LEHIGH VALLEY
HOSPITAL

Medical Staff Progress Notes

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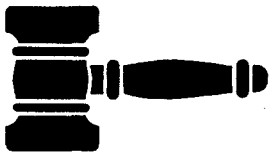
In This Issue . . .



From the President

We have, over the past two dozen years or so, built an incredible medical complex, capable of taking on some of natures worst diseases and disasters. We have done this by honing great skill in nursing and in diagnosis, medical therapeutics, surgery and rehabilitation. And for the most part we have done this through continuing education, dedication, drive and virtually unlimited resources. Our results are more than good; they are outstanding. We can, in many areas, compare ourselves with any of this nation's greatest Council of Teaching Hospitals, only we exist in a friendlier physical environment and our costs are a fraction of their costs per adjusted admission.

Even so, the great paradox is that many of these accomplishments have occurred for over a decade in an atmosphere that often pits medical staff against administration with the adverse consequences frequently reported in the local newspaper. It creates negativity in which we often revel. To some extent, this is a product of how we value physician autonomy and the sanctity of the physician-patient relationship. It is also a cherished Populist view of our time which views big hospitals much the same as U.S. citizens view big government -- wasteful, bureaucratic, and unable to focus on individual needs. We see practitioner autonomy as the "greatest good" much as we see patient autonomy, free from physician or hospital "coercion", as one of our highest ethical principles.

But as physicians, we have seen a gradual attrition of our independence and power over the years, and we are emotionally ill-equipped to surrender any more of it for a perceived "greater good" of the hospital or community as a whole. The principles in dynamic tension are many; we crave order in a medical institution, but reject its authority and governance over any aspect of our lives as health care providers. We are enamored with internal competition and control often to the detriment of programmatic and collaborative endeavor. We view ourselves as highly trustworthy, but are largely unprepared to trust others, even colleagues in the same field. We earnestly desire an administration which provides for the appropriate medical environment in which to practice medicine, but we resent its control and adjudication of vital hospital resources when it comes to limiting the growth or efficiency of our individual practices.

This dichotomous relationship between physicians and administration exists in nearly all medical staffs and ours is no exception. Administration doubts that the needs of individual private practices will ultimately meet the needs of the institutions' program development. Physicians, likewise, are skeptical that administration, in planning the needs of a multi-million dollar medical complex, will protect and respect their individual private practice for its contributions to the health status of the community. Both, in fact, need and respect each other, yet neither goes out of their way to admit it.

One wonders about the impact on community perception of our effectiveness when the public is routinely subjected to reports about a health care system in conflict. I can only believe it jeopardizes our patient's confidence in our ability to make sound, collective judgments in their best interests.

Change is fodder for disagreement, regardless of the nature of the decision. In the not too distant past, the hospital banked large sums of money at the expense of renovation and cutting edge technologies, and the administration was accused of "building a war chest to meet its own management needs."

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During current times of catch-up renovation and refurbishing, the rebuilding of the nephrology, dialysis, GI, Cardiac Cath, ER and Radiology areas; and the restructuring of many med/surg floors, administration has been seen as "wasteful," especially during these trying times of cost cutting "operations improvement."

Physician panels created to oversee administration projects and voice physician needs are viewed by "rank and file" doctors as suspect because "they spend too much time with the enemy." Physicians who take their patients to other institutions are viewed by administration as non-supportive of the organizational good. The upheaval is much akin to that witnessed by the great American car manufacturers of the 1980's who saw profits plummet as Japanese corporations built better products for less. Loyal GM and Ford customers bought Hondas and Toyotas in droves. Pulitzer prize winner Paul Ingrassia and Joseph B. White, in their book titled Comeback - The Fall and Rise of the American Automobile Industry, describe the tumultuous time and what was required to bring an industry back from the brink of extinction; to humbly learn from its past mistakes, to retool, re-engineer and rebuild much greater companies and products in the 90's. We have before us similar challenges both for the field of medicine and for hospitals that are interdigitated throughout it. Our leadership, like that of the automotive industry, must move rapidly and decisively in a chaotic environment of change. At the same time, they need to gain the support, admiration and respect of the foot soldiers that are required to win the war, without devastating casualties.

But how, with a medical staff of 788 doctors and 5,000 employees, is this done? How can we move with dispatch and with consensus without being ensconced in endless meetings? Samuel Johnson once said that "nothing will ever be attempted if all possible objections must be overcome." This most certainly is true. Trust is the fuel that makes great engines turn. It is the foundation of a community that transcends negativity and doubt and boldly builds great things on no more than energy and a dream.

Some suggestions to move forward together:

1) Let us accept and respect the value of each other in our workplace. We are in enormous need of each other -- physician, nurse, employee, administrator -- to accomplish great things now and in the future. Let us actively find ways to applaud and appreciate our wonderful achievements along the way.

2) Recognizing that honesty is the source of trust, let us set out to learn what is true and then speak the truth in every aspect of our communication with each other and at every level of our community and let us do this courageously but civilly. Avoid grand pronouncements and predictions. The truth of the matter is usually known somewhere and is often a quiet and uneventful subject. Where the truth is not known, seek simple answers in personal interactions before making broad and only partially true assumptions to each other or in the press and email, and to the community at large.

3) Let us create the forums for open, interactive, honest communications in our division, department and staff meetings and let us expect that this important function will be led by our Chairs, Chiefs, and administrative leadership in timely fashion as key deliberations take place. This form of collaboration will move us from valuing rumor to valuing the "word of mouth" from people in elected positions of leadership, which, after all, should be even more valuable and reliable than a whole stack of legal documents. There will be disagreements, but they will be honest ones, and we should all be able to grow with that.

4) Let us recognize that the good of the one is not always the same as the good of the whole, and the whole is always greater than the sum of its parts. Individuals may be called upon to make sacrifices (time, energy, practice style) for the good of the many. The whole may be called upon to make sacrifices for the good of its individual members to protect and respect their continued valued service. We must all be afforded opportunity to voice our professional needs, concerns and expectations in this process, and we must feel comfortable that we have been heard. But when a deliberation falls short of meeting those needs we should be able to accept and respect the process and move forward without looking back.

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5) Let us re-dedicate ourselves to the power of human relationship, which thrives on presence and verbal communication. Administration must walk the floors of our hospital and must intimately be aware of what goes on there. Daily they must meet physicians, nurses and employees in their workplace to come to know them on a personal level and understand their needs. Physicians, nurses and employees must walk the floors of the management suite and be intimately aware of what goes on there. They must come to know administration on a personal level in the workplace and understand the balance between institutional and individual needs. We cannot play on the same team without learning what position we play in the game, and without learning to communicate well with each other at all levels of the organization. Communication takes time and energy, both in the willingness to speak the truth and in the willingness to hear it.

6) When things go wrong, and they will, let us refrain from the futile activity of accusation and fault finding. There is usually plenty of blame to go around for all of us and assigning it serves no useful purpose. A wise man once said "every time you point your finger at someone there are three more pointing right back at you!" Rather, let us devote our energies to solutions and problem solving, asking what went wrong and how do we fix it rather than who do we blame. It has been my experience that it is usually the system that fails, not the individual. Change your perception. Problems are indeed opportunities for great things to happen.

7) Accept that no one has all of the answers. Each of us has a piece of the puzzle, but none of us the whole picture. Physicians and nurses have great insights into the needs of taking daily care of the sick. Administrators have great insights into the needs of the community of patients, businesses and insurers of the Valley. Therein lie solutions to a great number of problems. But it requires deliberation, communication, and collaboration. And it requires a change in polarity, moving from negativity and skepticism to a spirit of positivity and faith. Only then will we unleash the potential to achieve the excellence of service to ourselves, hospital and community of which we are capable.

John E. Castaldo, MD
President, Medical Staff

NEWS FROM LEHIGH COUNTY MEDICAL SOCIETY

Lehigh County Medical Society, as you know, will hold a rally in support of House Bill 2122, the TORT REFORM BILL, on May 7, 1996 in Harrisburg.

The President of the Pennsylvania Trial Bar has stated before the House Judiciary Committee that, " THERE IS NOT A SINGLE COMMA IN THE BILL THAT THE TRIAL BAR CAN SUPPORT."

The only way this bill will pass will be if a sufficient number of health care providers will be on hand to support the cause. THIS IS AN ABSOLUTELY CRITICAL EFFORT! Please plan on attending the rally on May 7, 1996. Encourage your employees, friends and families to attend as well. If we do not make a sufficient show of force to carry the day, we will have no one to blame but ourselves!

Please contact Mr. Lou Eister at the Lehigh County Medical Society at 437-2288 for further information.

Robert X. Murphy, Jr., M.D.
Chairman, Legislative Committee, Lehigh County Medical Society
and HMSS Representative, Lehigh Valley Hospital

At-Large Members Needed for Medical Executive Committee

The Medical Staff Nominating Committee is soliciting nominations for four at-large seats, each for a three-year term, beginning July 1, 1996, on the Medical Executive Committee.

Nominations should be submitted in writing to Robert X. Murphy, Jr., MD, Chairman of the Nominating Committee, via the Medical Staff Services Office, Cedar Crest & I-78, or verbally to John W. Hart, Vice President. All nominations must be submitted by Monday, May 20, 1996.

If you have any questions regarding this issue, please contact Dr. Murphy or Mr. Hart at 402-8900.

Work Force Expense Reduction Update

In response to many suggestions made by employees, the following cost-saving opportunities have been taken:

- Effective immediately, there will be no more catering. The only exceptions will be those limited occasions when the event is focused on an outside audience or when the duration and location of a meeting require it.

- Effective immediately, *CheckUp This Week* will no longer be printed and distributed. The news sheet will be produced on E-mail. To accommodate those who do not have E-mail, each department will print and post a copy from E-mail.

- Effective immediately, retreats will not be held at off-site facilities that charge a fee.

- Spring plantings and landscaping will only be purchased with money that has been donated for this purpose. All plantings will be perennials and trees in order to avoid major new expenses each year. For your information, the donations for this year's plantings came from the Auxiliary of the Lehigh Valley Hospital, Tsoi/Kobus and Associates (an architect firm), and Alvin H. Butz, Inc. Routine grounds maintenance will be paid from hospital funds.

- The OI Incentive Program will be postponed until a more appropriate time.

Many other ideas have been recommended and are also under consideration. Reports on these will be forthcoming as the work force expense reduction plan unfolds.

Radiology Reorganizes to Face the Future

Like many Lehigh Valley Hospital and Health Network departments, the Department of Radiology/Diagnostic Medical Imaging is changing to prepare for the future of health care. According to Walter Eberts, Administrative Director, about 15 supervisory positions have been consolidated into five, and duties have been reassigned to create a more efficient team. While it is never easy to consolidate positions, Radiology's new structure promotes greater employee autonomy and strengthens the idea of taking ownership of the job. For example, employees now schedule their own patients and make day-to-day decisions. "We are trying to stress to everyone in the department that they should treat their job as if it were their own small business," Eberts said.

The department is also changing physically. Since late 1995, construction at Cedar Crest & I-78 has been joining the Emergency and Radiology departments. This will allow patients needing radiological procedures to receive them faster and in a more private setting. Phases I and II will soon be completed. They include an expanded reception area to accommodate more patients, updated file and record rooms, and new ultrasound areas.

"Although we are still in the midst of change, I think the team as a whole has really stepped up to the plate and is making the transition as smooth as possible," Eberts said.

Building Project Re-evaluated

The planning of a multi-story addition at Cedar Crest & I-78 is being re-evaluated to consider more appropriate options in light of current and forecasted utilization and economic trends in the health care environment, according to Louis Liebhaber, chief operating officer. The building is slated to house inpatient OB/GYN services, inpatient psychiatry, and ambulatory diagnostics and testing services.

"Given the volatility and uncertainty of market conditions, we are re-thinking the timing and size of any future building programs," Liebhaber said. "We are committed to the continued consolidation of acute inpatient services at Cedar Crest & I-78 and a strong ambulatory presence at 17th & Chew. But we need additional time and study to best determine how to use this community's resources."

Options for the proposed addition being considered include constructing a smaller building or renovating existing space in the hospital to accommodate relocated services. These options will be discussed at a special senior management council meeting in late April, and it is quite likely that definitive action will be delayed, Liebhaber stated.

In 1994 when the Board of Trustees of Lehigh Valley Hospital and Health Network authorized funding for a three- to five-year multi-phased functional and facilities plan, it was with the caveat that the plan would be flexible and allow for changes in the health care environment.

"When we developed these plans for the future of Lehigh Valley Hospital and Health Network, we didn't have a crystal ball. We knew we would constantly have to test our assumptions to make sure we were still on the right track," Liebhaber said. "We have almost completed the first two phases of the plan. And from a budgetary standpoint, all projects have come in right where we expected them to."

The first and second phases included the renovation of obstetrics and the dental clinic, and the creation of the transitional skilled unit at 17th & Chew. Inpatient pediatrics and the GI Lab were relocated to Cedar Crest & I-78 during this part of the plan. And most laboratory services will be consolidated at 2024 Lehigh Street in a soon to be completed addition.

Since the planning initiative began in 1994, much has changed in the health care arena.

LVHHN launched operations improvements to achieve cost savings and has made significant progress on the non-personnel side. However, less and less savings have been achieved on the staffing side and to correct this imbalance, Lehigh Valley Hospital must now reduce staffing expenses by nearly $13 million in fiscal year 1997.

In addition, the health care environment has been dramatically altered by the emergence of managed care in the hospital's service region. This has resulted in an environment of decreasing hospital admissions, shorter lengths of stays and growing health plan options. LVHHN has responded by developing Valley Preferred, a cost-effective business health care product and by forming PennCARE, the health partnership of physicians and eight hospitals. PennCARE has been officially incorporated and can now enter into contractual arrangements with insurance companies on behalf of participating hospitals and physicians.

While these developments position Lehigh Valley Hospital to thrive in a changing health care environment, it will take some time for these programs to show results, according to Liebhaber.

"At this point, we cannot predict the impact of managed care. It just makes sense to watch how the market shakes out," Liebhaber said.

PCC Unit Telephone Directory for TTU

Director: Marilyn Guidi		x8769
Nurse Practitioner:		x0254
Physician Assistant:		x0249
Room #	RN Cellular	"Server"/"Team"
4-6	x0251	x8766
8, 9, 12, 13	x0252	x8767
16-20	x0253	x8768
General Info:		x8765
Administrative Partner:		x0250
CNF: Judy Bailey		x8908
Observation Room:		x4550
Fax:		x1669

PennCARE Partners Ease Access for Bethlehem Residents

Lehigh Valley Hospital and Health Network (LVHHN) and Muhlenberg Hospital Center, both members of PennCARE, established a new home care service to benefit Bethlehem residents. A program of Lehigh Valley Home Care, Muhlenberg Home Health opened on February 28 and is staffed primarily by Muhlenberg Hospital Center employees. Lehigh Valley Home Care provides speech therapy and management services.

According to William Dunstan, Administrator, Lehigh Valley Home Care, "Muhlenberg Home Health illustrates the true spirit of the PennCARE partnership with each partner contributing a resource that benefits the community. Greater Bethlehem residents receive the benefits of an established, quality home health program delivered by health professionals from Muhlenberg Hospital Center in their own neighborhood."

Muhlenberg Home Health program offers services to patients whose care does not require all of the resources of the hospital. Examples include patients and families who:

- need assistance during an acute illness and after hospitalization to live independently at home;
- have a disability or chronic condition such as heart and lung disease, muscle-nerve problem, or bone and joint disorder which requires the need of a skilled professional; or
- require help in their home after surgery.

For more information about home care services, call 402-CARE.

NCI Clinical Announcement: Tamoxifen Update

The National Cancer Institute has recently emphasized new information regarding the optimal duration of adjuvant tamoxifen therapy. Recent results were released from the National Surgical Adjuvant Breast and Bowel Project (NSABP) Protocol B-14. Designed to evaluate five versus ten years of adjuvant tamoxifen for early stage breast cancer, the results from B-14 indicate no advantage for continuation of tamoxifen beyond five years in women with node-negative, estrogen receptor-positive breast cancers. In view of the proven benefits of five years of adjuvant tamoxifen, this treatment should continue to be administered whenever appropriate to women with early stage breast cancer. However, the new data suggest that **more than five years of adjuvant treatment is not warranted in routine clinical practice** in this patient population. Both the B-14 and a separate Scottish trial suggest a greater likelihood of relapse in women who take tamoxifen for durations greater than five years when compared to women who receive five years of therapy.

Although additional data is needed to clarify the issue, it is very unlikely that continuation of tamoxifen beyond five years will result in a disease-free survival or overall survival benefit in women with node-negative, estrogen receptor-positive breast cancers. Ongoing trials are continuing to compare five years of treatment versus longer durations. While those results are eagerly anticipated, all available evidence indicates that five years of tamoxifen is a reasonable standard for the adjuvant setting.

Attention Physicians and Office Personnel

Patients are sometimes scheduled for a GI Lab procedure on the same day as a scheduled admission or O.R. procedure. The attending physician may or may not remain the same. Physician offices are reminded to relay this information to GI Lab and Central Scheduling when making the patient's reservations. This will enable the most efficient coordination of your patient's care. Please call Marie Porter at 402-8850 with any questions.

Document Imaging Project - Vendor Demonstrations May 1, 2 & 3

A Document Imaging Management System (DIMS) Task Force was established in December, 1995, to assist Lehigh Valley Hospital in electronically capturing, storing, and retrieving archival, but active medical record information. Document Imaging Technology will allow multiple users to simultaneously access patient medical records currently stored on paper. During the past several months, various work groups have been formed, composed of hospital staff and members of the medical staff, to assist with converting paper records to an electronic format for improved accessibility. In an effort to keep the medical staff informed of the Document Imaging Management project, members of the Document Imaging Task Force have been giving short presentations at the various department meetings.

The Task Force has narrowed the vendor selection to three vendors. On-site demonstrations will be held at both hospital sites on May 1, 2 and 3.

May 1 - 8 a.m. to 4:30 p.m., Anderson Wing Lobby, Cedar Crest & I-78
May 2 - 8 a.m. to 4:30 p.m., Auditorium, 17th & Chew
May 3 - 8 a.m. to 4:30 p.m., Classrooms 2 & 3, Cedar Crest & I-78

Please visit the vendor demonstrations on the above dates to view this new technology. Evaluation forms will be available to provide your input as to which system will best meet your needs.

DRG Options Update

The DRG Options Program, designed to improve medical record documentation, has been underway for approximately two months. The program's value to the hospital and medical staff continues to be demonstrated through improved documentation. Work sheets are placed on all Medicare admissions to give physicians an option in selecting the principle diagnosis based on coding guidelines and an assessment of clinical, medical and surgical findings. Clinical Documentation Managers, who have been trained to identify any treatment or condition that complicates or prolongs treatment in the eyes of DRG-reimbursement carriers, are available for assistance with questions regarding the DRG worksheets. Overall response to the program has been very good.

Recommendation from the consultants who implemented the program required that we make some changes in our process. Prior to implementation of the program, coding questionnaires were faxed or mailed to physician offices following patient discharge. Documentation in the form of answers to the questions never appeared in the medical record, only on the questionnaires which were not part of the record. Following implementation, questions are now appearing on the discharged patient's record in the physician incomplete chart area of the Medical Record Department. Physicians are requested to respond to the questionnaires in the medical record (discharge summary, progress notes, etc.) to assure that the medical record accurately reflects the diagnosis and care of the patient.

On April 9, seminars were held for physicians and physician office staff at Cedar Crest & I-78. The information disseminated at these sessions regarding physician billing practices was well received by the audience. Coordinating hospital documentation with physician office documentation reduces the likelihood of denials and quality issues, while providing better justification for professional services rendered and a more accurate profile of severity of illness for your patients. Documentation in office records is as important as documentation in the hospital record.

For more information or if you have questions regarding this program, contact Zelda Greene, Director of Medical Records, at 402-8330.

5C Construction Update

Since November, 1995, 5C has had half of the unit closed for renovations. Operating with only 16 beds, 5C is very eager to complete the renovation process and implement PCC.

With the current census trends of the past few weeks, an opportunity has been identified to speed up the process considerably by temporarily closing the remainder of the unit to complete construction. This closure will allow the project to be completed by mid-June rather than early August.

To accommodate the relocation of the orthopedic patients, the following changes have been made:

- six ambulatory beds on 5B have been put into service for inpatients increasing their capacity from 26 to 32.
- SCU room #1 will be utilized for overflow ambulatory patients not accommodated on 5B. 5B staff nurses will staff this area.
- If 5B beds are "tight," post-op renal transplants will remain on SCU and be charged a med/surg rate.
- TTU14 will be put back into service, if the need arises, and will be staffed by the 5B/5C staff.
- Urology, orthopedics, renal transplants, and general surgery patients will receive priority for 5B. Every effort will be made to minimize the relocation of surgical patients off the 5th floor.

The 5C staff will be utilized on 5B to assure the standard of care for orthopedic patients is met when those patients are assigned to the unit.

If you have any questions regarding this issue, please contact Mary Agnes Fox, RN, MSN, Administrator, Patient Care Services, at 402-1630.

What's New in the Library?

The following books are available in the Health Sciences Library at Cedar Crest & I-78:

Otorhinolaryngology: Head and Neck Surgery, 15th edition
Author: Ballenger, John Jacob, et al.
Call # WV 100 O874 1995

Cancer of the Breast, 4th edition
Author: Donegan, William, et al.
Call # WP 870 C2155 1995

Health Promotion and Disease Prevention in Clinical Practice
Editor: Woolf, Steven, et al.
Call # WA 110 H4345 1995 (Reference Section)

Emergency Medicine: A Comprehensive Study Guide, 4th edition
Editor-in-Chief: Tintinalli, Judith
Call # WB 105 E552 1996

Theological Voices in Medical Ethics
Editor: Lammers, Stephen, et al.
Call # W 50 V513t.

The following books are available in the Health Sciences Library at 17th & Chew:

Intensive Care of the Fetus and Neonate
Author: Spitzer, Alan
Call # WS 421 I61 1996

Clinical Problems, Injuries, and Complications of Gynecologic and Obstetric Surgery, 3rd edition
Editor: Nicholas, David, et al.
Call # WP 600 C641 1995

Pocket Handbook of Clinical Psychiatry, 2nd edition
Author: Kaplan, Harold, et al.
Call # WM 34 K17p 1996

Web Site Address

The Pennsylvania Society for Respiratory Care: http://member.aol.com/psrchome/index.htm

...providing links to state pulmonary conferences, sleep medicine, job tips, and to the American Association for Respiratory Care.

Stroke Outcomes Study

Thirty patients are currently needed to become part of a Stroke Outcomes Pilot Study. The study will include a neurologic assessment, evaluation, and interview to be completed within the hospital, extended care facilities, and at home throughout a 12-month period.

Any patient, over 18 years of age, who was admitted to Lehigh Valley Hospital with a diagnosis of new stroke due to vascular occlusion, thrombosis, or emboli, is eligible for the study.

For more information or if you have an eligible patient, please contact Peter J. Barbour, MD, at 402-8420, Donna Jenny, RN, at 402-9830, or Sue DeSanto, RN, at 402-1728.

Golf Tournament to Benefit Burn Center

The First Annual Kerry Griffith Golf Tournament will be held on Monday, June 10, at Berkleigh Country Club. All proceeds will benefit Lehigh Valley Hospital's Burn Center.

Kerry Griffith, himself a former burn patient, was so impressed with the care he received at our Burn Center that he took it upon himself to organize this benefit.

There are approximately 40 spots left for playing. Entrance fee per golfer is $125.00 which includes greens fee with cart, use of locker rooms, Firethorn golf shirt, commemorative logo ball, three prizes for net and three for gross, lunch and refreshments.

For more information, contact Catherine Lienhard in the Development Office at 402-3031.

Pennsylvania SPARC - Stroke Prevention Awareness and Recognition Campaign

The Keystone Peer Review Organization (KePRO) has taken the lead with a number of other organizations and individuals in a statewide stroke prevention project called the Pennsylvania Stroke Prevention Awareness and Recognition Campaign (SPARC). Participating in SPARC are Governor Tom Ridge, PSU football coach Joe Paterno, the American Heart Association, Temple University School of Medicine, and the Pennsylvania Medical Society Alliance, to name just a few. The Pennsylvania Medical Society Board of Trustees took an action at the March 6 meeting to support this effort.

Temple's Office for continuing Medical Education developed an educational monograph entitled *Atrial Fibrillation: Comprehensive Management in the Primary Care Setting* and mailed it to approximately 13,000 primary care physicians near the end of March. KePRO is now in the process of scheduling sites and volunteers for free public screenings throughout the state to be held during May, which is National Stroke Prevention Month. As of mid-March, more than 150 sites have been volunteered.

KePRO believes this will be the first statewide effort which has been attempted in the nation, and other states are watching Pennsylvania's project with great interest. In order to make this program a great success, and to create greater awareness and attention to stroke risk factors, KePRO would be grateful for any support for this program by members of the Lehigh County Medical Society and its affiliated Auxiliary. They would also welcome volunteers to assist at the screening sites, especially those who have sufficient medical background to take a brief history, pulse, and blood pressure and check for carotid bruit. Volunteers may be physicians or nurses in active or retired practice, medical students, EMTs, etc.

Call today to Volunteer - 1-800-618-2887

Penn State University Faculty Appointments Made

The Center for Education is proud to announce that the following physicians have been approved for faculty appointments to the Pennsylvania State University, College of Medicine:

Department of Anesthesiology

Clinical Associate Professor of Anesthesia and Associate Chair
Alphonse A. Maffeo, MD

Assistant Professor of Anesthesiology
Bruce D. Nicholson, MD

Clinical Assistant Professor of Anesthesia
Karen A. Bretz, MD
J. John Collins, MD
Edgudo S. Cruz, MD
Ramon J. Deeb, MD
Domenico Falcone, MD
Dorothy I. Hartman, MD
Howard E. Hudson, Jr., MD
Jay S. Jung, MD
Carmen B. Montaner, MD
Toeruna S. Widge, MD
Wen-Shiong Yang, MD

Department of Emergency Medicine

Clinical Associate Professor of Emergency Medicine
Ronald A. Lutz, MD

Clinical Assistant Professor of Medicine
Eric J. Bodish, MD
Jerome C. Deutsch, DO
Joseph J. Fassl, MD
Stephen P. Fooskas, MD
John F. McCarthy, DO
James G. McHugh, MD
Alexander M. Rosenau, DO
Diane M. Saldukas-Mazur, MD
Joseph L. Spadoni, MD
Anthony T. Werhun, MD
William E. Zajdel, DO

Department of Family Practice

Associate Professor of Family and Community Medicine
William L. Miller, MD

Clinical Associate Professor of Family and Community Medicine
Headley S. White, MD

Clinical Assistant Professor of Family and Community Medicine
Chalres T. Bonos III, MD
Bruce A. Ellsweig, MD
John D. Farrell, MD
Narien K. Grover, MD
Susan E. Kostenblatt, MD
Jack A. Lenhart, MD
Linda Loffredo, MD
J. Stephen Long, MD
Dennis M. McGorry, DO
Stephen J. Motsay, MD
Peter H. Neumann, MD
Harvey B. Passman, DO
Howard A. Silverman, MD
Louis E. Spikol, MD
Brian Stello, MD
Brian D. Wilson, MD

Department of Medicine

Professor of Medicine and Associate Chair
John P. Fitzgibbons, MD

Professor of Medicine
Elliot J. Sussman, MD
Mark J. Young, MD

Professor of Clinical Medicine
Lawrence P. Levitt, MD
David Prager, MD

Clinical Professor of Medicine
Dean F. Dimick, MD

Associate Professor of Clinical Medicine
John E. Castaldo, MD
Robert J. Laskowski, MD
Yehia Y. Mishriki, MD
D. Lynn Morris, MD
Alexander Rae-Grant, MD
Richard H. Snyder, MD

Clinical Associate Professor of Medicine
Albert D. Abrams, MD
Peter J. Barbour, MD
Donald E. Barilla, MD
David M. Caccese, MD
Joseph A. Candio, MD
Jane Dorval, MD
Joseph C. Guzzo, MD
Herbert L. Hyman, MD
James E. Kintzel, MD
Larry N. Merkle, MD
Luther V. Rhodes III, MD
Francis A. Salerno, MD
Alan H. Schragger, MD
Joseph E. Vincent, MD

Assistant Professor of Medicine
Gina N. Karess, MD
Jenni Levy, MD

Clinical Assistant Professor of Medicine
Lawrence W. Bardawil, MD
Lloyd E. Barron II, MD
Donald J. Belmont, MD
Kenneth A. Bernhard, MD
Thomas G. Brandecker, MD
Charles M. Brooks, MD
David P. Carney, MD
Robert J. Coni, DO
Luis Constantin, MD
Jay S. Cowen, MD
Carl F. D'Angelo, MD
Jeffery A. Debuque, DO
Robert B. Doll, Jr., MD

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Gary M. DuGan, MD
Wayne E. Dubov, MD
Bruce A. Feldman, DO
Larry B. Feldman, MD
John P. Galgon, MD
Hugh S. Gallagher, MD
Joseph W. Gastinger, MD
Dennis J. Giangiulio, MD
Gene H. Ginsberg, MD
David B. Goldner, MD
Michael Goldner, DO
Charles A. Gordon, MD
Joseph J. Grassi, MD
Paul Guillard, MD
Paul Gulotta, MD
Jonathan Hertz, MD
Douglas E. Johnson, MD
Barre Kaufman, MD
Jay H. Kaufman, MD
John A. Kibelstis, MD
J. Patrick Kleaveland, MD
Jay E. Kloin, MD
Bryan W. Kluck, DO
Pieter Knibbe, MD
Mark C. Knouse, MD
Robert J. Kovacs, MD
Jeffrey R. Kralstein, MD
Glenn S. Kratzer, MD
Harold Kreithen, MD
Richard L. London, MD
Christopher C. Lynch, MD
Norman H. Marcus, MD
John W. Margraf, MD
William M. Markson, MD
Stephen C. Matchett, MD
James T. McNelis, DO
Kerry D. Miller, MD
Mark N. Mishkin, MD
Minh Ly Nguyen, MD
John D. Nuschke, MD
Stephen T. Olex, DO
Robert J. Oriel, MD
James A. Pantano, MD
Charles D. Peters, MD
J. Harry Pickle IV, MD
Robert M. Post, MD
Stephen M. Purcell, DO
Gerald E. Pytlewski, DO
Daniel M. Rappaport, MD
James E. Redenbaugh, MD
Russell J. Rentler, MD
Randy A. Rosen, MD
Michael A. Rossi, MD
John H. Samies, MD
James A. Sandberg, MD
Norman S. Sarachek, MD
Melvin H. Schwartz, MD
Francis Schwiep, MD
Steven A. Scott, MD
Surendra S. Shah, MD
Stephen R. Shore, MD
Glenn M. Short, MD
Bruce J. Silverberg, MD
Arthur C. Sosis, MD
Lorraine J. Spikol, MD
Ronald A. Stein, MD
William R. Swayser, Jr., DO
Robert J. Thompson, MD
Margaret S. Tretter, DO
William A. Tuffiash, MD
Michael H. Ufberg, MD
Ronald E. Wasserman, MD
Christopher J. Wohlberg, MD

Department of Obstetrics and Gynecology

Associate Professor of Clinical Obstetrics and Gynecology
Stephen K. Klasko, MD
Bruce I. Rose, MD

Assistant Professor of Clinical Obstetrics and Gynecology
Robert D. Atlas, MD
James Balducci, MD
Vincent Lucente, MD
Stacie J. Weil, MD

Clinical Assistant Professor of Obstetrics and Gynecology
Lisa Baker-Vaughn, MD
Henry H. Fetterman, MD
Edward E. Geosits, DO
Larry R. Glazerman, MD
T. A. Gopal, MD
Thomas A. Hutchinson, MD
Earl S. Jefferis, Jr., MD
Carl A. Lam, MD
Sheldon H. Linn, MD
Howard M. Listwa, DO
Ernest Y. Normington II, MD
Michael S. Patriarco, DO
Gregory J. Radio, MD

Department of Pathology

Clinical Professor of Pathology
John J. Shane, MD

Associate Professor of Pathology
Brian W. Little, MD

Clinical Assistant Professor of Pathology
Bala B. Carver, MD
Malcolm L. Cowen, MD
William B. Dupree, MD
Michael Scarlato, MD

Department of Pediatrics

Associate Professor of Clinical Pediatrics and Associate Chair
John D. VanBrakle, MD

Clinical Associate Professor of Pediatrics
Dennis W. Kean, MD
Donald L. Levick, MD
Martha Lusser, MD
Robert W. Miller, MD
Oscar A. Morffi, MD
Russell B. Puschak, MD
Charles F. Smith, MD

Assistant Professor of Clinical Pediatrics
Claire E. Bolon, MD

Clinical Assistant Professor of Pediatrics
Kimberly C. Brown, MD
Sarah J. Fernsler, MD
Ian M. Gertner, MD
Elizabeth Goff, MD
Leonard M. Golub, MD
John P. Hentosh, MD

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Charles F. Kelley, Jr., MD
Nicholas C. Kyriazi, MD
Shantha V. Mathews, MD
Mark P. Shampain, MD
Catherine L. Shaner, MD
Mary S. Shields, MD
Jere P. Smith, MD
Kenneth J. Toff, DO
Marijo A. Zelinka, MD

Department of Psychiatry

Associate Chair and Professor of Clinical Psychiatry
Michael W. Kaufmann, MD

Clinical Associate Professor of Psychiatry
John F. Campion, MD
Susan D. Wiley, MD

Assistant Professor of Clinical Psychiatry
Joseph L. Antonowicz, MD
Ralph A. Primelo, MD
James G. Showalter, MD
Peggy E. Showalter, MD

Clinical Assistant Professor of Psychiatry
Paul K. Gross, MD
Clifford H. Schilke, MD
Farhad Sholevar, MD
Kenneth Zemanek, MD

Department of Radiation Oncology

Associate Chair and Associate Professor of Clinical Radiology
Victor R. Risch, MD

Clinical Assistant Professor of Radiology
Charles F. Andrews, MD

Department of Radiology/Diagnostic Medical Imaging

Associate Chair and Clinical Associate Professor of Radiology
Mark A. Osborne, MD

Associate Professor of Radiology
Robert Kricun, MD

Clinical Associate Professor of Radiology
Michael H. Geller, MD
James W. Jaffe, MD
Stuart A. Jones, MD
Zwu S. Lin, MD
Alan H. Wolson, MD

Clinical Assistant Professor of Radiology
Walter J. Dex, MD
Elliot I. Shoemaker, MD

Department of Research

Associate Professor of Medicine
James F. Reed III, PhD

Clinical Assistant Professor of Medicine
Thomas E. Wasser, Med

Department of Surgery

Professor of Surgery and Associate Chair
Herbert C. Hoover, Jr., MD

Professor of Surgery
Indru T. Khubchandani, MD
Gary G. Nicholas, MD
Michael Rhodes, MD

Professor of Clinical Surgery
William Gee, MD
Lester Rosen, MD

Clinical Professor of Surgery
George W. Hartzell, MD
Robert X. Murphy, Jr., MD
Walter J. Okunski, MD

Associate Professor of Clinical Surgery
Kevin J. Farrell, MD
Craig R. Reckard, MD

Clinical Associate Professor of Surgery
Raj P. Chowdary, MD
William W. Frailey, MD
John S. Jaffe, MD
Mark C. Lester, MD
Richard M. Lieberman, MD
Robert A. Morrow, MD
Edward M. Mullin, Jr., MD
John J. Stasik, MD

Assistant Professor of Surgery
Mark D. Cipolle, MD
Michael D. Pasquale, MD

Assistant Professor of Clinical Surgery
George I. Chovanes, MD

Clinical Assistant Professor of Surgery
John A. Altobelli, MD
Alan Berger, MD
Richard C. Boorse, MD
Victor J. Celani, MD
Chris CN. Chang, MD
Michael A. Chernofsky, MD
David L. Clair, MD
Tamar D. Earnest, MD
Zev Elias, MD
Arthur E. Fetzer, MD
Theodore H. Gaylor, MD
Mark A. Gittleman, MD
Kevin E. Glancy, MD
James J. Goodreau, MD
David A. Gordon, MD
Michael J. Gordon, MD
John D. Harwick, MD
Robert B. Kevitch, MD
Thomas J. Koch, MD
Linda L. Lapos, MD
Mark N. Martz, MD
James L. McCullough, MD
Kenneth M. McDonald, MD
Brian P. Murphy, MD
Antonio C. Panebianco, MD
John S. Papola, MD
Joseph Pascal, MD
Theodore G. Phillips, MD
Robert D. Riether, MD
Peter F. Rovito, MD

(Continued on Page 13)

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Farrokh S. Sadr, MD
Charles J. Scagliotti, MD
Kamalesh T. Shah, MD
James A. Sheets, MD
Gerald P. Sherwin, MD
Daniel M. Silverberg, MD
Michael C. Sinclair, MD
Raymond L. Singer, MD
Barry H. Slaven, MD
F. Geoffrey Toonder, MD
Douglas R. Trostle, MD
John F. Welkie, MD
Geary L. Yeisley, MD
Luke CK. Yip, MD

Division of Ophthalmology

Clinical Assistant Professor of Ophthalmology
Glen L. Oliver, MD

Division of Orthopedic Surgery

Associate Professor of Clinical Orthopedics
Peter A. Keblish, Jr., MD

Clinical Associate Professor of Orthopedics
George A. Arangio, MD

Clinical Assistant Professor of Orthopedics
Thomas D. DiBenedetto, MD
Thomas B. Dickson, Jr., MD
Thomas D. Meade, MD
Patrick B. Respet, MD
David B. Sussman, MD

Clinical Instructor of Orthopedics
Steven J. Lawrence, MD

The Center for Education will continue to submit faculty appointments as they are approved. If you have any questions regarding faculty appointments, please contact Helga Klemp in the Center for Education at 402-5243.

Congratulations!

Yehia Y. Mishriki, MD, Chief, Division of Ambulatory Care, was recently notified by the Medical College of Pennsylvania and Hahnemann University that he has been selected to receive the Dean's Special Award for Excellence in Clinical Teaching at Lehigh Valley Hospital for 1996. Dr. Mishriki has earned this honor for the fourth year in a row!

Edward Zebovitz, DDS, Division of Oral and Maxillofacial Surgery, successfully completed the 1996 Oral Certifying Exam for certification as a Diplomate of the American Board of Oral and Maxillofacial Surgery.

Papers, Publications and Presentations

Michael W. Kaufmann, MD, Chairperson, Department of Psychiatry, **Stephen K. Klasko, MD**, Acting Interim Chairperson, Department of Obstetrics and Gynecology, and **Elliot J. Sussman, MD**, President and CEO, co-authored the paper, "Reduction of Stress and Prediction of Burnout in Multi-Disciplinary Residency Programs," which was recently presented by Drs. Kaufmann and Klasko at the AMA International Conference on Physician Health held in Chandler, Ariz.

Indru T. Khubchandani, MD, Division of Colon-Rectal Surgery, was on the faculty of the Seventh Annual International Colorectal Disease Symposium sponsored by the Cleveland Clinic in Fort Lauderdale, Fla. Dr. Khubchandani chaired the panel on "Cancer" and gave presentations on "Pruritus Ani" and "C. Difficile and Antibiotic Related Colitis."

Larry N. Merkle, MD, Chief, Division of Endocrinology/Metabolism, **Sheldon H. Linn, MD**, Division of Primary Obstetrics and Gynecology, **Joseph C. Guzzo, MD**, Chief, Division of Nephrology, **Russell B. Puschak, MD**, Division of General Pediatrics, and **Edwin Lee, MD**, former medical resident, co-authored an article, "Frasier Syndrome," which was published in the March/April 1996 issue of ***Endocrine Practice***.

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David P. Steed, DPM, Chief, Section of Podiatry, and **Scott J. Lipkin, DPM**, Section of Podiatry, are now involved in the research of Dermagraft, a cultured human dermis used to treat diabetic foot ulcers. An article, which was published in the April 1996 issue of ***The Journal of Clinical and Applied Research and Education-Diabetes Care,*** describes the method of treatment. Both Drs. Steed and Lipkin were among the co-authors of the article.

Prodromos A. Ververeli, MD, Division of Orthopedic Surgery, was invited to be a guest lecturer at the Orthopaedic Surgery Board Review Course sponsored by the Osler Institute. Dr. Ververeli lectured on Total Knee Replacement.

Upcoming ***Seminars, Conferences and Meetings***

Medical Staff/Administrative Exchange Session

The next Medical Staff/Administrative Exchange Session will be held on Thursday, May 16, beginning at 5:30 p.m., in **Classroom 1, Anderson Wing, Cedar Crest & I-78.**

The topic for this session will be announced prior to the meeting.

For more information, contact John E. Castaldo, MD, Medical Staff President, through Physician Relations at 402-9853.

Regional Symposium Series

Sixteenth Annual Update in Cardiology will be held on Thursday, May 2, from 7:30 a.m. to 12:45 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Physicians, nurses, and other health professionals interested in the latest breakthroughs in selected aspects in cardiology will benefit from this program.

At the completion of this program, participants should be able to:
- describe the role of coronary disease in the elderly
- discuss the current status and controversies on use of calcium channel blockers
- discuss the diagnosis and treatment of supraventricular tachycardia
- discuss the treatment of atrial fibrillation and flutter.

For more information about this program, please contact the Center for Educational Development and Support at 402-1210.

Department of Pediatrics

Recent Advances in Diagnosis of Neonatal Sepsis will be presented by Richard Polin, MD, Department of Neonatology, Children's Hospital of Philadelphia, on Friday, May 10.

Neuroblastoma will be presented by Dave Ungar, MD, Hershey Medical Center, on Friday, May 24.

The above conferences will be held at noon in the hospital Auditorium at 17th & Chew. For more information, please contact Cindy Williams at 402-2536.

Psychiatric Grand Rounds

The Emerging Link; Depression and Sleep Disturbance will be presented by Karl Doghramji, MD, Director of Sleep Disorder Center, Jefferson Medical College, on Thursday, May 16, from noon to 1 p.m., in the hospital's Auditorium at 17th & Chew. For more information, please call Lisa Frick in the Department of Psychiatry at 402-9722.

The Ambulatory Surgery Unit at 17th & Chew is in the process of revising its discharge instruction protocol book. In order to coordinate the information you give to your patients with the information the hospital provides, please send copies of all discharge instructions and pre-operative instructions which you give to your patients in the office to: Cindy Hertzog, CNF, Ambulatory Surgery Unit, Lehigh Valley Hospital, 17th & Chew, P.O. Box 7017, Allentown, PA 18105-7017.

If you have any questions, please contact Cindy Hertzog at 402-3435.

As a result of input from the Telecommunications Physicians Advisory Committee, the following recommendations were made for Call Park usage:

Call Park Instructions

A. Recommendations for Call Park Usage

1. Emergencies and/or priorities - Physician to physician should be done for emergencies and/or priority calls.
2. Paging from a car phone or from a place where a call back is not possible.
3. Patient to Physician - Only when a call back is not possible.
4. Not to be used by Physician's or Employee's families
5. Not to be used for personal reasons.

B. Call Park Prefixes

111 - STAT Call
222 - Call from a family member
333 - Call from a hospital employee
444 - Call from a patient
666 - Call from a physician
777 - Business call

C. Call Park Retrieval

1. Inside the Hospital
   a. Dial the last 4 digits of the call park number as indicated on the pager display. (The last 4 digits will always begin with 09.)
   b. Call is connected, begin the conversation.

   Example of a call park call from a physician:
   Pager display 666-402-0963
   Dial: 0963
   Begin conversation

2. Outside the Hospital
   a. Dial 402 plus the 4 digit call park number indicated on the pager display.
   b. You will hear a dial tone for approximately 3 seconds.
   c. When dial tone **stops**, wait for a connect which takes approximately 2 seconds.
   d. Caller is connected. Begin conversation.

   Example of a call park call from a patient:
   Pager display 444-402-0963
   Dial: 402-0963
   Hear dial tone
   Hear silence for 2 seconds
   Connection made; begin conversation.

3. Busy Signal
   a. If you receive a fast busy signal, all circuits are busy. Hangup and dial the call park number again.
   b. If you receive a regular busy signal, the caller has hung up. Call the Page Operator (402-8999) for the caller's name and number.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, status changes, etc. Please remember that each department or unit is responsible for updating its directory and rolodexes with this information.

Medical Staff
Appointments

Ruben A. Gonzalez-Florin, MD
Allentown Pediatrics Association
(Dr. Ramos)
1728 Jonathan Street
Suite 200
Allentown, PA 18104-3170
(610) 776-4141
FAX: (610) 776-2055
Department of Pediatrics
Division of General Pediatrics
Provisional Active

Thomas M. McLoughlin, Jr., MD
Allentown Anesthesia Associates, Inc.
(Dr. Maffeo)
1251 S. Cedar Crest Blvd.
Suite 212C
Allentown, PA 18103-6243
(610) 402-8810
FAX: (610) 402-8008
Department of Anesthesiology
Provisional Active

Change of Status

Francis S. Kleckner, MD
Department of Medicine
Division of Gastroenterology
From Active to Emeritus Active

Charles L. Knecht III, MD
Department of Radiology/Diagnostic Medical Imaging
Division of Diagnostic Radiology
From Consulting to Emeritus Consulting

Gary M. Pryblick, DO
Department of Family Practice
From Referring to Provisional Active

Edward A. Schwartz, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Podiatry
From Referring to Provisional Active

Resignations

William J. Bryan, DDS
Department of Dentistry
Division of Orthodontics

Howard L. Carbaugh, MD
Department of Family Practice

Robert H. Dixon, MD
Department of Pediatrics
Division of General Pediatrics

Michael J. Greenberg, MD
Department of Radiation Oncology

Diedre J. Greene, MD
Department of Pediatrics
Division of General Pediatrics

Nancy R. Matus, MD
Department of Medicine
Division of Dermatology

Mary G. Pixler, MD
Department of Medicine
Division of General Internal Medicine

Raymond P. Seckinger, MD
Department of Psychiatry

George S. Smith, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology

Maheshwer B. Verma, MD
Department of Pediatrics
Division of General Pediatrics

Allied Health Professionals
Appointments

Catherine E. Donati, CRNP
Physician Extender
Professional - CRNP
(Hospital Outpatient Pediatrics - Dr. Smith)

Claudette Geist
Physician Extender
Technical
Surgical Technician
(Lehigh Valley Ophthalmic Associates - Dr. Burkholder)

Tina M. Paganetti
Physician Extender
Technical
Surgical Technician
(Lehigh Valley Ophthalmic Associates - Dr. Burkholder)

Brenda R. Snyder
Physician Extender
Technical
Medical Assistant
(Dr. Zelenkofske)

Shelly A. Whitby
Physician Extender
Technical
Medical Assistant
(Dr. Zelenkofske)

HEALTH SCIENCES LIBRARY
COMPUTER LEARNING RESOURCES
MAY 1996

OVID.....

In Search of Quality Articles

"Quality Filtering" is not a new concept. An article appeared in the January 15, 1971 issue of SCIENCE advocating the need to reduce the number of articles retrieved in a computerized literature search by applying quality indicators. There are several quality LIMITERS in OVID that can be used to search for only the *best* articles. ^G is the OVID command for limiting a search. OVID provides a list of limiters along with their definitions. Try the following 2 limiters, but not in the same search:

AIM Journals- 119 " core reputable clinical" journals which often contain practice parameters, consensus statements, policy statements, of National Organizations, i.e., American College of Physicians. Journals included in this subset are JAMA, NEJM, Annals of ..., Archives of..., American Journal of...., etc.

Publication Type- (When publication type is selected, another list appears. The following choices from that list can be used as quality filters): Clinical Trials- Phases I-IV, (searchable separately), Consensus Development Conference, Controlled Clinical Trial, Guideline, Meta Analysis, Multicenter Study, Practice Guideline, Randomized Controlled Trial, Scientific Integrity Review, and Technical Report.

A word of caution: Applying more than one limiter in the same search may reduce your retrieval to zero.

Sample Search: Type diabetes mellitus/ and press enter. (The forward slash tells the computer to search for a MESH term or subject heading.) Press the control key and

(Sample Search con't)
hold it while pressing the G key (^G) to obtain the list of limiters; Use the spacebar to hightlight the limiter and then press enter. Apply the following limiters: Human, English, Publication Type, Practice Guideline. After applying these limiters, press the ESC key to return to the main screen and ^K to view the results of the last set.

1	diabetes mellitus/	4470
2	limit 1 to human	4350
3	limit 2 to english language	3508
4	limit 3 to pracice guideline	21

TRAINING WORKSHOPS.....

Location: I/S classroom, 4th Floor, Cancer Ctr.

All workshops are hands-on, you must have the icon on your desktop in order to participate. Call 8410 to register.

Internet
Wednesday, May 1, 5-7pm
Basic internet functions will be covered utilizing the hospital connection to access relevent information.

Introduction to OVID, Micromedex, OPAC, and Internet
Wednesday, May 15, 5-7 pm
A basic overview of all the applications will be covered and how their usage can best be integrated into our daily job functions.

Suggestions and ideas are welcome! Contact Sherry Giardiniere, ext. 8406 or Chris Sarley, ext. 1641. Both are available via email.

INTERNET WEB SITES

Keep in mind that internet addresses change constantly.

MEDWEB
http://www.emory.edu/WHSCL/medweb.html
MEDWEB provides a central source for a variety of medical subjects. The index for grants and funding is a good link. Also try "News and What's New".

MEDICAL MATRIX
http://www.kumc.edu:80/mmatrix
This web site, a project of the American Medical Informatics Association (AMIA), provids a comprehensive index for medical links. It is designed in such a way to provide efficient access based on the current methods available to the majority of users. Not a lot of glitter but good usable links.

CLINIWEB
http://www.ohsu.edu/cliniweb/
Cliniweb is a project of the Oregon Health Sciences University designed to provide a table of contents and searching capabilities utilizing the NLM MeSH Vocabulary. This is definitely and indication that an effort is being made to organize the medical information available on the Internet.

Virtual Medical Center
http://www-sci.lib.uci.edu/~martindale/medical.html
A good resource for many types of medical/healthcare links including teaching files, medical cases, courses and textbooks. Provides a link to Reuters Medical News.

Internet "how to" guides
http:www.yahoo.com/computers/internet/beginner_s_guides/
This is a great "spot" which provides 8 pages of links of internet guides and educational materials. A good way to learn internet by using internet!

Looking for medical images or image links?
Dept. Of Radiology, Penn State University
http://www.xray.hmc.psu.edu/

Another one close to home!
Pennsylvania Society for Respiratory Care
http://member.aol.com/psrchome/index.htm
Provides links to state pulmonary conferences, Sleep Medicine, job tips and to the American Association for Respiratory Care.

Virtual Glossaries:
Managed Care Glossary:
http://www.bcm.tmc.edu/ama-mss/glossary.html
Managed Care Acronyms:
http://www.cybergate.com/im/4acronyms.html
Internet Terms Glossary:
http://www.matisse.net/files/glossary.html

*Reminder: Remember to read the **Internet_Services Bulletin Board** in Email for tips and and new resources as they become available! If you find a good site you can send an email to the BB and share your wealth! To do this use the name "internet_services" in the to: section of quickmail.*

P & T HIGHLIGHTS

The following action were taken at the March 20, 1996 Pharmacy and Therapeutics Committee Meeting - Maria Barr, Pharm.D., BCPS, Barbara Leri, Pharm.D., Richard Townsend,R.Ph., M.S..

THE UNIT-BASED PHARMACIST - A positive impact on the cost of drug therapy!

Since our decentralization of the pharmacists from the satellite pharmacies to the patient care floors, many interactions and opportunities to positively effect the care of patients have occurred. Many of the interactions have resulted in overall reduction of cost while the quality of care of the patient is maintained. Some examples of the interventions include..

1. A patient was receiving parenteral conjugated estrogen 30mg (Premarin[R])QD. The vials are available in 25mg only rather than 30mg. To prepare the daily dose, 2 vials were required to be reconstituted with 20mg of the 2nd vial being wasted. By having the pharmacist speak with the MD and equally decrease the dose from 30mg to an effective 25mg dose for the completion of 4 days of therapy, a cost savings of $98.60 was realized.

2. A neutropenic patient was receiving filgrastim 480ug QD to increase the WBC after chemotherapy. The unit based pharmacist, upon reviewing the labs, discovered the patient's WBC had risen to 15.2 in the a.m. prior to the dose being administered. The dose was discontinued prior to being prepared that day, resulting in a savings of $120.00. A team approach in patient care assists in meeting the goals of providing optimum QUALITY of care in the most cost effective manner. To all physicians: We appreciate your support.

BACITRACIN CAPSULES - An Old Drug Returns

Bacitracin is a polypeptide antibiotic with gram-positive bacterial activity including enterococcus and Clostridia difficile. Now with the era of vancomycin resistant enterococcus and prudent vancomycin utilization, it is time to look back to older drugs.

Bacitracin, given orally as extemporaneously prepared 25,000 unit capsules four times daily, is an effective alternative therapy to metronidazole for C.difficile colitis. Bacitracin would be considered second line therapy after metronidazole. It also has activity against bowel flora colonized with enterococcus to assist with controlling nosocomial transmission.

Acquisition Cost Comparison

metronidazole (Flagyl[R])
250mg PO QID $0.08/day
500mg PO QID $0.24/day

bacitracin capsules
25,000 units PO QID approx. $2.00/day

vancomycin PO solution
125mg PO QID $3.60/day
250mg PO QID $7.20/day

TAKING A BITE OUT OF HIGH BLOOD SUGAR IN TYPE II DIABETES: A New Angle on Glycemic Control

Acarbose (Precose, Bayer), the first alpha-glucosidase inhibitor marketed in the United States for treatment of non-insulin-dependent diabetes mellitus, was added to formulary by P&T Committee at the March meeting. The new drug interferes with the digestion of carbohydrates resulting in a decrease in postprandial glucose and glycosylated hemoglobin. Acarbose is indicated for patients with Type II diabetes mellitus who do not achieve glycemic control on diet alone. It is also indicated for combination therapy with a sulfonylurea when monotherapy does not result in adequate glycemic control. Combination therapy achieves greater reduction in postprandial glucose because the drugs control blood glucose by different mechanisms. Acarbose lowers blood sugar without stimulating insulin secretion or producing hypoglycemia. The drug also reduces weight gain seen with the sulfonylureas when used in combination therapy.

Acarbose should be taken with the first bite of each meal to be fully effective. The recommended starting dose is 25 mg three times (tid) a day with meals. The dosage may be increased to a maximum of 100 mg tid at 4 to 8 week intervals based on response to therapy and patient tolerance. The maximum recommended dose for patients weighing less than 60 kg is 50 mg tid due to elevation of serum transaminases at the higher dose.

Gastrointestinal (GI) side effects are the most frequent adverse reactions seen with acarbose. Abdominal pain (21%), diarrhea (33%), and gas (77%) are common and are related to the presence of undigested carbohydrate in the lower GI tract. These effects tend to diminish with time. Patients should be counseled regarding their occurrence and encouraged to continue therapy as tolerated. Hypoglycemia may occur when acarbose is combined with insulin or a sulfonylurea. Glucose, not sucrose, should be used to treat hypoglycemia in patients on acarbose.

Acarbose is available in 50 mg and 100 mg tablets. The outpatient pharmacy cost for a one-month supply at 50 mg tid is $41.05 (AWP - Drug Topics Redbook 1996).

FYI

Dobutamine and dopamine infusions for select patients on med/surg units was approved by the Pharmacy and Therapeutics Committee. Call for more information on dosing if you have a candidate for therapy.

PEDIATRIC CODE BLUE DOSAGE GUIDELINES GO ONLINE

The Pediatric Code Blue Committee recently revised the Pediatric Code Blue Dosage Guidelines to incorporate current recommendations for Pediatric Advanced Life Support published by the American Heart Association. The guidelines contain suggested dosage guidelines and patient-specific dosages for patients under the age of 18 years and with a weight of less than 50 kilograms. The revisions were done as part of a larger, multidisciplinary effort to review and standardize the Pediatric Code Carts throughout the institution and improve the quality of care delivered to pediatric patients. The committee recommended implementation of an online version of the guidelines to enable quick access to the information in all areas where pediatric

patients are cared for. Members of the Pharmacy Department identified the requirements for a computer-based version of the guidelines and worked with Information Services to develop, test, and implement the version now available in PHAMIS (attached).

A copy of the report can be printed by a pharmacist, physician, nurse, or administrative partner from any PHAMIS terminal using the following procedure.

A. Obtain patient specific information including the name, medical record number, and weight in kilograms.

B. Enter PEDREP in the command field at the Main Menu in PHAMIS.

C. Specify the patient's Medical Record Number and press F1 to send.

D. Select the appropriate report number from the screen -

#1 Pediatric Code Blue Dosage Guidelines Page 1
#2 Pediatric Code Blue Dosage Guidelines Page 2
#3 IV Maintenance Fluid Calculations Page 3

E. Enter the patient weight in kilograms.

F. Specify the printer.
Hint: Enter the unit where you want the report to print and hit F8 for a list of printers (ie. to print on the Pediatrics Unit, enter 4B and hit F8). If you are unsure of the print location, check the P number on the printer attached to the computer. Use compressed print only!

G. Hit F1 to send the report to the printer. The report is 3 pages long. You must print each page individually.

H. The caregiver will verify the patient weight and place the guidelines in the front of the medical record.

Length-based pediatric resuscitation guidelines (Broselow tape) are in the medication drawer of the Pediatric Code Cart in the event that access to the guidelines via PHAMIS is unavailable. Please contact Clinical Pharmacy Services at 402-8610 regarding questions about the Pediatric Code Blue Dosage Guidelines.

pt\32096.hi

PEDIATRIC CODE BLUE DOSAGE GUIDELINES

Patient:
Weight: 5.00 KGS
Date: 11APR96 10:17:18 AM

DRUG	HOW SUPPLIED	SUGGESTED DOSAGE	PATIENT DOSAGE
EPINEPHRINE INFUSION	1:1000 1mg/ml(30ml)	USE WHEN PATIENT WEIGHT <= 15kg 0.6 x body weight (kg) is the mg dose added to make 100ml. Then 1ml/hr delivers 0.1mcg/kg/min.	Add 3.0mls (Maximum 9mls) of Epinephrine to make 100ml. Infuse at 1 ml/hr
		USE WHEN PATIENT WEIGHT > 15kg 0.06 x body weight (kg) is the mg dose added to make 100ml. Then 10ml/hr delivers 0.1mcg/kg/min.	Add 0.0mls (Maximum 3mls) of Epinephrine to make 100ml. Infuse at 10 ml/hr
FUROSEMIDE (LASIX)	10mg/ml	1mg/kg IV. Subsequent doses, 2mg/kg IV.	5.00mg= 0.50ml
ISOPROTERENOL (ISUPREL)	1:5000 1mg/5ml	Dilute 0.6mg (3ml) in 100ml of NSS = 6mcg/ml; infuse 1ml/kg/hr = 0.1mcg/kg/min; Increase rate every 5 minutes to MAX. of 1 mcg/kg/min for effect.	* Dose based on 0.1mcg/kg/min 5.00ml/hr
LIDOCAINE	10mg/ml(1%) 5ml syringe	1mg/kg IV, IO or ET. Repeat in 5 mins. x 3 doses.	5.00mg= 0.50ml
LIDOCAINE INFUSION	2 mg/ml	Infuse at 20-50mcg/kg/minute.	* Dose based on 20mcg/kg/min 3.00ml/hr
NALOXONE (NARCAN)	0.4mg/ml	0.1mg/kg IV, IO or ET. Repeating q1-3 minutes as needed (for patients 5 yrs. or 20kg; minimum dose = 2 mg).	0.50mg= 1.25ml
PROCAINAMIDE	100mg/ml	3-6mg/kg loading dose over 5 minutes. Do not exceed 100mg/dose. Repeat q5-10 minutes to a total of 15mg/kg.	* Dose based on 3mg/kg 15.00mg= 0.15ml
PROCAINAMIDE INFUSION	2 mg/ml	Dilute 500mg (5ml) in 250ml. Infuse at 20-80mcg/kg/min. Maximum = 2gm/24h.	* Dose based on 20mcg/kg/min 3.00ml/hr
SODIUM BICARBONATE NEONATAL SYRINGE PEDIATRIC	0.5mEq/ml 1mEq/ml	1mEq/kg(< 5kg). Use Neonatal Syringe. 1mEq/kg(>5kg) Use Pediatric Syringe.	5.00mEq= 10.00ml

Unsynchronized Cardioversion 2 joules/kg Subsequently use 4J/Kg, may repeat x 2	Synchronized Cardioversion (0.5-1.0 J/kg) Subsequently use 2.0 J/kg	Age	Neonate	Infant	Child	Adoles.
		Vent.	40	20	15	12
		Comp. Depth	1/2-3/4	1/2-1	1-1 1/2	1 1/2-2
		Heart Rate	120	100	100	80-100

PEDIATRIC CODE BLUE DOSAGE GUIDELINES

Patient: Age :
Weight: 5.00 KGS Date: 11APR96 10:17:13 AM

Printed by: _____

* Patient weight should be reviewed by the caregiver and updated as clinically indicated.

DRUG	HOW SUPPLIED	SUGGESTED DOSAGE	PATIENT DOSAGE
ADENOSINE	3 mg/ml	0.1mg/kg IV; if no effect give 0.2mg/kg Maximum Total Dose = 18mg	Initial: 0.50mg= 0.17ml Repeat: 1.00mg= 0.33ml
ATROPINE	0.1mg/ml	0.02mg/kg IV, IO or ET; May repeat in 5 min. to a max total dose of 1mg (child) or 2mg adolescent * (MIN DOSE 0.1MG=1ML).	0.10mg= 1.00ml
BRETILLIUM (BRETYLOL)	50mg/ml	5mg/kg initial dose (over 10 min). Subsequent dose 10mg/kg (max. 30mg/kg).	Initial: 25.00mg= 0.50ml Subsequent: 50.00mg= 1.00ml
CALCIUM CHLORIDE	100mg/ml (10%)	20-25mg/kg therefore 0.2-0.25ml/kg IV repeat in 10 min x 1. Subsequent doses will be based on CA++ levels. Max dose 1G.	* Dose based on 20mg/kg 100.00mg= 1.00ml
DEXAMETHASONE	4mg/ml	1mg/kg IV Maximum dose 6mg/kg.	5.00mg= 1.25ml
DEXTROSE 25%	250mg/ml	0.5-1G/kg (2-4ml/kg). Subsequent doses based on blood sugars. Use when patient weight <= 15kg.	* Dose based on 0.5G/kg 2.50G= 10.00ml
DEXTROSE 50%	500mg/ml	0.5-1Gm/kg (1-2ml/kg). Use when patient weight > 15kg.	* Dose based on 0.5G/kg 0.00G= 0.00ml
DIAZEPAM (VALIUM)	5mg/ml	0.1mg/kg IV,IO,ET q15 min x 3 for seizure control, give slowly over a 2 min period. May increase dose for effect. Max dose = 10mg(2ml).	0.50mg= 0.10ml
DOBUTAMINE	12.5mg/ml	6 x weight(kg) is the dose(mg) added to diluent to make 100ml; then 1ml/hr delivers 1mcg/kg/minute.	Add 2.40ml to make 100ml 2mcg/kg/min = 2ml/hr 5mcg/kg/min = 5ml/hr 10mcg/kg/min = 10ml/hr
DOPAMINE	40mg/ml	6 x weight(kg) is the dose(mg) added to diluent to make 100ml; then 1ml/hr delivers 1mcg/kg/minute.	Add 0.75ml to make 100ml 2mcg/kg/min = 2ml/hr 5mcg/kg/min = 5ml/hr 10mcg/kg/min = 10ml/hr
EPINEPHRINE	1:10,000 0.1mg/ml	0.01mg/kg IV or IO for bradycardia or as the initial dose for asystole. For subsequent doses in asystole use 1:1000	0.05mg= 0.50ml
EPINEPHRINE	1:1000 1mg/ml	0.1mg/kg ET for bradycardia or asystole. Subsequent doses for asystole give 0.1mg/kg IV, IO, or ET. Doses as high as 0.2mg/kg may be effective.	0.50mg= 0.50ml

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