LEHIGH VALLEY HOSPITAL

Medical Staff Progress Notes

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From the President

The quarterly meeting of the Medical Staff took place on September 9 and was well attended. At that meeting, David Caccese, MD, whose name had been submitted by the Nomination Committee for President-Elect, was unanimously endorsed as the next President-Elect of the Medical Staff. David will begin his term in January 1997, and we greatly look forward to his participation in the Medical Staff leadership process over the next six years. David's position as head of the Care Management Committee of the PHO, Chief of the Division of Internal Medicine, as well as a well respected and seasoned clinician position him well for this great responsibility. On a personal note, Bob Murphy and I are delighted with Dave's willingness to take on this responsibility, and we very much look forward to his wisdom and counsel in the years to come.

A series of Medical Staff category changes, which were previously discussed at Division and Department meetings and at a prior quarterly meeting, came to vote and were accepted at the September session. We extend our appreciation and thanks to the Bylaws Committee members who toiled many hours at perfecting these changes for the benefit of the Lehigh Valley Hospital Medical Staff membership.

An update on the functional plan was given by myself as well as Lou Liebhaber, Bob Laskowski and Mary Kinneman. A number of changes will take place on med/surg floors. This will include 7C closing at the end of September with employees of that unit being reallocated to other areas of need in the hospital. The 7C space becomes swing space for other units as they undergo refurbishing and reconstruction. The construction on 5B will be completed by September 30, 1996. It will then be followed by construction on the 4C Med/Surg Unit.

The Emergency Department moves to the last phase of its reconstruction. September saw four more emergency bays open to help alleviate the congestion of this busy department. We continue to interview candidates for a Chair of this department. It will not be until January 1997 that the architectural and process plan changes will be complete such that patients may flow more rapidly in and through the Emergency Department at our hospital.

Sizing considerations for the East Wing building have been completed, and we extend our thanks to the Chairs of various departments who have provided the input and collaboration of their respective department members. This new building is

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currently under consideration for a Certificate of Need, and the final recommendations will be presented to the Board of Trustees for their approval in November of this year. The East Wing is anticipated to be located in the space between MOB I and the Hospital and to be completed late in 1999. This building will complete our consolidation efforts by allowing Labor and Delivery, Psychiatry, Ambulatory Surgery, and Outpatient Ambulatory Services to move to Cedar Crest & I-78.

Lastly, the Medical Staff/ Administrative Exchange Sessions have resumed and are held on the third Thursday of the month. In order to better accommodate your schedules, we will try to alternate between 7 a.m. and 5:30 p.m. meeting times. As a result of one of these sessions, the suggestion of polling the medical staff's opinion regarding the Staff Development Plan will soon come to fruition. I very much recommend that when you receive this poll, you take the few minutes required to send me your suggestions and opinions so I may better represent the medical staff in future meetings with administration and the Board of Trustees.

John E. Castaldo

John E. Castaldo, MD
Medical Staff President

General Internist to Serve as President-Elect

David M. Caccese, MD, general internist, was recently nominated and unanimously elected to serve as Medical Staff President-elect for a two-year term beginning January 1, 1997.

Dr. Caccese joined the Medical Staff in 1976, and is Chief of the Division of General Internal Medicine. He is also Chairman of the Care Management Committee of the Lehigh Valley Physician Hospital Organization.

A graduate of the University of Pennsylvania School of Medicine, Dr. Caccese completed his Internal Medicine residency and a Hypertension fellowship at the University of Pennsylvania.

Dr. Caccese is certified in both Internal Medicine and Geriatric Medicine by the American Board of Internal Medicine.

He is a member of Peters, Caccese, Scott & DuGan, located at 401 N. 17th Street, Allentown.

Dr. Caccese is married to the former Deborah Strauss who is Executive Secretary in the hospital's Information Services Department.

On September 1, Lehigh Valley Diagnostic Imaging became a Preferred Provider of US Healthcare. Please remember a referral form, identification card, and specialist co-pay are necessary at time of examination.

Working Wonders

Many people talk about the way things were in the past. It's time to start talking about how things could be in the future. That's why Lehigh Valley Hospital and Health Network (LVHHN) recently introduced the Working Wonders program. Working Wonders is an opportunity for individuals and teams of employees, physicians, volunteers, and auxiliary members to share ideas to help LVHHN reduce costs, enhance revenue, and improve quality. For their creativity and efforts, participants can earn leisure and household merchandise, vacations, and cash prizes for valuable operations improvement suggestions. And, if LVHHN achieves its fiscal year 1997 OI goal, all Working Wonders winners will be awarded a bonus for their efforts.

More than 60 launch events took place during the week of September 15 to build momentum and participation for the Working Wonders idea recognition and reward program. Attendees learned about rewards, program rules, and hospital resources to help turn their ideas into reality. A special video explaining the program and featuring LVHHN employees was shown at each meeting. An awards catalog and a guide book were distributed at the launches, and attendees who signed a pledge card to participate received a gift.

If you were unable to attend one of the launch meetings and want to participate, please contact George Ellis, Process Director, at 402-7551.

Construction Update and Parking Changes

Construction is under way in the employee and physician parking areas at Cedar Crest & I-78. Although some construction has already been completed, the bulk of construction is slated to take place over the next several months. The construction schedule is very aggressive. Parking may be tight during construction, but with your cooperation in obeying all parking restrictions and changes, there will be adequate space for everyone. Additional security staff will be in parking lots to assist and direct anyone.

Following is a tentative schedule of construction:

September 23 - Lot 6 (physician lot) and part of Lot 5 will be under construction. All doctors and 3-11 shift employees will be relocated to Lot 4, 7 and 9 (next to engineering building). Employees who currently park in Lot 4 (black parking tags) will park in the day lot behind the day care center and near the MedEvac hangar. Individuals who park in the MOB II lot must display orange parking tags. All MOB II practices should direct their patients to park in the main parking area located on the east side of the hospital's main access road.

October 1 - Lot 7 will close to facilitate construction of the new south access road and change the configuration of the lot. Employees who normally park in Lot 7 will relocate to the west sides of Lot 5 and new Lot 6.

October 22 - The east side of Lot 5 will close and those employees will park in Lots 4 and 7 and the day lot behind the day care center.

November 1 - The east side of Lot 6 will be closed. Physicians will relocate to available spaces in Lots 4, 5 and 7.

LVHHN Maps Financial Goals for FY '97

Like the blueprint of a building, the Lehigh Valley Hospital and Health Network budget for fiscal year 1997 clearly illustrates the financial goals of the organization over the next 12 months. Highlighted in the plan is the task of restoring the patient services margin to previous levels through a balance of cost reduction and growth projects.

The network's patient services margin (patient operating revenue minus patient operating expenses) dropped 55 percent in fiscal year 1996 compared to the prior year. But a $13 million stock market gain, coupled with $16.4 million in operations improvements, took the organization from a potential $13.2 million deficit to a $16 million surplus by June 1996.

"The 1997 budget makes the assumption that investment income returns to prior levels, which means we must restore the patient services margin to a level that will provide sufficient cash flow to save for future needs, pay for FY '97 equipment and facilities budgets, and repay debt on schedule," said Vaughn Gower, Senior Vice President of Finance and Chief Financial Officer for LVHHN. That level represents a 5 percent margin on patient service revenues, double that of 1996.

About $500,000 of the $7.5 million budgeted margin increase will be generated from improvements at the Lehigh Valley Physician Group and the Health Services Division. Hospital improvements, mainly through operations improvement and growth expectations, account for the rest of the increase.

Prepared in the context of a changing health care marketplace, the budget reflects the increasing managed care impact on LVHHN as employers and insurers continue to look for cost reductions and quality improvement.

About 80 percent of the $22 million budgeted for operations improvement in 1997 is specifically identified in budget line items and make up the majority of the patient services margin improvement. The OI projects fall into two categories -- workforce expense reduction activities of 1996 and clinical cost improvement through the use of process improvements and supplier relationship changes.

The newly introduced benchmarking project is the result of last year's workforce expense reduction project. Although benchmarking will not materially impact the financial results for 1997, it lays the groundwork for effective operations improvements throughout the network in 1998.

But cost reduction is only one side of the equation. According to Mr. Gower, "The budget also provides for the growth and change in health care services. The network uses the budget process as an opportunity to differentiate itself by enhancing its dual capabilities as a tertiary care referral center and a community hospital services provider.

Growth is expected in new or expanded services and new technology, including a bone marrow transplant program, a comprehensive breast health services program, the increased use of stents for angioplasties, an immunotherapy laboratory and the increased use of ReoPro to prevent reocclusion of arteries after cardiac catheterization procedures.

The use of inpatient services also is expected to increase over last year because of PennCARE and Valley Preferred contracts. This type of growth can mitigate or offset declining admissions and shortened lengths of stays as health care services shift to outpatient and managed care reduces use.

"LVHHN's financial plan establishes the organization's four-year financial outlook. The annual budget is a piece of that multi-year plan over the next 12 months," said Mr. Gower. "Like most plans, circumstances such as new legislation may necessitate changes. But a balance of cost reductions and growth will continue to be the objective of both the financial plan and the annual budget, enabling us to allocate resources appropriately so we can carry out our mission of serving the community."

LVH Ranked as Top Provider in Geriatric Care

Lehigh Valley Hospital (LVH) ranked as one of the top providers in the country of geriatric care in ***U.S. News & World Report's*** seventh annual guide to "America's Best Hospitals."

LVH is the only Pennsylvania hospital outside of Philadelphia or Pittsburgh to be listed in this year's guide. According to magazine officials, the top 42 medical centers in any specialty should be considered a leading center, however, the rankings do not imply that other hospitals cannot or do not deliver quality care.

The geriatrics program at LVH was introduced in 1990 by Francis A. Salerno, MD. It was designed to help older individuals and families improve the quality of their lives through a comprehensive health screening and evaluation process.

At LVH, a team of geriatric specialists -- including a physician, nurse practitioner, and social worker -- coordinate all aspects of the patient's care. They evaluate the patient's medical, functional, psychological, social, and economic needs and then recommend treatment options, living arrangements, and community agencies to provide assistance and family support. The goal is to help the patient remain independent as long as possible. More than 30 of the hospital's doctors are certified in geriatrics.

According to ***U.S. News & World Report***, this year's "America's Best Hospitals" list assesses care for 16 specialties at 126 hospitals nationwide. Rankings for 12 of the specialties were based on reputation and other medical data. Those specialties include: AIDS, cancer, cardiology, endocrinology, gastroenterology, geriatrics, gynecology, neurology, orthopedics, otolaryngology, rheumatology, and urology. Rankings in ophthalmology, pediatrics, psychiatry, and rehabilitation were based on reputation alone.

To be considered for ranking, a hospital had to be a member of the Council of Teaching Hospitals (COTH), or be affiliated with a medical school, or have at least nine of 18 significant items of medical technology. This year, 1,961 hospitals were evaluated.

LVH ranked 39 out of 42 medical centers noted for geriatrics. The hospital was evaluated on its reputation, mortality rate, service mix, technology, the ratio of registered nurses to beds, discharge planning and geriatric services. Consideration also was given if the hospital was a COTH member. Of the 6,300 hospitals in the United States, only 400 are members of COTH.

The Phlebotomy Station of Health Network Laboratories, located in the Outpatient Laboratory on the first floor of Lehigh Valley Hospital, Cedar Crest & I-78, closed on September 1. Please direct patients requiring phlebotomy services to the Outpatient Laboratory in the Medical Office Building at 1230 S. Cedar Crest Blvd., Suite 102.

The MOB Outpatient Laboratory offers the convenience of being located in the same building as Lehigh Valley Diagnostic Imaging and in close proximity to Spectrum Apothecary. For patients requiring services located only within the hospital, i.e., EKG, the Pre-Admission Testing area is also available for phlebotomy services.

Hours of Operation for the Outpatient Laboratory in the 1230 Medical Office Building are Monday through Friday, 7:30 a.m. to 5 p.m., and Saturday, 8 a.m. to noon. The telephone number is 402-8170.

Emergency Room Renovations Enhance Quality, Speed of Care

Completion of the new Emergency Department at Cedar Crest & I-78 is expected by the end of the year, and the result will be a state-of-the-art department that will exceed many current standards of emergency care.

One of the most significant changes is the relocation of the ambulance entrance, which occurred on September 9. The new entrance allows EMS crews access to the high-acuity area immediately upon entering the hospital, eliminating the need to traverse the department with a critically ill or injured patient.

A new decontamination area located at the ambulance entrance features one room for the care of patients exposed to hazardous materials and a second room for the cleaning and storing of EMS equipment.

The renovations are expanding the department by more than 7,300 square feet to a total of about 18,440 square feet. When fully operational, the new Emergency Department will have two dedicated radiology suites with computerized radiography, which allows physicians to review x-rays "online." Other features include seven high-acuity rooms, five moderate-acuity rooms, six low-acuity rooms, three psychiatric rooms, two fully equipped ob/gyn rooms, one fully-equipped eye room, and two family rooms.

Transitional Skilled Unit Adds New Wing with 24 Beds

On September 3, Lehigh Valley Hospital opened the new 24-bed wing of the Transitional Skilled Unit (TSU) at 17th & Chew. Adjoining the original 28-bed unit to form an "L" on the fifth floor, the beautiful, new wing is located in space occupied by the inpatient pediatric unit before it moved to Cedar Crest & I-78.

The expansion completes the TSU project, begun in March 1995, when the 28-bed wing opened. Demand for TSU services created a waiting list, and construction of the new wing started in April.

The new wing includes 14 private rooms and five, large semi-private rooms. The semi-private rooms maximize patient privacy by using a center wall between the two beds. On each side of the wall is a television, closet and cabinets. Wood trim, carpet, wallcovering, and artwork give the unit a homelike feel. The rooms also have the latest equipment to meet the needs of the TSU residents, from tilting mirrors and ADA-specified bathrooms to hydraulic tables in the dining area.

The TSU serves as a bridge from hospital to home, or long-term care facility, for patients recovering from illness, injury or surgery. It offers patients a lower cost alternative to traditional inpatient care. Patients stay an average of 16 days, and two-thirds are discharged to their homes.

One feature of the new wing is a spacious dining and recreational area, made possible by a large donation from The Allentown Auxiliary of Lehigh Valley Hospital. The area was built in the space formerly occupied by the pediatric play deck.

Legislative Update

Tort Reform

Rewind to May 7, 1996. After nearly seven months of planning, well over 2,000 physicians converged on Capitol Hill in Harrisburg to demonstrate their support for tort reform. With the State Society's legislative groundwork already in place, and lobbying strategy well underway, the House of Representatives responded positively and approved legislation reforming Pennsylvania's medical liability tort system. The measure, Senate Bill 790, was sent to the Senate for consideration but was delayed due to the Senate's deliberation on the state budget and workers' compensation.

The prospects for enacting tort reform prior to the end of the legislative session on November 30 remain high. It is very likely that whatever action is taken by the Senate, the issue will return to the House for concurrence in Senate amendments. The process of amending legislation and multiple votes on these changes can become confusing. We must not allow ourselves to get bogged down in the minutiae of parliamentary procedures; rather, we must continue to focus our efforts on enacting tort reform through our physician grassroots network.

Senate Bill 1122 and House Bill 2294, CAT Fund Privatization/Reform

Senator Edwin Holl (R-Montgomery) and Representative Nicholas Micozzie (R-Delaware), the chairmen of the respective Senate and House committees with insurance industry jurisdiction, each introduced legislation aimed at addressing medical CAT Fund reforms brought to light by the emergency surcharge in 1995. Although both committees have moved toward legislative remedies related to the operation of the CAT Fund, each committee has been stalled over the issues of allowing hospitals to "opt out" of the CAT Fund or increasing the mandated primary carrier coverage. These measures remained in committee during the summer recess with the expectation that each committee would continue to work on the legislation.

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

Support the Legislators Who Have Supported Medicine!

On Thursday evening, October 10, from 5:30 to 9 p.m., a reception, hosted by Sherry Chernofsky, will be held at the Lehigh County Medical Society building, 1620 Highland Street, Allentown, to provide an opportunity for physicians to meet the legislators who have pushed through these monumental bills regarding healthcare.

Featured representatives will be Charles Dent and Pat Browne although other representatives will also be present. We ask -- implore -- physicians to come and express their personal thanks to these champions of medicine. A personal check tendered at the time you shake their hand is suggested to indicate just how strongly we are supporting their re-election bids.

Please RSVP by Friday, October 4, to Sherry Chernofsky at 776-7754.

Please make every effort to attend. A poor showing would indicate that we do not put our money where our mouths are!

Medical Record Document Imaging Update

Selecting the System

The Document Imaging Vendor Selection Committee, comprised of physicians and other key support staff, is close to selecting a medical record imaging system vendor. The process began with several site visits and interviews of potential vendors. Because the system will become a critical source of patient information, the selection process is intense. A Request For Proposal was sent to the three vendors that best fit the hospital's criteria. In response, proposals were recently submitted to the hospital. The Selection Committee was presented with a summation of the proposals including pros and cons of each vendor. The Committee will participate in either an additional site visit or on-site demonstrations to confirm their choice.

The Imaging System will provide immediate, simultaneous access to medical record documents scanned into the system, while automating medical record processes in the medical record department. With a document imaging system, users at different hospital sites can access and view the same patient record on an imaging workstation. This eliminates long waits for a requested medical record, as well as lost records.

Initially, inpatient, emergency room, and ambulatory surgery records will be scanned. Other medical records, including outpatient records, will be scanned in a later phase.

Forms Re-Design

There is an overwhelming amount of planning and preparation for the installation of a document imaging system. An extensive forms redesign process must occur in order to make the forms "scannable." A high speed document scanner can accept about 100 pages per minute. Because of that remarkable speed, it is desirable to enable all forms to be scanned by a high end scanner. In order to do so, all forms must be redesigned so that they can be fed into a high end scanner without problems or jams. Much like feeding a batch of paper into a photocopier, forms must be the same width, length, weight, and color in order to result in quality documents.

In addition to redesigning forms to this criteria, bar codes will also be affixed to medical record forms. The bar codes identify the "form type" which is automatically read by the imaging system. Using bar codes eliminates the need for manual intervention, saving thousands of hours in manpower. This process is currently in progress.

Stay tuned to ***Medical Staff Progress Notes*** for status reports on Medical Record Document Imaging.

Janet M. Seifert, Physician Relations Rep, recently relocated her office to Medical Staff Services on the first floor of the hospital adjacent to the Medical Staff Lounge. Her new telephone number is 402-8590; fax number is 402-8938.

Nuclear Medicine Approved for Accreditation

The Division of Nuclear Medicine has been approved for accreditation by the American College of Nuclear Physicians (ACNP) Quality Assurance Committee. Additionally, the Nuclear Medicine facility at Lehigh Valley Hospital was also recognized for special qualification in the imaging of prostate cancer with a new prostate imaging agent which is pending approval by the FDA. In addition to commenting on the Division of Nuclear Medicine's compliance with the ACNP requirements for accreditation, the review panel cited especially noteworthy certain elements that enhance the practice of nuclear medicine such as the high quality of imaging being performed and the strong interactions with referring physicians.

ACNP accreditation is not easily achieved. The entire Division of Nuclear Medicine is to be congratulated on this achievement.

Partners in PennCARE

Doylestown Hospital has teamed up with the Central Bucks School District to promote healthy lifestyles and to increase physical fitness in children. On September 27, they kicked off Project Fit America (PFA) at Doyle Elementary School. PFA is a national, non-profit organization sponsored by local hospitals and participating schools to implement programs in cardiovascular health and fitness education. Children are taught about fitness with fun activities, instruction on state-of-the-art cardiovascular playground equipment and programs that encourage positive attitudes toward health and fitness.

Easton Hospital and its physician-hospital organization are the newest PennCARE members, announcing the decision to join the network on August 20. Easton Hospital is a 369-bed, acute-care teaching hospital located in Northampton County. Its 230-member medical staff provides primary and specialty care.

Easton Hospital's surgery and internal medicine residency programs recently received accreditation for four years from the Accreditation Council for Graduate Medical Education.

North Penn Hospital, Lansdale, announced the election of its medical staff officers, who will serve two-year terms. Richard Minehart, MD, general surgeon, will serve as president. Joseph Kraynak, MD, cardiologist, was named vice president; Michael Seidner, MD, family practitioner, will serve as secretary; and Frederick Shisler, MD, family practitioner, will act as treasurer.

Home Infusion Program

Operations improvement efforts related to specific DRG's have been an ongoing process of review for our organization over the past three years. A work group including Luther Rhodes, MD, Chief, Division of Infection Control; Barbara Leri, pharmacist; Terry Burger, Infection Control Manager; Sue Lawrence and Patti Kopko, Clinical Resource Management; Elizabeth Karoly, Care Management; the PICC team, and representatives from Lehigh Valley Home Care and Health Spectrum Pharmacy met to assess DRG 416, septicemia. The work group determined that many patients with septicemia and other diagnoses treated in the hospital with antibiotics for a longer length of stay could be successfully treated at home after treatment was started. A home infusion therapy program maintains quality and positive clinical outcomes, decreases inpatient length of stay, and improves patient satisfaction. Services are provided in familiar surroundings of the patient's home where family support could be provided and, at the same time, decrease the possibility of nosocomial hazards. Although home antibiotic infusion therapy has been available, it was not used as much or as early as it could be.

The work group recommended and received approval to appoint a home infusion coordinator (HIC) to facilitate implementation of the program for appropriate patients. The HIC will identify patients who will benefit from this program early in their admission and will be available to assist the physician by coordinating all aspects of planning. The HIC is Darla Stephens, RN, CRNI (certified RN intravenous) who will serve as the "point person" to communicate with the physician, the patient, the infusion company, and home health agency.

Darla graduated from Allentown Hospital School of Nursing and has both clinical and managerial experience in the inpatient setting. She currently works for Lehigh Valley Home Care where she has been a staff nurse, preceptor, and charge nurse. As charge nurse, she has negotiated with insurance providers and managed care systems while coordinating intake referrals. A Certified Intravenous Nurse and PICC-certified, she has taken the chemotherapy course, and has experience educating a wide variety of patients and families at home. She also participates in inservices and validation for Lehigh Valley Home Care and Lehigh Valley Hospice.

The position and program developed by the hospital in conjunction with Lehigh Valley Home Care and Health Spectrum Pharmacy does not limit the patient only to LVHN services. Each patient will be free to choose any infusion company or home health agency. The HIC will fulfill the same function for every case.

The Home Infusion Program began on September 9, and consults may be ordered on PHAMIS. Although the program was established for patients on IV antibiotics, it will apply to any patient on an infusion which could be given at home. Darla Stephens will assist with evaluation of the home circumstances including caregiver support and finances, and will coordinate education and discharge as determined by the physician. Infusion therapy at home could include but is not limited to TPN, hydration, Heparin therapy, vasoactive medications, and analgesia. If you have questions, you may contact Darla Stephens at 402-7375, through her pager at 907-7914, or through e-mail.

Congratulations!

Thomas M. McLoughlin, Jr., MD, anesthesiologist, was recently appointed as an Associate Examiner for the American Board of Anesthesiology.

Thomas D. Meade, MD, orthopedic surgeon, has been selected by the Lehighton School Board to serve in the capacity of Sports Medicine physician for the school district for the 1996-1997 school year. Dr. Meade serves in a similar capacity at Emmaus, Parkland, Whitehall, and Catasauqua school districts. Additionally, Dr. Meade was selected by the Philadelphia Eagles to serve as their local orthopedic consultant for their pre-season summer camp at Lehigh University.

Michael A. Rossi, MD, cardiologist, successfully passed the certification examination in the subspecialty in cardiology of echocardiography, which was given by the American Society of Echocardiography in June 1996.

Papers, Publications and Presentations

George F. Carr, DMD, prosthodontist, recently presented to an international forum of dentists from Columbia and Chile at New York University College of Dentistry. Dr. Carr's topic for the series of "Current Concepts in American Dentistry" was "Advances and Complications in Traditional Prosthetics and Implant Dentistry."

Chief Surgical Resident, **James P. Clancy III, MD,** and **Indru T. Khubchandani, MD,** colon-rectal surgeon, co-authored a paper titled "Granular Cell Tumor of the Rectum: Case Report" which was published in the July/August issue of ***Contemporary Surgery for Residents.*** Their report was the lead article for this issue.

Former Chief Surgical Resident, **Scott D. Croll, MD, Gary G. Nicholas, MD,** Program Director, General Surgery Residency and Chief, Division of Vascular Surgery, **Mark A. Osborne, MD,** Chairperson, Department of Radiology/Diagnostic Medical Imaging, **Thomas E. Wasser, MEd,** of Community Health & Health Studies, and **Stuart A. Jones, MD,** Chief, Division of Nuclear Medicine, co-authored "Role of Magnetic Resonance Imaging in the Diagnosis of Osteomyelitis in Diabetic Foot Infections" which was recently published in the ***Journal of Vascular Surgery.***

Thomas M. McLoughlin, Jr., MD, anesthesiologist, co-authored an article, "Profound Normovolemic Hemodilution: Hemostatic Effects in Patients and in a Porcine Model," which appeared in the September issue of ***Anesthesia and Analgesia.*** In addition, Dr. McLoughlin joined the editorial board of a new journal -- ***The Cardiovascular and Thoracic Anesthesia Journal Club Journal.***

Howard S. Selden, DDS, endodontist, authored a paper, "Repair of Incomplete Vertical Root Fractures in Endodontically Treated Teeth In Vivo Trials," which was published in the August issue of the ***Journal of Endodontics.***

Library News

New hours for the 17th & Chew Health Sciences Library are Monday through Friday - 9 a.m. to 3:30 p.m.

The following book has been acquired for the 17th & Chew and Cedar Crest & I-78 Health Sciences Library:

The Harriet Lane Handbook: A Manual for Pediatric House Officers, 14th edition
Editor: Michael Barone
Call No. WS 39 H297 1996
(Reference Section)

The following book is now available in the Cedar Crest & I-78 Library:

The Physician as Learner: Linking Research to Practice
Editor: David Davis, et al.
Call No. W 18 D261p 1994

Upcoming Seminars, Conferences and Meetings

Medical Staff/Administrative Exchange Session

The next Medical Staff/Administrative Exchange Session will be held on Thursday, October 17, beginning at **7 a.m., in the Doctors' Lounge on the hospital's first floor at 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 402-8590.

Regional Symposium Series

Eighth Annual Neurology Symposium: Brain and Heart: Topics in Neurocardiology will be held on Saturday, October 19, from 7:30 a.m. to 12:30 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Physicians, nurses, and other health professionals interested in neurology and cardiology will benefit from this program.

At the completion of the program, participants should be able to:
- describe the work-up of syncope and autonomic testing
- describe the neurological complications of open heart surgery
- discuss the neurological complications between the brain and heart

Pain Management for the Primary Care Provider will be held on Saturday, October 26, from 8 a.m. to 3:20 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Physicians, nurses, and other health professionals interested in a pain management update will benefit from this program.

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At the completion of the program, the participant should be able to:
- discuss the basic treatment algorithm of chronic pain management
- discuss the basic treatment algorithm of cancer pain management
- identify current concepts in palliative care

For more information about these programs, contact the Center for Educational Development and Support at 402-1210.

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday from noon to 1 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Topics to be discussed in October include: October 1 - Endocrinology; October 8 - Pulmonary; October 15 - General Internal Medicine; October 22 - Hematology/Medical Oncology; and October 29 - Gastroenterology.

For more information, please contact Becky Sherman in the Department of Medicine at 402-8200.

Department of Pediatrics

Recent Advances in Pediatric Therapy will be presented by Cheston Berlin, Jr., MD, Chief, Division of General Pediatrics, Hershey Medical Center, on Friday, October 11, beginning at noon.

Urinary Tract Infection will be presented by Alejandro Hoberman, MD, Assistant Professor, General Academic Pediatrics Division, Children's Hospital of Pittsburgh, on Tuesday, October 22, beginning at 8 a.m.

Both programs will be held in the hospital's Auditorium at 17th & Chew. For more information, contact Cindy Williams at 402-2536.

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

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Department of Emergency Medicine
Division of Emergency Medicine
Provisional Active

Change of Status

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Department of Medicine
Division of Dermatology
From Referring to Honorary

Appointment to Medical Staff Leadership Position

James J. Goodreau, MD
Department of Surgery
Associate Chief, Division of Vascular Surgery

Gregory R. Harper, MD
Medical Director
John & Dorothy Morgan Cancer Center

(Continued on Page 15)

(Continued from Page 14)

Richard M. Lieberman, MD
Department of Surgery
Associate Chief, Division of Urology

Gary G. Nicholas, MD
Department of Surgery
Chief, Division of Vascular Surgery

Constance B. Sutilla, MD
Department of Radiology/Diagnostic Medical Imaging
Division of Diagnostic Radiology
Chief, Section of Chest AND
Chief, Section of Mammography

Resignation

Andrew T. Costarino, MD
Department of Pediatrics
Division of General Pediatrics
Consulting

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

Christopher J. Stille, MD
Department of Pediatrics
Division of General Pediatrics
Active

Death

Michael V. **Buenaflor, MD**
Department of Family Practice
Courtesy

Allied Health Professionals

Appointment

Ginger O'Sullivan, GRNP
Physician Extender
Professional
GRNP
(John J. Cassel, MD, PC)

HEALTH NETWORK LABORATORIES

A Service of LEHIGH VALLEY HOSPITAL

BIOCHEMICAL CONSEQUENCES OF EXERCISE

PART II HYPOKALEMIA

Potassium is an analyte that is included on every profile and rightly so. We are all familiar with the danger of life threatening cardioarrythmia's of hyperkalemia and the numerous symptoms of hypokalemia (anorexia, nausea, vomiting, muscle cramps, paresthesia and EKG changes). If one focuses on hypokalemia caused by extreme exercise/heat stress is there a difference between men and women when it come to water and electrolyte balance? The answer is an unequivocal **YES**. Even in the absence of extreme exercise, women makeup more than 85% of patients with plasma potassium levels less than 3 mmol/L.

There are a number of reasons for this starting with total body water. For the same surface area women have 11-15% less body water than men. This explains why they are more subject to dehydration when exposed to heat stress. Moreover, women have significantly less total body potassium.

Men	64.5 mmol/kg of lean mass
Women	57.0 mmol/kg of lean mass

Even if one compares a lean 60kg female to a lean male there is a 450 mmol potassium deficit in women when compared to men (-12%). The third factor which needs to be factored into this equation is that even a lean women will have 10% more body fat than a comparable man. Though it is recognized that each person is an individual and all comparisons should be made on a case by case basis, women can have as much as 22% less total body potassium in comparison to men. To compound this potassium deficit problem in women, exercise in heat stimulates a higher production of aldosterone that facilitates urinary potassium excretion despite a need to conserve body potassium due to normal losses in sweat.

We assume that the trainers of the female participants at the Olympic Games in Atlanta recognized the added danger of potassium loss in these athletics. However, if the female population is going to challenge the admission policy of southern military schools as the Citadel, some one must be prepared to advise the applicant and school of the medial problems associated with potassium loss in an already potassium compromised individual during vigorous exercise in extreme heat.

NONDISEASE FACTORS THAT ALTER PLASMA/SERUM POTASSIUM LEVELS			
FACTOR	**EFFECT**	**MECHANISM**	**MAGNITUDE**
ACE Inhibitor	⇑	Suppresses aldosterone secretion	Incidence up to 5% patients treated
Cold storage temperature	⇑	Inhibits glycolysis	
Exercise	⇑	Release from muscles	Up to 0.9 mmol/L
Fist clenching	⇑	Release from muscles	Up to 1 mmol/L
Heparin Therapy	⇑	Suppresses aldosterone secretion	
Hyperventilation, acute	⇑⇓	pH effect	Up to 0.3 mmol/L
Leukemia, acute myelogenous	⇓	Exaggerated rate of glycolysis	
Posture	⇑⇓	Supine position lowers potassium	Up to 0.5 mmol/L
Pregnancy	⇑	Undefined	Increase with each trimester
Thrombocytosis	⇑	Release from platelets during clotting	May be greater than 1 mmol/L

Gerald E. Clement, PhD
Technical Director,
Health Network Laboratories

John J. Shane, MD
Chairperson, Department of Pathology
Health Network Laboratories

Academic Information and Media Services

News and Notes *October, 1996*

PowerPoint Training

Classes continue to be held on the use of Microsoft PowerPoint 4.0.

Module I (Introduction) covers the basics of PowerPoint and allows you to create a simple slide or computer show. Prerequisite for this class is a knowledge of Windows.

Module I classes are:

Thurs., October 3, 0900-1200, JDMCC I/S Classroom
Mon., October 7, 0900-1200, JDMCC I/S Classroom
Tues., October 8, 1700-2000, JDMCC I/S Classroom
Thurs., October 10, 0900-1200, 17SON I/S Classroom
Tues., October 15, 1300-1600, JDMCC I/S Classroom
Friday, October 18, 0900-1200, JDMCC I/S Classroom

Module II (Intermediate) class covers some more advanced features of PowerPoint including charts, graphs and customizing certain PowerPoint features. Prerequisite for Module II is completion of Module I.

Module II classes are:

Wed., October 9, 0800-1100, JDMCC I/S Classroom
Thurs., October 24, 1700-2000, JDMCC I/S Classroom
Tues., October 29, 1300-1600, 17SON I/S Classroom

To register, or for more information, please e-mail Dean Shaffer in the AIMS department (or phone x-0055). Class size is limited.

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Spell Cheking Woes

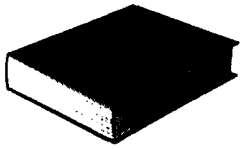
A real time-saver when creating documents is a good spell checker. However, many documents we create are filled with technical terminology.

Stedman's Plus comes to the rescue with an excellent medical and pharmaceutical spell checker. After installing the program, the spell-checker works seamlessly with Microsoft's spell checker, but checks spelling on more than 320,000 medical and pharmaceutical terms and over 20,000 trade and generic drug names from the *PDR™ Generics Database*. One of the sources for this valuable program is the AMA publications catalog.

Photo/Graphics Services

Even though we are working with a smaller crew, if at all possible we would like to maintain the same level of quality and service as we have provided in the past. It would be most helpful to us if, when bringing work to the department, you would adhere to the following guidelines:

If the work is from journals, textbooks or the like and is pure black and white (i.e., no grey tones), Xerox each page and bring the full sheet to us. Please do not cut, tape or paste it to another sheet. [We will cut it down ourselves, so be sure it is a disposable copy!]



For color or black and white pictures (such as x-rays, portraits, surgery, patient conditions, etc.) it is still be necessary to bring us the books. Please list each book and what must be photographed on a separate sheet of paper. This speeds our work as we can check off the list as we go and we can be sure nothing is missed.

Thanks for the cooperation!

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PowerPoint Tips

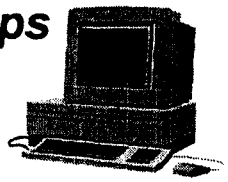
Those little yellow tags that explain what each icon means when you point to it are a great help when working with PowerPoint.

If the tags are not turned on, you may do so by selecting **View** on the menu toolbar, then select **Toolbars**. On the Toolbars menu in the lower right corner is **Show Tooltips**. Click on the box in front of this item to display an **X**, click **OK**, and your little tags will be ready to help you create that special slide show.

Use this help button on the Standard Tool Bar to find out about an icon or specific feature on the PowerPoint Screen. Click once on this button and then click on the item you want to know about. The related help topic is displayed on your screen.

Academic Information and Media Services

Physician Workshops



Computer workshops for physicians are offered on:

The Internet

Tuesday, Oct. 22, 6-8pm

Basic internet functions using the hospital connection to access text-based medical information are covered.

OVID, Micromedex, OPAC & Internet

Tuesday, Oct. 15, 5-7pm

A basic overview of all the applications will be covered. These data and research tools can be used to enhance daily job functions.

The Physician Workshops are hands-on. Call the library at 402-8410 to register. All applications are available via the hospital network. You are required to have the icons available to you when you sign into the network. As a reminder, we are still working with the Internet Icon, not Netscape for these classes. To obtain the icons, contact Pat Skrovanek in the POPS office, 402-9859.

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Micromedex Update

The REPRORISK System has recently been added to Micromedex.

The REPRORISK System is a unique collection of reproductive risk information databases. It provides information covering full-range health effects that is helpful when assessing reproductive risks of drugs, chemicals, and physical and environmental agents. Risks to females, males, and unborn children are available.

REPRORISK Includes:
REPROTEXT® Reproductive Hazard Reference
REPROTOX® Reproductive Hazard Information
Shepard's Catalog of Teratogenic Agents
TERIS Teratogenic Information System

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Audio Visual Services

Shedding Some Light on Auditorium Projection

When making a presentation in the CC Auditorium, it may be necessary at times to switch between 35mm slides and a computer (or Elmo) image. Here are some suggestions:

- Switch to the VIDEO input source on the touch screen. This will produce a dark image from the video projector enabling you to project your slides.
- Either leave blank spaces in the slide tray or switch the slide projector off when you need to go back to the video projector,
- Touch COMPUTER or ELMO to switch back to the appropriate video projected source.

REMEMBER, always allow 5 seconds for the video projector to switch sources when making selection on the touch screen!!

AIMS Request Forms

The AIMS_Forms on E-mail Bulletin Board should be used when requesting:

- Audio/Visual equipment reservations
- Video conferencing
- Other AIMS services

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More WWW

http://www.trauma.lsumc.edu

Trauma Network & Education Tool at LSU Medical Center - SHREVEPORT focusing on trauma and critical care. Case presentations are available.

Suggestions and ideas are always welcome. If you would like to see a particular topic addressed, please contact Christopher Sarley, ext. 1641, or Dean Shaffer, ext. 0055. Both are available via E-mail.

LEHIGH VALLEY
HOSPITAL

Issues In Medical Ethics

Summer 1996

Medical Charity: an old concept, a new need.

Editorial:

There is nothing new about medical charity. Over many years physicians and nurses have provided care without charge in clinics, hospitals, homes and offices everywhere. Medical charity is part of why many of us went into medicine. Whether altruism is innate, learned, or elicited, as asked by Dr. Young, it still has a valuable place in the care of those less fortunate than us. Whether it is a noble activity, as suggested by Dr. Hyman, there is no arguing that it is at least a very necessary one. Finally, maybe we shouldn't call it charity at all, but a necessary outcome of a just society, as Dr.Lammers suggests.

At this time late in the millennium, care for those without the means to pay for care is becoming a growth industry. While at last sketchy count, 42 million people are without some kind of medical insurance, hospitals and physicians are being rocked by managed care and tightening payment schemes, so that they are becoming less and less charity minded. How will we budget this squeeze against our wish to do the proper things by humanity? How will we continue the great charitable traditions of medicine which extend well before the past century?

In response, I will crib from Dr. Hyman and invoke the voice of Sir William Osler. He was perhaps the most famous physician of the last century, a founding father of Johns Hopkins, the author of the first modern medical textbook, and a world renowned teacher. In a lecture printed in the Montreal Medical Journal in 1903, Osler laid out a few great lessons in life. In company with our guest columnists, these words may in part answer the question.

"A conscientious pursuit of Plato's ideal perfection may teach you the three great lessons of life. You may learn to consume your own smoke. The atmosphere is darkened by the murmurings and whimperings of men and women over the non-essentials, the trifles that are inevitably incident to the hurly-burly of the day's routine. Things cannot always go your way. Learn to accept in silence the minor aggravations, cultivate the gift of taciturnity and consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and soot of your complaints.

More than any other the practitioner of medicine may illustrate the second great lesson, that we are here not to get all we can out of life for ourselves, but to try to make the lives of others happier. This is the essence of that oft-repeated admonition of Christ, 'He that findeth his life shall lose it, and he that loseth his life for My sake shall find it', on which hard saying if the children of this generation would only lay hold, there would be less misery and discontent in the world. It is not possible for any one to have better opportunities to live this lesson than you will enjoy. The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders, but with the

Continued on Page 2

itors:
Alex Rae-Grant,
Stephen Lammers

Contributors:
Herbert Hyman,
Mark Young

exercise of an influence of the strong upon the weak, of the righteous upon the wicked, of the wise upon the foolish. To you, as the trusted family counselor, the father will come with his anxieties, the mother with her hidden grief, the daughter with her trials, and the son with his follies. Fully one-third of the work you do will be entered in other books than yours. Courage and cheerfulness will not only carry you over the rough places of life, but will enable you to bring comfort and help to the weak-hearted and will console you in the sad hours when, like Uncle Toby, you have 'to whistle that you may not weep.' "

-A. Rae-Grant

Caring and Charity

The Identity of Physicians

As a senior physician, I lament the "deep seated malaise"[1] in many modern physicians. It is not acceptable to blame it on lawyers, insurance companies or any other "third party." As a physician writes: "I used to be a Doctor; now I'm a Health Care Provider."[2] When I started practice in Allentown in 1954, a senior colleague told me that 40% of a physician's time was devoted to non-income producing professional activities. There were huge charity wards, clinics and at times, E.R. responsibilities. There were also indigent patients who came to your office. Physicians considered the ward service a privilege as well as an education; they rarely complained about these duties. It was my impression that they enjoyed the practice of medicine more.

This sense of fulfillment and satisfaction is particularly realized in caring for the "underprivileged.". Forty-two million Americans have no medical insurance, (The Morning Call, April 27, 1996). Interestingly, however, a third of uninsured live in households with annual incomes of more than $30,300 - double the federal poverty level for a family of four. They too must be considered underprivileged. This declining coverage is a moral as well as an economic crisis! As physicians, it is incumbent upon us to feel obliged to help care for the underprivileged.

One of the founders of modern medicine, William Osler, thought that the practical outcome of all the long years of medical education was a glorious opportunity to "befriend the sick and suffering... to lessen the sad sum of human misery and pain."[1] Bringing "brotherly love" to the medical practice may have been William Osler's greatest contribution. Brotherly love may be an essential quality for any one who aspires to be a truly great physician.[1]

Much in modern medicine can be dehumanizing. "It is hardly reasonable to assume that today's doctors will be humane, relaxed, and gentle with their patients when their own lives have lost emphasis on human values".[1] Humanism is learned at the bedside by offering patients comfort, compassion, and caring, The physician is rewarded by a very special kind of interpersonal relationship and professional satisfaction.[3] Rather than becoming overly concerned with the material advantages, we must learn from Osler to concentrate on seeing what we can add to life. True happiness in our profession comes primarily from service to others.

The greatest reward to the true physician comes simply from the service itself.

-Herbert L, Hyman , M. D. , F. A. C. P.

REFERENCES

1. "Shattuck Lecture - Healing and Heroism" H.B. Wheeler, M.D. . New England Journal of Medicine. 1990; 332:1540-1548.
2. "Depth of Compassion: The Endangered Doctor-Patient Relationship." Jeff Thurston, M.D. WRS Publishing, Waco, Texas, 1996.
3. "Caring for Patients,: A. Barbour, M.D., Stanford Press, 1996.

On Helping the Poor:

The Brighter Side of (Our) Human Nature?

Mark Young, MD

All physicians at Lehigh Valley remember answering the question 'so why do you want to be a doctor?'. We tried to say more than the cliched 'because I want to help people'. One could imagine a skeptical professor questioning our powers of critical thinking or our naivete if our answer were too idealistic or altruistic.

In my case, that tough professor has written three books that have informed some of my thinking over the last several years. The professor is Alfie Kohn and the books are about competition (No Contest), intrinsic motivation (Punished by Rewards), and altruism (The Brighter Side of Human Nature). Competition, intrinsic motivation, and altruism are recurring themes when I think about my roles as an individual, a father and husband, a physician/ manager, and a community leader. I will focus on the idea that altruism is part of our human nature.

On a personal note, my wife and I have had discussions (sometimes arguments) for the last eighteen years about human nature being inherently good or bad. I started out very strongly on the side of "we are inherently bad but capable of doing good things." You might speculate that I've changed my position because I wanted to stay married and that my wife is a convincing teacher. You'd be right on both counts but I've also done a great deal of writing, reflecting and reading - which brings us back, to Alfie Kohn.

The subtitle of Kohn's book is: altruism and empathy in everyday life. The basic approach Kohn takes in all of his writing is to look carefully at both assumptions about human nature as well as empirical evidence. When one considers human nature vs nature, the assumptions of biological determinism that we are predisposed towards self-preservation are appealing. Those assumptions lead to cynical statements like "we're only human" and "a conservative is a liberal who has been mugged" and to general acceptance of the claim that human aggression is hard-wired and inevitable. Instead of following this line of thought, Kohn chooses to look at studies by social psychologists that probe more deeply into behaviors that can be considered prosocial or altruistic. If one asks, how often does prosocial behavior occur and why does it occur, four categories of research emerge: *environmental factors, situational elements, the person's state of mind, and the enduring traits of the individual.* I'll next describe each of these categories and attempt to draw implications to issues we face as potentially altruistic physicians.

The *environmental factor* most often cited is the influence of the number of bystanders on deciding to help someone. In both laboratory studies and real life, helping behavior varies inversely with the number of bystanders and the size of the community. (Think of the likelihood of stopping to help a stranded motorist in downtown Philadelphia vs. a remote road in Alburtis). Another environmental factor is the cultural message embedded in our society - increasing cynicism leads to the view that only a sucker lets herself get drawn into other people's problems. I believe that some well-intentioned social policies such as Medicaid have unintended consequences to us as physicians. We feel that someone else (there are enough doctors who will accept Medicaid so that I do not have to) can help. Furthermore, physicians are sometimes drawn into patients' problems that have no clear-cut solution (I do not want to increase my ability to identify depression and drug

Continued on Page 4

abuse that is rooted in social factors that I cannot influence).

The *situational factors* deal with the relationship between the helper and the person being helped. The probability of helping someone increases if one likes or is similar to that person. One is more likely to help a family member, friend, or colleague than a stranger, Direct exposure to an appeal is more likely to produce results than a remote request; consider how you respond to the 2nd year medical student who personally calls and asks you to support the student scholarship program vs. the mass mailing from the dean. In my own work I find that it is possible and useful to establish commonalities of interest with patients, with friends, and with colleagues. I'll never forget the disheveled, surly, middle-aged man I saw in a Milwaukee walk-in clinic. For some reason I asked him if he enjoyed reading and he pulled out of his tattered bag Stephen Hawking's, A Brief History of Time. After he explained some of the black-hole physics that mystified me, I explained some of the chronic abdominal pain that mystified him.

The *person's state of mind* is the third category of influences on helping behaviors.

One of the more interesting and consistent findings shows that contented people are more likely to extend themselves to others, "feel good, do good." Some of the studies have been done by a colleague, Professor Alice Isen, with whom I've collaborated in studies of medical decision making. We have shown that positive feedback enhances learning and creativity in several medical situations. Reflecting on our profession, our collective state of mind does not bode well for sudden increases in prosocial behaviors. Physicians think that their autonomy has been eroded, patient respect has diminished, and income is falling. As a result, I am not surprised at the animosity and distrust we sometimes exhibit. However, I believe that enhanced personal relationships and the power of creativity can improve our collective state of mind and enable us to help individual patients and our community.

The final category is *the enduring traits of the individual.* Self-esteem, assertiveness, and interpersonal skills are interesting constructs. While one might not be surprised that they correlate positively with helping behaviors, one might wonder if they actually represent enduring traits vs. learned skills. As a "both/and" thinker, I believe that we do have traits and tendencies but that they can be successfully modified. There are several implications for me. I find it easier to accept differences in style; the quiet thinker, the excited visionary, the detail-oriented implementer all have value. Ironically, the ability to understand that individuals do have traits that account for differences is itself a teachable attitude and skill. My own shifts in attitudes and beliefs that have been strongly influenced by my wife Ellen; she's quiet and contemplative where I'm always the first person to ask a question, state and opinion, do something. Together we make a good team.

In summary, my answer to the admissions school question remains, "because I want to help people." *Environmental factors, situational elements, the person's state of mind, and the enduring traits of the individual* all influence our abilities to help others. When we think about the topic at hand, helping the poor, we have to think about how we might try to influence those *environmental factors*, those *situational elements, persons' states of mind*, and our own (and others) *enduring traits* so as to make it more likely that we would be willing to do what we said we would do when we answered that medical school admissions question.

Let me end on a personal note. Our family's decision to come to Allentown reflects some altruistic pragmatism that is inspired by my new physician colleagues at Lehigh Valley Hospital. They (we) contribute 44,000 hours of service in uncompensated care and to the teaching programs, despite the wrenching changes we face as a profession. To me this is a sign that together we can measurably enhance the status of health in our patients and achieve the brighter side of all our human natures.

On Discussing Medical Treatment for the Unfortunate:

The Character of the Physician and the Nature of our Society, with some Attention to the Character Of LVH

-Dr.Stephen Lammers

In articles earlier in this issue, Herbert Hyman and Mark Young have spoken about the nature of what it means to be a physician and have set that in the context of our human nature and the particular commitments of the physician. As one who thinks discussion of the character of the physician is important in health care ethics, I applaud their efforts. In this brief piece, I want to focus on something different but not unrelated, the character of our society and its commitments to caring for those who are less fortunate. I do this because a full discussion of these issues cannot rest by pointing only to the physician; we must instead think about the society we both claim to be and the society we want to be. This means that we will have to take up issues of justice and ask ourselves how we are implicated in the raising and responding to questions of justice.

At the beginning, I want to reject two views, and my rejections are controversial. First, I want to reject the view that health care is simply like all the other goods in this society and that we should treat it in that way. That is to say, the proponents of the view I am opposing argue that we should treat health care as a good which can be purchased if you have the resources to pay for it. If you do not have the resources to pay for it, then you have no entitlement to health care. I claim instead that health care is something which is due to you because you are a human being. I do not have time to defend that view here, although I do think that it can be defended. Secondly, I want to claim that health care is a matter of justice and not a matter of charity. The American tradition of viewing 'care of the poor' as charity is itself a view which is questionable. Charity in the American, (not the Jewish or the Christian traditions, incidentally) is something which is not required. Thus one can forgo doing charitable works and still be a good citizen. If health care is something which persons deserve simply by being human beings, then health care is not a matter of charity but a matter of justice, a human right to use another language, and we have obligations to make sure that it is provided. There may be complex ways in which these obligations are met, but they are obligations which fall on the larger society. As we shall see, this becomes very important when speaking about the character of physicians and the commitments of hospitals. What are the implications of my view for treating the unfortunate in our society?

One of the first things that must be discussed, is "who are the unfortunate?" This issue is more complicated than it used to be. In the past, the assumption was that persons who could pay for their own health care would do so. There was no intervening party. In an age where health insurance or protection of some kind is a much sought after benefit, the assumption is that persons do not pay directly for their own health care but that this is a benefit provided by someone else. It is of course still the case that some persons provide the funds for their own health care.

Thus the first understanding here should not be between the poor and others but between those who do and do not have health care coverage of some sort, whether health insurance in the traditional sense or membership in a managed care plan. This does not correlate between the poor and

Continued on Page 6

others but it does identify persons who may not be able to pay for their own health care and those for whom payment of some sort is provided. Those persons may be working but without any kind of health benefits from their employer and who are not paid well enough to afford health insurance or membership in an HMO as well as others who have no employment. The care of the medically poor, would not be an issue if this society provided health care for everyone. One of the central difficulties of this discussion is that this society, unlike other industrial societies, has not made any universal mandates for health care. It is one of the injustices of the present United States society that this commitment is not present. It is in that context that this discussion proceeds.

The care of the poor and the unfortunate assumes that the poor are those "without" something that the rest of us have. Increasingly, this is not the case, that the difference between the poor and the rest of us is not as clear as it once was. That is not necessarily a disadvantage. It forces us to rethink how we are providing health care for human beings.

There is one way in which the poor may be treated that is especially problematic. That is to say, if you are poor, you will be treated differently than someone who is "full paying" for their medical care. One of the difficulties with this approach is that it distinguishes between us on the basis of conditions over which we very well might not have control. By this, I mean that often illness strikes us independent of our responsibility for it and that in addition we are often poor or wealthy independent of anything we have done. (I know that there are many who do not believe this: I can only ask them to reflect on their choice of parents.)

In the past, there have been two approaches to this problem; one focuses on the virtues of those who are asked to care for those without health care coverage. The second asks us to look at the systems which we have put into place in order to insure that all of us have health care coverage. I want to focus on the systems as a way of complementing the discussion of Drs. Hyman and Young.

We should note that given that there is no societal commitment to treat the poor and the unfortunate to a decent minimum of health care, it has fallen upon hospitals as part of the society to take care of the poor. This has led many hospitals to have mission statements to have commitments similar to that of Lehigh Valley Hospital, that persons will be treated regardless of ability to pay. The larger society put in place many formal and informal systems which made it possible to do this and for the hospital to survive. Given what is happening in modern medicine, it is not clear that those societal commitments are present and that leads to a questioning of the viability of the commitments of not-for-profit hospitals to their original mission statements.

It is my own view that the hospital needs to think again what it means to treat persons "without ability to pay." I do not mean that the hospital should think of abandoning this commitment; my own view is that it is more complicated today to figure out what this means. It is complicated in the first place by the lack of a societal commitment to the equitable treatment of all persons. It is complicated in the second place by the unjust advantages for-profit medical care systems have in the financial markets when seeking capital. It is complicated in the third place by the way in which local taxing authorities do not take into account our changed context when arguing about the charitable status of hospitals.

If someone questions my view that there is no societal commitment to the health care of all of us, we need only to reflect on the current state of affairs with employer provided health insurance. What is interesting is that given our preference for employer based health care coverage in this society, we still do not demand that employers provide a "decent minimum" of health care coverage of some kind. In this

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sense, we are truly schizophrenic, in that we reject alternatives to employer based plans and at the same time, refuse to mandate coverage on employers. As bad as the Clinton plan was, it faced this issue directly. For anyone who knew anything about the comparative data, the responses of employer groups were simply "incredible", that is unbelievable. The example the British papers loved was the difference between working for McDonald's in the United States and working for McDonald's in Germany. In Germany, employer provided health insurance was mandatory; in the U.S. it was not. Somehow, McDonald's in Germany manages to compete.

It should be clear by now why there has been such a strong tradition of "charitable care" for the poor and unfortunate in our country. We are unwilling to make the societal commitment to provide health care for all of us. Nor are we willing to insist that employers be required to provide health care coverage to their employees yet we expect that those of us who work will have such coverage. What is left is the good will of the professional, the tradition of charitable care in the local hospital, and a patchwork of governmental and privately supported programs which proceed out of assumptions which sometimes are in tension with one another, if they are not absolutely contradictory.

There is an irony here which should not be lost on us. Health care workers have enjoyed a certain status in our society because of their willingness to care for us even when we did not have the resources to pay for that care. Unfortunately, health care workers are losing some of that status for reasons that are not always under their control. What is not under their control are the compensation packages of large health care companies, yet it is assumed by many that they are paid in like manner. What is under their control is their own approach to the care of those who need care and who cannot pay for it. If that second part is not clearly displayed as one in favor of the least of us, then the loss of status will be permanent. If instead ways are found to display this willingness to care even when compensation is uncertain, then that status is assured. The choices are clear. What is not clear is what the choice will be.

Krank's Corner:

The Krank is sitting in a cottage on Nantucket overlooking Jetties Beach, sipping a Marguerita, putting feet up on a favorite ottoman, petting a favorite Labrador, and reading a favorite book; dinner is cooking in the kitchen. This fall, rested and fed, the Krank will return with 'Vim and Vigor', once again a 'Healthy You'.

LEHIGH VALLEY
HOSPITAL

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