LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

September, 2000 ❖ Volume 12, Number 9

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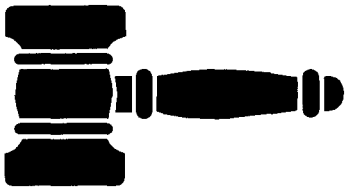

From the President

"In this country doctors are, as a rule, bad citizens, taking little or no interest in civic, state or national politics. Let me...tell of one of us...who...has found time to serve his city and his country. For more than twenty years Virchow has sat in the Berlin City Council as an alderman, and to no feature in his extraordinary life does the Berliner point with more justifiable pride. It is a combination of qualities only too rare, when the learned professor can leave his laboratory and take his share in practical, municipal work." *William Osler, 1891*[1]

Colleagues:

The days of summer are fleeting, and September is now upon us. With that in mind, I wanted to take this opportunity to tell you about the big plans for the September 11 General Medical Staff meeting. As I've been telling you for the past few months, we are planning to demonstrate the PHAMIS 4.N Patient Management System with computerized order entry. Representatives from LVH Information Services (I/S) and I will present a demonstration version of the new system. Over the past couple of weeks, I've been working with members of the I/S staff to begin the process of developing our physician order entry system so that it will be "user friendly" and will help us to make our hospital rounds more efficient.

In August, the Medical Executive Committee viewed the first demonstration of the new computerized order entry system, which is planned for introduction in early summer 2001. Members of the committee had a number of comments and suggestions about the demonstration version of the system. Overall, I felt the first demonstration of this new software package was a success. However, much needs to be done before the rollout next year. We all need to be prepared to help in tailoring the system for our own use.

As well, on September 11, from 7 a.m. to 9 p.m., representatives from I/S will be in the Presidents' Room with multiple computer terminals set up so that members of the Medical Staff can sit down and take time to have a "hands on" demonstration of the system. These terminals will also be available after the Medical Staff meeting for your use. Please remember that the demonstration system we will be seeing on the 11th of September is not the final version that will be implemented at LVH. The newest version of this software is being upgraded and will be available in October, 2000.

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[1] Osler, William. Rudolph Virchow: the man and the student. Boston Med Surg J. 1891; 125:425-7 [Reprinted in McGovern JP, Roland CG (eds). The Collected Essays of Sir William Osler, vol. III. Birmingham, AL: Classics of Medicine Library; 1985, pp. 426-7].

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The Physician Order Entry Committee, chaired by Dr. John Jaffe, will be meeting regularly to help with the rollout of the computer order entry system so that the members of our staff will find it workable and easy to use. Members of the LVPHO Information Services Committee will also help in the development and rollout of this new and revolutionary system.

From my conversations with Mr. Harry Lukens, Sr. Vice President and CIO, and members of his I/S staff, I can assure you that they want our input and are prepared to do everything possible to make the introduction of this new system as trouble free and "physician friendly" as possible. If your input and recommendations are solicited, please don't hesitate to offer your opinion. By getting as much participation and buy-in from the Medical Staff early on, we will be able to have a system which will work for all of us and will help us do a better job taking care of our patients.

By now you are probably asking yourself what benefits will I, as a physician, reap from the use of a computerized physician order entry system? Below, I have listed just a few.

- Maximizes the efficiency of care
- Reduces delay and errors from transcription
- Permits remote ordering
- Corrects illegible and incorrect orders
- Allows interface of orders to scheduling
- Allows interface of orders with managed care processes
- Improves quality of care
- Allows direct interface with physicians
- Allows notice of drug interactions
- Provides allergy checking
- Reduces health care costs
- Guides cost efficient choices
- Supports clinical education
- Provides online references
- Provides online rules and references

Once again, I ask for your patience, cooperation, and assistance as this installation and implementation progresses over the next nine months. We have much work to do. This will be "our" system. We can make it work the way we want it to. I believe in the benefits of this new system. I hope you will begin to share my enthusiasm for this revolutionary system that is being implemented primarily to reduce errors and to improve the quality of care we deliver to our patients.

Sit, Answer and Touch!

Remember, when you are making hospital rounds to sit at your patient's bedside, ask for their questions, answer their questions, and make physical contact with the patient.

Legibility of our medical records continues to be a problem. I'll remind you again of the action taken at the June Medical Executive Committee meeting. The committee adopted a resolution to "**require that signatures must be followed by the physician's printed name whenever it appears in the chart**. A signature stamp will be provided by the hospital to physicians who feel that printing their name is too burdensome." The Medical Record Department will consider charts, in which signatures are illegible, incomplete, and appropriate action, as specified in the Medical Staff Bylaws, will be enforced.

In my last month's ***Medical Staff Progress Notes*** article, I made some remarks about the rising cost of pharmaceuticals that we prescribe for our patients. I've heard a number of comments about these remarks. At our Medical Executive Committee meeting in August, we had a brief discussion about the topic, and I plan to bring this subject up again for discussion at the September meeting of the Medical Executive Committee.

It is not uncommon or unheard of for many of my Medicare patients with several chronic illnesses to have to spend upwards of $4,000/year for medications that I have prescribed for them to deal with their various illnesses. These medications can be remarkably effective in helping them deal with their chronic conditions. They may also reduce the number of hospitalizations that are required to take care of these patients. With these medications, patients may live more functional and productive lives. I am all in favor of the development and marketing of new and effective medications which are proven in large controlled studies to help reduce morbidity, prolong life, reduce hospitalization, and improve the quality of life. I recognize that the development of these new medications cost a great deal of money for the pharmaceutical industry, which invests in research and development required in producing these new products. I also believe that monetary incentives are necessary to stimulate this research which, on many occasions, is not rewarded with the success of marketing a new drug.

I am very concerned, however, with several aspects of the current pharmaceutical industry's approach to drug development and marketing. The first of these is the development of "look alike" drugs. Do we really need 15 to 20 ACE inhibitors for the treatment of hypertension, CHF, and diabetic renal disease? Do we really need four "proton pump" inhibitors at $3.00/capsule for the treatment of acid reflux disease? These are just examples of the tendency for competing drug companies to develop similar drugs with minor chemical modifications so that they can reduce their R&D costs and then devote huge marketing budgets to promote these medications to physicians and now directly to the public.

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All of the drug companies want to get on the "gravy train" so they can share in the windfall profits that are now available in this uncontrolled marketplace.

Why do most of these "look alike" drugs cost almost the same amount for a one-month supply? Each company knows that the mark-up on their drugs is so high that by competing on price they would soon be involved in a price war and they would all lose. With the advent of drug prescription plans that pay for medications, the pharmaceutical industry is unfettered in its propensity to continually increase the cost of drugs to our patients and to those who pay for the drugs. We, the physicians, are the consumers, but we do not bear any of the responsibility for having to pay for medications that we prescribe for our patients. Our patients are placed in the position of having to pay for medications which they have no choice in selecting. They can't decide whether they want to buy the BMW or the Yugo when it comes to prescription medications. The usual market forces that drive consumer choices do not apply to prescription drugs that are prescribed by physicians and taken by patients.

Would you want your physician recommending a drug for your use because he has been given tickets to the U.S. Senior Open at Saucon Valley Country Club, the Philadelphia Phillies, or the Philadelphia Eagles? I don't believe that I should choose a medication for my patient because I was given $40 worth of Chinese food at Wegman's at a "dine & dash," or free ice cream at Ice Cream World, or bagels at Chesapeake Bagel Company on Tuesday and Thursday mornings every month? Ask yourself, "Why are the majority of the drug representatives very attractive young women (or handsome young men)?" I believe that my colleagues and I should be receiving our drug information from appropriate, reputable, readily available peer reviewed sources in the medical literature, not from attractive salespersons who hand out pens, notepads, paperweights, coffee mugs, and the like. Just imagine what could happen to the market price of prescription medications if the pharmaceutical companies reduced their marketing budgets by 25– 50%, used this windfall to reinvest in R&D, and lowered the price of prescription medications. Wouldn't that be a revolutionary thought! What would happen if we depended on intelligent physicians to prescribe medications based on their knowledge about pharmaceuticals obtained from the peer reviewed medical literature? What might happen if all members of the LVH Medical Staff read ***The Medical Letter***[2] every two weeks?

Remember, we are not talking about antibiotics which are usually only used for a short time period. I am primarily concerned about medications that are prescribed for chronic conditions. Fortunately, many of us can afford to purchase these medications because of our success or good luck. Many Americans are not as fortunate. Wouldn't it be better for Merck to sell Zocor™ for $0.20/tablet to the 10 million Americans who would benefit from its use than to sell it for $2.00/tablet to the one million who were fortunate enough to be able to afford it? Wouldn't it be great if people could afford to take their medications and buy groceries at the same time?

I hope that I am not the only physician on this medical staff who is outraged by the continuing rise in prescription drug prices. I hope that other members of our staff are equally concerned by the exorbitant profits that the pharmaceutical industry reaps at the expense of our patients. Prescription drug costs rose by approximately 14% last year. It has been estimated that 18% of the nation's health care budget is related to physician charges. The same study estimates that prescription drug costs account for 20% of the nation's health care budget! I hope that the members of our Medical Staff will write to their senators and congressmen supporting federal legislation designed to place some control on prescription drug costs, and to control the huge expenditures that the drug companies spend on marketing to physicians and directly to the public. *(We should all be cognizant of Osler's comments about Virchow and the value of physician involvement in a political cause.)*

E-MAIL

One more time, I'd like to encourage all members of the Medical Staff to read their e-mail regularly or to designate a staff member to be your appointed "surrogate" who can read and print out your e-mail messages for you on a daily basis. If you or your staff need help in assigning a "surrogate," please call Information Services at (610) 402-8303.

Many of you remember my involvement in a project several years ago to try to improve our care for patients with congestive heart failure. This project included efforts to shorten inpatient length of stay, reduce the costs of inpatient care, improve the quality of outpatient care, and reduce the readmission rate for these patients. Dr. Keith Doram has been managing this project for over one year. I've recently received some data about the success of this program. From July, 1999 through May, 2000, the length of hospital stay for patients admitted with a diagnosis of CHF has fallen from 5.6 days to 4.5 days. The average cost/case for patients hospitalized with CHF over the same period fell from $2,100 to slightly less than $1,800. This is real progress! I want to commend Dr. Doram and all of those involved in this project for their successful efforts. A great deal of the credit for this success is due to the efforts of all of the physicians who care for patients with congestive heart failure admitted to LVH and LVH-M.

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[2] http://medletter.com

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I look forward to seeing you at the General Medical Staff meeting on Monday, September 11, at 6 p.m., in the Auditorium at Lehigh Valley Hospital, Cedar Crest & I-78. We will be nominating and holding the election for the new President-elect of the LVH Medical Staff at this meeting. Please try to attend this important meeting. Also, please take some time to stop by the Presidents' Room between 7 a.m. to 9 p.m., on September 11 for a hands-on session with the physician order entry software!

David M. Caccese, MD
Medical Staff President

Physician Order Entry Is Coming...

Demo's with hands-on sessions will be available for members of the Medical Staff on Monday, September 11, from 7 a.m. to 9 p.m., in the Presidents' Room at Lehigh Valley Hospital, Cedar Crest & I-78.

Ambulation Protocol Approved

At its June 6 meeting, the Medical Executive Committee approved an ambulation protocol that was designed to facilitate early and appropriate ambulation with patients. Education related to the protocol is currently underway, and implementation is scheduled for October, 2000.

If you have any questions, please contact Kathleen Baker, Director of Physical and Occupational Therapy, at (610) 402-8480.

Cancer Staging at LVH-Muhlenberg

In order to comply with the Commission on Cancer's program accreditation requirements, cancer staging is being implemented at LVH-M on September 1, 2000. Physicians with privileges at LVH-Muhlenberg will receive an individual mailing which contains a description of the staging process, a listing of the organ sites for which staging is required, and samples of several staging sheets. If you have any questions regarding this issue, please contact the Tumor Registry at (610) 402-0520.

Interactive Safety Training

According to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), all members of the hospital's staff, including employees, volunteers, and physicians, must complete an annual mandatory safety training program. To accomplish this paramount task in a more efficient, user-friendly manner, the hospital has introduced a new computer-based interactive learning system.

This system -- de'Medici -- has been installed on numerous PC workstations throughout LVHHN and encompasses all JCAHO/OSHA requirements such as fire safety, infection control, bloodborne pathogens, workplace violence, and emergency preparedness.

The following areas are available for physicians to drop in to do their de'Medici training:

Cedar Crest & I-78
Learning Resource Center
Health Sciences Library

17th & Chew
Medical Staff Lounge
Health Sciences Library

LVH-M
Medical Staff Lounge
Health Sciences Library

As you may know, JCAHO inspection of Lehigh Valley Hospital is scheduled for later this year. Therefore, ALL members of the staff should complete their training before the end of October.

If you have any questions regarding the de'Medici interactive safety training, please contact Suzanne Rice via e-mail or at 484-884-2560.

Medical Staff Dues

On September 1, letters regarding annual Medical Staff dues will be distributed to members of the common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. Payment of dues is requested **on or before September 15, 2000.** Timely remittance of dues is both requested and appreciated.

If you have any questions regarding your Medical Staff dues, please contact Janet M. Seifert in Physician Relations at (610) 402-8590.

News from the HIM Department

Document Imaging

Dictation Record View

Input from physicians has been requested for ways to improve the document imaging system. One of the concerns is the increased time it takes to do dictations after records are scanned into the imaging system. In an effort to improve the process, "Physician Dictation View" has been created. The dictation view eliminates all of the administrative documents from view. To utilize this view, scroll on the tool bar directly above the document lists until you get to the "Physician Dictation View" (views are in alphabetical order). Click on the "Physician Dictation View" and only the documents in this view will appear. If you need to view documents not contained in this view, you may, at any time, change to the "All Documents" view.

Record Completion Process

Wednesday, prior to current week, letters are mailed to medical staff listing all medical records with deficiencies.
Thursday, prior to current week, resident staff receive letters for deficiencies.
Monday of current week, a list is generated of all pending suspension charts, including any H&Ps and OPs which have not been completed.
Tuesday of current week, a courtesy call is placed to all physicians who have deficiencies that are listed as "pending suspension" stating that these must be completed by Wednesday of the current week.
Wednesday of current week, a suspension list is generated at 3 p.m. for deficiencies not completed by this time.

Deficiency Assignment

Deficiency assignments are made according to the guidelines that have been established by physician groups or individual physicians. The same guidelines that were in place prior to the document imaging system are being utilized, unless new instructions were provided to the HIM Department by the physicians. If changes need to be made to the assignment process, please contact the HIM Department.

For ease in completing records, the document imaging system continues to be available on any "document imaging enabled" workstation on the units or in the HIM Department. The system enables the HIM Department staff to alert the physicians to chart deficiencies (histories and physicals) within 24 hours after admission. Once the dictation has been transcribed, the deficiency is translated into a sign deficiency automatically. ***Since the system is updated on an ongoing basis, it is a good idea to sign in for chart completion frequently.***

Pending Suspension Deficiencies

Remember, in the old paper world when physicians had to physically report to the HIM Department, the HIM staff knew when records were completed. With access conveniently available throughout the organization, even though the system is constantly checked, it is sometimes difficult to know that all suspension deficiencies have been completed. Please notify the HIM Department if you have completed "pending suspension" deficiencies outside the HIM Department at (610) 402-8345.

Personal Identification Number

If you forget your "signing PIN number," please call the I/S Help Desk at (610) 402-8303. Staff is available Monday through Friday, 8 a.m. to 5 p.m. to assist you. Your PIN number is utilized for electronic signature/chart completion and does not interfere with your ability to access and review historical medical records.

If you have any questions regarding Document Imaging, please contact Sue Cassium, Operations Coordinator, at (610) 402-4451.

Verbal/Telephone Orders

Please remember to check your charts on rounds every day for yellow "sign-here" labels that indicate that there is a verbal/telephone order that needs a signature.

For Your Calendar

- A meeting of the **General Medical Staff** will be held on **Monday, September 11**, beginning at 6 p.m., in the Auditorium at Lehigh Valley Hospital, Cedar Crest & I-78. An election of the next President-elect of the Medical Staff will be held at the meeting. All members of the Medical Staff are encouraged to attend.

- The quarterly **General Membership Meeting of the Greater Lehigh Valley Independent Practice Association** will be held on **Tuesday, September 26**, at 6 p.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78. To receive credit for your attendance toward the Incentive Plan, please remember to sign in.

- The next **Physician Recognition Dinner** will be held on **Saturday, March 31, 2001**, at the Holiday Inn Conference Center in Fogelsville. Please mark your calendar! More information will follow as the date gets closer.

Patient Transport Service

In an effort to decrease the amount of time that patients wait to go to testing or return from testing, members of Clinical Services and Materials Management have worked together to create a Patient Transport Service which will begin on September 5 at Cedar Crest & I-78.

Currently, patients are transported by Support Partners. Through a study completed by a workflow analysis group, it was found that Support Partners spend 60% of their time off the floors transporting patients. This results in decreased productivity on the units.

With the new Patient Transport Service, transporters will be dispatched through a centralized location. This should decrease the amount of patient wait time and allow for increased productivity by Support Partners on the units.

Hours for the Patient Transport Service will be 7 a.m. to 8 p.m., Monday through Friday, and 7:30 a.m. to 4 p.m., on weekends and holidays. The main telephone number for the Patient Transport Service is (610) 402-6777.

If you have any questions regarding this service, please contact Will Mest, Supervisor, Mailroom/Printshop, at (610) 402-5043.

Upcoming Screening Programs

Legs for Life Screening

The early detection and treatment of vascular disease can mitigate more serious future health problems. Lehigh Valley Hospital-Muhlenberg will host Legs for Life, a free Peripheral Vascular Disease (PVD) screening program for the community, as part of a national screening week sponsored by the Society of Cardiovascular & Interventional Radiology (SCVIR). SCVIR is the national professional society of interventional radiologists who treat PVD and many other conditions using minimally invasive procedures that are often alternatives to surgery.

Lehigh Valley Hospital-Muhlenberg will offer Legs for Life screenings in the following locations throughout the area:

September 25 - 6 to 9 p.m.
Health Center at Trexlertown
Trexler Mall, Route 222, Trexlertown

September 26 - 8 a.m. to Noon
Lehigh Valley Hospital-Muhlenberg
Outpatient Registration - Kolb Center
2545 Schoenersville Road, Bethlehem

September 27 - 6 to 9 p.m.
Lehigh Valley Hospital
Diagnostic Care Center - Jaindl Family Pavilion
Cedar Crest & I-78, Allentown

September 28 & 29 - 10 a.m. to 2 p.m.
Senior Horizons
Agricultural Hall, Allentown Fairgrounds
17th & Chew Streets, Allentown

Pre-registration is requested for the program. Patients may call (610) 402-CARE to register.

During the screening, participants will answer a brief questionnaire to assess their risk for PVD. Medical staff will determine the Ankle Brachial Index (ABI) for signs of circulatory problems. Participants with multiple risk factors and symptoms, and those with abnormal ABIs, will be advised to visit their primary care physician. The results from your patient's participation in the program, along with the screening physician's recommendations, will be sent to you following the program completion. If identified, you can then guide your patients in an appropriate treatment program.

National Depression Screening Day

In observance of National Depression Screening Day on Thursday, October 5, the Department of Psychiatry will offer free screenings at the following locations:

Lehigh Valley Hospital
John & Dorothy Morgan Cancer Center
1240 S. Cedar Crest Blvd.
Classrooms 1A & 1B
Allentown, Pa.
3 to 5 p.m.

Lehigh Valley Hospital-Muhlenberg
Banko Family Community Center
2545 Schoenersville Road
Rooms 1 & 2
Bethlehem, Pa.
4 to 7 p.m.

Each session will begin promptly with an education lecture and slide presentation. Free, anonymous depression screenings will follow.

Reservations are suggested, but not required. For more information or to make a reservation, please call (610) 402-CARE.

Good Shepherd Specialty Hospital-Allentown Highlights its Programs

Medically stable but fragile patients often need extended clinical care. Patients needing this level of care may be too ill for discharge to an acute rehabilitation hospital, nursing facility or their homes. For such patients, the Good Shepherd Specialty Hospital-Allentown (GSSH-A) provides outstanding acute care tailored to the needs of the patient. Over the next few months, the three major programs --Pulmonary Ventilator, Complex Medical, and Transitional Rehabilitation -- will be highlighted in ***Medical Staff Progress Notes.***

The Pulmonary Ventilator Program – Under the direction of an experienced critical care pulmonologist, GSSH-A provides an aggressive team approach to meeting the needs of the complex respiratory patient. Patients with tracheostomies, those on ventilators, and those requiring extensive help to maintain normal breathing without mechanical support are ideal candidates for this program.

GSSH-A has 24-hour/day coverage by Registered Respiratory Therapists. All have at least five years of critical care experience at leading centers of excellence, including Lehigh Valley Hosptial and Thomas Jefferson University Hospital. Therapists are experienced in waveform analysis, drawing ABG's, use of the Inexsufflator, Intra-pulmonary Ventilator, BIPAP, and are current with the new respiratory technology to enhance patient weaning and comfort.

Currently, GSSH-A uses 7200 Ventilators with waveforms, flowby, pressure support, pressure controlled ventilation mechanisms and many other functions to enhance weaning. In addition, transport ventilators are available for patients requiring mechanical ventilation to facilitate patient mobility and ease of transport for special studies or procedures as are walking ventilators for patients that are slow weans but can benefit from more aggressive physical, occupational and speech therapy.

Team conferences, led by the attending physician and including all members of the care team (respiratory, physical, occupational, speech therapy, care management, pharmacy and nursing), are held to evaluate individual patient needs and develop treatment plans to maximize progress toward goals. On-going patient and family education, that is disease specific, is part of the individualized treatment plans to maximize personal independence.

If you have any questions or would like further information regarding the Pulmonary/Ventilator Program, please contact a member of the administrative team listed below or Stephen C. Matchett, Director, Pulmonary/Ventilator Program, at (610) 439-8856 or pager (610) 920-7225.

- Jane Dorval, MD, President, Medical Staff, (610) 776-3340 or pager (610) 830-2793
- Beverly Snyder, RN, Assistant Administrator/Director of Nursing, (610) 402-8599 or pager (610) 830-7665
- Joseph Pitingolo, Administrator, (610) 402-8559 or pager (610) 830-4023
- Linda Dean, Administrative Consultant, (610) 402-8963 or pager (610) 830-3110
- Nancy Hardick, Medical Staff Affairs, (610) 402-8962

Do You Currently Have a Cafeteria Account?

If so, your account number will be changing within the next few weeks. For those physicians who currently have cafeteria accounts, barcode stickers were issued to you when the new cafeteria barcode system was implemented. However, in an effort to simplify the process, the new Photo ID badges have built-in barcodes on the back of the badge. These barcode numbers will be input into the cafeteria barcode system and will replace your existing account number. **Your new barcode number will go into effect on Friday, September 29.**

For those physicians with existing cafeteria accounts, new ID badges have been ordered and are available in Medical Staff Services on the first floor (just up the hall from Medical Records and the Medical Staff Lounge). If you have not yet picked up your new ID badge, please stop in Medical Staff Services, 8 a.m. to 5 p.m., Monday through Friday. If you have any questions, please contact Janet M. Seifert in Physician Relations at (610) 402-8590.

Congratulations!

Jon E. Brndjar, DO, and **David M. Stein, DO**, Division of General Internal Medicine, were recently notified of their election into the Conclave of Fellows of the American College of Osteopathic Internists. They will be recognized and awarded their fellowship certificates at the ACOI's annual convention to be held October 4-8 in Boston, Mass.

Mark A. Gittleman, MD, Division of General Surgery, has been named an auditor for the Senologic International Society, which is an international society for the study of breast disease and breast cancer treatment.

2000 United Way Campaign

Lehigh Valley Hospital and Health Network will kick off its 2000 United Way Campaign on September 21, 2000. This year, LVHHN's goal is a gift of $230,000 to the community! Last year, with the help of hundreds of LVHHN physicians and staff, nearly $220,000 was raised to support more than 115 health and human services programs. In order to guarantee the community easy access to high-quality, diverse programs, each United Way funded program is reviewed with careful consideration. With input from its volunteers and donors, United Way supports programs and initiatives that deliver the impact and results which the community needs. Their mission is to increase the organized capacity of people to care for one another. By helping people when they need it most - in the formative years of early childhood - we can prevent problems before they develop and significantly increase the number of successful adults in our community. That's why three of United Way's four strategic goals address the needs of children: 1) Children healthy and ready to learn when they start school; 2) Children succeeding in school; 3) Young people making positive choices, and 4) A safety net of services.

This year's LVHHN campaign theme is "A Dollar Round-Up for OUR Community." This theme builds on the legend of the Lone Ranger and Tonto. This profound message embedded in the Lone Ranger Creed echoes our plea for your support.

"I believe that to have a friend, a person must be one. That all people are created equal and that everyone has within themselves the power to make this a better world. Our Higher Power put the firewood there, but that every person must gather and light it themselves. In being prepared physically, mentally, and morally to fight when necessary for that which is right."

Please fight for that which is right by supporting this year's campaign!

All physicians and staff will be receiving a personalized pledge and designation form in the upcoming weeks. Please join Elliot J. Sussman, MD, David M. Caccese, MD, Robert J. Laskowski, MD, Mark C. Lester, MD, Brian A. Nester, DO, Donald L. Levick, MD, Theresa A. Ryan-Mitlyng, MD, John Jaffe, MD, Louis L. Liebhaber, and other organizational leaders through a pledge to this year's campaign. For more information, please refer to the United Way Intranet website on the LVHHN Intranet or contact a member of the campaign team: Linda Durishin (484-884-4867), Maureen Sawyer (484-884-2304) or Donna Kulp (484-884-4860).

The United Way is the way to a better Lehigh Valley!

At its August 8 meeting, the Medical Executive Committee reviewed and approved the Withholding/Withdrawing Treatment Policy. A copy of the policy is attached for your information and review.

Papers, Publications and Presentations

Dennis B. Cornfield, MD, Section of Hematopathology, co-authored a paper -- "Follicular Lymphoma Can Be Distinguished From Benign Follicular Hyperplasia by Flow Cytometry Using Simultaneous Staining of Cytoplasmic bcl-2 and Cell Surface CD20" -- which was published in the August, 2000 edition of the ***American Journal of Clinical Pathology***.

Gabriela Ghitulescu, MD, former Colon/Rectal Surgery resident, co-authored a chapter with **Indru T. Khubchandani, MD**, Division of Colon and Rectal Surgery, titled, "The Genetics of Colon and Rectal Cancer," which was included in a book published by Revinter Brazil in July 2000 -- ***New Trends in Coloproctology***. This was a multi-author book with invited contribution by authors from around the world.

Mark A. Gittleman, MD, Division of General Surgery, presented a Stereotactic Breast Biopsy Seminar at Gottlieb Memorial Hospital in Melrose Park, Ill., on July 8.

Herbert C. Hoover, Jr., MD, Chairperson, Department of Surgery, co-authored the article, "Somatostatinoma of the ampulla of Vater in celiac sprue," which appeared in the July/August, 2000 issue of the ***Journal of Gastrointestinal Surgery***.

Indru T. Khubchandani, MD, Division of Colon and Rectal Surgery, was the Program Chairman at the XVIII Biennial Meeting of the International Society of University Colon and Rectal Surgeons held in Sao Paulo, Brazil, from July 23 to 27. Dr. Khubchandani serves as Director General of this society.

Dr. Khubchandani participated in the Panel on Carcinoma of the Rectum and gave an oration titled, "New Trends in the Management of Inflammatory Bowel Disease," at the Conjoint Meeting of the Brazilian Society of Colon and Rectal Surgeons.

Gary G. Nicholas, MD, Program Director, General Surgery Residency; **Dona C. Hobart, MD**, former General Surgery resident; **James F. Reed III**, Senior Scientist/Biostatistician, Department of Community Health and Health Studies; and **Susan Nastasee**, former surgical editor, co-authored the paper, "Carotid endarterectomy outcomes research: reduced resource utilization using a clinical protocol," which appeared in the August issue of ***Cardiovascular Surgery***.

(Continued from Page 8)

Robert D. Riether, MD, Director, Colon/Rectal Residency Program; **Khawaja Azimuddin, MD**, former Colon/Rectal Surgery resident; **Indru T. Khubchandani, MD**, Division of Colon and Rectal Surgery; **Lester Rosen, MD**, Associate Chief, Division of Colon and Rectal Surgery; and **John J. Stasik, MD**, Chief, Division of Colon and Rectal Surgery, co-authored a paper -- "Transanal Endoscopic Microsurgery for Excision of Rectal Lesions: Technique and Initial Results" -- which was accepted for publication in a forthcoming issue of ***Surgical Laparoscopy, Endoscopy & Percutaneous Techniques***.

Michael C. Sinclair, MD, Acting Chief, Division of Cardio-Thoracic Surgery; **Martin LeBoutillier III, MD**, Division of Cardio-Thoracic Surgery; **William Gee, MD**, Division of Vascular Surgery; **Theodore Phillips, MD**, Division of Cardio-Thoracic Surgery, and **Raymond L. Singer, MD**, Division of Cardio-Thoracic Surgery, co-authored the paper, "Extra-anatomic redo MIDCAB/OPCAB--an early experience," which appeared in the June, 2000 issue of ***Heart Surgery Forum***.

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

Medical Grand Rounds will resume on Tuesday, September 5. Medical Grand Rounds are held every Tuesday beginning at noon in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at Lehigh Valley Hospital-Muhlenberg, and in the Video Teleconference Room (formerly the Medical Staff Lounge) at 17th & Chew.

Topics to be discussed in September will include:

- September 5 - Selection of Appropriate Antibiotics for Critically Ill Patients
- September 12 - Remissive Therapies for Rheumatoid Disease: Present - Future
- September 19 - Up to Date: Access tot he Most Recent Clinical Literature
- September 26 - The Challenges of Developing Systems of Coordinated Care for Older Adults

For more information, please contact Diane Biernacki in the Department of Medicine at (610) 402-5200.

LVH Medical Staff Listing Available via Internet

A listing of members of the LVH Medical Staff is now available via the internet at the following website: http://www.lvh.com. At the top of the home page, click on "lvhhn.org," then, click on "Physicians Directory." You may then select a physician by last name or by specialty. This information is updated on a monthly basis.

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

Frank J. Altomare, Jr., MD
Altomare & Associates
5930 Hamilton Blvd.
Allentown, PA 18106-9654
(610) 435-2001
Fax: (610) 435-6948

Bausch & Jones Eye Associates
- Andrew N. Bausch, MD
- David G. Jones, MD

Plaza West
1616 Allen Street
Allentown, PA 18102-2012
(610) 432-0201
Fax: (610) 434-1210

Frank DeFrank, MD
(No longer with Bethlehem Steel Family Health Center)
2246 High Road
Cresco, PA 18326-9708

Stephen P. Falatyn, MD
Orthopedic Surgical Group
701 Ostrum Street
Suite 602
Bethlehem, PA 18015-1153
(610) 807-9400
Fax: (610) 691-5533

(Continued from Page 9)

Fred Laufer, MD
4501 Crackersport Road
Allentown, PA 18104-9326
(610) 336-9000
Fax: (610) 336-9424

Lehigh Valley Internists
- David P. Carney, MD
- Glenn S. Kratzer, MD
- Judith A. McDonald, MD
- Daniel T. Mulcahy, DO
- John D. Nuschke, Jr., MD
- Timothy E. Steckel, MD

798 Hausman Road
Suite 220
Allentown, PA 18104-9124
(610) 530-2290
Fax: (610) 530-2287
(Effective 8/28/00)

LVPG-Psychiatry
- Joseph L. Antonowicz, MD
- Yelena Yermak, MD
- Kenneth J. Zemanek, MD

1251 S. Cedar Crest Blvd.
Suite 202A
Allentown, PA 18103-6214
(610) 402-5766
Fax: (610) 402-5763
(Effective 8/28/00)

Joseph T. Sembrot, MD
(Retired from VA Clinic)
1402 Cedarwood Road
Allentown, PA 18104-2112
(610) 395-4565

Howard A. Silverman, MD
798 Hausman Road
Suite 270
Allentown, PA 18104-9124
(610) 871-0100
Fax: (610) 871-0102
(Effective 9/1/00)

The 5th Edition of the Medical Staff Handbook has been published and is now available in Medical Staff Services and in the Medical Staff Lounge, both on the first floor of Lehigh Valley Hospital, Cedar Crest & I-78.

New Practice Name and Address

Wasserman, Redenbaugh, Margraf & Spikol, PC
New Practice Name - Valley Neurology Consultants, PC
- John W. Margraf, MD
- James E. Redenbaugh, MD
- Lorraine J. Spikol, MD
- Ronald E. Wasserman, MD

1210 S. Cedar Crest Blvd.
Suite 1000
Allentown, PA 18103-6208
(610) 434-0107
Fax: (610) 434-5337

New Practice

Geraldo A. Saavedra, MD
(No longer with Sam Bub, MD, PC)
Medical Associates of Monroe County
239 E. Brown Street
Suite C
East Stroudsburg, PA 18301-3096
(570) 421-3872
Fax: (570) 421-0842

Practice Disassociation

Jenni Levy, MD
(No longer with LVPG-Medicine)
128 Fairhill Road
Hatfield, PA 19440

Pager Number Correction

In the new 5th Edition of the Medical Staff Handbook, the pager number for **D'nese M. Sokolowski, MD**, was incorrect. Her correct pager number is **610-778-7754**.

Report from the Nominating Committee

The following name has been submitted by the Nominating Committee for the position of President-elect:
Alexander D. Rae-Grant, MD

An election will be held at the General Medical Staff Meeting on September 11. Nominations will also be accepted from the floor.

Policy: Administrative
Subject: Withholding/Withdrawing Treatment

Withholding/Withdrawing Treatment

I. Policy

The Lehigh Valley Health Network has dedicated itself and its resources to the provision of high quality, compassionate and ethical medical care to patients, their families and the community at large. Lehigh Valley Health Network is dedicated to helping the people of our service area achieve and maintain optimum health status. As a charitable, not-for-profit organization, we provide health services to our patients based on need, regardless of ability to pay. As a part of that care, this hospital recognizes that withholding/withdrawing medical treatment (including CPR) can be a part of a patient/family's wishes, consistent with the patient's self-determination, the duties of the health care professionals providing the care, and the mission of the hospital.

The Policy recognizes the relief of suffering, the stabilization of disease processes and the curing of illness to be a spectrum of care which must be tailored to each patient's needs and possibilities. It espouses the ancient professional adage, "To cure sometimes, to relieve often, to comfort always."

Purpose:

To provide the rationale and guidelines for withholding/withdrawing life-sustaining medical treatment(s)

Presumptions:

A. Patients may accept or refuse recommended medical care even when life-threatening conditions are present, whether or not they are terminally ill. This is the principle of **autonomy** or self-determination which has been upheld by the courts and ethical scrutiny.

B. Self-determination requires the patient with capacity (competent) to have adequate information which he/she can understand and accept or reject without coercion. **Informed consent/refusal** is a requirement of the legal and ethical systems for the person who has capacity (is competent).

C. When a patient does not have the capacity to make decisions about medical treatment, it is appropriate for a person who has either legal standing (guardian or durable power of attorney) or a loving, caring familial relationship with the patient to make medical decisions regarding his/her treatment. This person is called a **surrogate decision-maker** and is a person (usually a family member) who knows and has a caring relationship with the patient.

D. Professional health care clinicians have duties toward the patient which are part of the provider-patient relationship. The **principle of beneficence** or doing good for the patient must be balanced with the patient's wishes and decisions. Informing and convincing without coercion are part of that duty, trying to help the patient make decisions which are consistent with his/her values.

E. **WITHHOLDING AND WITHDRAWING MEDICAL TREATMENTS** are equivalent acts from both a legal and ethical point of view. The conditions which make withholding medical treatment legitimate also justify withdrawing similar treatments. It is recognized that the two concepts in practice often feel different and may elicit different emotional responses in carrying out the decisions.

F. When comfort care is needed in withholding and withdrawing situations, the **principle of double effect** is generally recognized and accepted. This principle states that actions may have two effects and one of these effects is unintended. These actions meant for comfort may hasten death but are not intended for that end and have no acceptable alternatives. Pain and dyspnea control with adequate analgesics, usually narcotics, become part of the treatment but may also hasten death, the double effect.

G. Food and/or fluid given by tube or intravenous means are considered medical treatment and may be withheld/withdrawn under the same ethical principles as other medical treatments such as CPR, mechanical ventilation, dialysis, etc. Every effort should be made to continue nourishment by mouth whenever feasible. **(Refer to Attachment A)**

H. Withholding a specific treatment does not indicate that other care deemed necessary for the patient will be diminished or not provided. The patient and family should never be abandoned in fact or perception. Comfort measures and compassionate caring must be continued and may need to be intensified when the decision to withhold/withdraw has been made. Under no circumstances should caring be withheld/withdrawn.

I. The hospital recognizes the difficulties of defining futility and futile medical treatment but believes that there are situations where continuing previously recommended aggressive therapy is medically useless and is counter to the patient's best interests (and perhaps his/her wishes) as well as the best interests of the family, friends and society. A process for working through these situations is provided in **Attachment B.**

J. Thorough communications are required among the persons involved with the care of the patient and with the patient and the family (if permitted by the patient). The patient with decision-making capacity does not require a surrogate and should make her/his own decisions about medical treatment and evaluation. If the patient does not have the capacity to make autonomous decisions, information to make informed consent/refusal needs to be provided to the appropriate surrogate decision-maker. Patient, compassionate, understandable communication with the patient or surrogate are required before and after decisions to pursue or withhold/withdraw therapy. Meaningful communication between the patient and the patient's family along with the multi disciplinary health care team and also among the health care team should continue throughout the patient's illness and hospitalization.

K. Time-limited trials of therapy are possible because withholding and withdrawing therapy are ethically and legally permissible. These trials permit time for clarification of medical uncertainties by testing, observation and progression. Because of continued reasonable uncertainty or changes in conditions, time-limited trials may be extended by mutual agreement among the health care team and patient/surrogate but should not be used as a mechanism to avoid appropriate but difficult decisions or to ignore the wishes of the patient/surrogate.

L. This policy purposefully does not deal with health care costs and allocation of scarce resources since these are issues which must be determined on a "macro" or societal level and apply to all patients if they are to be equitable and fair. This policy speaks to issues between individual patients and their surrogate(s) and the health care team caring for that patient. This does not preclude the consideration of medical futility as addressed in Section I and Attachment B.

M. In Pennsylvania there is living will legislation which, if executed and signed by a patient, may obligate the provider(s) to withhold/withdraw therapy which is life-sustaining if the patient is in an irreversible coma or has a terminal illness. Conditions and prognoses which fall outside these parameters are not legally binding, but, ethically, the living will must be interpreted to attempt to understand patients' wishes for a particular condition and prognosis applying to them at that time. In Pennsylvania special requirements apply to pregnant women in the living will legislation. (Pennsylvania Senate Bill #3).

N. A durable power of attorney for health care is a person designated in writing by the patient (when mentally competent) to speak for the incapacitated patient in medical decision making. The durable power does not become effective until the patient is deemed incapacitated and cannot make decisions for her/himself. If the patient should regain capacity the decision-making authority reverts back to the patient. If there is a durable power of attorney named, that person becomes the designated surrogate decision-maker.

O. Clinical Circumstances:

1. The patient with capacity (competent) should make decisions about his/her own treatments. The patient should participate in appropriate discussions with family and clinicians to assess information about diagnosis, prognosis and benefits and burdens, allowing the patient to make an informed decision. Persuasion, not coercion, is legitimate on the part of clinicians. The family does not have the ethical or legal right to make decisions for a competent patient without that patient's consent or formal transfer of decision-making authority.

2. Patients who lack capacity for decision-making can be represented by a legitimate surrogate decision-maker who tries to use **substituted judgment** to extend the patient's wishes. The surrogate should interpret the information and make decisions as they believe the patient would if he/she could make the decision autonomously. If the surrogate does not have enough information about the patient's previous wishes or thoughts about death and dying, suffering, pain, quality of life, etc., to make a substituted judgment decision, the principle of **best interest** can be used. This weighs the benefits and burdens of the active pursuit of medical care and assesses whether or not the benefits outweigh the burdens. If so, therapy should be continued, if not, therapy can be withheld/withdrawn.

3. Persons who never had capacity to be autonomous (children, never competent adults, etc.), present different problems in decision making since autonomy has never been achieved. Therefore decisions must be made using the principles of **beneficence and non-maleficence.** In these cases surrogates must be designated for the patients and these surrogates should make decisions in the best interest of the patients. It may be necessary to ask the courts to appoint a guardian who will act as a surrogate in some of these cases.

4. A previously autonomous person who is now incapacitated and who has no known relatives or family or other legitimate surrogate, presents a difficult set of problems for the health care providers. In most cases the health care team in consultation with the Ethics Committee and Legal Services can reach a consensus about an appropriate course of action. If the issue is controversial with divergent opinions, a judge may be asked to intervene and appoint a guardian.

II. Scope

Adult patients with capacity to make health care decisions or appropriate surrogate(s).

III. Definitions

Types of Treatments:

Examples of life-sustaining medical treatment include, but are not limited to, the following:

A. Cardiopulmonary resuscitation
B. Mechanical Ventilation **with intubation**
C. **No Non-Invasive ventilation for any reason (Bi-PAP)**
D. Dialysis
E. Artificial hydration and nutrition
F. Antibiotic therapy and other life-sustaining medications
G. Administration of blood and blood products
H. Surgery

IV. Procedure

A. Decisions to withhold or withdraw medical therapy should be a result of continual interchange of information and ideas between the health care team and the patient/surrogate.

B. Once the decision has been made to limit medical therapy, an order must be written by the attending physician defining the limits.

C. A progress note should reflect the thinking and process used to arrive at the decision to limit therapy.

D. When the decision is made to withhold therapy, the Withholding of Therapy Order Sheet must be completed as well as an order to this effect on the blue order sheet.

E. The Withholding of Therapy Order Sheet will be placed inside the front cover of the chart, (the first document in the chart).

F. When a Withholding Order is stopped, **"VOID"** will be written across the care order check sheet and it will be moved to the order sheet section of the chart. The order must be written on the usual order sheet as well. If the Withholding Order is later re-instated, a new form must be completed.

G. Whenever a patient with a Withholding Order leaves a patient care unit, the receiving department should be contacted by phone to alert them about the patient's withholding status, e.g. going to x-ray for chest file, etc., or patient for therapy.

H. It is the responsibility of the receiving department to clarify the order, chart or phone message if not clearly understood by them.

I. Canceling a Withholding of Therapy Order requires discussion and documentation similar to that required to write a Withholding order. The communication of the change must be transmitted to all who need to know.

J. If a patient with a Withholding of Therapy Order has a procedure (test, therapy, etc.) which has some risk of causing a cardiac and/or respiratory arrest, clarification by the patient or appropriate surrogate regarding resuscitation is required. This should be obtained by the attending physician and affirmed by the physician performing the procedure as well as the anesthesiologist. This should be documented in the record.

K. If conflict arises concerning the decision a team/family conference should be held to attempt to clarify the issues and develop consensus.

L. If the team/family conference along with input from other sources does not resolve the conflict, an Ethics Consultation should be requested. **(Refer to, Ethics Consultation Process Policy)**

V. Attachments

Attachment A - Artificial Nutrition and Hydration
Attachment B - Futile* Care
Attachment C - Withholding/Withdrawing Treatment Order Sheet

VI. Distribution

Administrative Policy Manual

VII. Approval

_____	President & CEO	_____
Signature	Title	Date
_____	President of Medical Staff	_____
Signature	Title	Date

VIII. Policy Responsibility

President and Chief Executive Officer

In Coordination With:

Ethics Committee
Medical Staff
Legal Affairs

IX. References

Withholding/Withdrawing Life-Sustaining Therapy, Official Statement of the American Thoracic Society, American Review of Respiratory Disease September 1991; Volume 144, No. 3:726-731.

Consensus Report on the Ethics of Foregoing Life-Sustaining Treatments in the Critical Ill, Critical Care Medicine December, 1990; Volume 18:1435-1439.

Ethical and Moral Guidelines for the Initiation, Continuation and Withdrawal of Intensive Care, ACCP/SCCM Consensus Panel, Chest April 1990; Volume 97:949-958.

Schneiderman, Lawrence J. and Spragg, Roger G., Ethical Decisions in Discontinuing Mechanical Ventilation, New England journal of Medicine April 14, 1988;984-988.

Luce, John M. and Faffin, Thomas A., Withholding and Withdrawal of Life Support from Critically Ill Patients /September 1988; Volume 94:(3) 621-626.

X. Disclaimer Statement

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements, that make compliance inappropriate. For advice in these circumstances, consult with the Department of Risk Management/Legal Services.

XI. Revision Dates

Origination: August 1995
Review/Revised: March 2000

ATTACHMENT A

ARTIFICIAL NUTRITION AND HYDRATION

1. Ethically and legally, artificial nutrition and hydration is no different than other forms of life-sustaining medical treatment. In appropriate cases, discontinuing certain medical treatments is accepted despite the fact that death is as certain as with withholding medical nutrition and hydration. Withholding dialysis in a patient without kidney function is an example.

2. In many instances, the burden of administering artificial nutrition and hydration outweighs potential benefits. Such burdens include: risk of infection such as pneumonia and sinusitis secondary to nasogastric tubes, discomfort secondary to nasogastric tube, and risks of hemorrhage, infection, fluid overload, and thrombosis associated with central venous parenteral alimentation.

3. Potentially beneficial effects of dehydration in the terminal patient include decrease in G.I. fluid resulting in less vomiting, reduction in pulmonary secretions with less coughing and drowning sensation, and reduction in edema around tumors leading to decreased pain.

4. Studies have addressed the comfort of terminally ill patients from whom artificial nutrition and hydration was withheld.

   Physiologic adaptation to fasting leads to lipolysis and increased ketone production which decreases the feeling of hunger.

   Most patients studied never experienced any hunger. When present, symptoms of hunger, thirst and dry mouth were alleviated with small amounts of food and fluid given orally or by the application of ice chips and lubrication of the lips.

   Although it has been felt that the major distressing symptom of dehydration is dry mouth, Hospice experts report that dying patients who are dehydrated are rarely thirsty.

5. The provision of nutrition and hydration has been equated with care and compassion. It is, nevertheless, possible to provide a high level of compassion and dignity to the dying patient without artificial nutrition.

References:

1. McCann, et al. *Comfort Care of Terminally Ill Patients - The Appropriate Use of Nutrition and Hydration*. JAMA,1994:276(16);1263-1266.
2. Andrews,,MR and Levre, AM. *Dehydration in the Terminal Patient: Perception of Hospice Nurses*. The American Journal of Hospice Care. January/February 1989;31-34.

ATTACHMENT B

FUTILE* CARE

Purpose: To provide guidelines when the attending physician believes that further care (other than comfort care) is futile, but the patient or the patient's family insist on continuing the effort. This statement does not apply to rationing medical care and should not be used for this purpose.

1 The attending physician should take enough time to carefully explain to the aware patient and to the family the nature of the ailment, the options and the prognosis. The physician should explain that abandoning the treatment does not mean abandoning the patient in terms of comfort, dignity and psychological support.

2 The attending physician should provide the names of appropriate consultants to provide an independent opinion concerning the futility of the situation.

3 The assistance of the nurses, chaplain, patient representative and social services should be offered to the patient's family. A joint conference with the doctor is desirable.

4 An Ethics Consultation may be called to consider the matter and offer advice and counsel to the physician, family and healthcare team. **(Refer to AD#1600.06, Ethics Consultation Process)**

5 Adequate time should be given for the patient and family to consider this information.

6 If all of these steps are taken and the family remains unconvinced, neither the doctor nor the hospital are required to provide care that is not medically indicated, and the family may seek a substitute physician (if one can be found) and another hospital (if available). The Lehigh Valley Hospital will assist the family in their efforts to find those substitutes.

7 If the patient can no longer benefit from an acute hospital stay and the patient or family insists on staying, the mechanism for personal payment can be invoked.

FUTILE* CARE - Any clinical circumstance in which the doctor and his/her consultants, consistent with the available medical literature, conclude that further treatment (except comfort care) cannot, within reasonable possibility, cure, improve or restore a quality of life that would be satisfactory to the patient.

References: Rivin, AU. Are Futile-Care Policies The Answer? Hospitals and Health Networks,1994:February 20.

Attachment C

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA
LEHIGH VALLEY HOSPITAL - MUHLENBERG
BETHLEHEM, PA

WITHHOLDING OF THERAPY ORDER SHEET

(Also write "See Withholding Order Sheet" on the regular order sheet).

WITHHOLDING OF THERAPY ORDER

The patient and/or surrogate request the withholding of medical therapy as indicated below: (Currently active orders will continue until altered by further orders.)

DATE	TIME

- ☐ No CPR-cardiopulmonary resuscitation, code blue, ACLS Protocol
- ☐ No Electrical defibrillation
- ☐ No Mechanical ventilation with intubation for any reason
- ☐ No Non-Invasive mechanical ventilation for any reason (bi-pap)
- ☐ No Vasopressors/ionotropic agents
- ☐ No Antiarrhythmics
- ☐ No Dialysis
- ☐ No Hyperalimentation
- ☐ No Tube feedings
- ☐ No Blood or blood products
- ☐ No Antibiotics
- ☐ No Electrolytes or acid/base corrective measures
- ☐ No Treatment for low urine output
- ☐ No Transfer to ICU or monitored bed

The above list is not meant to be all-inclusive. If the patient's/surrogate's wishes cannot be expressed through this list, clarify and explain those wishes below.

_____

_____

_____

_____

I have discussed this with the patient/patient surrogate _____ who understands the order.

NAME

_____ _____

PHYSICIAN'S SIGNATURE PRINTED NAME

STATUS CHANGE

DATE	TIME

☐ DISCONTINUE THE ABOVE ORDER(S) IMMEDIATELY.

(See next order sheet for specific orders)

_____ _____

PHYSICIAN'S SIGNATURE PRINTED NAME

(ALSO, WRITE ORDER TO DISCONTINUE WITHHOLDING STATUS ON REGULAR ORDER SHEET)

LEHIGH VALLEY HOSPITAL
WITHHOLDING OF THERAPY ORDER SHEET

1. The Withholding Order Sheet will be placed inside the front cover of the chart, (the first document in the chart).

2. When a no CPR order is stopped, "VOID" will be written across the order check sheet and it will be moved to the order sheet section of the chart. The order must be written on the usual order sheet, as well. If the no CPR is later reinstated, a new form must be completed.

3. Whenever a patient with a no CPR order leaves a patient care unit, the receiving department should be contacted by phone to alert them about the patient's resuscitation status, e.g., going to X-ray for chest film, etc., or patient for therapy. This should be done by the primary nurse or his/her designee.

4. It is the responsibility of the receiving department to clarify the order if the chart or phone message is not clearly understood by them.

5. Cancelling a no CPR order requires discussion and documentation similar to that required to write a no CPR order. The communication of the change must be transmitted to all who need to know.

6. If a patient with an active no CPR order has a procedure (test, therapy, etc.) which has some risk of causing a cardiac and/or respiratory arrest, clarification by the patient or appropriate surrogate regarding resuscitation is required. This should be obtained by the attending physician and affirmed by the physician performing the procedure.

THERAPEUTICS AT A GLANCE

The following actions were taken at the July/August 2000 Therapeutics Committee Meeting - James Sianis, Pharm.D., Christopher Moore, PharmD., Joseph Ottinger, R.Ph., MS, MBA

ADR Reporting

Suspected ADR reports for the second quarter of 2000 demonstrated a similar quantity of notations and 'severity' to those of the previous quarter. Anticoagulation therapies continue to comprise the largest measure of reports considered "Severe". Comparative incident/volume activity levels (e.g., reports per 10,000 doses administered and reports per 1,000 adjusted admissions) were almost identical to the previous quarters data. One death was recorded in the 61 reports. Drug therapy was not considered to be a primary contributing factor. An additional report of bleeding associated with use of enoxaparin in a patient with a calculated estimated creatinine clearance of < 30 ml/min was noted. This drug is renally excreted. Physicians are reminded that use of enoxaparin in patients with an estimated creatinine clearance of less than 30 ml/min. is not widely studied. These patients were excluded from all the major published studies to date. Therefore, dosing alterations are not well described. In addition, patients would require laboratory monitoring via use of ant-factor Xa heparin activity levels. Pharmacy "notes" restating this information are placed on appropriate patient charts identified through a daily monitoring process.

All health-care personnel are encouraged to report suspected adverse drug reactions. Copies of the Suspected Adverse Drug Reaction Documentation Form are available in all patient care areas. Complete as many portions of the form as you can or at least notify the Pharmacy staff of your observations. A pharmacist will review the case and complete/initiate the form as necessary. ALL REPORTS are confidential and they are summarized and presented to the Therapeutics committee. Cause-effect analysis and trending considerations are reviewed in this process. Patient allergy data are updated in accordance with the level of suspicion based on the Naranjo scale and patient's may receive "ID" cards describing the nature of the reactions and the presumed associated cause. This information card can be carried by the patient and presented in future health-care interventions requiring drug treatments.

Following are the particulars for this quarter

	Second quarter	First quarter
Reports per 10,000 doses	0.63	0.62
Reports per 1,000 admissions	5.53	5.54

Second Quarter Data

Table 1: **Adverse Reactions By Reporter**

Reporter	# Reports	% Reports
Pharmacist	341	67.2
Nurse	17	27.9
X-Ray Technician	3	4.9
Physician	0	0
TOTAL	61	100

Table 2: **Adverse Reactions By Drug Category**

Drug Category	# Reports	% Reports
Antibiotics	12	19.7
Contrast Dyes	9	14.8
Psych/Neurologic Agents	7	11.5
Narcotic Analgesics	3	4.9
Anticoagulants	16	26.2
Dopamine	0	0
Cardiac	3	4.9
Oncology	5	8.2
Other	6	9.8
TOTAL	61	100

Table 3: **Probability of Drug-Related Reactions**

Probability	# Reports	% Reports
Doubtful	0	0
Possible	20	32.8
Probable	38	62.3
Highly Probable	3	4.9
TOTAL	61	100

Table 4: **Adverse Reaction Severity**

Classification	# Reports	% Reports
Mild	24	39.3
Moderate	23	37.7
Severe	14	23.0
TOTAL	61	100

Most Common Agent
Contrast dye- 8
heparin w/others - 6
Abciximab (W/ HEP)- 3

Drug Formulary Issues

The Therapeutics Committee at its August meeting approved the addition of the Class III antiarrhythmic, dofetilide (Tikosyn). Dofetilide is indicated for the conversion of atrial fibrillation and atrial flutter to normal sinus rhythm. It has not been shown to be effective in patients with paroxysmal atrial fibrillation. Dofetilide is also indicated for the maintenance of normal sinus rhythm in patients with atrial fibrillation and atrial flutter of greater than 1 week duration who have been converted to normal sinus rhythm. Because dofetilide is associated with life-threatening ventricular arrhythmias, its use should be reserved for patients in whom atrial fibrillation or atrial flutter is highly symptomatic.

Therapy with dofetilide must be initiated or re-initiated only in patients placed for a minimum of 3 days in a facility that can provide calculations of creatinine clearance, continuous electrocardiographic monitoring, and cardiac resuscitation in order to minimize the risk of induced ventricular arrhythmias. In addition, only those physicians certified to prescribe dofetilide may initiate (re-initiate) therapy.

Initiation of therapy will require use of a preprinted order form that provides all the mandated monitoring and prescribing information necessary to facilitate therapy. Patient education materials will also be given to the patient that highlight the need for screening for drug-drug interactions prior to the initiation of 'other' therapies.. Once the patient leaves the Hospital, drug must be obtained from Stadtlander's Pharmacy (the only licensed Pharmacy supplier) via mail order. The patient does receive a 7 day supply of medicine upon discharge from the hospital that provides a 'bridge' until the Stadtlander's materials arrive.

Patients re-admitted to the hospital may have therapy continued by the attending service, unless therapy is discontinued for longer than 24 hours (Must be reinitiated via protocol). These patients will have a Pharmacy information sheet placed on the chart elaborating drug interactions and other particulars. (See attached)

Also reviewed and approved to the formulary was the short-acting, non-depolarizing neuromuscular blocker rapacuronium (Raplon). Rapacuronium is a rapid onset neuromuscular blocker with a short duration of action. It may be possible to use rapacuronium as a replacement for succinylcholine and other neuromuscular blockers, in selected situations. (See contraindications)

An additional niche for rapacuronium use has been identified in 'short' procedure cases, where it would be utilized to replace the 'longer half-life' agents currently utilized facilitating a faster recovery. The Anesthesia department has developed usage guidelines for this agent, which are described below.

- Cases where an agent with the duration of action less than 30 minutes are needed.
- Cases in which succinylcholine is contraindicated and rocuronium is inappropriate.

- Pediatric cases greater than 1 month of age where rocuronium is contraindicated.
- When cases exceed a 30 minute time limit, use of a second muscle relaxant is indicated.

Current Contraindications for the use of Succinylcholine
Hypersensitivity to succinylcholine.
Patients with a personal or family history of malignant hyperthermia or a history of skeletal muscle myopathy.
Patients in the acute phase of injury with major burns, multiple trauma, extensive denervation of skeletal muscle or upper motor neuron injury.
Acute narrow angle glaucoma.
Penetrating eye injury.

Also has 'black box' warning for risk of cardiac arrest from hyperkalemic rhambdomyolysis in otherwise healthy pediatric patients.

Heparin Order sheet

A revised intravenous heparin order sheet has been developed to facilitate use of this important agent. The order sheet will contain the more widely used dosing schemes, but physicians will be able to describe individually tailored regimens, if necessary. The order format was approved, but the form will be 'held', as the laboratory will shortly be converting to a more sensitive reagent to measure aPTT. Notification of the new therapeutic range will be forthcoming in a future edition of this newsletter.

Vioxx (Rofecoxib) Approved for Formulary

After much anticipation, Therapeutics committee voted to add rofecoxib (Vioxx) to the LVH formulary. This agent selectively inhibits the cox-2 enzyme and prevents the synthesis of inflammatory prostaglandins. Rofecoxib is indicated for the management of the pain associated with osteoarthritis as well as acute pain. The advantage of agents such as rofecoxib is the ability to take advantage of the properties of an NSAID, without the undesirable side effects of traditional NSAIDS. The committee also voted to allow the pharmacy to automatically substitute rofecoxib for celecoxib(Celebrex) when ordered by the residents and medical staff. The following scheme will be used for this substitution:

Celecoxib up to 200 mg per day- Rofecoxib 12.5 mg PO qd

Celecoxib >200-400 mg/ day - Rofecoxib 25 mg PO qd

Dofetilide Information Sheet

Dear Doctor,
This patient has been prescribed dofetilide (Tikosyn). Please, be aware that these patients should be closely monitored for changes in renal function, prolonged QT interval and electrolyte (potassium) disturbances. In addition, this agent is contraindicated with certain drugs and should be administered with caution when given with other agents that prolong the QT interval. Below is a list of agents that have been identified as potentially problematic.

Additionally, patients NOT receiving therapy for longer than 24 hours should be re-titrated on dofetilide using the FDA mandated dosing schedule. This will require that a Physician certified via the FDA mandated program to initiate (reinitiate) therapy be contacted. Pharmacy can provide a list of those individuals whose credentials are on file.

Tikosyn (dofetilide) can NEVER be co-administered with verapamil (Isoptin; Calan), ketoconazole (Nizoral), cimetidine (Tagamet), trimethoprim (Trimpex, Bactrim, Septra), prochlorperazine (Compazine), or megesterol (Megace).

In addition, the following list of drugs may prolong the QT interval and precipitate irregular heart beats. They are best avoided if you are receiving Tikosyn (dofetilide).

GENERIC NAME
Bepridil
Ciprofloxacin
Cisapride
Diphenhydramine
Disopyramide Epinephrine
Erythromycin
Fluconazole
Haloperidol
Indapamide
Itraconazole
Levofloxacin
Pentamidine
Phenothiazine derivative
Pimozide
Procainamide
Quinidine
Risperidone
Sotalol
Tricyclic antidepressants

POTASSIUM LOSS
In addition to these drugs, try to avoid low blood potassium and probably low magnesium as well. Low blood potassium levels can prolong the QT interval and precipitate the irregular heart beats of the Long QT Syndrome.

The Center for Educational Development and Support

September, 2000

News from the Library

OVID Training.

The Library has completely converted to OVID's on-line MEDLINE system. This Web-based system is updated daily by Ovid. Call Barbara Iobst in the Health Sciences Library at 610-402-8408 to schedule a one-on-one training session.

NEW TELEPHONE/FAX NUMBERS FOR LEHIGH VALLEY HOSPITAL-MUHLENBERG LIBRARY.

Please use the following telephone number when requesting information from the LVH-Muhlenberg Library: **610-402-8410**.

For faxing requests to the LVH-Muhlenberg campus Library, the fax number is **610-402-8409**.

The new numbers enable the Library staff to consolidate services in order to better serve our customers and control costs.

IN THE LITERATURE.

This is a reminder about the recent debut of our new, free table-of-contents service, "IN THE LITERATURE." You need not visit the Library to keep abreast of the latest medical information. From your PC, you can peruse the table of contents of such widely-read journals as "*JAMA*," "*New England Journal of Medicine*," "*Lancet*," "*Obstetrics and Gynecology*," "*Journal of Trauma*," "*Archives of Surgery*," "*American Journal of Medicine*," "*Critical Care Medicine*," "*American Journal of Public Health*," "*Pediatrics*," "*Annals of Internal Medicine*," "*American Heart Journal*, and "*Nature*," etc. This table-of-contents service allows you to request photocopies of articles published in these journals. Information about this service, a complete list of journal titles, and instructions explaining how to request an article can be found by visiting the LVHHN Intranet. Click on the arrow in the "*Resources*" box to display the drop-down menu. Select "Clinical." On the next screen, captioned "Clinical Links & Resources," click on "Table of Contents Service." If you need assistance in obtaining information about "IN THE LITERATURE," call 610-402-2263 or 610-402-8410

Computer-Based Training (CBT):

Computer Based Training (CBT) programs are available for LVHHN staff. Topics covered by the CBT programs include:

Access 2.0	Power-Point 4.0
Windows NT 4	Word 97
Excel 97	Access 97
PowerPoint 97	Lotus 1-2-3 Millennium
WordPerfect 8	E-mail GUI

PHAMIS LastWord Inquiry Only commands

CBT programs replace the instructor-led classes previously held at Lehigh Valley Hospital. A proctor will be in the room with the learner while he/she takes the CBT, but the learner will control the pace and objectives of the learning.

Computer Based Training takes place in **Suite 401** of the **John & Dorothy Morgan Cancer Center** (the computer training room) and in the **Muhlenberg Hospital Center computer training room** (off the front lobby). The schedule of upcoming dates is as follows:

CBT sessions for JDMCC, suite 401 are as follows:

September 12, 8am - Noon

Sessions at MHC, I.S. Training room are as follows:

September 26, 8am - Noon

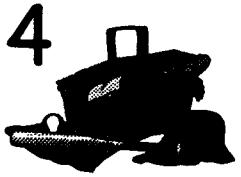
Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at 484-884-2560 with the following:

- date of session
- second date choice
- department
- phone number

You will receive an e-mail confirming your choice within two business days. If you have any questions, please contact Craig Koller at 610-402-1427 or through e-mail.

Any questions, concerns or comments on articles from CEDS, please contact Bonnie Schoeneberger 610-402-1210

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
# September 2000					1 7am GYN Tumor Board-CC-CL1 12noon Breast TB-JDMCC-CR1	2
3	4 	5 8am Pediatric GR- CC-Aud 12 noon Medical GR-CC-Aud	6	7	8 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	9
10	11	12 7am Surgical GR-CC-Aud 8am Pediatric GR-CC-Aud 12 noon Medical GR-CC-Aud	13 12noon Pulmo TB-JDMCC CR1	14 12noon Endo TB-JDMCC-CR1	15 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	16
17	18 12noon Colon/Rectal TB-JDMCC-CR1	19 7am Surgical GR-CC-Aud 8am Pediatric GR-CC-Aud 12 noon Medical GR-CC-Aud	20	21 12noon Combined TB-JDMCC-CR1	22 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	23
24	25	26 7am Surgical GR-CC-Aud 8am Pediatric GR-CC-Aud 12noon Urology TB-JDMCC-CR1 12 noon Medical GR-CC-Aud	27	28 12noon Combined TB-JDMCC-CR1	29 7am OBGYN GR-CC-CL1 12noon Breast TB-JDMCC-CR1	30

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Medical Staff Progress Notes

Medical Executive Committee

Medical Staff Progress Notes **is published monthly to inform the Medical Staff of Lehigh Valley Hospital 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 (610) 402-8590.