LEHIGH VALLEY HEALTH NETWORK

PROGRESS NOTES

Medical Staff

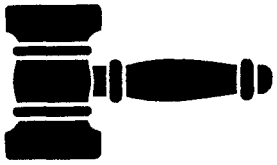
Lehigh Valley Hospital ⌘ Muhlenberg Hospital Center

March, 1998 ⌘ Volume 10, Number 3

In This Issue . . .

"The difference between perseverance and obstinacy is that one often comes from a strong will, and the other from a strong won't."

Henry Ward Beecher



From the President

Probably one of the most pervasive characteristics of physicians is perseverance. Without it, we would not have been able to survive the rigors of our training programs. Without it, we would not be able to put in long hours or dwell on the findings of a particular case until we've arrived at a diagnosis and initiated a treatment. In these changing fiscal times, we must persevere in our singular dedication to our patients' well-being.

Unfortunately, as we are all painfully aware, the corporate side of medicine continues to evolve. Almost all of us feel that the current direction of this evolution is very patient unfriendly. The almighty buck seems to be the bottom line in health care right now and that bottom seems to be falling out. Medicare cutbacks alone will result in a $15 million reduction in institutional income, to say nothing of the reduction in reimbursement to the practitioner, over the next three years. Many of us have heard of the recent poor economic performance of Lehigh Valley Hospital despite record numbers of patient admissions. This performance has been attributed to high staff/patient ratios, an ever increasing population of patients whose reimbursement is a fixed dollar amount based on capitation or DRG diagnosis, and an increasing percentage of physician controlled costs.

(Continued on Page 2)

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As I researched the physician component of this trend, I discovered several interesting points. In January, despite a relatively low patient acuity, inpatient testing doubled according to MECON data. Our patient length of stay continues to remain flat despite ever continuing reduction of length of stay at facilities very similar to our own. In a fixed dollar environment, this amounts to significant expense without reimbursement.

Why, as President of our Medical Staff, am I calling this to your attention? The answer is simple. As our patients' caretakers, protectors, and advocates we must be innovative and creative to meet the challenges presented to us by this new environment. Unless we physicians contribute to the solution, we will have fewer nurses and support personnel to care for our patients. Unless we contribute, we will not be able to develop programs here at Lehigh Valley Hospital to help attract patients to our practices. Unless we contribute, the very nature of Lehigh Valley Hospital will change dramatically for the worse where the almighty buck ultimately rules.

So, to protect our patients, our nurses, and ourselves, we must take advantage of our combined intellectual resources to help address this problem. We can't be obstinate and continue to practice in a manner which is impervious to our current medical environment. We should be utilizing clinical pathways where they exist and developing them where they do not. The members of the Medical Executive Committee had some excellent suggestions on how to meet our patients' needs while responding to this fiscal whirlpool in which we find ourselves. Some examples of these ideas are:

1. Have discharge planners present on the units at 0700 to be available to meet with physicians when they are making rounds.
2. Have discharge planners meet with patients at the time of pre-admission evaluation and provide physicians with information about DRG based expected length of stay.
3. Improve the capacity to discharge patients to intermediate care and rehabilitation facilities.
4. Improve the capacity and competence of home care services.
5. As we move to a computerized medical record, have clinical pathways instituted as standard orders for diagnoses. While left to the discretion of the individual physician, deviation from the pathway would require orders by exception.
6. Have centralized pre-admission testing process under the direction of the Department of Anesthesiology in order to standardize preoperative testing and eliminate extraneous studies.
7. Concentrate efforts on our top 10 DRGs.

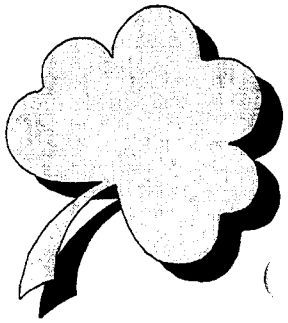
I would also like to reiterate the suggestion of Dave Caccese, Chairman of the Care Management Committee, that we ask ourselves "will this test or will another day in the hospital change the way I care for my patient?" with every stroke of our pen on our patients' order sheets. I would request, therefore, that you bring any and all suggestions to Troika so that we can support the creative solutions to this critical problem.

I am also going to ask for the help of each and every member of our staff in another area. Patient Centered Care has been present here at Lehigh Valley Hospital for two years. Even the ORs have recently adopted the PCC model. At various occasions in the past, the opinion of medical staff was solicited in a rather long questionnaire. After several discussions with Yvonne Bryan and Mae Ann Fuss, we have developed a more concise research tool. The purpose of this tool will be to obtain physician input on the good and bad aspects of the PCC model. The Office of Professional Development and the Medical Staff will be co-sponsoring this survey (see following page). I feel this is an excellent opportunity for the members of our staff to be heard. I urge you to take a few minutes from your busy schedules to complete and return these questionnaires. I will bring the results of this survey back to the staff either in this publication or at one of our Quarterly Medical Staff Meetings.

Happily, March is a month in which we will have two occasions to get together as a staff. Our next General Medical Staff meeting will take place on Monday, March 9, at 5:45 p.m. in the auditorium at Cedar Crest & I-78. On a slightly more festive note, the third triennial Physician Recognition Dinner will be held Saturday, March 28, at the Holiday Inn Conference Center in Fogelsville. I encourage all to attend what promises to be an exceptionally enjoyable evening.

While I apologize for being uncharacteristically wordy in this month of St. Patrick, I can't end this missive without an Irish toast --

We drink to your coffin,
May it be built from the wood
Of a hundred year old oak tree
That I shall plant tomorrow!



Sliante,

Robert X. Murphy, Jr., MD
President, Medical Staff

Measuring the Impact of PCC at LVH by Yvonne Bryan, RN, PhD

Since work redesign, based upon patient centered care (PCC) principles, was introduced in 1995, the success of the redesign process has been measured in part by asking the key customers -- patients, physicians and staff -- "How are we doing?" While we have heard from patients and staff, physicians, for the most part, have been somewhat silent.

Every six months, starting before the implementation of unit redesign efforts, the Office of Professional Development, Measurement and Research (PDMR) for Patient Care Services sends a stack of surveys -- one for each employee and designated physicians -- to each unit director. The PDMR office staff counts and collates the returns, and informs the unit directors when responses are low in hopes of improving the return rates. Currently, the response rate for staff is 63%, up from 25% one year ago.

The current response rate for physicians is approximately 32%, up from 18% one year ago, but half the staff response rate and significantly lower than the established threshold of 85%. Increasing the response rate is crucial since this will have a direct impact on the validity of the information gathered. More important, completing the surveys gives physicians and staff a chance to confidentially point out the positive and negative issues. This information, then, becomes the basis for action plans.

Over the past year, a variety of interventions have been successful in improving the staff response rates. In this vein, concerns expressed by physicians regarding the survey process have prompted a number of changes to improve physician participation.

Changes include such things as: 1) length of the survey; 2) number of surveys each physician receives; and 3) timely dissemination of findings. Specifically, through detailed factor analysis, seven questions have been eliminated from the physician survey. In addition, every attempt is being made to reduce the number of surveys to each physician, not to exceed four surveys (a maximum of two units assessed twice per year). Finally, a mechanism is now in place to provide feedback of each unit's measurement findings to those specific physicians surveyed. This will provide all interacting physicians a brief, but concise yardstick of that unit's performance.

As an additional measure to keep lines of communication open, please contact the Office of Professional Development, Measurement and Research at 402-8257 if you have any concerns or questions.

Legislative Update

Medicare E & M Documentation Guidelines

Organized medicine is outraged over new guidelines for documenting, evaluation and management services provided to Medicare patients scheduled to go into effect July 1, 1998. There are two reasons for the strong reaction: 1) the guidelines are viewed as excessively burdensome, difficult to apply to many cases, and requiring documentation of items unrelated to the care provided; and 2) a perception that anti-fraud and abuse provisions are excessive and could lead to criminal and civil penalties even in cases of "honest" coding errors.

There is now a two-pronged strategy being implemented so that physicians can be heard. The Pennsylvania Medical Society is urging all physicians in the commonwealth to voice their concerns, as well as potential solutions, to the American Medical Association. A copy of the letter written by Lee H. McCormick, MD, President of the Pennsylvania Medical Society, to the AMA delegation can be found on page 4 of this newsletter.

I urge you to contact the AMA and possibly our congressional representatives using Dr. McCormick's letter as a guide, but using your own words. Secondly, written recommendations/suggestions/solutions should be faxed directly to the AMA CPT Editorial Panel prior to March 15, 1998. Please fax this document to Ms. Celeste Kirschner, Director of AMA's Department of Coding and Nomenclature, at (312) 464-5762.

Thank you for your continued support as organized medicine attempts to protect our profession from governmental bureaucracy.

Robert X. Murphy, Jr., MD
Legislative Chairman
Lehigh County Medical Society

SAMPLE LETTER

February 12, 1998

<<Address>>

Dear Representative:

I am writing as President of the Pennsylvania Medical Society, the largest physician organization in Pennsylvania, to express grave concerns over the Evaluation and Management (E&M) Services documentation guidelines scheduled for implementation by the Health Care Financing Administration (HCFA). I am writing to urge you to contact HCFA to request a delay in the implementation sufficient to permit correction and modification of those guidelines.

The American Medical Association and the national specialty organizations have worked for over three years with HCFA in an effort to develop guidelines for physicians to use when documenting evaluation and management services provided to Medicare patients. The intent of these efforts was to create a national standard for payer audit purposes in order to ensure equitable and uniform pre and post payment review of claims. The Medical Society agrees with the intent, however, the resulting guidelines just don't work.

The published guidelines, scheduled to go into effect July 1, 1998, and the required documentation represent an onerous burden to physicians and do not reflect the way medicine is practiced. They don't reflect the value the physician brings to the treatment of the patient. There is no evidence that these new rules will improve the quality of care being delivered. In fact, with the increase in time required to comply with these new documentation guidelines, there will be less time to be spent in patient care.

The Society is also concerned about the assessment of criminal and civil penalties and other sanctions. We believe that true fraud should be prosecuted to the fullest. Our concern is that physicians will be investigated based on a misunderstanding or overzealous application of the guidelines and be forced to prove their innocence needlessly for what were genuine coding errors.

Again, I would urge you to contact HCFA to request a delay in the implementation of the E&M documentation guidelines for Medicare services.

Sincerely,

Lee H. McCormick, MD
President
Pennsylvania Medical Society

Semi-Annual Needs Survey

By now, you should have received a memo dated February 13, 1998, which marks the beginning of the Semi-Annual Needs Survey for the Medical Staff as called for in the Hospital Staff Development Plan. The Staff Development Plan calls for a semi-annual needs survey to be completed in January and July of each year in order that a review can be made of the clinical specialty needs of the Hospital.

At the present time, need has been identified in the Department of Family Practice, and in the Divisions of General Dentistry, General Internal Medicine, Geriatrics, Primary Obstetrics and Gynecology, and General Pediatrics, which are designated open divisions through the period ending June 30, 1998. Additional slot requests are **NOT** required for physicians to join these specialty areas.

In addition, specific slots have been approved for other areas where need exists. A list of these slots is available for review in the Medical Staff Services office.

Under the current Hospital Staff Development Plan, requests for slots in the Active and Associate categories must be made via the semi-annual needs survey. You may document any need for additional personpower (in your group, division, or other department) by completing the Hospital Staff Development Specification Statement which is available in Medical Staff Services at Cedar Crest & I-78.

Your completed request form must be received in the Medical Staff Services office at Cedar Crest & I-78 **NO LATER THAN MARCH 14, 1998** in order to be included in this semi-annual needs survey which will result in the May 6, 1998 approval of slots.

As part of the process, it is required that you discuss your request with the Department Chairperson, obtaining his signature (on the Hospital Staff Development Specification Statement) to indicate that a discussion took place, prior to the March 14, 1998 deadline. The Department Chairperson will acquire input concerning all slot requests in a manner determined by each department, however, recommendations by the applicable Division Chief, in writing, will be required and solicited by the Department Chairperson.

Please be reminded that, except as noted for the specialty areas listed above, **all Active and Associate staff appointments**, at Lehigh Valley Hospital, where there exists no presently approved slots, will required processing in this manner.

If you have any questions regarding this process, please contact either John W. Hart, Vice President, or Beth Martin, Executive Secretary, at 402-8980.

For Your Calendar

- A meeting of the General Medical Staff will be held on Monday, March 9, beginning at 5:45 p.m., in the hospital's Auditorium at Cedar Crest & I-78. All members of the Medical Staff are encouraged to attend.
- A general membership meeting of the Greater Lehigh Valley Independent Practice Association, Inc., will be held on Tuesday, March 24, beginning at 6 p.m., in the hospital's Auditorium at Cedar Crest & I-78.
- The Third Triennial Physician Recognition Dinner will be held on Saturday, March 28, at the Holiday Inn Conference Center, Fogelsville. Invitations have been mailed. If you did not yet receive one, please contact Janet M. Seifert in Physician Relations at 402-8590.

Attention Physicians and Office Managers

On March 2, the Reappointment Packets will be mailed to over 700 members of the Medical Staff.

Although much of the information on the application is preprinted, it is very important that you review ALL the information, make changes where necessary, fill in any missing data, and return the information in a timely manner.

Your assistance with this mammoth task is very much appreciated.

If you have any questions regarding the reappointment process, please contact Karen Fox in Medical Staff Services at 402-8957.

New Cancer Program Planned to Treat Bethlehem Patients

Muhlenberg Hospital Center (MHC), in conjunction with the John and Dorothy Morgan Cancer Center at Lehigh Valley Hospital (LVH), will develop a cancer program to provide a continuum of care for its cancer patients.

The Lehigh Valley Health Network board of trustees and the Muhlenberg Hospital Center Foundation board have approved the $2.2 million startup costs for the program. The new center will be housed in an existing facility on the Muhlenberg campus and is expected to begin operation by the end of the year. The prime site being considered is the vacant ground floor of the Kolb Ambulatory Center.

Based on current trends, MHC and its affiliated medical staff will diagnose in excess of 260 new cancer cases each year. Because of the scope of cancer treatment technology available on the campus, patients that are diagnosed and initially treated at MHC need to be referred to other hospitals for their follow-up care, including chemotherapy and radiation therapy services.

"This approach to care can be confusing and can put an unwarranted burden on patients and their families," said Gavin C. Barr, MD, Vice President-Medical Director, MHC Division. Now, patients and their families will benefit from having radiology, oncology inpatient services and inpatient/outpatient chemotherapy treatments in one location.

Patients will also have access to home care and hospice services, providing a continuum of care throughout the Lehigh Valley Health Network. And while the majority of the patients will be able to receive all of their care at the new Muhlenberg cancer center, advanced, tertiary services -- such as three dimensional radiation treatment planning, stereotactic radiosurgery, and soon to be added bone marrow transplant -- will be available through the Morgan Cancer Center.

"The expansion of cancer care services for the Muhlenberg community is just another example of the benefits of our newly merged organization," Dr. Barr said.

Revisiting the Health Office Visit

Any patient who is evaluated by their own physician in the Emergency Department requires assessment of vital signs and a COMPLETED medical record. In addition, per JCAHO standards and accepted medical legal standards, the patient is to be given written discharge instructions, a copy of which is appended to the chart. Although the attending of record may be a private physician, the patient is in the hospital and, therefore, patient care must meet the accepted standards of emergency care as defined above and by the federal COBRA statute. The patient is charged a facility fee for these services and any ancillary charges incurred during their visit.

The expectation is that these patients require emergent/urgent evaluation. There have been costly negative consequences for Lehigh Valley Hospital after health office visits associated with this lack of documentation.

An alternative site within the hospital is under review which would require no hospital services and, therefore, no facility fee; however, with the current practice a significant institutional liability exposure exists. An update will be forthcoming.

If you have any questions regarding this issue, please contact Michael S. Weinstock, MD, Chairperson, Department of Emergency Medicine, at 402-8130.

The Center for Educational Development and Support recently hired Sallie Urffer as Grant and Research Coordinator to assist members of the Medical Staff, residents, and hospital staff with the grant and research process.

In her position, Sallie will focus on pursuing grant and research opportunities, act as a liaison to funding sources, assist with abstract and proposal writing, and program development and planning.

For more information, contact Sallie Urffer via e-mail or by telephone at 402-1403.

Lehigh Valley Hospital Offers EMS Degree Program

Lehigh Valley Hospital is now the only institution in the region where paramedics and pre-hospital nurses can earn a bachelor's or associate's degree in emergency medical services (EMS).

LVH's Emergency Medicine Institute and Center for Education, in conjunction with Allegheny University of the Health Sciences (AUHS), Philadelphia, are offering the program, which began on January 29 in the Banko Building at Muhlenberg Hospital Center.

"There's a lot of competition among people who want to make a career out of EMS," said Richard Shurgalla, Administrative Director of LVH's Emergency Medicine and Pre-Hospital Services. "This program is a real benefit because there are so few options available for EMS crews to fine tune their skills and build on their interests."

LVH's involvement is an expansion of AUHS's 10-year-old EMS program. Before now in Pennsylvania, EMS degrees were only offered by AUHS in Philadelphia and Pittsburgh and by the University of Pittsburgh. In the Lehigh Valley, about 300 advanced life support providers qualify for the program.

"The field is evolving so quickly," Mr. Shurgalla said. "Twenty years ago, EMS was all volunteer and there were not a lot of people getting into management or administration. Now, EMS crews are paid, and there's a need for people to oversee the organizations, to manage budgets and negotiate contracts."

Through the program, students learn to provide competent clinical pre-hospital care, master skills essential to the management of EMS, and interact effectively with other health-care professionals and patients.

Faculty from AUHS's Philadelphia main campus will teach the courses, adding LVH instructors at a later date. "This a great opportunity to reach the EMS community outside Philadelphia," said Jean Will, AUHS's EMS program director. "Many of the EMS crews in the Lehigh Valley have good clinical education, and we can build on that."

The Emergency Medicine Institute (EMI), in conjunction with Lehigh Carbon Community College, has provided pre-hospital emergency training for nurses, paramedics and emergency medical technicians since 1987, when the institute was established by the late George E. Moerkirk, MD. This spring, EMI will be renamed the George E. Moerkirk Emergency Medicine Institute in his honor.

Dr. Moerkirk, who died in 1994, also established the University MedEvac program, which operates two emergency medical helicopters out of AUHS and LVH, in 1983 and was known as "the father of EMS." "He dedicated his entire life to being the foundation of the system we have today," Mr. Shurgalla said.

Annually, the institute provides training to more than 4,000 physicians, nurses, paramedics and other allied health care providers.

The first course being offered in the degree program, "Instructional Issues in EMS," will be held Thursdays from 6 to 9 p.m. until May 7. Classes will generally be held during the evenings or weekends to accommodate busy schedules. To register, call (215) 762-4177.

Transfer of Patient Service

Beginning February 2, 1998, all patients going to the Operating Room will be transferred to the surgeon's service by the "sending" patient care unit. This will require the Administrative Partner to enter the STACQ screen to change the attending physician in the computer. In addition, the tape on the outer edge of the patient's chart will be changed to reflect the surgeon (group) in charge of the patient's care. There will be no specific color coding for different services.

Post-operatively, if the patient's care will be managed by a medical or surgical physician other than the attending surgeon, a specific order should be written to state to whom the care of the patient is being transferred.

If you have any questions regarding this issue, please contact Jody Porter, Administrator, Patient Care Services, at 402-8030.

Radiology File Room Update

Last November, a large section of the viewing area in the Radiology File Room was lost due to the East Wing construction project. Since that time, as promised, members of Radiology administration have evaluated several options to renovate that space. The most viable option would entail a much larger construction project than the first, with finished space not much larger than the existing area. The cost estimates for this project are between $42,000 and $47,000.

As part of the East Wing construction project, expansion of the Radiology Department is being planned. Included in this expansion is a new file room, reading room, and viewing room. The projected time frame for this expansion is two years.

In light of the hospital's operation improvement efforts and the upcoming expansion of the Radiology Department, a decision was made by both Radiology administration and Troika to endure the next two years with the existing space and wait for the new file room, thus avoiding extra and unnecessary construction costs.

Radiology Orders

When ordering radiology studies, an **original** script, order or radiology requisition is required. For your convenience, orders may be faxed to the Radiology Department's front desk at (610) 402-7857.

Transfusion-Associated "Red Eye Syndrome"

Since December 1997, the Centers for Disease Control and Prevention (CDC) has received approximately 100 reports, from 10 different states, of patients who have developed severe conjunctivitis within 24 hours of transfusion. To date, all reported reactions have been associated with receipt of leukocyte-depleted blood components. In addition to "red eye," many patients have experienced ocular pain, periorbital edema, arthralgias, and headache. The symptoms have generally resolved within two to 14 days after onset; no permanent sequelae have been reported.

The CDC, Food and Drug Administration, and blood bank officials are conducting investigations to determine the potential etiology and extent of these reactions.

If you have any questions concerning this issue, please contact Bala Carver, MD, Medical Director, Blood Bank, at 402-8142, or Terry Burger, Manager, Infection Control, at 402-0685.

News from the Library

Copyright Revisited

While the arena may be changing for electronic publishing, it remains the same for printed materials. "Fair Use" allows an individual to copy an article for educational or research purposes. Distribution of multiple copies requires permission from the publisher.

The Library staff is prohibited from copying several articles for an individual from a particular journal issue. In addition, the number of articles that can be obtained on interlibrary loan from any one journal title is restricted.

OVID Training

To schedule a one-on-one OVID (MEDLINE) training session, call Barbara Iobst in the Health Sciences Library at 402-8408.

New Additions

At Cedar Crest & I-78

"Fishman's Pulmonary Diseases and Disorders," 3rd ed.
Author: A. Fishman, et al.
Call No. WF 600 F537 (Reference Section)

At 17th & Chew

"Handbook of Child and Adolescent Psychiatry"
Editor: J. Noshpitz
Call No. WS 350 H236

Outpatient Access to LMIC

The outpatient entrance to Lehigh Magnetic Imaging Center (LMIC) is located at the front of the 1220 building which faces the East Wing construction site. All outpatients coming to LMIC from any location on the hospital's campus must use this entrance since hallway access from the 1210, 1230, and 1240 buildings no longer exist due to construction. Convenient patient parking is available on the south side of LMIC between the 1230 building and the construction site.

The temporary trailer link is to be used for LVH inpatients and staff access only. Outpatients are currently being misdirected to LMIC via the inpatient/staff link which causes much patient confusion and raises safety concerns. Your assistance in informing your patients about the correct access to LMIC is greatly appreciated. If you have any questions regarding this issue, please call LMIC at 740-9500.

Depression

John had been feeling depressed for weeks though he didn't know why. He had lost his appetite and felt tired all the time. It wasn't until he couldn't get out of bed any more that his wife ook him to a mental health professional for treatment. He soon showed improvement and was able to return to work.

Depression can affect your productivity, judgment, ability to work with others, and overall job performance. The inability to concentrate fully or make decisions may lead to costly mistakes or accidents. In addition, it has been shown that depressed individuals have high rates of absenteeism and are more likely to abuse alcohol and drugs, resulting in other problems on and off the job.

Unfortunately, many depressed people suffer needlessly because they feel embarrassed, fear being perceived as weak, or do not recognize depression as a treatable illness.

When you need to talk . . .

. . . help is just a phone call away.

Physician Assistance Program

To arrange a confidential appointment or for more information, call (610) 433-8550 or 1-800-327-8878.

Congratulations!

Anthony P. Buonanno, MD, Department of Family Practice, was informed by the American Board of Internal Medicine that he passed the certifying exam and is now certified as a Diplomate in Internal Medicine. In addition, Dr. Buonanno passed the General Pediatrics Certifying Examination and has also become a Diplomate of the American Board of Pediatrics.

Kevin E. Glancy, MD, Division of Trauma-Surgical Critical Care/General Surgery, was recently notified by the American Board of Surgery that he successfully completed the recertification process and is now recognized as recertified in Surgical Critical Care.

Vincent E. Lucente, MD, Chief, Division of Gynecology, was recently appointed by the American College of Obstetricians and Gynecologists president to serve as a member of the Committee on Coding and Nomenclature for the 1998-99 college year, beginning May 1998.

Shantha V. Mathews, MD, Division of Neonatology, recently received notification from the American Board of Pediatrics that she passed the Neonatal-Perinatal Medicine Certifying Examination given in November and is now certified in the pediatric subspecialty of Neonatal-Perinatal Medicine.

Francis A. Salerno, MD, Chief, Division of Geriatrics, was recently notified by the American Board of Internal Medicine that he passed the Recertification Final Examination and has become recertified in Geriatric Medicine.

Harvey T. Starr, DO, Division of General Internal Medicine, has been notified by the American Board of Internal Medicine the he passed the 1997 Recertification Final Examination and has become recertified in Critical Care Medicine.

Michael S. Weinstock, MD, Chairperson, Department of Emergency Medicine, has been appointed as a Professor of Clinical Medicine at The Pennsylvania State University's College of Medicine.

Papers, Publications and Presentations

"Splenic Infarction Caused by a Large Thoracic Aortic Thrombus" was published in the December 1997 issue of the ***Journal of Vascular Surgery***. The authors of the paper include **Stefano Agolini, MD**, Chief Surgical Resident; **Kamalesh T. Shah, MD**, Division of General Surgery/Trauma-Surgical Critical Care; **James J. Goodreau, MD**, Associate Chief, Division of Vascular Surgery; **Thomas M. McLoughlin, Jr., MD**, Chief, Division of Cardiac Anesthesia; and **Michael C. Sinclair, MD**, Division of Cardio-Thoracic Surgery.

Joseph L. Antonowicz, MD, Chief, Division of Consultation/Liaison Psychiatry, was a co-presenter at a seminar -- "Assessing Capacity - Legal and Medical Perspectives" -- at the Pennsylvania Bar Institute's First Annual Institute on Elder Law, which was held on February 11 in Philadelphia.

Mark A. Gittleman, MD, Division of General Surgery, was recently invited to present lectures and hands-on training concerning stereotactic and ultrasound-guided breast biopsy interventional techniques to physicians and industry leaders at the European Ethicon Endosurgery Institute which was held January 28 to February 4 in Hamburg, Germany. Dr. Gittleman has developed instructional teaching manuals for the training of European surgeons utilizing these techniques.

In addition, Dr. Gittleman was invited to author the chapter "Breast Ultrasound" in the textbook ***Ultrasound in Surgical Practice: Basic Principles and Clinical Applications*** which is scheduled to be published this year.

Dona C. Hobart, MD, Chief Surgical Resident, presented her poster, "Carotid Endarterectomy: Reduced Resource Utilization Using a Clinical Protocol," at the 23rd International Joint Conference on Stroke and Cerebral Circulation in Orlando, Fla., February 4-7. Co-authors of the paper include **Gary G. Nicholas, MD**, Chief, Division of Vascular Surgery; **James F. Reed III, PhD**, Director, Health Services Research; and **Susan A. Nastasee**, Surgical Editor, Department of Surgery.

Nelson P. Kopyt, DO, Division of Nephrology, was a member of the guest faculty at the 16th Annual Winter CME Festival, a program of Penn State's College of Medicine, which was held February 18-21, in Lancaster, Pa. Dr. Kopyt's topic was "Renal Aspects of Hypertension."

Vincent E. Lucente, MD, Chief, Division of Gynecology, recently was accepted into two clinical trials. The first is the Surgical Treatments Outcomes Project for Dysfunctional Uterine Bleeding (STOP-DUB). STOP-DUB is a multicenter, randomized clinical trial funded for $6.6 million over five years by the Agency for Health Care Policy and Research (AHCPR). It is being performed through the Gynecologic Studies Group (GSG), an organization of academic institutions dedicated to the development and implementation of multicenter trials evaluating non-oncologic gynecologic conditions and administered by ACOG. The second trial is through Boston Healthcare Associates and is a phase II randomized double-blind study to evaluate the safety and compare efficiency of a drug for stress urinary incontinence with that of placebo in women.

Michael D. Pasquale, MD, Chief, Division of Trauma-Surgical Critical Care, co-authored "Practice Parameters for Evaluating New Fever in Critically Ill Adult Patients," which was published in the February issue of ***Critical Care Medicine.*** Dr. Pasquale is a member of the Task Force of the American College of Critical Care Medicine of the Society of Critical Care Medicine which collaborated with the Infectious Disease Society of America to develop these guidelines.

Upcoming Seminars, Conferences and Meetings

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 March include:

- March 3 - PSA Screening in Diagnosis and Treatment of Prostate Cancer and the LVH Treatment
- March 10 - IBD
- March 17 - MS Current and Future Therapies
- March 24 - Conservative Management of Chronic Renal Failure
- March 31 - The Appropriate Drug Management of Pain

For more information, please contact Evalene Patten in the Department of Medicine at 402-1649.

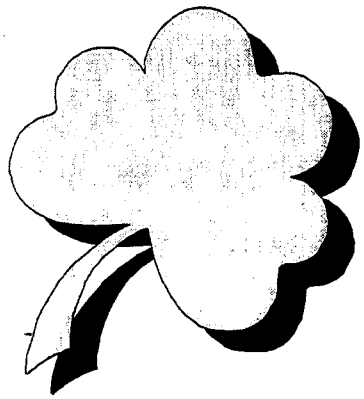
Department of Pediatrics Conferences

Pediatric conferences are held on Fridays beginning at Noon, in the hospital's Auditorium at 17th & Chew.

Topics to be discussed in March include:

- March 13 - Approach to Metabolic Disease
- March 27 - Breastfeeding in the 90's

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



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 to update your directory and rolodexes with this information.

Medical Staff

Address Changes

In February, the members of ABC Pediatrics and Family Pediatricians merged to form a new group known as **ABC Family Pediatricians**. Please make note of the physicians and their appropriate office address changes.

Sangeeta Agrawala, MD
Scott M. Brenner, MD
Thomas J. Durkin, Jr., MD
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(Effective March 3, 1998)

Practice Disassociation

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Practice Name Change

The practice name for
Bruce I. Rose, MD
has changed to
Infertility Solutions, PC

HOMOCYSTEINE CHALLENGE TEST

(Note: This has been prepared as a protocol for the Endocrine Testing Station of the Lehigh Valley Hospital. It is being made available to all local physicians as it can be performed properly in almost any out-patient laboratory setting. D. F. Dimick, M.D.)

I. Indication for Use

Hyperhomocysteinemia is a potent independent risk factor for thromboembolic disorder, coronary heart disease, cerebral vascular disease and peripheral vascular disease. This test should be employed to investigate those patients at high risk for thromboembolic and/or macro-vascular disease - especially those patients inadequately explained by other risk factors such as hyperlipidemia, smoking, diabetes and hypertension. However, the presence of these other risk factors does not exclude the presence of hyperhomocysteinemia.

II. Rationale

Homocysteine is not an amino acid found in any protein of the body; it is an intermediary metabolite. While the homozygous disease of homocysteinuria has seven possible biochemical disorders - cystathionine beta synthase deficiency and 5, 10 - methylene tetrahydrofolate reductase deficiency account for the vast majority. It is believed that the heterozygous forms of these disorders account for the vast majority of patients with hyperhomocysteinemia. One should recognize that certain nutritional deficiencies (Vitamin B6, Vitamin B12 and folate), certain disease states (severe psoriasis, acute lymphoblastic leukemia and chronic renal failure), and certain medications (methotrexate, phenytoin, carbamazepine, and oral contraceptives) all may increase blood levels of

homocysteine. Importantly, the measurement of only the fasting levels of homocysteine will identify between 28 to 40 percent less of hyperhomocysteinemic patients that can be diagnosed after an oral methionine challenge. Further, the blood samples taken for homocysteine assays must be immediately placed in an ice bath and soon have the plasma separated from the red cells in order not to have an artificially elevated homocysteine level. Homocysteine assays are expensive. Therefore, the following would appear most prudent: Obtain a properly collected and preserved sample six hours after the patient has received a 100mg/kg methionine load and has maintained the correct diet during the day of the test.

III. Method

1. Patient is weighed and given a prescription for l-methionine 100mg/kg of patient's weight. The patient can pick up this calculated amount of l-methionine at the Spectrum Apothecary or any other interested participating pharmacy. The cost is only about $0.35/gm. Be sure to specify "l-methionine."
2. Patient is given an instruction sheet:
   (a) How to take the methionine at 8:00 a.m. during the test day.
   (b) How to follow dietary modifications during the day of the test.
   (c) To have an appointment to have blood drawn at 2:00 p.m. in the Endocrine Testing Station - or any other outpatient laboratory provided the criteria below are met.
3. Blood sample is drawn and placed immediately in an ice bath.

4. The blood sample is soon transported to the Laboratory for separation of the plasma from the red blood cells within 2 hours - or is spun down and separated in the drawing station if such separation in a laboratory cannot be accomplished within two hours.

IV. Interpretation

1. Values >40 μmol/liter are definitely abnormal.
2. Some clinicians start therapy for the borderline values between 30 - 40 μmol/liter.

V. References - (a selected few of many.)

E.L. Mayer et al. Homocysteine and Coronary Atherosclerosis. (Review article). Amer Coll Cardiol 27:S17-27, 1996.

Plasma Homocysteine as a Risk Factor for Vascular Disease. (The European Concerted Action Project.) JAMA 277:1775-81, 1997.

A. D'Angelo et al. Homocysteine and Thrombotic Disease. Blood 90:1-11, 1997.

R. Clarke et al. Hyperhomocysteinemia: An Independent Risk Factor for Vascular Disease. N Eng J Med 324:1149-55, 1991.

J. A. Friedman et al. Hyperhomocysteinemia as a risk factor of Cardiovascular Disease in Patients Undergoing Hemodialysis. (Review) Nutrition Reviews 53:197-201, 1995.

P. M. Neland et al. Total Homocysteine in Plasma or Serum: Methods and Clinical Applications. Chemical Chemistry 39:1764-79, 1993.

M. N. Munshi et al. Hyperhomocysteinemia following a Methionine Load in Patients with NIDDM and Macrovascular Disease. Metabolism: Clin. & Exp. 45:133-5, 1996

HYPERHOMOCYSTEINEMIA - PATIENT INSTRUCTIONS

PATIENT'S NAME:_____TELEPHONE #_____

PATIENT'S APPOINTMENT (DAY AND TIME):_____

Homocysteine (pronounced ho-mo-sis-teen) is like an amino acid - but is actually a metabolic product and not found in any of the proteins in our body. "Hyper" means too much, and "emia" means in the blood. So hyperhomocysteinemia means the level of homocysteine is too high in the blood. This condition can cause coronary artery disease (heart attacks), cerebral vascular disease (strokes), peripheral vascular disease (gangrene in the legs), and thromboembolic problems (clots in the veins and/or pulmonary emboli - that is clots traveling up to the lungs). There is an uncommon disorder with very high homocysteine levels in very young children that causes severe vascular and brain disease. You are being tested for a much more mild genetic disorder. This disorder usually can be effectively treated with the Vitamin B-6 (pyridoxine), Vitamin B-12, and folic acid. Much higher amounts of these vitamins are required than in the usual vitamin pills. Your physician will prescribe these if necessary.

THE PATIENT MUST DO THE FOLLOWING:

1. Schedule the test at the Endocrine Testing Station or another blood drawing station(out patient lab) which will be determined by your doctor. Obtain a prescription for the correct amount of l-methionine from your Doctor. Have it filled at the Spectrum Apothecary or any other pharmacy who will provide methionine. Methionine is an amino acid.
2. Drink the methionine powder mixed with any juice at 8:00 a.m. on a fasting stomach.

3. Do not eat or drink any protein until after the 2 p.m. blood collection is accomplished - that is - no meats (beef, pork, chicken, fish, etc.), dairy products, eggs, protein fortified foods or peanuts.

4. Do not drink milk, milk products or protein fortified drinks.

5. You can eat vegetables, fruits, salads, breads like muffins, toast or bagels.

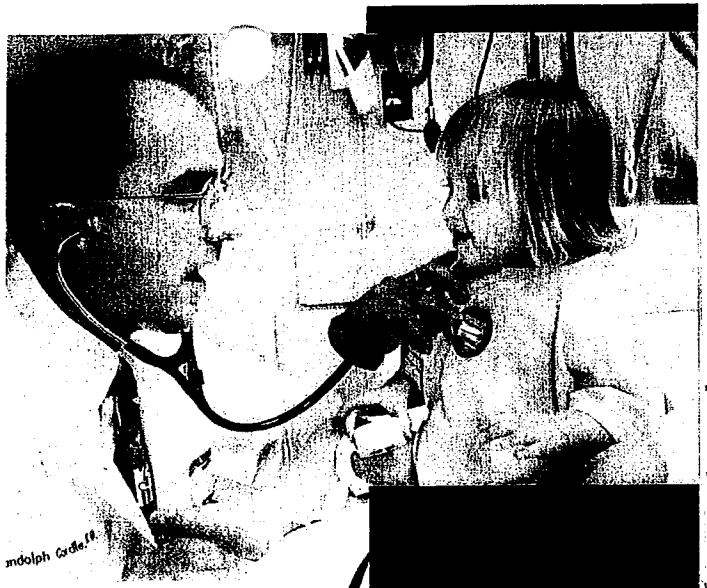
6. You can drink anything except milk and milk products.

7. Be sure to be at the Endocrine Testing Station or your designated outpatient lab before 2:00 p.m. to have your blood drawn.

8. If you go to an outpatient laboratory, show the Lab Technician this instruction sheet so they will take the sample close to 2:00 p.m., put the sample in an ice bath, and arrange for the separation of the plasma and red cells within 2 hours.

11-20-97 Prepared and approved - D. F. Dimick, M.D.

1/13/98 Revised text - D. F. Dimick, M.D.



CALL X1210

FOR MORE

INFORMATION

OR TO REGISTER

MARCH 27

7:30 a.m.	Registration
8:00 a.m.	Welcome & Introduction Michael Weinstock, M.D.
8:15 a.m.	PALS Update Randolph Cordle, M.D.
9:00 a.m.	Respiratory Distress Robert Miller, M.D.
9:30 a.m.	Pediatric Shock Charles Worrilow, M.D.
10:00 a.m.	Break
10:15 a.m.	Head Trauma Gary Bonfante, D.O.
10:45 a.m.	Trauma Kevin Glancy, M.D.
11:15 a.m.	Approach to the Critically Ill Child Michael Weinstock, M.D.
11:45 a.m.	Methods of Emergency Drug Dose And Equipment Selection Michael Weinstock, M.D.
Noon	Lunch
1:30 p.m.	Advanced Airway Management: RSI for Emergent Intubation Gavin Barr, Jr., M.D.
2:30-6:45 p.m.	Labs

(Participants rotate through each 60 minute lab. There will be one 15 minute break.)

Megacode	Michael Weinstock, M.D. Gary Bonfante, D.O.
Advanced Airway	Gavin Barr, Jr., M.D. Charles Worrilow, M.D.
X-Ray	Jerome Deutsch, D.O.
Procedure Lab	James Cushman, M.D. Ronald Lutz, Sr., M.D.

day one

MARCH 28

7:30 a.m.	Registration
8:00 a.m.	Status Epilepticus Michael Barone, M.D.
8:30 a.m.	Cervical Spine Trauma David Richardson, M.D.
9:00 a.m.	Cardiovascular Disorders Mark Farin, M.D.
9:30 a.m.	Pain Management/Sedation John McCarthy, D.O.
10:00 a.m.	Break
10:15 a.m.	Respiratory Distress Cases John VanBrakle, M.D.
11:15 a.m.	Trauma Cases Michael Pasquale, M.D.
12:15 p.m.	Lunch
1:45 p.m.	Skills Stations/Labs

(Participants rotate through each 60 minute lab. There will be one 15 minute break.)

Critically Ill-Appearing Child

Cases	Randolph Cordle, M.D.
Procedure Lab	John McCarthy, D.O.
Megacode	William Zajdel, D.O.
Selected Cases	Alexander Rosenau, D.O.
6-9:30 p.m.	PALS Re-certification Test Randolph Cordle, M.D.

Pediatric Advanced Life Support (PALS) Provider Renewal Course (optional).

The AHA AAP Program recommends renewal within 2 years. Pre-requisites include current PALS provider status and completion of a (CPR) Basic Life Support Course within 2 years. A copy of your current PALS and CPR cards with expiration date shown must accompany the registration form. Participants will be given the opportunity to refresh skills prior to demonstrating cognitive and practical expertise through a written and performance evaluation.

day two

ACCREDITATION: **Lehigh Valley Hospital is accredited by the Pennsylvania Medical Society to sponsor continuing medical education programs. Lehigh Valley Hospital designates this continuing medical education activity for 16.5 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society membership requirement. All faculty participating in continuing medical education programs sponsored by Lehigh Valley Hospital are to disclose to the program audience any real or apparent conflict(s) of interest related to the content of their presentation(s). Lehigh Valley Hospital is a provider of continuing nursing education (CNE) as approved by the Pennsylvania Nurses Association, an accredited approver of CNE by the American Nurses Credentialing Center's Commission on Accreditation. This course has been approved for 19.8 PNA contact hours for registered nurses or 16.5 clock hours. This course is approved by the American College of Emergency Physicians and the American Academy of Pediatrics for a maximum of 16.5 hours of ACEP Category 1 credit and AAP credit.**

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Medical Staff Progress Notes

Medical Executive Committee

Medical Staff Progress Notes **is published monthly to inform the Lehigh Valley Hospital Medical Staff and employees of important issues concerning the Medical Staff. Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at 402-8590.**
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