end of the bed with inquisitive looks? And do you avoid talking to the nurses about what your plans are, what the patient has, and what prognosis might be?

I bet you do it all just fine. I'm sure you do all the things that Dr. Caccese urged us to do – sit with the patient, ask what their problem is, answer their questions, touch them reassuringly. But maybe the next time you do rounds, take a breath before you get onto the unit and think about your body language and interactions with others. How you act has a direct effect on care, and becomes an important part of your therapeutic efficacy. If you treat the nurses and staff with kindness, they might be more inclined to provide kindness to the patients. If you are caring and reassuring with the patients on rounds with your students and residents, they will model their behavior after yours. As the captain of the team, the team looks to you to understand how they should behave; help them find the right tone for the environment of care.

Continued on next page

Now, even if you aren't a doctor, don't feel you are off the hook. Loud conversations about how awful your boyfriend or girlfriend is don't positively affect the atmosphere of care. Walking around in a grumpy silence bothers everyone else. I've had the experience of talking with a patient and being interrupted by someone bustling in to check a blood pressure, check a temperature, or take blood. The person interrupting me did not acknowledge my presence in the room, and proceeded to attack the patients without asking if they could, explaining what they were doing, or reassuring the patient.

It's not rocket surgery or brain science. Treat others as you would be treated. Cast yourself into the role of the patient or family, and try to see the world through their eyes. Every interaction they have while in the hospital affects their perception of the care they receive. None of us does our work in a plastic bubble. We all participate in the environment of care. Ask yourself next time you go on shift, or start rounds, or begin your workday or night; are you part of the problem, or part of the solution? Are you going to bring your positive spirits to the floor to share with others, or carry your baggage to dump on everyone else?

It's your choice. Just remember – no plastic bubble has yet been devised which keeps your behavior away from everyone else. You are the environment of health care, and everyone is watching.

Alexander D. Rae-Grant, MD
Medical Staff President

Physician Recognition Dinner Awards

Nominations are still being accepted for the special awards which will be presented at the Physician Recognition Dinner to be held on **Saturday, May 1, 2004**, at the Holiday Inn Conference Center in Fogelsville. Plan to attend the event to celebrate with your colleagues and recognize those who will be celebrating 25 and 50 years of service on the hospital's medical staff. In addition to the years of service awards, there will be several new awards presented at this year's big event. These new awards will be presented to the individuals who best meet the criteria for each award. The awards and criteria include:

- **Community Service Award** - Given to the physician who best embodies the importance of participation in community activities in terms of service on boards, involvement in community groups, philanthropic interests, or other community activities over a period of years.
- **Team Builder Award** - Given to the physician who best embodies the ability to build a team of physicians, allied health professionals, or other health care workers and to nurture the cohesive actions of the team over a period of years.
- **Physician Research Award** - Given to the physician who has shown excellence in the pursuit of academic activities in clinical research, primarily in terms of peer reviewed publications.
- **Friend of the Medical Staff Award** - Given to the allied health professional, management professional, or other health care worker who over a period of years has shown exceptional ability in assisting physicians in improving the care of patients at Lehigh Valley Hospital and Health Network.

Nominations for these awards will be accepted until **Friday, February 6**. To submit a nomination, list the name of the award, the nominee's name, and your name, and send them to Janet M. Seifert, Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556 or send an email to janet.seifert@lvh.com.

Safety Pearl of the Month

DO NOT write additional physician orders once the order sheet has been sent to the Pharmacy. Orders are being written in columns and at the very bottom of the page where the Pharmacy and nurses have missed them since it appears that they are ADDED after the orders had been seen by the nurse and sent to the Pharmacy.

Mandatory Psychiatric Consults

As it has become standard practice with other medical specialists, in order to ensure optimal care, the Medical Executive Committee has determined that a mandatory psychiatric consult will be requested under two conditions: 1) patients being admitted to medical/surgical units of the hospital when they come from Allentown State Hospital, and 2) patients being transferred from the inpatient psychiatry units of the hospital to any of the medical/surgical beds. The timeline for responding to the consults will follow the existing guidelines for routine, urgent or emergency consults.

The reasons behind this decision are that patients coming from these settings are often complex to treat and are receiving highly specialized medication combinations. It has occurred several times that upon admission to a med/surg bed these patients are relatively clinically stable from their psychiatric illness, psychotropic medications are on hold, and within 2-3 days their psychiatric condition flares up severely and an emergency or stat psych consult is required. As you will agree, this complicates their medical and psychiatric management unnecessarily. This arrangement will further improve the collaboration and support of our colleagues by the consultation/liaison psychiatrists, in managing some of these difficult cases.

If you have any questions regarding this issue, please contact Michael W. Kaufmann, MD, Chair, Department of Psychiatry, at 484-884-6503.

Important SARS Update

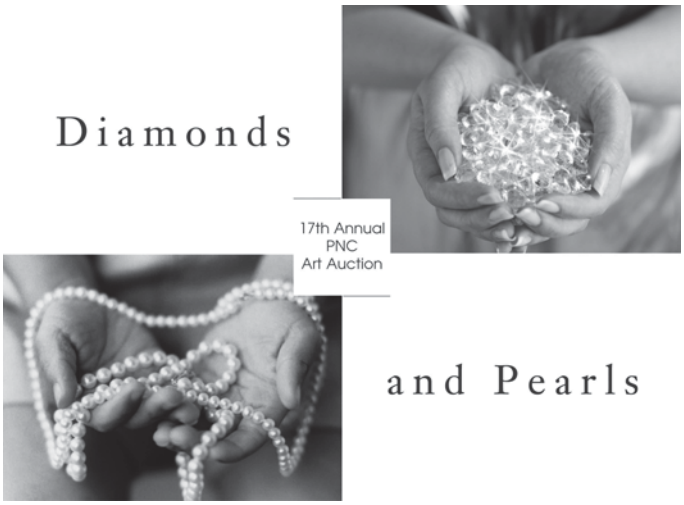
For your information, following is the Clinical Guidance on the Identification and Evaluation of Possible SARS-CoV Disease among Persons Presenting with Community-Acquired Illness. Please become familiar with them and share them with your staff. Respiratory etiquette MUST be practiced by all personnel, patients and visitors.

1) Do not come to work if you are sick with a respiratory infection.
2) Cover your mouth with hand and/or tissues when coughing or sneezing.
3) Assure masks, tissues, and waterless hand sanitizer are available at all outpatient registration areas.
4) Ask patients or visitors to cover mouth when coughing or sneezing and provide them with tissues. Masks can also be offered to patients who are unable to practice good respiratory etiquette.
5) Practice good hand hygiene. Encourage the use of waterless hand sanitizers.
6) Assure patients with respiratory symptoms have read the SARS screening signage.
7) Triage patients out of general waiting areas if they exhibit respiratory like symptoms.
8) Consider SARS in the list of differential diagnoses if the patient presents with pneumonia and meets the recommended screening criteria (travel, HCW, contact with pneumonia).
9) Err on the side of caution. It is always better to isolate if suspicion of SARS exists.
10) Early identification and isolation is the BEST PROTECTION!
11) Contact Infection Control at 610-402-0680 or via the page operator if a suspected case of SARS is identified.

If you have any questions regarding this issue, please contact Terry L. Burger, Manager, Infection Control, at 610-402-0680.

Coding Tip of the Month

Respiratory failure is the failure to exchange respiratory gases. Acute respiratory failure usually requires intensive care/treatment as well as intensive modalities such as mechanical ventilation. Chronic respiratory failure usually requires ongoing treatment such as oxygen or intensive respiratory therapy. The etiology of respiratory failure needs to be clearly documented in the medical record. Some of the most frequent causes are COPD, CHF, asthma, pneumonia, neuromuscular disease, and drug overdose. Specify the etiology of the respiratory failure, whether the patient had acute, chronic, or acute and chronic respiratory failure and if the respiratory failure occurred upon or after admission to the hospital.



Mark your calendars! The Professional Nurse Council Annual Art Auction will be held on Friday, April 2, in the Jaindl Family Pavilion. Collectable art, diamond and pearl jewelry and art glass will be presented at this year's event. A cocktail buffet reception will be held from 6 to 7:30 p.m., during which time guests can preview the items being auctioned. The Auction will begin at 7:30 p.m. Tickets for the event are $30.00 per person.

For tickets or information regarding the Art Auction, please contact Barbara Versage, Project Specialist, Center for Professional Excellence, at 610-402-1704.

Are You Doing All You Can to Eliminate Insulin Errors?

Recently, many new insulin products with very different action profiles, yet very similar nomenclatures, have been released on the market. Unfortunately, the similarities in insulin names have resulted in increased risk for insulin errors. Using correct names for available insulin products can help reduce the risk for improper insulin administration.

Currently, the hospital contracts with Novo Nordisk Pharmaceuticals as its main supplier for insulin products. This affects the insulins products that are available for use by staff nurses. For example, in one situation, a physician ordered "Humalog" sliding scale insulin over the phone and a patient received Humalog Mix 75/25 for the sliding scale. While "Humalog" is a term that is still used in daily lingo, the Novo product, "Novolog," is the available rapid-acting insulin analog and should be the term used in the hospital when a quick acting insulin is needed for quick glucose control. This is just one example of how using the correct insulin name could have helped to eliminate a medication error.

Laminated posters comparing the insulin names, types, proper timing, action profiles, compatibility have recently been posted in all inpatient medication areas in LVHHN to help guide quality patient care. These posters are available as a reference for all healthcare professionals responsible for ordering or administering insulin. Please take time to become familiar with this available resource. As a quick overview to help you to give clear insulin orders, here is a summary of the nomenclature of the available insulin preparations:

1. "**Novolog**" (rapid acting insulin analog)
2. "**Novolin R**" (regular)
3. "**Novolin N**" (NPH)
4. "**Novolin L**"(Lente)
5. "**Novolin 70/30**" (Mix of NPH and Regular)

(Note: the above are comparable insulins to the Lilly insulin preparations – Humalog; Humulin R, N, L and Humulin 70/30.)

In addition to the above, the following products are available:

- **"Humalog Mix 75/25"** – a mixed preparation of rapid acting insulin analog with an insulin lispro protomine suspension, manufactured by Eli Lilly. (**Note: In this case, the Lilly product is used to avoid error and confusion with the similar Novo Nordisk Pharmaceuticals product – i.e. the Novo mixed analog is titled Novolog Mix 70/30 and is too close a name to the "Novolin 70/30" (N/R) combination.)** If a patient uses Novolog Mix 70/30 at home, the Humalog Mix 75/25 would be an automatic therapeutic substitution.
- **"Lantus (Glargine)"Insulin** – this is a clear, long acting insulin designed to provide basal insulin coverage. It should be used in conjunction with either oral DM medications or a meal based insulin analog. **Note: Please be aware that NO INSULINS CAN BE MIXED IN THE SAME SYRINGE AS LANTUS. Also, please do not refer to Lantus as "L" as it may be confused with Lente.**

If you have any questions or comments regarding this issue, please contact the Clinical Pharmacy Department at 610-402-8884, or Joyce Najarian, Inpatient Diabetes Nurse Specialist, Helwig Diabetes Center, at 610-402-1731.

Palliative Care Initiative

Because of growing interest in palliative care initiatives, members of the LVHHN community have organized the Palliative Care Advisory Group (PCAG). The mission of this group is to promote the integration of palliative care practices for all patients served by the Lehigh Valley Hospital and Health Network (LVHHN).

Chaired by Gregory R. Harper, MD, PhD, and Daniel E. Ray, MD, the PCAG has identified several goals on which to focus. These goals include:

- To bring together medical professional and lay personnel interested in palliative medicine
- To provide a forum for educating members of the advisory group, and to identify educational opportunities for both professional and the public concerning palliative care practices
- To identify opportunities for the improvement and integration of palliative care practices in the care of all patients served by LVHHN
- To assist in the evaluation of palliative care initiatives within a defined patient population or across the network
- To provide a network of shared resources in palliative care
- To aid in securing financial support of projects by identifying grant opportunities

Anyone interested in participating in the PCAG, please contact Diane Biernacki at 610-402-8450.

Fast Fact of the Month

Title: Fast Fact and Concept #027: Dyspnea at End-of-Life

Author(s): Weissman, D.E.

Few problems cause as much distress for patients, families and the care team, as the management of dyspnea at end-of-life.

Assessment: Dyspnea at end-of-life may be present during the **Syndrome of Imminent Death (see Fast Fact #3)** or occur earlier in the disease trajectory. Looking for simple problems is always warranted: is the Oxygen turned on? is the tubing kinked? is there fluid overload from IV fluids or TPN? is dyspnea part of an acute anxiety episode, severe pain, constipation or urinary retention? is there a new pneumothorax or worsening pleural effusion? Understanding 1) where patients are at in the dying trajectory and 2) their identified goals of care, is essential to guide the extent of workup seeking reversible causes. If the patient is clearly dying, and the goals of care are comfort, then pulse oximetry, blood gas, EKG, CXR, etc., are not indicated.

Treatment-General Measures: Positioning (sitting up), increasing air movement via a fan or open window, and use of bedside relaxation techniques are all helpful; decrease or discontinue use of IV fluids.

Treatment w/ Opioids is the drug of choice for dyspnea. In the opioid naïve patient, low doses of oral (10-15 mg) or parenteral morphine (2-5 mg), will provide relief for most patients; higher doses will be needed for patients on chronic opioids (50% over baseline). When dyspnea is acute and severe, parenteral is the route of choice: 2-5 mg IV every 5-10 minutes until relief. In the inpatient setting, a continuous opioid infusion, with a PCA dose that patients, nurses or families can administer, will provide the timeliest relief. Nebulized morphine can be used, but its relative benefit compared to po/IV in controlled trials has not be proven.

Treatment w/Oxygen: Nasal cannula is better tolerated than a mask, especially in the terminal setting; Oxygen is not always helpful; a therapeutic trial, based on symptom relief, not pulse oximetry, is indicated. There is little reason to go beyond 4-6 L/min of oxygen via nasal cannula in the actively dying patient. Request a face-tent for patients who are claustrophobic from a mask.

Treatment w/Other Drugs: Antitussives can help with cough, anticholinergics (e.g. Scopolamine) will help reduce secretions and anxiolytics (e.g. lorazepam) can reduce the anxiety component of dyspnea.

Family/Team Discussions: While there is no good evidence that proper symptom management for terminal dyspnea significantly hastens death, the course and management of terminal dyspnea, especially when opioids are used, should be fully discussed with family members, nurses and others participating in care to avoid confusion about symptom relief vs. fears of euthanasia or assisted suicide.

References: Bruera E and Ripamonti C. Dyspnea in patients with advanced cancer. In: Principles and Practice of Supportive Oncology. Berger A, Portenoy R and Weissman DE (eds). Lippincott-Raven, 1998.

Bruera E, Stoutz N, Velasco-Levla A, et al. Effects of oxygen on dyspnea in hypoxamic terminal cancer patients. Lancet 1993;342:13-14.

Fohr SA. The double effect of pain medication: separating myth from reality. J Pall Med 1998; 1:315-328.

Chandler S. Nebulized opioids to treat dyspnea. Am J Hosp Pall Care 1999; 16: 418-422.

Disclaimer: *Fast Facts* provide educational information, this information is not medical advice. Health care providers should exercise their own independent clinical judgment. Some *Fast Fact* information cites the use of a product in dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.

If you have any questions regarding palliative care, please contact Daniel E. Ray, MD, Division of Pulmonary/Critical Care Medicine, at 610-439-8856.

News from CAPOE Central

Winning the CAPOE Compliance Trip – It's Contagious

The third CAPOE Compliance Trip drawing was held Christmas Eve afternoon with several die-hard CAPOE users in attendance. Dr. David Caccese volunteered to pull the winning name out of the hat – and the winner was **Dr. Eric Young**, the second winner from Allentown Infectious Disease Services. Dr. Naktin won the first drawing several months ago. Dr. Young was in the hospital at the time and came down to gladly accept his prize – a voucher worth $2,000 for a trip to a destination of his choice (arrangements to be made through East Penn AAA).

Keep your CAPOE compliance over 60% and you, too, may be a winner some month!

Transferring Your Patient? – Did You Remember to Review the Orders

To facilitate the transfer of patients from one unit to another, a new order set has been created under the ADMIT button. It is the 'Transfer Patient Order Set' and includes only two orders. One order is the Transfer Order, which allows the physician to specify the Preferred Unit and Isolation. This order does not ask for diagnosis or service, since this usually remains the same. The second order – "Orders Reviewed, Continue Current Orders" – is the reminder to review the existing on-line orders. No action needs to be taken on this order. It is there as a reminder to review the patient's existing orders and discontinue any orders that do not apply to the receiving unit, and to enter any new orders. This order will appear on the Med Profile screen, thus alerting nursing and pharmacy that the orders have been reviewed and are current. The guidelines for using these orders when transferring patients is listed in the reference on the order set screen. It is very important that you review current orders and make any necessary changes when transferring patients between units.

Some Tips from Our Colleagues in Pharmacy

The Pharmacy staff does a wonderful job of interpreting medication orders and clarifying potential problematic situations. In the written world, a large part of their job was interpreting the handwriting of the physicians. In the CAPOE world, the Pharmacists can use their clinical expertise to help with the ordering process. However, they still spend part of their time clarifying electronic orders. One of the common miscommunications occurs when ordering meds with stop dates and times or max doses. Please remember to designate when a medication or IV should stop by using the end date/time field or Max Doses field. Do not rely solely on using the Comment Field to enter comments such as "D/C after second dose" or "D/C after two liters." Another area of potential confusion occurs when patients bring in their own medications. Please do not order this using the Communication to Nurse Order. Instead, choose the "Patients Personal Medication Supply" order from the M-Z Medication list, and supply the required information in the comment field.

Looking for some light reading? Try "The Last Word"

The LastWord is the monthly newsletter highlighting recent enhancements to CAPOE and reviewing recurring issues. There is a lot of helpful information in these newsletters. For those of you who haven't saved the back issues and would like to review the many improvements that have been made in the system, you can view back issues from any computer that can access the LVH Intranet Home Page. Click on "Medical Staff Services" under the "What's' New" area on the right; then click on "Newsletters", and then click on "The Last Word." All previous issues are listed by date.

If you have any questions or concerns regarding any of these issues, please contact me.

Don Levick, MD, MBA
Physician Liaison, Information Services
Phone: 610-402-1426
Pager: 610-402-5100 7481

Ethics Committee to Present "Wit"

The Ethics Committee of Lehigh Valley Hospital will present the showing of the movie – "Wit" – on Wednesday, February 11, from 7 to 9 p.m., in the Educational Conference Room 1, located on the first floor of the Anderson Wing at Cedar Crest & I-78.

Joseph E. Vincent, MD, Chair, Ethics Committee; Stephen Lammers, PhD, Ethics Program Consultant; and Patricia Lyndale, PhD, Clinical Ethics Fellow, will have a panel discussion following the movie.

For more information, please contact the Critical Care Office at 610-402-8450.

News from the Libraries

OVID Training

To arrange for instruction in the use of OVID's MEDLINE and its other databases, please contact Barbara Iobst, Director of Library Services, at 610-402-8408.

Have you Moved or Changed Practices?

If you have moved your office or changed practices, please remember to fax the information to Medical Staff Services at 610-402-8938. Current information is required in order to send your patient and hospital information to the correct address in a timely manner. If you have any questions, please contact Janet M. Seifert in Medical Staff Services at 610-402-8590.

Congratulations!

The following members of the Medical Staff were listed among "Top Doctors" in an article regarding "Best Hospitals" in the Fall 2003 issue of **Money**:

Coronary Bypass Surgery – **Theodore G. Phillips, MD, James K. Wu, MD**, and **Gary W. Szydlowski, MD**

Heart Attack – **Robert J. Oriel, MD, Theodore G. Phillips, MD**, and **Jeffrey C. Snyder, MD**

Carotid Endarterectomy – **Victor J. Celani, MD, James L. McCullough, MD**, and **Alan Berger, MD**

The hospitals mentioned in the article are the top-rated facilities that handle the most cases for 20 common medical treatments, according to health-care rating, information and advisory services company HealthGrades. Using Medicare data, HealthGrades rates more than 5,000 hospitals based on quality measures such as mortality and complication rates. The doctors listed are those who see the most patients with that condition or are the supervising physician, according to the hospitals.

A LOVAR poster presentation – "Aggressive Preventive Medicine and Case Management Improves Risk Factor Modification, Health Outcomes, and Quality of Life in High-Risk Vascular Patients – presented by **John E. Castaldo, MD**, Chief, Division of Neurology, received the Population Science Award at the annual American Heart Association's 2003 Scientific Sessions held in November in Orlando, Fla.

Douglas P. Harr, MD, Division of General Internal Medicine/ Geriatrics, recently became recertified in Nuclear Medicine by the American Board of Nuclear Medicine.

Thomas D. Meade, MD, Division of Orthopedic Surgery, Section of Ortho Trauma, was part of two record-setting relay teams in the U.S. Masters Northern Zone Short Course Meter Swimming Championships held at Rutgers University on December 6 and 7. Dr. Meade combined with his teammates to set the world record in the 200+ (cumulative age add to 200 or more) 200 meter freestyle relay with a time of 1:40:71. It shattered the previous world record set by a Canadian team in May, and ironically was faster than the same group's previous world record set in a younger age group eight years ago. The same relay team also set the national record in the 400 meter freestyle relay with a time of 3:47:59, breaking the previous record by five seconds. Dr. Meade won the 50 meter freestyle and took second in the 50 meter butterfly events.

Papers, Publications and Presentations

John E. Castaldo, MD, Chief, Division of Neurology; **Joanne Rodgers, RN, BS**, Research Specialist, Neurosciences Center; **Alexander D. Rae-Grant, MD**, Medical Staff President and Division of Neurology; **Peter J. Barbour, MD**, Division of Neurology; and **Donna Jenny, RN, MPA**, Director, Neurosciences Center, co-authored an article which was published in the November-December 2003 issue of the ***Journal of Stroke and Cerebrovascular Diseases***. The article was titled "Diagnosis and Neuroimaging of Acute Stroke Producing Distal Arm Monoparesis."

Geoffrey G. Hallock, MD, Associate Chief (LVH), Division of Plastic Surgery, and **Debra A. Lutz, RN**, co-authored an article which was published in the January 2004, Volume 52, issue of the ***Annals of Plastic Surgery***. The article, "Turnover TRAM Flap as a Diaphragmatic Patch," described the use of the skin of the lower abdomen transferred normally as in a breast reconstruction, but instead used to serve as a vascularized patch of a hole involving almost the entire hemidiaphragm after an infected mesh had to be removed.

Indru T. Khubchandani, MD, Division of Colon and Rectal Surgery, was the Keynote Speaker at the Annual Meeting of the Association of Colon and Rectal Surgeons at Pune, India, from December 28-30. The guest lecture was titled "Surgeon as a factor in prognosis for rectal cancer." Dr. Khubchandani also moderated a panel on inflammatory bowel disease.

Donald L. Levick, MD, MBA, Medical Staff President-elect and Division of General Pediatrics, was a contributing author of the ***Encyclopedia of Health Care Management***. With over 600 entries, this encyclopedia is the most comprehensive reference work on health care management with a broad range of timely topics, spanning academic, corporate and governmental arenas.

Steven A. Oberlender, MD, Division of Dermatology, and **Stephen M. Purcell, DO**, Program Director, Dermatology Residency, co-authored an article, "Full-Face Carbon Dioxide Laser Resurfacing in the Management of a Patient with the Nevoid Basal Cell Carcinoma Syndrome," which was published in Volume 29, 2003 of ***Dermatology Surgery***.

Stephen M. Purcell, DO, Program Director, Dermatology Residency, and **Jocelyn Harris, DO**, Dermatology resident, were co-authors of "Protracted Calciphylaxis, Part I" and "Protracted Calciphylaxis, Part II," which were published in Volumes 71 and 72, 2003 of ***Cutis***.

Alexander D. Rae-Grant, MD, Medical Staff President and Division of Neurology, was one of the editors of the ***5-Minute Neurology Consult***, an 800-page book published in December 2003 by Lippincott, Williams and Wilkins.

Patrice M. Weiss, MD, Director of Medical Education and Residency Program Director, Department of OB/GYN; **Craig Koller**, Center for Educational Development and Support; **L. Wayne Hess, MD**, Chair, Department of OB/GYN; and **Thomas Wasser, PhD**, Director, Health Studies, presented a poster at the 28th Annual Meeting of the Association of American Medical Colleges in Washington DC, in November. The poster was titled "Does Medical Students' Self-Assessment Correlate with Final Clerkship Grades?"

Upcoming Seminars, Conferences and Meetings

Emergency Medicine Grand Rounds

Emergency Medicine Grand Rounds are held on Thursdays, beginning at 8 a.m., at various locations. Topics for February will include:

February 5 – Cedar Crest & I-78 Auditorium
- Visiting Speaker – Ward Donovan, MD – TBA
- "Esophageal Disorders"
- St. Luke's case review

February 12 – LVH-Muhlenberg, 4th Floor Classroom
- Radiology Review
- M & M
- Resident Lecture
- Rosen's (pages 938-1011)

February 19 – EMI, 2166 S. 12th Street
- "Heart Failure"
- "Emergent Deliveries"
- Resident Lecture
- Resident Lecture

February 26 – LVH-Muhlenberg, 4th Floor Classroom
- Pediatric topic – TBA
- "Skin Rashes"
- Resident Lecture
- Rosen's (pages 1011-1099)

For more information, please contact Dawn Yenser in the Department of Emergency Medicine at 484-884-2888.

Family Medicine Grand Rounds

Family Medicine Grand Rounds are held the first Tuesday of every month from 7 to 8 a.m., in the Educational Conference Room 1, Lehigh Valley Hospital, Cedar Crest & I-78, unless otherwise noted. The topics for February and March are:

- February 3 – "Mildly Atypical Pap Smears"
- March 2 – "Sentinel Lymph Node Biopsy in Breast Cancer"

For more information, please contact Staci Smith in the Department of Family Medicine, at 610-402-4950.

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday beginning at noon in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed in February include:

- February 3 – "Combination Therapy, Strategies for MI/ Unstable Angina Patients: Preventing the Next Event"
- February 10 – "Managing HIT: Preventing Life – Limb Threatening Thrombosis"
- February 17 – "Update in Pulmonary Medicine"
- February 24 – "Fragility Fractures . . . Do We Have a Bone to Pick With You"

For more information, please contact Judy Welter in the Department of Medicine at 610-402-5200.

OB/GYN Grand Rounds

OB/GYN Grand Rounds are held on Fridays from 7 to 8 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, unless otherwise noted. Topics to be discussed in February will include:

- February 6 – Tumor Board
- February 13 – "Code Crimson"
- February 20 – "Reducing the Transmission and Prevention of Herpatic (HSV) Infections"
- February 27 – "Fetal Fibronectin"

For more information, please contact Teresa Benner in the Department of OB/GYN at 610-402-9515.

Department of Pediatrics

Pediatrics conferences are held every Tuesday beginning at 8 a.m. Pediatric conferences are held in the Educational Conference Room 1 at Lehigh Valley Hospital, Cedar Crest & I-78, unless otherwise noted. Topics to be discussed in February will include:

- February 3 – "Pediatric Jeopardy"
- February 10 – "Enzyme Replacement Therapy for Fabry Disease"
- February 17 – "Influenza 2003"
- February 24 – "Pediatric Abdominal Masses"

For more information, please contact Kelli Ripperger in the Department of Pediatrics at 610-402-2540.

Surgical Grand Rounds

Surgical Grand Rounds are held every Tuesday at 7 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed in February will include:

- February 3 – "Melanoma"
- February 10 – "Frontiers in Laparoscopy: Past, Present and Future"
- February 17 – "Ocular Manifestations of AIDS and Immunodeficiency Disorders"
- February 24 – Transplant – TBA

For more information, please contact Cathy Glenn in the Department of Surgery at 610-402-7839.

General Medical Staff Meetings for 2004

Following are the dates of the General Medical Staff meetings for 2004. The meetings, which begin at 6 p.m., will be held in the hospital's Auditorium at Cedar Crest & I-78 and videoconferenced to the First Floor Conference Room at LVH-M.

- Monday, March 8
- Monday, June 14
- Monday, September 13
- Monday, December 13

Please mark your calendar!

Who's New

This section contains an update of new appointments, address changes, status changes, resignations, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

New Appointments

Michael J. Durkin, MD
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Suzanne R. Fanning, DO
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Terrence Grady, DO, PhD
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Jennifer A. Haines, MD
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Robert J. Kruklitis, MD
Pulmonary Associates
1210 S. Cedar Crest Blvd.
Suite 2300
Allentown, PA 18103-6286
610-439-8856
Fax: 610-439-1314
Department of Medicine
Division of Pulmonary/
Critical Care Medicine
Provisional Active

Bharat K. Mehta, MD
2632 Nazareth Road
Easton, PA 18045-2715
610-253-5257
Fax: 610-253-2336
Department of Medicine
Division of General Internal Medicine
Provisional Active

Kevin P. Meitz, DO
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Marie S. O'Brien, DO
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Victor M. Otero, MD
Riverside Family Practice
Riverside Professional Center
5649 Wynnewood Drive
Suite 203
Laurys Station, PA 18059-1124
610-261-1123
Fax: 610-262-1739
Department of Family Medicine
Provisional Active

Gregory M. Stout, DO
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-5200
Fax: 610-402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty

Ronald W. Swinfard, MD
Chief Medical Officer
Lehigh Valley Hospital
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
610-402-7502
Fax: 610-402-7523
Department of Medicine
Division of Dermatology
Provisional Active

Practice Changes

Marjorie R. Cooper, MD
(No longer in practice with Allentown Associates in Psychiatry)
The Mitchell Psychiatric Center
555 Harrison Street
Emmaus, PA 18049-2339
610-965-6418 Fax: 610-965-6382

Lisa H. Medina, MD
(No longer with Northampton Medical Associates, Inc.)
Louis E. Spikol, MD Family Medicine
1111 Sixth Street
Whitehall, PA 18052-5212
610-403-3800 Fax: 610-403-3805

Jeffrey W. Thompson, MD
(No longer with West End Medical Group)
121 N. Cedar Crest Blvd., Suite F
Allentown, PA 18104-4664
610-433-0246 Fax: 610-433-0248

Address Changes

Jeffrey D. Gould, MD
Neurology and Sleep Medicine, PC
701 Ostrum Street, Suite 302
Bethlehem, PA 18015-1152
610-866-6614 Fax: 610-866-8836

John F. Mitchell, MD
The Mitchell Psychiatric Center
555 Harrison Street
Emmaus, PA 18049-2339
610-965-6418 Fax: 610-965-6382

Linda P. Augelli-Hodor, DO
Muhlenberg Primary Care, PC
2649 Schoenersville Road, Suite 201
Bethlehem, PA 18017-7326
610-868-6880 Fax: 610-868-5333
(Effective February 9, 2004)

Brooks Betts II, DO
Muhlenberg Primary Care, PC
2101 Emrick Blvd., First Floor
Bethlehem, PA 18020-8001
610-868-4100 Fax: 610-868-4033
(Effective February 9, 2004)

Gnanaprakash Gopal, MD
Muhlenberg Primary Care, PC
2101 Emrick Blvd., First Floor
Bethlehem, PA 18020-8001
610-868-4100 Fax: 610-868-4033
(Effective February 9, 2004)

Theodore Kowalyshyn, MD
Muhlenberg Primary Care, PC
2101 Emrick Blvd., First Floor
Bethlehem, PA 18020-8001
610-868-4100 Fax: 610-868-4033
(Effective February 9, 2004)

Status Changes

Lisa H. Medina, MD
Department of Family Medicine
From: Affiliate
To: Provisional Active

Additional One-Year Leave of Absence

William J. Vostinak, MD
Department of Surgery
Division of Orthopedic Surgery
Affiliate/LOA

Resignations

Joseph R. Drago, MD
Department of Surgery
Division of Urology

Joseph V. Episcopio, MD
Department of Medicine
Division of General Internal Medicine

Cathleen Roberts, DO
Department of Pediatrics
Division of Pediatric Subspecialties
Section of Developmental-Rehabilitation

Death

Charles D. Schaeffer, MD
Department of Surgery
Division of General Surgery
Honorary

Allied Health Staff

New Appointments

Judy L. House, CRNP
Certified Registered Nurse Practitioner
(Lehigh County Child Advocacy Center – John D. Van Brakle, MD)

Svetlana Konstantinova, PA-C
Physician Assistant-Certified
(Surgical Specialists of the Lehigh Valley – William R. Dougherty, MD)

Weirui Li, PA-C
Physician Assistant-Certified
(Northeastern Rehabilitation Associates, PC – Scott Naftulin, DO)

Cynthia A. Maugle, GRNA
Graduate Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC – Thomas M. McLoughlin, Jr., MD)

Gregg A. Miller, PA-C
Physician Assistant-Certified
(Surgical Specialists of the Lehigh Valley – Sigrid A. Blome-Eberwein, MD)

John L. Pomper, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC – Thomas M. McLoughlin, Jr., MD)

Edward F. Sayres, GRNA
Graduate Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC – Thomas M. McLoughlin, Jr., MD)

Change of Supervising Physician

Archie W. Hartzell, Jr., PA-C
Physician Assistant-Certified
From: Orthopaedic Associates of Bethlehem, Inc. – Thomas S. Sauer, MD
To: Valley Sports & Arthritis Surgeons – Neal A. Stansbury, MD

Donna F. Petrucelli, CRNP
Certified Registered Nurse Practitioner
(The Heart Care Group, PC)
From: Donald J. Belmont, MD
To: James A. Sandberg, MD

Kelly C. Pompa, CRNP
From: Registered Nurse To: Certified Registered Nurse Practitioner
From: Lehigh Valley Cardiology Assoc – George A. Persin, DO
To: Lehigh Valley Cardiology Assoc – Nadeem V. Ahmad, MD

Resignations

N. Jayne Hatfield-Robinson, CRNP
Certified Registered Nurse Practitioner
(LVPG-Neonatology)

LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

Phone: 610-402-8590
Fax: 610-402-8938
Email: janet.seifert@lvh.com

Medical Staff Progress Notes

Alexander D. Rae-Grant, MD
President, Medical Staff

Donald L. Levick, MD, MBA
President-elect, Medical Staff

Edward M. Mullin, Jr., MD
Past President, Medical Staff

John W. Hart
Vice President, Medical Staff Services

Brenda E. Lehr
Director, Medical Staff Services

Janet M. Seifert
Coordinator, Communications & Special Events
Managing Editor

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Joseph A. Habig II, MD
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Herbert C. Hoover, Jr., MD
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Sophia C. Kladias, DMD
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Edward M. Mullin, Jr., MD
Michael J. Pasquale, MD
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Victor R. Risch, MD, PhD
Michael A. Rossi, MD
Raymond L. Singer, MD
Elliot J. Sussman, MD
Ronald W. Swinfard, MD
John D. Van Brakle, MD
Michael S. Weinstock, MD
James C. Weis, MD
Patrice M. Weiss, MD

We're on the Web!

If you have access to the Lehigh Valley Hospital intranet, you can find us on the LVH homepage under What's New — Medical Staff Services

Medical Staff Progress Notes *is published monthly to inform the Medical Staff and employees of Lehigh Valley Hospital of important issues concerning the Medical Staff.*

Articles should be submitted by e-mail to janet.seifert@lvh.com or sent to Janet M. Seifert, Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556 by the 15th of each month. If you have any questions about the newsletter, please contact Mrs. Seifert by e-mail or phone at (610) 402-8590.