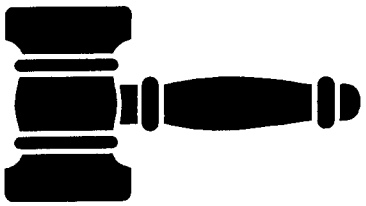
LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

May, 2001 Volume 13, Number 5

In This Issue . . .



From the President

"What the caterpillar thinks is the end of the world...the butterfly knows is only the beginning."

- Anonymous

Institute of Medicine Second Report

The Institute of Medicine (IOM) issued its first report at the end of 1999 concerning patient safety and succeeded in getting the attention of the public, the third-party payers and the health care industry, for a problem that apparently has been around for a number of years. In an interview with Dr. Lonnie Bristow, former president of the AMA and member of IOM, (www.physiciansnews.com) he describes the response of industry in forming the Leapfrog group (large Fortune 500 companies) and restructuring their insurance programs to reward those hospitals that are attempting to respond to patient safety concerns. He describes the president endorsing the safety focus in the VA system and all governmental (health) entities. He focused primarily on the second IOM report published in March 2001 titled "Crossing the Quality Chasm: A new health care system for the 21st century."

"Both reports identify that the problems either with safety or the overall quality of care in America lie with the systems of care that we give to Americans. That's terribly important... Health care, as it is rendered in America, frequently was organized in a fashion that was for a different time, not for the 21st century...That's marvelous news because it means that it's not really about incompetent physicians or nurses, or uncaring hospitals. In fact, the final report states very clearly that we are not going to achieve substantial improvement in the quality of care by simply exhorting those particular players to work harder to make the quality of care better. They can't...This is good news because it means we can stop beating up on each other and begin to look at the systems of care that we use, some of which were developed hundreds of years ago, for example, the way we write prescriptions." (my underlines)

The roadmap report goes on to discuss changes in medical education, chronic disease management (15 chronic diseases to be identified by AHCRQ), and 10 golden rules to guide innovation "such as customizing care based on patient needs

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and values, giving patients unfettered access to their own medical information, using evidence-based decision-making, anticipating patient needs rather than reacting to them, decreasing waste of resources or patient time, and ensuring cooperation among clinicians and institutions."

"The need for change? Well, let's take a lesson from nature: grow or die."
- Tor Dahl – Presentation @ Governance Institute 3/27/01

Does some of the report below seem far-fetched? As Leonard Parker Pool said 27 years ago, "look about you." LVH has already started the technology metamorphosis.

A Fully Digital Medical Center is being built in Birmingham by HealthSouth Corp. and Oracle Corp.

The joint venture between the operator of rehabilitation hospitals and surgery centers and the software developer will feature beds with Internet-linked computer screens, electronic medical-record systems, digital imaging instead of traditional X-ray film and a wireless communications network to provide physicians with real-time information about patients, while Internet links to physician offices will enable patients to be admitted to the hospital electronically from their doctor's office rather than having to wait and fill out paperwork upon arrival, the Wall Street Journal reported. The full-service, 218-bed hospital is slated for completion by late 2003 and may serve as a prototype for as many as ten more to be built in different markets over several years, the Journal added, citing Richard Scrushy, HealthSouth chairman and chief executive. (Wall Street Journal, March 27, 2001)
http://interactive.wsj.com/articles/SB985645540678313327.htm

"Hear that sound, Morpheus? ...that's the sound of inevitability."
- Agent Smith in the movie, "The Matrix"

PA Malpractice Crisis Continues – "We can't fight this alone" - Dr. Carol Rose

In the March/April 2001 Supplement to Pennsylvania Medicine:

"In 2001, forces combined to make the CAT Fund an intolerable burden – the hardening of the insurance market, increases in premiums and skyrocketing medical liability court awards." Pennsylvania Medical Society President Carol E. Rose explains: "After extensive study and consultation with the nation's top medical liability experts, your State Society concluded that only a multi-stage plan could finally and fully solve this very complex problem."

She then describes the five-part plan, including immediate legislative relief, long term legal reform, a constitutional amendment, judicial reforms and a public awareness campaign.

I urge you to contribute to this effort on our behalf and support your medical society. If you don't think this is your fight too, check your malpractice premium for this year.

"The Medical Society is the only organization in this fight for the long run. We're the only ones in it for our profession, and to protect the physician-patient relationship."

Never be afraid to try something new. Remember, amateurs built the ark, professionals built the Titanic.

Last month, we expressed real concern (and surprise) about the selling of prescribing information – which I now find is relatively common. With all the discussion about the upcoming Health Insurance Portability and Privacy Act, we expect more rulings like the case below:

A New York Court Ruled that Pharmacists Could Have a Duty to Keep Customers' Prescriptions and Medical Histories Confidential

In what is believed to be a first-of-its-kind ruling on a pharmacy's role in prescription privacy, the court ruled last month that a man with AIDS will be allowed to go forward with a lawsuit that claims his privacy was violated when a local pharmacy went out of business and sold his records to a national chain without his consent, reported AMNews. In recent years, physicians have raised concerns that drug manufacturers and insurance companies are gaining too much access to doctors' prescribing patterns and to patient information through prescription records. (American Medical News, April 2, 2001)
http://www.ama-assn.org/sci-pubs/amnews/pick_01/prsb0402.htm

E-mail surrogates and GUI – Graphic User Interface (sounds kinky – try it, you'll like it)

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The program to communicate with the medical staff on a timely basis using e-mail is working. Our feedback indicates that a substantial number of the medical staff (or their surrogates) read their e-mail. I would like to thank the Physician Relations team (POPS) and LVH Information Services for their work in this area. We are encouraging all users to employ the GUI system for their e-mail. Once again, if you do not personally use the e-mail system, designate a surrogate (usually in your office) to print it for you. The system can work for you – and it's painless. We are declaring cyber-amnesty. Just call Pat Skrovanek in Physician Relations at (610) 402-9190.

You can communicate with medical staff leadership directly via e-mail (generally all your suggestions and comments are read and discussed at Troika). You have a direct voice – albeit, an electronic one – but a voice nonetheless to your elected representatives who want to know your concerns, issues, and views.

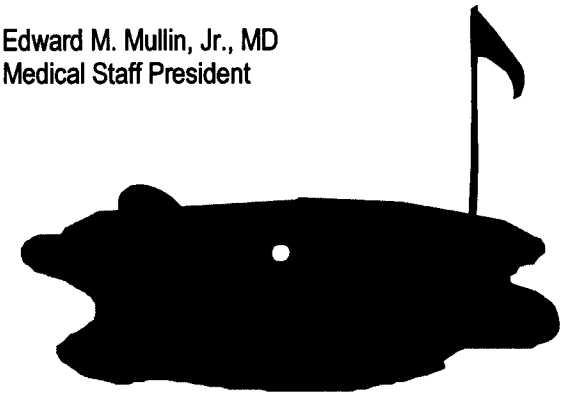
Physicians' Recognition Dinner – 2001

The March 31 event was a very memorable and enjoyable evening for our medical staff. I have received significant positive feedback. I would like to thank Dr. Elliot Sussman and Mr. Marv Woodall for their comments. I would like to add special thanks to Janet Seifert and Beth Martin, as well as the entire staff of the Medical Staff Services office -- Cindi Ault, Karen Fox, Marge Kratzer, Rita Mest, Kathy Schaeffer, Pat Skrovanek, and Lori Tucker.

Golfer: "Please stop checking your watch all the time, caddy. It's distracting."
Caddy: "This isn't a watch, sir. It's a compass."

Ed

Edward M. Mullin, Jr., MD
Medical Staff President



Physicians Honored for Career Milestones

Over 60 members of the Lehigh Valley Hospital (LVH) medical staff were honored for their years of service, commitment and dedication at the 2001 Physician Recognition Dinner held at the Holiday Inn Conference Center, Fogelsville, on March 31.

Edward M. Mullin, Jr., MD, President of the LVH medical staff, told more than 300 physicians, board members, hospital administrators and guests that his colleagues were being recognized for their service to patients and the community in partnership with LVHHN. "We've chosen a demanding field only we can truly understand. All of us can take satisfaction in this accomplishment."

Receiving special recognition were past presidents of the medical staff, physicians who served 50 years on the medical staff and those who served 25 years.

Past presidents who were honored include **David M. Caccese, MD**, Department of Medicine, Division of General Internal Medicine, and **Robert X. Murphy, Jr., MD**, Department of Surgery, Division of Plastic Surgery.

Honored for 50 years of service were **Charles D. Schaeffer, MD**, Department of Surgery, Division of General Surgery, and **Lawrence M. Weisbrod, MD**, Department of Surgery, Division of Orthopedic Surgery.

Those honored for 25 years of service include:

Department of Anesthesiology

- **In-Ho Chang, MD**
- **Ramon J. Deeb, MD**
- **Howard E. Hudson, Jr., MD**
- **Jay S. Jung, MD**
- **Samuel M. Lerner, MD**
- **Carmen B. Montaner, MD**
- **Toeruna S. Widge, MD**
- **Wen-Shiong Yang, MD**

Department of Dentistry

- **Russel S. Bleiler, Jr., DDS**, Division of General Dentistry/Special Care
- **Peter T. Davis, DDS**, Division of Prosthodontics
- **Michael F. Lentz, DDS**, Division of General Dentistry/Special Care
- **Dominic P. Lu, DDS**, Division of General Dentistry/Special Care

Department of Emergency Medicine

- **Joseph J. Fassl, MD**
- **Ronald A. Lutz, Sr., MD**

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Department of Family Practice

- **LeRoy B. Gerchman, MD**
- **Dennis M. McGorry, DO**, Section of Geriatrics
- **John J. Mecca, MD**

Department of Medicine

- **Lloyd E. Barron II, MD**, Division of Hematology-Medical Oncology
- **Ki T. Boo, MD**, Division of General Internal Medicine
- **Charles M. Brooks, MD**, Division of Gastroenterology
- **David M. Caccese, MD**, Division of General Internal Medicine/Geriatrics
- **Joseph V. Episcopio, MD**, Division of General Internal Medicine
- **Peter K. Ghatak, MD**, Division of General Internal Medicine
- **Robert W. Grunberg, MD**, Division of Nephrology
- **John B. Longenhagen, MD**, Division of General Internal Medicine
- **John K. Mahon, MD**, Division of Neurology
- **James A. Pantano, MD**, Division of Cardiology
- **Robert M. Post, MD**, Division of Hematology-Medical Oncology
- **Cynthia D. Starr, MD**, Division of Hematology-Medical Oncology

Department of Obstetrics and Gynecology

- **Ernest Y. Normington II, MD**, Division of Primary Obstetrics and Gynecology

Department of Pathology

- **Arthur A. Altman, MD**, Division of Anatomic Pathology
- **Raymond A. Rachman, MD**, Division of Anatomic Pathology
- **Michael Scarlato, MD**, Division of Anatomic Pathology
- **John J. Shane, MD**, Division of Anatomic Pathology

Department of Pediatrics

- **Martha A. Lusser, MD**, Section of Neurology
- **Charles F. Smith, MD**, Division of General Pediatrics

Department of Psychiatry

- **Paul K. Gross, MD**, Division of Adult Inpatient Psychiatry

Department of Radiology-Diagnostic Medical Imaging

- **Stanley Benzel, MD**, Division of Diagnostic Radiology
- **Robert Kricun, MD**, Division of Diagnostic Radiology
- **Thomas E. Leet, MD**, Division of Diagnostic Radiology
- **Zwu S. Lin, MD**, Division of Diagnostic Radiology
- **Alan H. Wolson, MD**, Division of Diagnostic Radiology, Section of Chest

Department of Surgery

- **George A. Arangio, MD**, Division of Orthopedic Surgery, Section of Ortho Trauma
- **Pricha Boonswang, MD**, Division of Colon and Rectal Surgery
- **Tamar D. Earnest, MD**, Division of General Surgery
- **J. Victor Ehrens, DMD**, Division of Oral and Maxillofacial Surgery
- **Walter J. Finnegan, MD**, Division of Orthopedic Surgery
- **William W. Frailey, Jr., MD**, Division of General Surgery
- **Charles S. McConnel, Jr., MD**, Division of Otolaryngology-Head & Neck Surgery
- **Kenneth M. McDonald, MD**, Division of Vascular Surgery
- **Edward M. Mullin, Jr., MD**, Division of Urology
- **Farrokh S. Sadr, MD**, Division of Cardio-Thoracic Surgery
- **Charles J. Scagliotti, MD**, Division of General Surgery/Trauma-Surgical Critical Care
- **Paul H. Schenck, MD**, Division of Ophthalmology
- **John J. Stasik, MD**, Division of Colon and Rectal Surgery
- **David B. Sussman, MD**, Division of Orthopedic Surgery, Section of Ortho Trauma
- **William M. Trachtenberg, MD**, Division of Ophthalmology
- **Howard D. Trimpi, MD**, Division of Colon and Rectal Surgery

The Physician Recognition Dinner is held every three years to recognize and acknowledge the countless efforts and contributions made by physicians to Lehigh Valley Hospital and Health Network. This year's dinner was the first since the medical staffs of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg merged in December 1998.

Physician Order Sets

The newly merged Adult Community Acquired Pneumonia and the Chronic Obstructive Airway Disease Admission Order Sets are currently available at all sites. These evidence-based order sets were developed by a collaborative interdisciplinary group of caregivers. If you are unable to locate either of these order sets for your admission, ask the administrative partner for assistance or contact Marlene Ritter at LVH-CC at (610) 402-1707 or Ruth Davis at LVH-M at (484) 884-2307.

Radiology News

PET Scanning Has Arrived!

Positron Emission Tomography (PET) is now available at Lehigh Valley Hospital, Cedar Crest & I-78. CDL Medical Technologies has been contracted to provide mobile PET services to LVH. The system that has been chosen is a state-of-the-art Siemen's dedicated PET scanner which can detect lesions as small as several millimeters. Scanning will initially be performed one day per week with the potential of expanded services as volume builds.

The clinical usefulness of PET will mainly be in the field of oncology. PET utilizes an isotope of glucose, i.e., 2-deoxy-2-[^{18}F] fluoro-D-glucose (FDG). Since most tumors have high glyolytic rates, FDG uptake is seen in many tumors. PET FDG has been shown to detect tumor foci of a variety of histologic types.

PET is unique in providing functional assessment of the anatomic abnormalities usually found on CT or MRI scans. Studies indicate that PET may be used as a compliment to CT by helping to characterize, as benign or malignant, solitary pulmonary nodules found to be indeterminate on CT. By reducing false-positive studies, radiologists can more accurately identify patients for surgical resection and decrease unnecessary interventions for benign nodules.

PET is important in tumor staging. For example, in the evaluation of a patient with non-small cell lung cancer, accurate evaluation of the mediastinum is important for staging and treatment decisions. PET can detect tumors in normal sized lymph nodes and, therefore, more accurately stage patients with lung cancer. PET can improve the sensitivity and specificity for mediastinal staging of these patients.

PET also has been shown to increase accuracy in detecting recurrent disease in patients with colorectal cancer and melanoma. PET can detect small tumor foci in patients with colon cancer with a rising CEA level and a normal or equivocal CT scan. PET can help stage Hodgkin's and non-Hodgkin's lymphoma much better than Gallium scans.

There are some limitations to PET scanning. Although specificity is usually high, inflammatory or infectious processes may result in false-positive interpretations. Also, PET does not provide the level of precise anatomic localization of tumor required for surgical excision or targeted radiation therapy and requires complimentary anatomic correlation with CT or MRI.

The relative amount of radiation to a patient from a PET FDG scan is similar to that of a body computed tomography scan.

PET scans are currently approved by HCFA for the following indications:

- Characterization of solitary pulmonary nodules
- Initial staging and follow-up of :
  - non-small cell lung cancer
  - colorectal cancer
  - melanoma
  - Hodgkin's and non-Hodgkin's lymphoma

These studies will be interpreted by Nuclear Medicine physicians, Robert Rienzo, MD, and Kathleen McDonald, MD, who are board certified by both the American Board of Radiology and the American Board of Nuclear Medicine.

If you have any questions concerning PET, please contact either Dr. Rienzo or Dr. McDonald in Nuclear Medicine at (610) 402-8373.

(Some of the information in this article was obtained from the Oncology Roundtable of the Advisory Board Company of Washington, D.C.)

Nuclear Medicine Reminder

Federal and State regulations governing the medical use of radioactive materials define a misadministration as one involving administration of a radiopharmaceutical (1) to the wrong patient, (2) involving the wrong route of administration, or (3) *administration of a radiopharmaceutical other than the one intended or prescribed.* Misadministrations compromise patient care, as well as representing significant violations of our radioactive materials license conditions.

Prevention of misadministrations requires diligence by all parties with respect to making certain that the clinical objective of all diagnostic exams or radiopharmaceuticals are understood and met.

Toward this end, all referrals for radiopharmaceutical-based procedures must be made by prescription. Also, please stress to your patients that they present the prescription to the attending Nuclear Medicine technologist at the time of their exam. ***No procedure will be preformed without a prescription.***

Thank you for your attention to this issue. If you have any questions, please contact Bernard Valasek, Nuclear Medicine Technologist (Cedar Crest & I-78), at (610) 402-8390, or Sandra Bobryk, Lead Technologist, Nuclear Medicine (LVH-Muhlenberg), at (484) 884-2235.

Please Note - The telephone number for the Nuclear Medicine Physicians' Viewing Room at Cedar Crest & I-78 has been changed to **(610) 402-8373**.

News from CAPOE Central

Several weeks ago, I was demonstrating the CAPOE system to a group of doctors. They were impressed by the capabilities of the system, including the ability to look up and re-activate orders from previous admissions, the use of order sets, and the allergy and drug interaction checking. However, like many of the medical staff, one of them was concerned about the time required to enter orders into the computer. He wrote out eight separate orders and handed them to me. "Now, enter these as quickly as you can," he challenged. I would have complied, but I could not read the first two orders he had written (and neither could one of the other people in the room). I was tempted to page him an hour later to ask him for clarification of his orders (as would have happened in the hospital).

A recent report was released by the **Agency for Healthcare Research and Quality** entitled, "Research in Action: Reducing and Preventing Adverse Drug Events (ADE) to Decrease Hospital Costs." Highlights from the report follow:

- Incidence rates of ADEs vary from 2 per 100 admissions to 7 per 100 admissions among the hospitals that have conducted ADE studies.
- Anywhere from 28 percent to 95 percent of ADEs can be prevented by reducing medication errors through computerized monitoring and order entry systems.
- For example, at least two studies attribute 42-60 percent of ADEs to excessive drug dosage for the patient's age, weight, underlying condition, and renal function.
- According to another AHRQ-funded study at Brigham and Women's Hospital, computerized medication order entry has the potential to prevent an estimated 84 percent of dose, frequency, and route errors. Their system, which is similar to our CAPOE system, eliminates illegible orders that lead to medication errors. Programmed within the system are algorithms that check dosage frequency, medication interactions, and patient allergies.
- Patients who experienced adverse drug events (ADEs) were hospitalized an average of 8 to 12 days longer than patients who did not suffer ADEs, and their hospitalization cost $16,000 to $24,000 more.
- Hospitals can save as much as $500,000 annually in direct costs by using computerized systems.

The literature continues to provide evidence that physician order entry improves the quality of care. I believe that with CAPOE, we are on the correct path to achieve this goal while having an overall beneficial impact on the work process of our physicians/providers.

We will provide an opportunity for true "hands-on" experience with CAPOE outside the Cedar Crest & I-78 Auditorium all day on Tuesday and Wednesday, May 8 and 9. There will be live demonstrations and workstations set up to provide physicians and staff an opportunity to "play with the system." Please stop by and give it a test drive.

Don Levick, M.D., MBA
(484) 884-4593
(610) 402-5100 7481 (pager)

Recommendation from the Therapeutic (Transfusion) Committee: Blood Infusion Rates

By Bala B. Carver, MD, Chief, Section of Transfusion Medicine & HLA

Red Blood Cells:

In a clinically stable patient, red blood cells should be infused over 1.5-2 hours.

It was brought to the committee's attention that many transfusions are being given over 3-4 hours. Blood is an excellent culture medium and, at room temperature, the potential of bacterial growth exists which is directly proportional to the length of time the blood is at room temperature.

If rapid transfusion is needed, blood can be infused as rapidly as the patient's circulatory system will tolerate, and the type of vascular access will allow. If there is a concern about the fluid status of the patient and a slower transfusion is required, either the unit should be divided into two or the patient should be premedicated with a diuretic.

Other Blood Components (e.g., fresh frozen plasma, platelets, cryoprecipitate):

These other components can be infused as rapidly as the patient will tolerate.

The infusion rate needs to be ordered for each transfusion on the **Blood Component Transfusion Order** form.

If you have any questions regarding this issue, please contact Bala B. Carver, MD, Chief, Section of Transfusion Medicine & HLA, at (610) 402-8142.

Physician Assistant Order Writing

Recently, a number of questions have been raised as to what physician assistants can do. The following list of medications can be prescribed by a physician assistant, if so delegated by a physician assistant supervisor (a physician who is identified as the supervising physician of a physician assistant in the written agreement and is registered with the Medical Board as such). Written agreements need to be submitted to the Medical Staff Office.

- Antihistamines
- Anti-infective agents
- Cardiovascular drugs
- Contraceptives - eg: foams and devices
- Diagnostic agents
- Disinfectants -for agents used on objects other then skin
- Electrolytic, caloric and water balance
- Enzymes
- Antitussives, expectorants, mucolytic agents
- Gastrointestinal agents
- Local anesthetics
- Serums, toxoids and vaccines
- Skin and mucous membrane agents
- Smooth muscle relaxants
- Vitamins

Categories from which Physician Assistants May Prescribe (subject to exclusions and limitations listed)

Autonomic drugs
Drugs excluded under this category:
- Sympathomimetic (adrenergic) agents

Blood formation and coagulation
Drugs excluded under this category:
- Anti-coagulants and coagulants
- Thrombolytic agents

Central Nervous System agents
Drugs excluded under this category:

- General anesthetics
- Monoamine oxidase inhibitors

Eye, ear, nose and throat preparations
Drugs limited under this category:
- Miotics and mydriatrics used as eye preparations require specific approval from the physician assistant supervisor for a named patient.

Hormones and synthetic substitutes
Drugs excluded under this category:
- Pituitary hormones and synthetics
- Parathyroid hormones and synthetics

Categories from which Physician Assistants May Not Prescribe or Dispense

- Antineoplastic agents
- Dental agents
- Gold compounds
- Heavy metal antagonists
- Oxytocics
- Radioactive agents
- Unclassified therapeutic agents
- Devices
- Pharmaceutical aids

A physician assistant may not prescribe or dispense Schedule I or II controlled substances (i.e., Morphine, Percocet, etc.)

A physician assistant may not prescribe whole blood and blood components.

It is important to understand what physician assistants may or may not do. If an order is written for a medication or blood product which is not approved according to the State Rules and Regulations, a nurse cannot act on the order, the Blood Bank cannot dispense the blood, or the Pharmacy cannot dispense the medication, unless co-signed by the physician assistant supervisor.

If you have any questions or concerns regarding this issue, please contact Rita M. Mest, Director, Medical Staff Services, at (610) 402-8975, or Fred J. Pane, R.Ph., Director, Pharmacy, at (610) 402-8882.

Coding Tip of the Month

All OB cases require an OB code as principle diagnosis EXCEPT when the condition being treated is NOT affecting the pregnancy. The attending physician must document that the condition being treated is NOT AFFECTING the pregnancy or that the condition being treated IS INCIDENTAL to the pregnancy in order for it to be coded that way. Otherwise, the coder must default to an OB code which can adversely affect reimbursement and statistical data.

(Taken from OB coding guidelines)

A Word About Consults

By David M. Caccese, MD, Division of General Internal Medicine/Geriatrics

Envision the following all too common scenario: You've been working at the hospital and in your office all day. You started rounds at the hospital at 7 a.m. After a long afternoon in the office, you do get home to have dinner with your family. Since you are on call for your group, you have to go back to the hospital after dinner to evaluate and admit two patents that are in the emergency room. Finally, at 10:30 p.m., you are able to leave the hospital and drive home. You're fatigued after a long day, but are hopeful that the remainder of the night "won't be too bad."

Shortly after getting home and turning on the 11 p.m. news, your pager goes off with a message to call your answering service. You call immediately and are told by the answering service operator that there is an "urgent consult" at LVH. The consult request simply says "please see tonight!" No other information is given, other than the name of the patient's attending physician, and patient's room location.

Think about the reaction that all of us have had in this unfortunately, not uncommon situation. First, there is a rapid rise in systemic catecholanine levels. Anger follows. This is frequently followed by an expletive. Then the questions begin: "What is wrong with the patient?" "Why do I need to see the patient *tonight*?" "Do I really need to see the patient *tonight*?" "Why didn't the doctor who wanted me to see his/her patient *tonight* call me to tell me what this was all about?"

All of us have been confronted with the above scenario at some point in our careers. What is the answer for this problem? One word helps to diffuse the issue -- **COMMUNICATION!!**

We are professionals. We expect and want to be treated as professionals by our patients, our nursing colleagues in the hospital, and especially by our physician colleagues. How much better would it be for us as individual physicians if the above scenario did not occur as frequently as it does? Wouldn't it be better for patient care (and physician catecholamine levels) if the physician requesting an urgent consultation had the courtesy and respect for his professional colleague to call him/her and tell him why he was requesting an urgent consultation on the patient? The requesting physician might be able to provide important historical information, and most importantly, would be able to ask the question which the consultant was to address in an urgent fashion.

Communication between professionals could help to build a better working relationship. It might even result in a long lasting referral relationship that could benefit both parties. Most of all, it would improve the quality of patient care. Think about it!

Sleep Disorders Center Relocating to 17th & Chew

On May 1, the Sleep Disorders Center, which has been located at Cedar Crest & I-78, will move to the fourth floor of Lehigh Valley Hospital at 17th & Chew. The new laboratory, with improved diagnostic equipment, will expand from its current six beds to 13 beds effectively doubling the ability to perform sleep studies. In addition to expanding in capacity, the new Center will offer significant improvements in comfort to patients including a private bath with a shower in each room, televisions, refreshment center, and attractive "hotel room" décor. For patients' convenience, valet parking will be available at the front entrance of the hospital.

To schedule an appointment, please contact Central Scheduling at (610) 402-8378 (TEST). For information about sleep studies, please contact the Sleep Disorders Center at (610) 402-9777.

Sleep Disorders Center

New and Improved Features

- 13 beds
- Private baths and televisions
- Hotel room décor
- Valet parking at the hospital entrance

Central Scheduling to Handle Reservations for MRI and Sleep Disorder Studies at LVH-M

Beginning April 30, the Central Scheduling Department will handle reservations for MRI and Sleep Disorder Studies at LVH-Muhlenberg. Previously, the individual departments handled the scheduling of reservations. This change is part of the continuing effort to streamline access to the services available at LVH-Muhlenberg.

In order to expedite the scheduling process, please have the patient's demographic information, including their insurance information, available at the time of the scheduling call. As with the other tests and procedures you order through Central Scheduling, this will allow patients to be pre-registered and speed the intake process when they arrive at the hospital.

To schedule an MRI or Sleep Disorder Study at LVH-Muhlenberg, please call Central Scheduling at (484) 884-2279, Monday through Friday, from 7 a.m. to 7 p.m.

If you have any questions, comments or concerns, please contact Lisa Coleman, Director, Support Services, at (610) 402-8066, or Mark Holtz, Vice President of Operations, at (484) 884-4710.

Infection Control News

Animal bites are listed as reportable diseases in the Commonwealth of Pennsylvania. Health care providers are required to **immediately report** all types of animal bites to their local Health Bureau. This includes all warm-blooded and cold-blooded animals (snakes and other reptiles). Rapid reporting of animal bites assists the Health Bureau in helping to identify dangerous animals and removing them from the community, if necessary, or by requiring owners to properly restrain and vaccinate pets. Reportable disease forms are available from the Health Bureau.

Allentown Health Bureau
245 N. 6th Street
Allentown, PA 18102
Phone: (610) 437-7577
Page: (610) 218-3266
Fax: (610) 437-8799

Bethlehem Health Bureau
10 E. Church Street
Bethlehem, PA 18018
Phone: (610) 865-7087
Fax: (610) 865-7019

Lehigh County PA-DOH
3730 Lehigh Street
Whitehall, PA 18052
Phone: (610) 821-6770
Emergencies: (717) 826-2062
Fax: (610) 821-6564

If you have any questions regarding this issue, please contact a member of the Infection Control Department at (610) 402-0680.

Osteoporosis: Could Your Patients Be At Risk?

Osteoporosis arises when the balance between bone formation and bone resorption is disrupted in favor of bone resorption. It is a widespread condition affecting more than 28 million individuals in the U.S. In a demographic analysis of a nine county region of Pennsylvania (including Lehigh County) conducted a few years ago, one-third of all women and men age 45-75+ were found to have osteoporosis or to have low bone mass and be at risk for osteoporosis. As a silent risk factor for fracture, osteoporosis represents a major cause of morbidity, hospitalization and mortality. One of every two white women will experience an osteoporotic fracture sometime in her lifetime.

Osteoporosis is a multifactorial condition with well-recognized risk factors. These include: age, gender, genetics, body size, lifestyle factors, other illnesses and drug treatments. Bone density declines after age 30, particularly in post-menopausal women. While the lighter and smaller skeleton of women make them more likely to develop osteoporosis, 20% of all people with osteoporosis are men. Caucasians and Asians have a higher prevalence of osteoporosis. Excessive alcohol consumption, tobacco use, sedentary lifestyle, and a diet low in calcium increase the risk for osteoporosis. Illnesses that speed bone loss or cause immobility increase risk. Medications that affect bone metabolism include: Glucocorticoids, Adrenocorticotrophin, excessive use of Thyroxine, Anticonvulsants, long term Heparin use, Lithium, Cytotoxic drugs (Methotrexate), Aluminum, Gonadotrophin-releasing hormone agonists, and Cyclosporin A. Early identification of individuals at risk and implementation of preventative measures, where possible, can result in minimization of bone loss, better skeletal preservation, and reduction in fracture risk.

Osteoporosis is not an inevitable aspect of aging, but preventative efforts need to be lifelong. Individuals must be assessed in terms of their medical history and predisposing factors to determine their risk for low bone mass. Because bone mass in men and women increases until about age 30 before beginning to decline, efforts in this population should be directed toward maximizing peak bone mass. After age 30, efforts must be directed toward preventing bone loss. Adults with vertebral, rib, hip or distal forearm fractures should be evaluated for osteoporosis via bone mineral density testing. Universal recommendations to maximize and preserve bone mass include: adequate intake of calcium and vitamin D, regular weight bearing and muscle-strengthening exercises, and avoidance of both tobacco use and excessive alcohol intake.

May is National Osteoporosis Prevention Month. Regardless of the age of your patients, it is never too soon or too late to think about bone health. The National Osteoporosis Foundation's annual prevention campaign message for 2001 emphasizes the consequences of osteoporosis and the need for all healthcare practitioners to take a preventative approach with their patients -- "Every 20 seconds osteoporosis causes a fracture."

If you are interested in more information related to osteoporosis or bone mineral density testing, please contact the Metabolic Bone Program at the Health Center at Trexlertown at (610) 402-WELL.

(Source: National Osteoporosis Foundation & Osteoporosis Learning Series: A CME-accredited self-study program)

Experience the Newest Release of GUI Email

The Information Services Department would like to invite you to experience the newest release of GUI email. This newest version takes minutes to install and provides many new enhancements -- all done in response to user requests. GUI email opens the door to allow you to keep your existing mail files, yet provides you with a Windows-based interface to all the luxuries that come with Windows: attachments (Word documents, spreadsheets, pictures), PC composition options (choice of fonts, colors, spell check, margins, etc.), archive of your own files off-line if you wish (locally), and printing to local printers (even in color, if one is available to you).

Information Services would like to especially welcome on board those of you who are still using the original email display ("Green Screen") and hope you will allow I/S to bring your PC up to the best it can be. Some are still using the original version to print to an old nearby Fax machine (via T###), which is a carryover from the old days of five to seven years ago when printers weren't as common, and it was your only option to print locally. If you are among this group and are still plugging away with the original green screen version and printing to your old Fax machine, please contact either Barrie Borger (Barrie.Borger@lvh.com, (610) 402-5715), or Rob Bortz (Rob.Bortz@lvh.com, (610) 402-1482). One of these individuals will schedule you STAT, ahead of the rest, to replace these old, costly fax prints.

Informal drop-in sessions, designed to help people convert to the GUI E-mail from the older emulation system, have been scheduled: Monday, May 7, from 1 to 3:45 p.m., and Thursday, May 10, from 12:45 to 3:30 p.m., both in Classroom 1 at Cedar Crest & I-78. Everyone is welcome to drop in during these times to ask questions or to get an overview of GUI E-mail.

For Your Information - Lehigh Valley Hospital and Health Network has switched back to the Password Lifetime Option for the network systems. This means that you will be asked to change your password every 90 days. Changing the password helps to ensure that your accounts are kept safe, and complies with law and industry best practices. If you experience any problems while changing your password or if you have any questions, please contact the Information Services Help Desk at (610) 402-8303.

Congratulations!

Mark A. Gittleman, MD, Division of General Surgery, has been elected a Governor to the American College of Surgeons, representing the American Society of Breast Surgeons.

Thomas D. Meade, MD, Division of Orthopedic Surgery, Section of Ortho Trauma, was recently appointed to sit on the Executive Committee of the Alumni Association of Jefferson Medical College. Jefferson Medical College boasts the largest medical alumni association in the country.

Papers, Publications and Presentations

John A. Altobelli, MD, Division of Plastic Surgery, attended the Third International Congress of the Society of Pelvic Dysfunction in Cairo, Egypt, from March 14-18. He participated in the panel on "Pelvic Reconstruction Following Large Defects Following Removal of Cancer and Muscle Transposition for Incontinence."

Keith R. Doram, MD, Chief, Division of General Internal Medicine, along with two LVH Internal Medicine residents -- **David Shields, MD**, and **Imhotep Boukman, MD** -- presented two posters at the 21st Annual Regional Meeting of the Society of General Internal Medicine, held on March 16, at the University of Pennsylvania campus in Philadelphia. The posters were titled "Factors Associated with Colorectal Cancer Screening Compliance" and "Colorectal Cancer Screening: Urban vs. Rural Population."

In addition, Dr. Doram and **Yehia Y. Mishriki, MD**, Division of General Internal Medicine/Geriatrics, were co-authors of a chapter in the recently released 3rd Edition of John Noble's ***Textbook of Primary Care Medicine.*** The title of the chapter is **"Primary Care of the Eye."**

Kelly M. Freed, MD, Division of Diagnostic Radiology, co-authored two articles. "MRI of Conjoined Twins Illustrating Advances in Fetal Imaging," which was published in the January 2001 issue of the ***Journal of Computer Assisted Tomography***, reviewed two cases of thoracoomphalopagus twins. The first case, imaged a decade ago, required the use of an intrauterine paralytic agent to reduce fetal motion. This intervention is made obsolete by the advent of fast scanning techniques which can provide fetal images in seconds.

The second article, "Nonenhanced Helical CT and US in the Emergency Evaluation of Patients with Renal Colic: Prospective Comparison," which was published in the December 2000 issue of ***Radiology***, evaluated 45 patients by CT and US examination (kidney, ureters, bladder including ureteral jets). The conclusion made was that noncontrast CT was 96% sensitive in the diagnosis of nephroureteral lithiasis whereas ultrasound was 61% sensitive.

(Continued from Page 10)

Mark A. Gittleman, MD, Division of General Surgery, was an invited speaker at the TriCare Mid-Atlantic Region Breast Imaging Training Seminar held in Virginia Beach, Va., on March 8 and 9, where he presented "New Trends in Breast Cancer Diagnosis and Treatment." In addition, Dr. Gittleman was an invited participant and presenter at the International Consensus Conference on Image-Detected Breast Cancer, sponsored by the University of Southern California Comprehensive Cancer Center, held in Palm Beach, Fla., March 22-24.

Gary S. Greenberg, DPM, Division of Orthopedic Surgery, Section of Foot and Ankle Surgery, spoke at the meeting of the Council of Teaching Hospitals of the American Association of Colleges of Podiatric Medicine in Chicago on March 16 and 17. Dr. Greenberg presented a lecture on evaluation of the resident, and conducted several workshops on developing faculty as educators.

Geoffrey G. Hallock, MD, Division of Plastic Surgery, recently had an article published in the ***Journal of Plastic and Reconstructive Surgery*** titled "The Plastic Surgeon of the 20th Century," which was originally presented at the American Association of Plastic Surgeons' meeting in Laguna Niguel, Calif.

Vincent R. Lucente, MD, Acting Chairperson, Department of Obstetrics and Gynecology, was the Visiting Professor for Grand Rounds at the Greater Baltimore Medical Center on March 16, where he lectured on "New Concepts in Lower Urinary Tract Infections."

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

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.

Topics to be discussed in May will include:

- May 1 - "Colorectal Cancer Surveillance: Who Gets Colonoscopy"
- May 8 - Stahler Rex Lecture -- "Where is the Genetic Revolution Headed: Testing, Therapy and Engineering"
- May 15 - "Unanswered Questions"
- May 22 - "Recent Advances in Bacterial Meningitis"
- May 29 - "Approach to Peripheral Neuropathy"

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

Pediatric Grand Rounds

"Novel Treatments for Atopic Dermatitis" will be presented on Tuesday, May 15, beginning at 8 a.m., in the hospital's Auditorium at Cedar Crest & I-78.

For more information, please contact Kelli Ripperger in the Department of Pediatrics at (610) 402-2540.

Guidelines to Respond to Critical Tetanus Vaccine Shortage for Adults and Adolescents

1. Anyone with three or more tetanus shots in the past will NOT need a Td booster (during the shortage)
2. Persons with 0, 1, 2 , or UNKNOWN prior tetanus shots WILL NEED a Td booster as part of wound management, prenatal, travel, school, or occupational assessment
3. TETANUS PRONE wounds** require TIG (tetanus immune globulin) regardless of any need or lack of need for Td immunization (** burns, avulsions, crush injury, penetrating wounds, neglected wounds, wounds contaminated with dirt or feces, farm implement associated injuries, thermal injuries, electrical injuries).

It is strongly recommended that health care facilities take inventory of existing supplies of Tetanus vaccine and contact suppliers if you foresee a shortfall using criteria of past usage needs.

Vaccine boosters that may be delayed by the shortage should be agendized for early 2002 for affected patients with a careful explanation given the patient of the need to "catch up."

Presently, pediatric vaccine and guidelines seem unaffected by shortage predictions, but this may change with new information and is unclear at present.

If you have any questions regarding this issue, please contact Luther V. Rhodes III, MD, Chief, Division of Infectious Diseases, at (610) 402-8430, pager (610) 778-7291, or via email at luther.rhodes@lvh.com.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, resignations, etc. Please remember to update your directory and rolodexes with this information. In addition, the Medical Staff Directory is now available on the e-mail Bulletin Board -- **Directories**. Updates will be made to the Medical Staff Directory in e-mail at the beginning of each month.

Medical Staff

Practice Changes

Brndjar & Freeman Medical Associates, P.C.
(assumed practice of Dr. John M. Kauffman, Jr.)

- Jon E. Brndjar, DO
- James J. Freeman, DO
- Maria L. Jones, MD

Jon E. Brndjar, DO
1210 S. Cedar Crest Blvd.
Suite 3700
Allentown, PA 18103-6237
(610) 402-0011
Fax: (610) 821-1186

James J. Freeman, DO
Maria L. Jones, MD
4 W. Main Street
Macungie, PA 18062-1309
(610) 967-4993
Fax: (610) 967-6553

Amitabha Gupta, MD
(no longer affiliated with Andrew S. Kimmel, MD)
1588 Woodfield Drive
Bethlehem, PA 18015-5550
(610) 997-0381

David Meir-Levi, DO
(no longer with Progressive Physician Associates Inc.)
Peripheral Vascular Surgeons, PC
1259 S. Cedar Crest Blvd., Suite 301
Allentown, PA 18103-6260
(610) 439-0372
Fax: (610) 439-8807
(Effective 5/1/2001)

Marnie P. O'Brien, DO
(joining Lehigh Valley Ophthalmic Associates - 4/30/2001)
400 N. 17th Street, Suite 101
Allentown, PA 18104-5099
(610) 433-0450
Fax: (610) 433-4655

Address Change

James K. Hoffman, MD
Valley Sports & Arthritis Surgeons
2649 Schoenersville Road
Suite 101
Bethlehem, PA 18017-7326
(610) 317-3440
Fax: (610) 317-3443

Status Change

William Gee, MD
Department of Surgery
Division of Vascular Surgery
From: Active/LOA
To: Honorary

Peter K. Ghatak, MD
Department of Medicine
Division of General Internal Medicine
From: Affiliate
To: Honorary

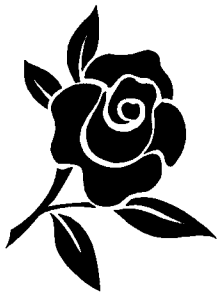
Christine E. Hinke, MD
Department of Medicine
Division of Physical Medicine-Rehabilitation
From: Provisional Active
To: Associate
Site of Privileges - LVH-M

Two-Year Leave of Absence

Philip L. Tighe, DMD
Department of Dentistry
Division of General Dentistry

Resignation

Colin Kopes-Kerr, MD
Department of Family Practice



(Continued on Page 13)

(Continued from Page 12)

Allied Health Staff

Appointments

Jelena Dinic, CRNP
Physician Extender
Professional - CRNP
(Allentown Anesthesia Associates Inc - Lisa A. Keglovitz, MD)
Site of Privileges - LVH & LVH-M

Joshua Singer, DC, CNIM
Physician Extender
Technical
Intraoperative Neurophysiological Monitoring Specialist
(Surgical Monitoring Associates)
(Supervising Physician - Mark C. Lester, MD)
Site of Privileges - LVH & LVH-M

Baoqing Wang, MSc, DABNM
Associate Scientific
Clinical Neurophysiologist
(Surgical Monitoring Associates)
(Supervising Physician - Mark C. Lester, MD)
Site of Privileges - LVH & LVH-M

Lawrence R. Wierzbowski, AuD, DABNM
Associate Scientific
Clinical Neurophysiologist
(Surgical Monitoring Associates)
(Supervising Physician - Mark C. Lester, MD)
Site of Privileges - LVH & LVH-M

Six-Month Leave of Absence

David S. Glosser, ScD
Associate Scientific
Psychologist

Resignations

Janet S. Clark, RN
Physician Extender
Professional
(John J. Cassel, MD, PC)

Patricia L. Donley, RN
Physician Extender
Professional
(ABC Family Pediatricians - Scott Brenner, MD)

Margery A. Fettig, RN
Physician Extender
Professional
(John J. Cassel, MD, PC)

Ruth A. Gerchufsky, RN
Physician Extender
Professional
(The Heart Care Group, PC)

Deborah R. Miller, CRNP
Physician Extender
Professional
(ABC Family Pediatricians - Donald L. Levick, MD)

Karen A. Moffat, RN
Physician Extender
Professional
(Yeisley Cardiothoracic Surgery, LLC)

Angela M. Toro, CRNP
Physician Extender
Professional
(Oncology Specialists of Lehigh Valley)

M. Deborah Vilegi-Abad, RN
Physician Extender
Professional
(Raul M. Abad, MD)

H. Douglas Widdowson, MEd
Associate Scientific
Audiologist

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

May 2001

Dear Colleagues,

Thankfully, I have many opportunities to work with our Hospice Home Care team. Why thankfully? Because without their support I would not have the resources I need to care for my patients throughout the continuum of their cancer care.

Many of you use and appreciate these services–and for you, it takes no further explanation of why Hospice is so important to our community.

Many others of you refer to Hospice, and your patients benefit from the care and support which Hospice provides.

This letter is being written both to thank Hospice Home Care for the excellent work they do, and to review with my physician colleagues what can be expected of them when they make a referral to Hospice Home Care.

[1] Your patients deserve to live with their terminal illness in comfort and dignity. Referral to Hospice well before the crisis of imminent death is always preferred. Referral in the crisis of imminent death is understood as sometimes inevitable.

[2] Referral to Hospice is like any other professional referral, and the same professional courtesies are expected. When making a referral, be clear about your role. If you intend to continue as the attending of record during Hospice care, please be sure to communicate that preference to Hospice intake, or to the person making the referral for you. Be prepared to talk with the hospice nurse about your referral to ensure that the appropriate care plan is undertaken with your direction. The Hospice nurse should never be made to feel that her calling you is an inconvenience.

If you intend to refer the patient to another physician, or to the Hospice Medical Director, please take the time to make a personal call to the physician who will be taking care of your patient to ensure, again, that the care plan you would wish for your patient is initiated. An accepting physician should never get an initial call from Hospice to the effect that Dr. So and So has referred Mrs. Who and Whom to Hospice, and "orders are needed."

[3] As the course of illness proceeds, care needs for the patient and family may change. Again, the Hospice nurse should always feel comfortable communicating these changes to you and to ask advice about making changes in the care plan.

[4] To assist you in your care of the Hospice patient, a small task force under the leadership of Dr. Salerno is developing "order sets" which will provide guidelines for you and for the nurse for initial management of common symptoms experienced by the home hospice patient–such as, nausea, bowel problems, pain, anxiety, and the like. These guidelines should lead to more informed communication between you and the caring home nurse.

Last, when you think of Hospice, think of how you would want you or a member of your family to be cared for at the time of dying. When that time comes for all of us, we know for sure that we will want to be comfortable, and we do not wish to be alone. Hospice home care ensures that our patients will be as comfortable as possible, and that the patient and family we have cared for will not be alone in their journey.

Please join me in thanking our Hospice team for their extraordinary efforts, and for helping us take better care of our patients.

Yours Sincerely,

Gregory R. Harper, MD, Ph.D.
Physician in Chief, Cancer Services
Lehigh Valley Hospital and Health Network

THE CENTER FOR EDUCATIONAL DEVELOPMENT AND SUPPORT

May 2001

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 Library Publications.

CC & I-78
"Textbook of Natural Medicine," 2nd edition

LVH-Muhlenberg
"Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice," 16th edition

17th & Chew Streets
"DeGowin's Diagnostic Examination," 7th edition

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:

May 8, 8 am – Noon
June 26, Noon – 4 pm
August 7 8 am - Noon

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

July 17, Noon – 4 pm

Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at 610-402-2475 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 610-402-2413 or through e-mail.

Any questions, concerns or comments on articles from CEDS, please contact Bonnie Schoeneberger 610-402-2584

May 2001

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 **7am** Family Practice GR - JDMCC 1A/B **7am** Surgical GR-CC-Aud **8am** Pediatric GR-CC-Aud **12 noon** Medical GR-CC-Aud	2	3 **12noon** Combined TB-JDMCC-CR1	4 **7am** GYN Tumor Board-CC-CL1 **12noon** Breast TB-JDMCC-CR1	5
6	7 **12noon** Colon/Rectal TB-JDMCC-CR1	8 **7am** Surgical GR-CC-Aud **8am** Pediatric GR-CC-Aud **12 noon** Medical GR-CC-Aud	9 **12noon** Pulmo TB-JDMCC-CR1	10 **12noon** ENT TB-JDMCC-CR1	11 **7am** OBGYN GR-CC-CL1 **12noon** Breast TB-JDMCC-CR1	12
13	14	15 **7am** Surgical GR-CC-Aud **8am** Pediatric GR-CC-Aud **12 noon** Medical GR-CC-Aud	16	17 **12noon** Endo TB-JDMCC-CR1	18 **7am** OBGYN GR-CC-CL1 **12noon** Breast TB-JDMCC-CR1	19
20	21 **12noon** Colon/Rectal TB-JDMCC-CR1	22 **7am** Surgical GR-CC-Aud **8am** Pediatric GR-CC-Aud **12 noon** Medical GR-CC-Aud	23	24 **12noon** Cancer Comm. - JDMCC-CR1	25 **7am** OBGYN GR-CC-CL1 **12noon** Breast TB-JDMCC-CR1	26
27	28	29 **7am** Surgical GR-CC-Aud **8am** Pediatric GR-CC-Aud **12 noon** Medical GR-CC-Aud **12noon** Urology TB-JDMCC-CR1	30	31 **12noon** Combined TB-JDMCC-CR1		

NEWS FROM THE HEALTH INFORMATION MANAGEMENT DEPARTMENT (MEDICAL RECORDS)

Volume 1, Issue 1 April 2001

Document Imaging Upgrade - *LVH CC/17/WG*

The PIM 2.0 Document Imaging Historical Medical Record Access and Electronic Chart Completion System will be upgraded on Tuesday, May 15, 2001 to the EPF PIM 4.0 system

Data Conversion

Tuesday 5/8/01 - Monday 5/14/01

During the data conversion period, the Imnet PIM 2.0 System will continue to be available in a "read only" mode with historical medical records from August 1998 through Saturday, May 12, 2001.

INSIDE THIS ISSUE

Downtime Procedures

Tuesday, 5/8/01 -Monday 5/14/01

- Medical record discharges from Sunday, May 6, 2001 - Monday, May 14, 2001 will be available at the CC site HIM Department for review in the original paper format.
- Transcribed H&P, DS, Consults, Ancillary Results and Lab Cums will continue to be available via the Phamis IDX system during the downtime.
- The HIM Department will be staffed at the Cedar Crest location 24 hours a day during the downtime and data conversion.
- The HIM Department will have the ability to print/fax medical records for patient care and release of information.
- Paper medical records will not be released from the HIM Department during downtime due to prepping processes for scanning following the conversion. Paper medical records must be reviewed in the HIM Department at the CC site.
- Abstracts will continue to be sent to the units for re-admits either from printed images or photocopies of paper records.
- Requests for paper medical records should be made by calling the HIM Department at 402-8240 (option 3).

Electronic Signature/Chart Completion

During the downtime and data conversion, physicians/clinicians will be unable to access the imaging system to complete medical record deficiencies.

- Physicians/clinicians are encouraged to come to the HIM Department at the CC site to complete any outstanding dictations (history and physicals, operative reports, discharge summaries, consults, etc.). This will prevent interruption in patient care and allow the facility to have appropriate documentation to avoid delays in the billing/reimbursement process.
- There will be no telephone notification for delinquent records from May 7, 2001 - May 25, 2001 during downtime, conversion, and catch-up processes. It is anticipated that normal processes will resume the week of May 28, 2001.

Hardware Upgrade

Information Services will upgrade the hardware and clinical workstations to provide increased capacity. This upgrade will quadruple the optical disk capacity while providing additional servers.

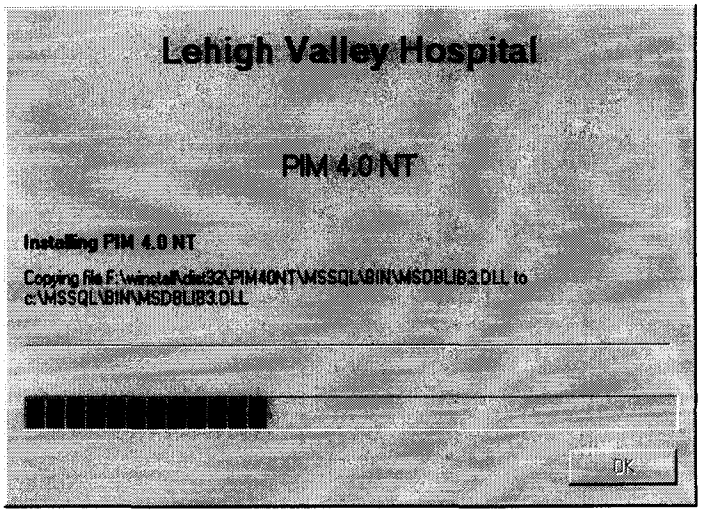
Software Upgrade

The software upgrade will provide additional features for the clinicians and Health Information Management Department. Some of the new features that will impact clinicians include:

- Physician Groups - Allows definition of physician groups with the ability to complete deficiencies for group members.
- AutoSign - Allows automatic presentation of documents for electronic signature with the ability to sign the entire batch at one time.
- Demographic Search - Allows more functionality, including moving from patient to patient on the same screen.
- User-Defined Record View - Allows users to set up and change his/her own record view (documents to be viewed).
- Missing Text - Gives clinician the ability to add missing text to imaged documents (transcription, written documents, etc.).

Software Download

The Window below will appear if PIM 4.0 has not been loaded on the PC you are using. The load process will take approximately 10 minutes to perform. Please be patient while this process completes the installation of the new software.



HIM Website

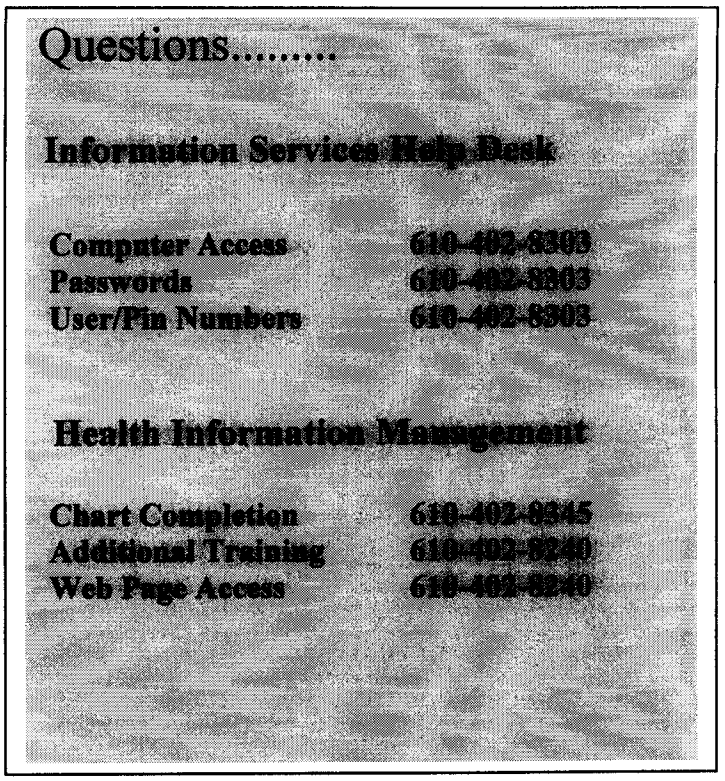
Visit the Health Information Management home site on the LVHHN intranet home page for updated information on the document imaging upgrade and other HIM related topics.

Physician/Clinician Computer Based Training (CBT)

Visit the HIM Website on the LVHHN Intranet home page for computer based training for medical record access and electronic chart completion

LVH-M Implementation

Implementation of Document Imaging record access and physician/clinician electronic chart completion is coming in ***June 17,2001***. Stay tuned for more information on specific dates, training, etc.



Health Network LABORATORIES

CHEMISTRY

LAB-LINK

Information And Advice About Our Laboratory

Effective May 1, 2001

THYROID TESTING UPDATE

To simplify thyroid test ordering, effective May 1, 2001 the following codes will be utilized:

Test Name	Test Code	Normal Range	Low End Reportable Range
Thyroid Stimulating Hormone	TSH	0.465 - 4.680 ulU/ml	0.003 ulU/ml
T_4, Free (Thyroxine)	FT4	0.78 - 2.19 ng/dl	0.030 ng/dl
T_4, Total (Thyroxine)	T4	5.50 - 11.00 ug/dl	0.300 ug/dl
T_3, Free (triiodothyronine)	FT3	2.77 - 5.27 pg/ml	0.390 pg/ml
T_3, Total (triiodothyronine)	T3T	0.96 - 1.69 ng/ml	0.10 ng/ml
T_3 Uptake (thyroid binding index)	T3U	23.50 - 40.60%	17.0%

PLEASE NOTE:

- The **THYROID PROFILE (TH7)** which contains a calculated index will **NO LONGER BE AVAILABLE** as of May 1, 2001 due to the increased sensitivity of the above tests.

- The **T_4 , Total** and **TSH** tests have been **removed** from the **critical call back notification list.**

If you have any questions, please call our Customer Care Call Center at 610-402-8170.

THERAPEUTICS AT A GLANCE

The following actions were taken at the March 2001 Therapeutics Committee Meeting - Fred Pane, Director of Pharmacy, Clinical Pharmacy Services - Joseph Ottinger, R.Ph., MS, MBA, Christopher Moore, R.Ph., Janine Barnaby, R.Ph.

Pharmacy Operations Improvement - Update First Quarter FY'01

One of the responsibilities of the Therapeutics Committee, a Medical Staff Committee, is to assist the Pharmacy Department in identifying Operations Improvement (OI) and implementation.

A number of programs have been successful, in helping to generate an estimated savings of $669,877 over the last 18 months at Lehigh Valley Hospital and $110,047 at Lehigh Valley Hospital - Muhlenberg.

For the first 6 months of FY'01 (July to December) an estimated $377,758 was achieved, through the support of the Medical Staff, at Lehigh Valley Hospital, alone.

Some of the ongoing OI projects include:

a) Therapeutic Substitution of Claforan for Rocephin, Levaquin for Cipro, Zocor for Lipitor, Zemuron for Nimbex (ventilator patients), Retavase for tPA (MI's and IR).

b) IV to oral step down therapy of Levaquin, Diflucan, Flagyl, Zofran and Zithromax.

c) Formulary Management

The pharmacy department continues to benchmark with national leaders in healthcare and works with groups like The Advisory Board in Washington, DC.

If you have OI suggestions, please contact Fred Pane, R.Ph., Director of Pharmacy at 610-402-8881. Thank you for your ongoing support.

OI Project Examples:

		Cost/day
A.	Claforan 1gm Q8H IV	$18.00
	Claforan 1gm Q12H IV (renal dose)	$12.00
	Rocephin 1gm Q24H IV (restricted to Pediatrics and Meningitis)	$38.85
B.	Levaquin 500mg Q24H IV	$15.25
	Levaquin 500mg Q24H PO	$ 5.93
	Cipro 400mg Q12H IV (restricted usage)	$47.00
C.	Zocor 5mg QD PO	$0.11
	Zocor 10mg QD PO	$0.14
	Zocor 20mg QD PO	$0.25
	Lipitor 10mg QD PO (not formulary)	$1.65
	Lipitor 20mg QD PO (not formulary)	$2.55

Drug Formulary Issues- Aggrenox, Pletal, Chirocaine

Aggrenox (Aspirin 25 mg/extended-release dipyridamole 200 mg) capsules are approved for the reduction of the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis.

CLINICAL PHARMACOLOGY:
Aspirin and dipyridamole are antiplatelet drugs. Aspirin works by irreversibly inhibiting the platelet cyclo-oxygenase and decreasing the production of thromboxane A_2. Dipyridamole works by inhibiting the reuptake of adenosine into the platelets, endothelial cells, and erythrocytes. The increased adenosine levels stimulate the platelet A_2-receptor that activates platelet adenylate cyclase and increases the platelet cyclic-3'-5'-adenosine monophosphate (cAMP) levels. This results in the inhibition of platelet aggregation. Dipyridamole also inhibits phosphodiesterase (PDE) in other tissues of the body. The inhibition of cAMP and cyclic-3'-5'-guanosine monophosphate-PDE (cGMP-PDE) is weak, but the levels of each are increased in various tissues. The impact on cGMP is greater since endothelium-derived relaxing factor (nitric oxide) plus dipyridamole can each augment the other's activities.

PHARMACOKINETICS: Peak plasma concentrations of aspirin are achieved within 1 hour. The aspirin is hydrolyzed to salicylic acid in the liver and gastrointestinal wall. Peak plasma salicylic acid levels are reached within 1 hour. The systemic bioavailability of aspirin is 50% to 75%. The apparent volume of distribution in 10 L. The protein binding of aspirin is low, but its metabolite (salicylic acid) is highly protein bound (90%). The half-life of aspirin is 20 minutes, and the half-life of salicylic acid is 1.71 hours at lower doses. The half-life of salicylic acid is dose dependent and will increase with dose. Peak plasma concentrations of dipyridamole are achieved within 2 hours with the extended-release formulation. The peak plasma concentrations are increased by 40% in geriatric patients. The steady-state volume of distribution is 92 liters. Protein binding is 99%. The drug does not cross the blood brain barrier, but is highly lipophilic. It is primarily metabolized by the liver to its monoglucuronide, which is a weak active metabolite. The terminal half-life of dipyridamole is 13.6 hours at lower doses. The half-life of salicylic acid is dose dependent and will increase with dose. Administration of aspirin and dipyridamole does not alter the pharmacokinetics of either agent.

ADVERSE REACTIONS: The most common adverse effects associated with aspirin 25 mg/extended-release dipyridamole 200 mg therapy included headache, dyspepsia, abdominal pain, nausea, diarrhea, and vomiting . A complete list of the adverse effects reported with aspirin 25 mg/extended-release dipyridamole 200 mg can be found in the product labeling.

DRUG INTERACTIONS: No drug interaction studies have been conducted with the aspirin 25 mg/extended-release dipyridamole 200 mg formulation. See the drug interactions reported in the product labeling; they are based on those reported with aspirin or dipyridamole therapy alone.

DOSING: Aspirin 25 mg/extended-release dipyridamole 200 mg capsules should be given orally twice daily, in the morning and evening. Each capsule should be swallowed whole and should not be crushed or chewed.

CONCLUSION: The combination of aspirin and dipyridamole may be better than aspirin alone in the prevention of stroke in patients with a prior history of stroke or TIA according to data from the European Stroke Prevention study 2 trial. This trial analysis was also the basis for a similar declaration in the Chest guidelines on stroke prevention

(grade 1A) Since the studies done with *Aggrenox* used a special formulation of aspirin and dipyridamole, the results of these trials cannot be applied to the combined use of separate prompt-release aspirin and dipyridamole products. Clinical comparisons of this formulation with ticlopidine and clopidogrel are not available.

Pletal (Cilostazol) is approved for use in the treatment of intermittent claudication. The drug is also being studied for use in post-stroke syndrome, the prevention of recurrent stroke, prevention of thrombosis and restenosis after stent placement, prevention of restenosis after angioplasty and the prevention of graft occlusion.

CLINICAL PHARMACOLOGY: Cilostazol is a potent and selective inhibitor of cGMP-inhibited cAMP phosphodiesterase (PDE type 3, PDE3). Cilostazol inhibits platelet aggregation, including platelet aggregation induced by stress, ADP, collagen, arachidonic acid and epinephrine.

PHARMACOKINETICS: Peak plasma concentrations occur 2 to 4 hours after oral administration. Absorption appears unaffected by administration with food. Peak anti-aggregatory effects are observed at 6 hours after oral administration. Cilostazol is extensively plasma protein bound, primarily to albumin. The mean terminal half-life is 12 to 26 hours, although it has not been well characterized due to apparent biphasic elimination. The distribution half-life is 2 to 3 hours, and the terminal half-life is 18 to 26 hours. Cilostazol is metabolized primarily by hydroxylation to numerous metabolites, which have half-lives comparable to the parent drug. Unchanged cilostazol is not detected in the urine. Pharmacokinetics have not varied with age or by gender.

ADVERSE REACTIONS: The most common adverse effects are headache, diarrhea, abnormal stools (loose stools), palpitation and dizziness, with headache occurring most frequently. Discontinuation of therapy due to side effects was reported for 16% of cilostazol-treated patients compared to 9% of placebo-treated patients in clinical trials. Headaches were most frequently described as mild and responded to nonprescription analgesics. Animal studies have shown cardiovascular lesions, including endocardial hemorrhage, hemosiderin deposition and fibrosis in the left ventricle, hemorrhage in the right atrial wall, hemorrhage and necrosis of the smooth muscle in the wall of the coronary artery, intimal thickening of the coronary artery and coronary arteritis and periarteritis. Pregnancy data are not currently available. In animal studies, cilostazol was excreted in breast milk at concentrations of 41% to 72% of blood concentrations.

DRUG INTERACTIONS: Drugs that inhibit the CYP3A4 and CYP2C19 isozymes will decrease the clearance and increase the peak plasma concentrations of cilostazol or its metabolite. Examples of CYP3A4 inhibitors are ketoconazole, itraconazole, erythromycin, diltiazem and grapefruit juice. An example of a CYP2C19 inhibitor is omeprazole. Erythromycin increases the peak plasma concentration of cilostazol by 47% and the AUC by 73% and increases the AUC of the 4'-trans-hydroxy-cilostazol by 141%. Diltiazem increases the peak plasma concentration by 53% Omeprazole does not affect the metabolism of cilostazol, but does affect the elimination of the 3,4-dehydro-cilostazol metabolite. The levels of this metabolite are increased by 69%. Aspirin plus cilostazol may further

decrease platelet aggregation, but it has no clinically significant impact on bleeding time compared to aspirin alone.

DOSING: Cilostazol has been dosed at 100 mg twice daily in the treatment of intermittent claudication and in the treatment of ischemic symptoms such as ulcer, pain and cold sensation due to severe peripheral arterial disease. The recommended adult dosage of cilostazol is 100 mg twice daily. The tablet should be taken at least half an hour before or 2 hours after breakfast and dinner. A lower dose (50 mg twice daily) should be considered if the patient is receiving concurrent therapy with ketoconazole, itraconazole, erythromycin, diltiazem or omeprazole. The patient should also be instructed to avoid grapefruit juice. Safety and effectiveness studies have not been conducted in children.

CONCLUSION: Cilostazol appears to produce moderate improvements in walking distance in patients with intermittent claudication and may prove useful as an alternative to pentoxifylline in this indication. Recent mutlticenter, randomized, placebo-controlled trials have shown its benefits with stable PAD compared with placebo and pentoxyfylline.

Dr Shaheen presented data on 200 patients that were treated with Chirociane (levobupivicaine) vs. ropivicaine for peripheral nerve blocks. According to his presentation, patients receiving levobupivicaine obtained a satisfactory level of blockade comparable to bupivicaine and ropivicaine. Additonally, the duration of action was comparable to bupivicaine, but this activity was provided without concerns related to the potential cardiotoxicity associated with large instillations of bupivicaine. The duration of effect was superior to that associated with ropivicaine, and can be provided at a lower cost compared with that agent.

INDICATIONS: Levobupivacaine is indicated for the production of local or regional anesthesia for surgery and obstetrics, and for post-operative pain management..

CLINICAL PHARMACOLOGY:
Bupivacaine is a racemic agent composed of R-(+) and S-(--) enantiomers. Levobupivacaine (S-(--)-bupivacaine) is an enantiomer of bupivacaine. Due to its long duration of action, bupivacaine is the most frequently used local anesthetic in epidural and peripheral nerve anesthesia; however, it is associated with considerable central nervous system and cardiovascular toxicity. The R-(+) enantiomer of bupivacaine is associated with greater CNS and cardiac toxicity. R-(+) bupivacaine is more potent than S-(--)-bupivacaine with regard to blocking of sodium and potassium channels. Because the R-(+) enantiomer is more potent at blocking cardiac sodium channels, the S-(--) enantiomer was pursued in hopes it would be associated with less cardiac toxicity. Ropivacaine, a propyl homologue of bupivacaine, is also an S-(--)-enantiomer which offers an improved safety profile compared to bupivacaine.

In animal studies, bupivacaine decreases cardiac output, myocardial contractility, myocardial blood flow, and intracardiac conduction velocity, and induces ventricular arrhythmias. Levobupivacaine also induced

QRS widening and ventricular arrhythmias, but at higher doses than bupivacaine and the reactions occurred less frequently and were less severe. In animal studies, levobupivacaine was also associated with less CNS toxicity than bupivacaine.

Levobupivacaine causes more vasoconstriction than the other enantiomer, resulting in delayed drug uptake from the site of administration and prolonged clinical effect

No studies compared levobupivacaine and ropivacaine.

CONTRAINDICATIONS, WARNINGS, AND PRECAUTIONS: Levobupivacaine is contraindicated in patients with a known hypersensitivity to levobupivacaine or to any local anesthetic of the amide type. Levobupivacaine should not be used for intravenous regional anesthesia (bier block) or for obstetrical paracervical block anesthesia.

Unintended intravenous injection may result in cardiac arrest. Prolonged resuscitation may be required. Levobupivacaine should be administered in incremental doses. Since it should not be injected rapidly in large doses, it is not recommended for use in emergency situations where a rapid onset is desired.

Levobupivacaine should be used with caution in patients with hepatic dysfunction, hypotension, hypovolemia, or impaired cardiovascular function, particularly heart block.

Levobupivacaine is included in Pregnancy Category B. Caution is recommended when levobupivacaine is administered to a nursing woman. The excretion of levobupivacaine or its metabolites in human milk has not been studied.

The safety and effectiveness of levobupivacaine in pediatric patients have not been studied.

ADVERSE REACTIONS: Adverse effects observed in more than 5% of levobupivacaine-treated patients in studies have included hypotension, nausea, post-operative pain, fever, vomiting, anemia, pruritus, pain, headache, constipation, dizziness, and fetal distress. Levobupivacaine may produce small increases in the PR interval and the corrected QT interval.

In animal studies, convulsions and excitatory CNS symptoms occurred at a lower dose with bupivacaine than with levobupivacaine.

DRUG INTERACTIONS: Although studies have not been conducted, it is likely that CYP3A4 inducers and inhibitors and CYP1A2 inducers and inhibitors may affect the metabolism of levobupivacaine.

DOSING: Dosage recommendations for levobupivacaine are included in the product labeling and vary according to its indication for use.

CONCLUSION: Dr Shaheen presented some data for use of levobupivicaine in lieu of ropivicaine in selected procedures. Levobupivicaine appeared to provide a level

of effectiveness comparable with bupivicaine and ropivicaine without the potential cardiotoxicity of the former and for a longer period of time than the latter. Additionally, levobupivicaine provided a cost advantage vs. ropivicaine in the population observed.

Drug interactions with enteral products
A revision to the policy coordinating the time of administration of selected medications with enteral feedings was approved. Pharmacy will be placing an interaction notice on the Nursing Medication Administration Record (MAR) to more clearly identify 'problem' issues and the recommended resolutions. A copy of the notification form is included below:

Lehigh Valley Hospital-Muhlenberg Hospital
Enteral Feeding/Drug Interaction Notice

Patient Name:_____
Nursing Area:_____
Date:_____

As per the Therapeutics Committee, the following agents have been identified as requiring administration on an "empty stomach". Your patient is currently receiving the drug(s) checked below. Please, follow the instructions appropriate to each item and adjust your MAR accordingly. If you have any questions, please, contact the Pharmacy.

___ lansoprazole (Prevacid)-stop tube feeding 1 hour per- and post dose.

___ phenytoin (Dilantin)- stop tube feeding 2 hours pre- and post dose

___ theophyllin- stop tube feeding 1 hour pre- and post dose.

___ levothyroxine (Synthroid, Levoxyl)-stop tube feeding 1 hour pre- and post dose

___ digoxin (Lanoxin)- stop tube feeding 1 hour pre- and post dose. ONLY IF SUPPLEMENT CONTAINS FIBER (i.e., Jevity)

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___ quinolones (Ciprofloxacin,Cipro;Levofloxacin,Levaquin)-stop tube feeding 30 minutes pre- and 1 hour post dose.

Please, adjust the tube feed goal rate accordingly.

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Pennsylvania Medical Society Physician Alert

(This information is bring provided to you by Robert X. Murphy, Jr., MD, OMSS Representative)

Subject: Medical Liability Matters

Liability Reform Action Center: 1-800-566-TORT (8678)

State Society's Medical Liability Reform Legislation Readied for Spring 2001 Introduction

While opposing several ill-advised CAT Fund reform measures now under House and Senate committee study, the Society is readying its legislative proposal for medical liability reform for introduction. The Society's proposal includes:

* CAT Fund reforms, and possibly abolishment, without financially burdening physicians, particularly young physicians who had nothing to do with the current crisis.

* A collateral source rule that allows juries to be informed if the victim will be compensated by other sources for losses such as wages and health care costs.

* A voluntary arbitration system that would be binding only if the patient chooses to sign a contract. Act 111 of 1975 included mandatory binding arbitration, but that portion of the measure was struck down by the courts.

* An expert witness rule that requires the witness to be board-certified if appropriate, and have the same qualifications as the defendant.

* Measures to clarify informed consent language in the existing law.

* Compensation for the PIC and PIE insolvencies to offset one year of these costs.

* Measures to strengthen the medical, osteopathic, and podiatric boards that would enable the boards to hire additional staff and to fully implement the boards' authority.

* An exemption for retired physicians from current mandatory CAT Fund participation.

The Society's legislative strategy is a multi-phase approach, with the initial measure introduced in 2001 and successive long-term measures. We believe that the answer to gaining medical liability reform lies in a mix of medical liability insurance, tort, and CAT Fund reforms that are strong enough to withstand attempts by the legislature to water them down and by the courts to strip them of any authority.

At the same time that our initial legislative measures move forward, we will continue to work toward judicial and legal system reforms, greater public awareness of the urgent need for reform, and developing patient safety and quality initiatives.

Key to the Society's long-term campaign is the enactment of a constitutional amendment to remove the state's prohibition against caps on non-economic damages. Because this requires a multi-year legislative procedure and a public referendum, the Society is preparing to commit substantial resources to this goal.

Watch for further details as the Society moves these reforms forward in the next few weeks. Go to http://www.lrac@pamedsoc.org/ www.lrac@pamedsoc.org, or call the LRAC for more information at 1-800-566-TORT (8678).

Doctors Descend on Lawmakers in Capitol on Tuesdays

On Tuesday, March 13, the halls of the Capitol were dotted with white coats as more than 120 physicians from southeastern Pennsylvania loudly warned lawmakers of the urgent need to "Save Pennsylvania Medicine." This was not a rally on the scale of the 1996 "Tort Reform Now!" statewide physician rally held by the Society, but rather the first in a series of waves of physicians to descend upon Harrisburg's legislators on Tuesdays from now until the close of session in May. Another 50 physicians joined the fray on March 20, and hundreds more are slated to come later this spring.

The strategy this time around, said State Society President Carol E. Rose, MD, is to "tell them our stories." Physicians must come to Harrisburg to personally tell lawmakers their stories about how the medical liability crisis is affecting their ability to serve their patients in their communities. "Tell them how you can't recruit a partner; why you're retiring early; how you've put off buying new equipment or cut back on higher-risk procedures like delivering babies," Dr. Rose told participants.

"We couldn't have had a more eloquent, impassioned group of physicians than we had today," Roger Mecum, the Society's executive vice president, said following the first "Tuesdays in Harrisburg" event. He noted that legislators were responding positively to the physicians' visits, and the event received wide media coverage.

The physicians were also asked to briefly explain to legislators why the Society opposes House Bill 649 and Senate Bill 556. Both bills would privatize the CAT Fund. While the Society supports privatization, we believe the bond proposal in HB 649 would be far too costly and would essentially mortgage the future for physicians.

Physicians are urged to join us by region for Tuesdays in Harrisburg. Dates still available are April 24, May 1, May 8, and May 22. If you'd like to join us at the Capitol, call the Liability Reform Action Center at 1-800-566-TORT (8678) for more information.

What's Your Story? We Care!

Our recent experience in the Capitol proves one basic political rule: The story of the individual always makes the greatest impact to the press and lawmakers. Physician's individual accounts of how the medical liability crisis is changing their relationships with patients and with their communities are the most powerful tools we have to get our message across.

What's your personal story?

* Has the cost of my medical liability premiums caused my colleagues or me to practice medicine differently in 2001 than we did in past years? How has this affected my patients or my community?
* Has my practice or my hospital, or any other health care facility in my community, had difficulty recruiting new physicians? What comments have new doctors made about practicing in Pennsylvania?
* Have medical liability premiums changed my retirement or business decisions?
* In five years, if the medical liability crisis continues, what affects to their access to health care could my patients expect to suffer? How will my relationship with my patients be different?

Once you have composed answers to these questions, tell the governor, your patients, your legislators, and the State Society your story. It's important to focus on the impact on your patients and your community-and to stick to that point! You can make a difference.

What Can YOU Do?

Call the governor: Call Tom Ridge at (717) 787-2500. Let him know you will detail your experiences in a personal letter. Be sure to fax a copy to the Society at (717) 558-7840.

Tell us how the crisis affects your practice and your patients:

Is it difficult to hire new physicians? Thinking of retiring? Have you cut back on services? Laid off staff? Email us at lrac@pamedsoc.org <mailto:lrac@pamedsoc.org> or fax (717) 558-7840, telling us how skyrocketing premiums and CAT Fund payments have affected your practice.

Identify your legislator: To identify your legislator, go to www.pamedsoc.org <http://www.pamedsoc.org/> , click on advocacy & information, legislation/regulation, "look up your congressman."

Join PAMPAC: Trial lawyers give generously to their political action committee (PAC). Doctors don't. Send a personal contribution to PAMPAC, Box 8820, Harrisburg, PA 17105-8820.

Help us contact local media: Know any local media personalities? Call Chuck Moran, ext. 1437.

Come to Harrisburg: Join us at the Capitol-call the Liability Reform Action Center for information at 1-800-566-TORT.

Get your patients involved:

Brochures and posters are available from the LRAC.

Got Them On Hold?

Here's a sample of the type of message you can record for those on hold with your office:

Thank you for holding. We will serve you as quickly as possible. While you wait, you may be interested to know that there is a medical crisis in Pennsylvania. The high cost of malpractice insurance is driving physicians out of the state. Other physicians aren't doing high-risk procedures anymore. And young physicians aren't coming to our state to practice. Politicians in Harrisburg are slow to take action because lawyers who sue doctors make big campaign donations. When you can't find a doctor, what will you do? Act now. Ask us for details on how you can help save Pennsylvania medicine.

Answering machine messages for patients

A very brief message inserted into your answering system may help break the ice in discussing the crisis with patients. Here are some suggestions:

Message 1: Hello. You have reached [name of practice]. Our top priority is preserving a positive relationship with our patients. That's getting harder and harder in the face of the medical liability crisis in Pennsylvania. Ask us for details....

Message 2: Hello. You have reached [name of practice]. When you come to see us, please ask us about the medical liability crisis in Pennsylvania. We think you'll be interested by what you hear...

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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.