Newsletter for the Allentown and Sacred Heart Hospital Center

update

Vol. 5, No. 1

January 18, 1982

A&SHHC designated Trauma Center

Trauma. It's the leading cause of death in people between the ages of one and 44, and kills one American every five minutes...

The Hospital Center was designated the first Trauma Center in the state of Pennsylvania, December 30, 1981.

H. Arnold Muller, M.D., Secretary of Health, announced the designation of A&SHHC as an areawide trauma center for the Eastern Pennsylvania Emergency Services region serving Lehigh, Northampton, Berks, Carbon, and Schuylkill counties in a letter to Ellwyn Spiker, Administrator.

In his letter, Dr. Muller states that the first unconditional designation "brings to your institution a great honor, but also a serious responsibility to demonstrate to the people of this state the vital importance of designated centers in reduction of trauma deaths."

The A&SHHC shock/trauma service was initiated two years ago under the direction of Michael Rhodes, M.D., Trauma Director. When a trauma patient is enroute to the Center, the ambulance personnel or referring hospital call our emergency room physician who then initiates a "trauma alert." This initiates the system of readiness to care for the patient. The trauma resuscitation team including a board certified general surgeon team leader, an anesthesiologist, the chief surgical resident, and the shock trauma residents are notified to join the emergency room physician and trauma nurses.

At the same time, support services including the operating room, the blood bank, the laboratory, x-ray, respiratory therapy, and pastoral care are notified. The whole process takes less than a minute.

Only 5-10% of all trauma victims have an injury severe enough to require care in a trauma center. For those individuals, however, trauma center care spells the difference between life and death.

The severe trauma victim has critical, usually multiple injuries which require simultaneous treatment to stabilize the patient. These critically injured patients often die of shock while they are being treated for the injuries that produced the shock. A trauma center combines the specialized personnel, equipment, and facilities necessary to care for the critically ill trauma patient.

Upon arrival, the patient is taken immediately to the shock trauma room which is ready to receive patients 24 hours a day and the resuscitation phase of trauma care begins. At this point, appropriate subspecialists are brought in as needed.

If necessary, the surgery phase of trauma care follows, often with multiple specialty surgeons working at the same time.

The patient then enters the critical care phase of trauma care when he or she is admitted to the shock/trauma unit, supervised 24 hours a day by resident physicians.

Following this phase, the patient begins the rehabilitative phase which often extends beyond discharge. The patient moves from the shock/trauma service to the appropriate subspecialty area, e.g., orthopedics, neurosurgery. Physical therapy begins as soon as possible. When well enough, the patient is transferred to less acute care, either in a hospital or rehabilitation center.

During the last year, 1,132 patients were admitted to our trauma service; of those, 552 were considered to be major trauma patients by the American College of Surgeons criteria. 37% of the major trauma patients were referred from other hospitals in the region.

"Trauma Alert. ETA 10 minutes."

It's a familiar announcement now, but there was a time when those few words brought just a bit of anxiety in addition to the normal sense of anticipation.

When Michael King, then 17, became our first actual trauma alert on July 14, 1978, a system that had been planned, rehearsed, and fine tuned since April, 1978, was actually put into effect. The whole procedure worked, fortunately for Michael, who was severely injured in an automobile accident.

And, according to Michael Rhodes, M.D., Trauma Services Director, even back then the goal was for one day to earn the designation recently given to the Hospital Center: the state's first official Trauma Center.

As all the individuals from many specialty areas and hospital departments were to find, the road to this designation was blocked with many an obstacle.

As Donald Gaylor, M.D., Chief of Surgery at A&SHHC and The Allentown Hospital, notes, "This distinction indicates people within the institution have done a fine job. It speaks well of our Departments of Surgery, Medicine, Nursing, Radiology, Laboratory, Radiology, Anesthesia, the Critical Care Units..."

Dr. Gaylor feels that the designation will "set high standards of care that other areas of the state will emulate" and that the continuing care trauma patients receive after admission will benefit all our educational programs, and co-chief Medical Resident Nat Levinson, M.D., agrees. "It will add to the types of cases seen on certain services, especially on a consult basis, with trauma patients who require ventilator management or other complications."

During the past 3 years, the maturation and success of the trauma program has been a source of pride and distinction not only to the institution, but to our staff as well. For the many individuals involved

(Continued on page 5)

The Center Welcomes

To Admitting
Patricia Milcetich

To Centrex
Joann Manwiller

To Engineering
David Carruthers
Daryl Geiger

To Escort
Kerry Knauss

To Housekeeping
Christopher Barry
Jeanette Biro
Stephanie Bishop
James Farley
Carol Haas
Rebecca Lawall
Mark Panek
Janis Warren

To Laboratory
Lisa Haberacker
Joy Hoffman
Karen Parra
Tina Rader

To Materials Management
Denise Yodis

To Medical Records
Rosemarie Reilly

To Nursing Services
Sheryl Ancharski
Martin Bright
Joan Cooley
Susan Crow
Ellyn Elstein
Debra Graner
Margaret Marquette
Kathleen Mauritzen
Nancy Oswald
Laurie Slaven
Patricia Tachayapong

To Physical Therapy
Carol Gober

To Planning
Roberta Ott

To Radiology
Michelo Gride
Joan Baron
Patricia Huber

To Respiratory Therapy
Natasha Stanton

To Security
Robert Ande

To Social Service
William Dunstan
David Schlegel
Linda Watsula

To SPD
Joshua Burgos
Catherine Malacosky
Justina Panebianco

Welcome Back
Linda Boland—Nursing Services
Colleen Burgess—EEG
Christine Gabrick—Dietary
Alice Lee—Laboratory
David Nadig—Laboratory
Anna Strasser—Radiology

THE WELLNESS CENTER

To Physicians: Wellness Center offers patient referral service

In an effort to respond to several requests by area physicians to offer wellness courses for patients, we will be taking patient referrals beginning mid-January, 1982.

As you may know, the task of the Wellness Center is to offer courses in health areas that require the patient to assume responsibility for problems that are within his or her control. These include such areas as weight control, smoking cessation, stress management, and exercise. The goal of the course is not only to inform patients about their problems, but also to teach them how to manage their lifestyles for eventual reduction of the problem(s) for which you are referring them. They do not consist of medical treatment, but are entirely educational and behavioral in nature. The Wellness Center will work with the physician, particularly if there are certain medical restrictions placed on individual patients.

Physicians will soon be receiving a packet of information, including a wellness brochure, physician referral forms, list of courses, course schedule, and a list of instructors and their qualifications, all of which will be explained within the packet. Also included will be patient packets, to tell patients about the Wellness Center and how to register for courses. They are provided for the convenience of physicians and are to be distributed to each patient who is referred.

on call

Appearing on "On Call: A Valley Health Series" broadcast on WLVT-TV, Channel 39, during January will be:

January 18, 7:30 P.M., January 23, 2:30 P.M. - Herpes Simplex - It is estimated that the virus herpes simplex, a relatively new venereal disease, afflicts as many as 20 million Americans. It appears as a painful lesion or blister on the body and it can be treated, but not completely cured at this time. Guests Howard Listwa, D.O., and Alan Schragger, M.D., discuss the medical and psychological complications of herpes simplex.

January 25, 7:30 P.M., January 30, 2:30 P.M. - Asthma - A disease which can effect people of all ages, asthma occurs in about 4% of the population and is the major cause of hospitalization among the allergic diseases. It is characterized by wheezing and shortness of breath. Guests William Tuffiash, M.D., and Joseph Vincent, M.D., explain the causes, symptoms, and treatment. Viewers are encouraged to phone in their questions which will be answered over the air by calling 867-4677.

CCAP pilot a success!

"I enjoyed this program immensely ... I'd do it all over again!"

"Thank you for the opportunity to be involved with the Critical Care Acquaintance Program!"

"I hope the CCAP will be continued in the future!"

These comments are just a few of many made by the participants in the Hospital Center's first Critical Care Acquaintance Program.

And, it seems from the positive tone of these remarks, that it was a successful event.

The six week program owes a great deal of its success to two members of the Nurse Recruitment Committee — Rose Trexler, R.N., ICU staff nurse, and Anna Marie Distasio, R.N., former clinical charge nurse, SCU, and now Assistant Director of Med/Surg Nursing at Sacred Heart Hospital. Both nurses recognized the need to acquaint med/surg staff nurses with critical care nursing as a means of recruiting nurses into this discipline, and felt a brief, but intense, exposure to critical care nursing would be the best method.

The idea caught on quickly, as seven med/surg R.N. "candidates" and seven critical care R.N. "mentors" were chosen to participate in a pilot project which began on October 11. Candidates involved included: Joan Flick, R.N., Nancy Strisovsky, R.N., Bonnie Graboski, R.N., Dorothy McGinley, R.N., Marian Lynn, R.N., Cynthia Eastman, R.N., and Karen Griffith, R.N.,

In the program, candidates worked one on one with their mentor getting a first hand look at the critical care nursing experience, learning specified procedures, while having an option of continuing into critical care nursing or returning to their previous floor assignment.

As candidate Cindy Eastman, R.N., relates, "I liked having the option of not having to stay in critical care if I decided it wasn't for me. Either way, it would be a good way to get experience."

CCAP mentor Kathy Crouthamel, R.N., shows CCAP candidate Bonnie Graboski, R.N., how to balance an arterial line.

Working with the mentor, Cindy says, was important, "I liked having someone there to go to. I felt very secure."

Providing the learning experience on SCU and ACU to the candidates were mentors Susan Marhon, R.N., Daniele Shollenberger, R.N., Kathryn Crouthamel, R.N., Kathleen Kiffer, R.N., Joan Gehris, R.N., Sally Ann Bozosi, R.N., and Beth Eck, R.N. Alternate mentors included Constance Denardo, R.N., Patricia Robinson, R.N., Deborah Swavely, R.N., Paula Malloy, R.N., Bonnie Wasilowsky, R.N., Adele Cadden, R.N., and Susan Merryfield, R.N. Lorraine Merington, R.N., Diane Bidwell, R.N., Geraldine Klem, R.N., and Laura Yeakel, R.N., were "Resource People" for ACU and SCU.

As a mentor, Sally Ann Bazosi felt the program went well. "It helped everyone get over the initial shock and noise of the units, and get used to the equipment used. I wish I had something like this when I started," she says, referring to the difficult nature of explaining, in detail, the routine tasks that are anything but routine to the neophyte critical care onlooker. Sally would "definitely recommend it to anyone interested in a career in critical care."

Nancy Strisovsky, R.N., also liked the concept of CCAP, but took advantage of the option to return to her prior assignment - 4B. "I learned a lot," Nancy states, "and I would encourage people to take it. But," she says, "I missed my old floor and critical care nursing really isn't for me. I like more patient contact."

Will the CCAP be run again? Right now, an Ad Hoc Committee of the Nurse Recruitment Committee is studying the evaluation, performance reports and other data to determine the overall effectiveness. Once an evaluation is made, a new CCAP just may be on its way!

updates

Gale Schmidt Hodavance — Editor
Jim Higgins — Associate Editor
Janet Laudenslager — Staff Assistant
Jack Dittbrenner — Photography
Darla Molnar — Photography

Burn Center Staff on TV

Look for Walter J. Okunski, M.D., Medical Director of the A&SHHC Burn Center, and Sandra C. Raymond, Program Director for the East/Northeast Pennsylvania Office of the Burn Foundation of Greater Delaware Valley, on WLVT-TV's "The Managers Chat" program, January 19, at 3:00 P.M., and 7:30 P.M., on Channel 39.

They will join program host Sheldon P. Siegel to discuss burn injury, a medical, social, environmental, and financial problem of national importance.

Critical Care Nursing: Challenge and Stress

This article, reprinted with permission from Nursing Job News, November, 1981, features two Hospital Center staff nurses and their opinions and views of the critical care environment.

More patients in today's critical-care units are seriously ill than ever before. Nurses caring for those patients face the challenge of performing increasingly more technical procedures, making decisions about the status of their patients' conditions, as well as consulting with families, physicians, and other hospital personnel.

Rachael Hoffman, R.N., B.S.N., M.A., C.C.R.N., describes the critical-care environment in "Stress and the Critical Care Nurse," *Supervisor Nurse,* August 1981. "...The atmosphere is permeated with noises (beeps, buzzes, and the alarms of the machines), the voices of patients and staff, and the smells of disease, excreta, and drainage... Patients are often in various stages of recovery or of dying and usually have tubes coming from every bodily orifice. Staff members may be rushing here and there to give emergency care or may be involved in provision of assistance and reassurance to patients and families."

Hoffman also describes some of the nursing functions in critical care. "The major repetitive tasks of critical care nurses are to collect, record and evaluate data. Observation and interpretation of subtle changes in patients' conditions are vital, and judgments must be made in order to take appropriate action—often without guidance from patients' physicians."

These functions, and the challenge of caring for the critically ill are what keeps nurses in the critical-care areas.

Connie DeNardo, R.N., B.S.N., a nurse in acute coronary care at Allentown & Sacred Heart Hospital Center, Allentown, PA, has been in critical care for seven years. "I need to be where the action is," she says, "and I need the one-to-one with the patient. I get a lot of satisfaction from working closely with the patient and the family. You're really helping them, and you can use your knowledge."

Nancy O'Connor, R.N., also at Allentown & Sacred Heart, agrees. "There is something challenging about the type of patient you find in critical care. There's a lot more going on, and since minor changes can be life-threatening, you have to make decisions." O'Connor, who, as a student nurse worked in an emergency room, has worked in critical care for over six years and is currently in a medical/surgical unit, waiting to transfer back.

Frances Sorlie, R.N., M.S., Ph.D., describes critical care nursing as an expanded role. In "Do You Want to Specialize in CCU Nursing?", *Nursing 78,* January, Sorlie says, "CCU nursing puts you at the forefront of an expanded role. Your clinical experience will include: observing patients for PVCs or ventricular fibrillation and giving treatment according to guidelines established by the patient's doctor...You'll be guided in the care of the patient by the doctor's standing orders, but some key decisions will be up to you...These experiences, plus your advanced knowledge of physiology, pharmacology and hemodynamics, add to your knowledge of patient care and increase your job satisfaction."

Critical care nursing is not limited to coronary, intensive, or progressive care units, but runs the gamut of specialties. In some hospitals nurses may care for the critically ill in medical/surgical units.

Experience is a Prerequisite

Because critical care is specialized, most nurses do not enter that area immediately upon graduation since most nursing programs cannot provide the necessary training within the student's period of study. In fact, most practicing critical care nurses advise graduate nurses to get at least six month's, and preferably a year's experience in basic nursing care before going into critical care.

Lane Turzan, R.N., weekend clinical supervisor of a critical care unit, who develops educational programs for the American Association of Critical-Care Nurses (a professional association that considers education as one of its prime functions), believes that medical/surgical experience is a good first step toward critical care. "I'd advise graduate nurses to get a good foundation in general nursing, say on a medical/surgical floor. Without that background, you can't always focus when decisions need to be made."

Nancy O'Connor agrees. "A year of med/surg experience helps nurses find out who they are as a nurse and develops their decision-making skills so they'll know how to handle a crisis when it occurs."

For most critical care nurses, education is an ongoing process. There is always new information. According to Joann Lamb, R.N., B.S., M.A., C.C.R.N., currently clinical administrator at the Department of Surgery in Presbyterian Hospital, New York, it is essential that critical care nurses continue to increase their knowledge. "Nursing education has to match technical advancements," she says, adding, "it's been said that the body of critical-care knowledge changes every two and one-half years."

Stress is Inherent

In addition to the technical knowledge required, one of the most frequently mentioned aspects of critical-care nursing is the stress inherent in caring for the critically ill. Few nurses would deny the reality of that stress, which is the result of working closely with patients who are seriously ill or dying, the sometimes unpredictable schedules, and the seeming lack of support from physicians and hospital administrators. "For me, the stress comes from working with patients you know you're not going to help," says Connie DeNardo.

However, many nurses would work nowhere but critical care and have found ways of dealing with the stress. DeNardo uses a number of techniques including her religious beliefs. "I have my own religious beliefs which help me as well as other things. For example, I'm currently chairing our Stress Committee and developing ways to use the resources at the hospital to help with the stress. Also, we have a Wellness Center and I've found that exercising after work really helps. It also helps to get away, to go to a conference, and of course, you have the support of your peers."

Joann Lamb also finds involvement in other areas a stress-reliever, but in addition, she says, "99 percent of the time I've been able to go home and forget about the hospital. Also, I've always been involved in other things, and I think that helps a great deal."

"Stresses are a reality," agrees Nancy O'Connor "but you can take a mental-health day, and generally there is a camaraderie among the nurses, which helps."

As for the factors causing the stress, they may be difficult to resolve, but nurses will continue to practice and grow in critical care since, as Joann Lambs says, "the practice in critical care is far more positive than not. It is a most exciting area of nursing, and it is at the forefront of technical advances in any hospital."

—Cynthia Derr

Trauma Alert ... *(Continued)*

in the approximately 1,500 major traumas since July 14, 1978, the distinction of being the first trauma center in the state is felt to be hard earned.

In the shock/trauma unit in ICU, clinical charge Cathy Kinard, R.N., recognizes the special needs of the trauma patient. "I think we've come to the point where we think in terms of the trauma patient as having total system failure ... The acuity level is rising and has probably risen 200% since I've been here!" she says.

It's difficult to discuss trauma care without observing its effect on staff and bed availability. Cathy notes that during the first week of January, 1982, for example, "every bed but 2 (in ICU-E) were all trauma patients," and this has an effect on the nurse to patient ratio. "With myself and 5 others R.N.'s, it's amost a one to one ratio. With the higher acuity of the trauma patient, it sometimes rises 2 nurses to one patient. And that means more staff."

The increased pace is felt elsewhere, also. When the difference between life or death is sometimes measured in minutes, or seconds, the response time of certain departments is critical.

In the Blood Bank, a trauma alert puts everyone into high gear. "When a trauma arrives, we get a (blood) specimen right away—we have to type it quickly," Judy Heffelfinger explains. "We needs the specimen to I.D. the patient for blood type. One tech will take 0+ or 0- out of the bank to make cell suspensions for cross-matching," she says. It is indeed a busy, but controlled series of events. With the distinct possibility that the Hospital Center will see an increase in the number of traumas brought in, Judy knows "we're gonna run into each other a lot."

The Radiology Department is another area that works to economize time. Traumas, according to Diane Baer, Radiologic Technician, "are a priority, and you can sense that in the department. Patients go back upstairs, outpatients leave or wait till it's over."

Few departments follow the course of a trauma patient's recovery. Respiratory Therapy does, Vicky Krause, Respiratory Technician, says. "We follow the whole continuity of care. Initially you see the patient on arrival, one therapist doing airway care (intubation, suction, setting the ventilator) and the other will run blood gases to Pulmonary Function." According to Vicky, when a patient is on the ventilator, Respiratory accompanies the patient to CAT scan, to the O.R., if necessary, or to ICU, then on to the special care areas and on to the general med/surg floors. "We get to see the patient getting better," Vicky explains, "as follow-up therapy is continued on the general med/surg floors with breathing treatment."

In the Emergency Room, where all the activity begins, Gloria George, R.N., sees trauma care as "another challenge and something exciting to be part of." E.R. nursing and the intensity of shock/trauma care appeals to Gloria. "I like unscheduled complicated days and I like to sort things out."

Everyone agrees that trauma care is vital, and proud that A&SHHC is doing it. Vicky Krause feels that "this should be the place to do it...the system is already down."

Diane Baer is glad that "there is one in the area for families and friends...and close by if needed," and Gloria George sees it as a "big benefit to the community."

Summing it up is Dr. Rhodes: "We've worked very hard to obtain designation as a Trauma Center, but it's a double edged sword because it gives us a serious responsibility. We have to have extra capabilities and that's expensive in terms of time, money and effort."

It is no mere coincidence that our concern, professionalism, and pride have produced quite a remarkable and significant achievement.

The designation is indeed a tribute to all members of the Hospital Center staff.

Winter Fanta Ski

The Recreation Committee is sponsoring a Winter Fanta Ski weekend with skiing at Greek Peak in Ithaca, New York, Friday, March 5-7, 1982. The trip includes transportation via lavatory-equipped motorcoach leaving from A&SHHC, 2 nights' accommodations at the Holiday Inn Ithaca, complimentary beer and pizza upon arrival, two hearty full American buffet breakfasts (Saturday and Sunday), and 2 delicious smorgasbord dinners (Saturday and Sunday). The trip also includes prefitting of ski equipment at the hotel, skiis, boots, and poles for the entire weekend, and a ski lesson Saturday morning by Greek Peak instructors. For entertainment, there is an Apres Ski Party Saturday afternoon with free beer and wine, cheese and crackers, live DJ entertainment Friday and Saturday nights in "The Oscar Nightclub," and live entertainment Saturday night in "Dapper Dan's Lounge." There is also a roller skating rink and the 90-store Pyramid shopping mall right next door! All this and more for only $124 per person (double occupancy). (Triple occupancy - $104 per person; quad - $99 per person.)

A $50.00 deposit is due prior to Friday, January 22, 1982. For more information and reservations, contact Janet Laudenslager in Public Relations at 3084.

Super Bowl Sunday!!

Join us on Sunday, January 24, when the Bengals take on the 49er's for Super Bowl 16. Game time is 4:00 P.M., and we'll be watching it on the Big Screen in the Hospital Center Auditorium. A cold buffet and beer and soft drinks, plus a special surprise during halftime can be all yours for the low, low price of $1.00 at the door. Pre-game "festivities" begin at 2:30 P.M. See you there!

PEOPLE!

Three new people have joined the Social Service staff, and in Utilization Review, a coordinator has been named, according to Marie Weissman, A.C.S.W., Director of Social Service and Utilization Review.

William Dunstan (left, in the photo at right) will be providing Social Work services to orthopedic patients. Bill received his Master's Degree in Social Work from Temple University, and previously worked in the Community Treatment Program at Wiley House, Bethlehem.

David W. Schlegel will be working with neuro patients. He received his Master's Degree in Social Work from Marywood College, Scranton, and was a social worker for the Good Shepherd Home and Rehabilitation Hospital.

Linda Watsula will be working with the A&SHHC Mobile Rehabilitation Team of the Comprehensive Community Cancer Center. She holds a Master's Degree in Social Work from Marywood College, and was previously working at Family and Children's Services, Allentown.

Donna Transue, R.N., has assumed the position of Utilization Review Coordinator. Donna is a graduate of The Allentown Hospital School of Nursing, and has been a staff nurse on 5A and at the Hospital Center since June, 1977.

Joe Lewandowski, Director of Biomedical Engineering, was recently appointed Secretary of the Clinical Engineering Society of the Hospital Association of Pennsylvania (HAP) and elected as an Executive Committee member at large of the Philadelphia Area Medical Instrumentation Association. Joe has been here since August, 1980.

Wayne Matheson, Biomedical Engineering, has recently been certified by the Association for the Advancement of Medical Instrumentation as a certified Biomedical Electronics Technician. Wayne has been at the Hospital since February, 1981.

Ronald Lutz, M.D., Chairman of the Department of Emergency Medicine, has been certified as a Diplomate of the American Board of Emergency Medicine. Dr. Lutz is a graduate of King's College, Wilkes-Barre, and Hahnemann Medical School, Philadelphia. He is a 1975 graduate of the Allentown Affiliated Hospitals Internal Medicine Program, and has also been certified as a Diplomate of the American Board of Internal Medicine.

Burn Center staffers **Alice Eby,** L.P.N., and **Susan Klapac,** L.P.N., participated as facilitators at an in-service workshop for teachers at Mosser Elementary School recently.

Sponsored by the Burn Foundation of Greater Delaware Valley, the workshop featured the teachers working with burn prevention curriculum materials for each grade level as well as exercise for instructing basic fire safety.

Sandy Raymond, Program Director, East/Northeast Pennsylvania office for the Burn Foundation, led the workshop.

GSB Open House - Dennis Fetters, Biomedical Engineering, explains the work he is doing on an intraaortic balloon pump to Shirley Eisenhard (left), secretary, Medical Records, Deborah Shearer, ART, Health Records Analyst, and Gail Gillespie, Medical Records correspondence clerk.

Christmas Dinner and Breakfast - *Chef Kuno Stadelmann, serves up a tasty portion of Steamship Round to Engineering's Larry Kincaid (top photo). Over 1300 lbs. of beef were consumed at the annual event—below, Dietary Director Ted Tobia handles the duties of serving eggs and homefries to employees enjoying the breakfast offered the day after the Christmas lunch.*

Which way did they go?

During the past few years, the tremendous growth of the Hospital Center services made for less room in a lot of departments.

Fortunately, the year 1981 saw the opening of two new buildings which are housing many areas, freeing up much needed space for others.

In March, the 3-story Medical Office Building, located on the northeast corner adjacent to the main building, opened. Hospital Center tenants located on the ground floor of the MOB include: Planning, Public Relations and Development, Business Office, Television Department, Research Associate, and Nurse Consultant. Also, an Outpatient Laboratory is located on the second floor.

Occupying the remainder of the space in the building are the offices of: George McGinley, M.D., Suite 1800; Charles Gordon, M.D., Gene Ginsberg, M.D., Robert Grunberg, M.D., Suite 1900; Cardiovascular Associates, Suite 2300; Joseph Miller, M.D., Suite 2500; Plastic Surgeons Professional Group, Suite 2700; Cardiothoracic Surgeons, Suite 2800; Charles Levine, M.D., Suite 3000; Richard Allman, M.D., Suite 3100; Urologic Associates, Suite 3600; and Luther Rhodes, M.D., Michael Rhodes, M.D., Suite 3900.

Over on the Southwest corner, adjacent to the hospital, is the new 2-story general services building, which opened in early November.

Located on the first floor are: Housekeeping, Linen Control, and Bulk Stores.

And on the second floor are: Engineering Office and shops, Biomedical Engineering, Mailroom/Messenger/Escort Services, and Materials Management. Microbiology will also be relocated to the second floor.

With the relocation of all these departments, what about the empty space left behind? The chart below outlines the work currently being done to move or expand many remaining hospital departments.

According to Ellwyn Spiker, Administrator, a decision regarding allocation of space for the empty Business Office area will be dependent upon the completion of the functional plan.

A decision should be made within 3 months, Mr. Spiker feels.

Old department location	**will become**
Engineering, Purchasing	Pharmacy, Chaplain offices
Bulk Storage Area	New Physical Therapy department
Housekeeping	Nuclear Medicine Expansion
Public Relations/Patient Representative	Educational Coordinator and Director of Educational Development; Patient Education Coordinator offices
Planning, Research Associate	Patient Representative; Quality Assurance; Administrative Resident; Health Records Analyst offices
Physical Therapy	Radiology Expansion

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