Published for the Medical Staff of Lehigh Valley Hospital

Volume 15, Number 5

May, 2003

Medical Staff PROGRESS NOTES

Inside This Issue:

LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

Leadership Positions Announced

On April 16, two important leadership appointments were announced that will allow LVH-Muhlenberg to continue to grow and provide the highest quality care to meet the community's needs.

Gavin C. Barr, MD, has accepted the new position of Senior Medical Consultant for Physician Network Development. As a senior member of the physician practice and network development team, Dr. Barr will be responsible for advising the Chief Medical Officer, all Department Chairs, and other members of the LVHHN management team on issues related to physician network development.

The significant growth at LVH-M requires a strong focus on building relationships with physicians and physician practices. Dr. Barr's nearly 40 years of physician leadership in Northampton County and the region make him uniquely qualified for the role of Senior Medical Consultant. Dr. Barr's pioneering innovations in practice development and anticipation of health care trends over the years allow him to provide insights that are invaluable as LVH-M continues to grow.

With Dr. Barr assuming his new role, **Robert X. Murphy, Jr., MD**, has been named Medical Director of LVH-Muhlenberg. He will be the senior, on-site LVH-M physician executive, responsible for quality improvement, patient safety and care management. Dr. Murphy's record of medical excellence and his experience as a past president of LVHHN's Medical Staff will serve him well in this leadership position. He will report to the Chief Medical Officer.

Best wishes to Dr. Barr and Dr. Murphy for much success in their new endeavors. Their new positions are effective on May 1, 2003.

Beginning with this issue, the editorial staff is pleased to introduce a new look for ***Medical Staff Progress Notes***, the monthly newsletter for and about members of the Medical Staff of Lehigh Valley Hospital.

From the President

"*Throw away, in the first place, the ambition beyond doing the day's work well.*" -Sir William Osler, Aphorisms, 1905

"Democracy is the worst form of Government. Except for all the others." -Sir Winston Churchill

Politicians command little respect, can make little change, and find themselves sliding irrevocably down the razor blade of public opinion. Politicians don't like to make big decisions because they find their voting record coming back to haunt them in re-election campaigns. Politicians are forever balancing each constituent's wishes against lobbyists concerns, party leaders pet projects, and the winds of change. Let's face it: politics is one messy, murky, dusty, dirty, but necessary evil of a just society.

No wonder doctors usually avoid politics like the plague. Many of us make complex decisions on a daily basis, where we can, in a moment, change the outcome for our patient. We usually command the respect of our patients, warranted or unwarranted. We are advocates for our individual patients, and don't usually concern ourselves with how society will pay for all the care we provide. Politics and medicine mix like oil and water, and our discomfiture with the political process is a symptom of our intrinsic disdain for the messiness of political discourse.

This is perhaps why physicians are poor when it comes to giving to politicians for political campaigns. We don't tend to vote in elections, we don't often run for office, and we don't campaign for local politicians. We tend to leave this to the trial lawyers, who seem to enjoy such activities. It's a mark of the deep discontent caused by the rapid escalation of malpractice costs, and the increasing difficulty of procuring malpractice coverage, that apolitical physicians have finally become politically energized.

Now is the time for action, but what action? We know that our ability to continue to practice ethical medicine in Pennsylvania is endangered by the exponential ratcheting up of malpractice premiums. We know of members of our staff who have had difficulty even obtaining insurance, though there are no instances of physicians being completely unable to obtain this commodity. We know that another 100% increase in costs, with no mechanism of offsetting this levy, will cause some among us to look around for greener pastures elsewhere. Some will stop providing care which, while needed, is high risk. The issue for the public, the politicians, and for us, is access to care. The business of doing the day's work well is at risk in the larger currents of change besetting us. So what action or actions should we take to make sure this issue is dealt with in a manner that will achieve the goal of stabilizing the cost of medical malpractice and ensuring that it is available to practicing physicians?

- www.keepdocsinthevalley.org

  The ball is already rolling with www.keepdocsinthevalley.org. Some 23,000 signatures, both on petitions and over the Internet, have made it to the legislature to let them know about the public's concern about access to care and the threat that the medical malpractice crisis presents. I encourage you to promote this site and encourage your patients to visit it.

- State Political Activities

  At the state level, you may be best served by pushing the MCARE surcharge relief promised by the Governor. This pledge is to eliminate the 2003 surcharge for OB/GYN, orthopedic surgery, neurosurgery and general surgery, as well as provide a 50% reduction for all other disciplines. This comes with a cost of $300 million, so it will need some major political support to carry through. Senate Bill 50 is a bill that would allow for capping jury awards in tort cases via a PA constitutional amendment. This is a tough, long-term process, requiring passage by two consecutive sessions of the legislature, and then approval by referendum on the ballot.

  The bottom line at a state level is for you to contact your state representative and senator about the situation, express personal true stories about your own malpractice insurance experience, and reinforce the theme that access to care for their constituents is the issue. To determine your state representative and senator, visit www.house.state.pa.us/.

- United States Senate

  At the present time, the U.S. Senate is the most important place to throw your political energies. Doctors should be encouraged to contact Senators Santorum and Specter on this matter. The U.S. Senate is expected to debate medical liability reform in May or June, so time is of the essence.

  The HEALTH Act (H.R.5) establishes a ceiling on non-economic damages and guidelines for the award of punitive damages, only in those states where the state legislature has failed to act. A state legislature may also act at any time in the future to impose a cap that limits of which differ from those provided for in the HEALTH Act.

Continued on next page

The bill does not set any limits on economic losses for plaintiff's lost wages/earnings, medical expenses, rehabilitation, and custodial care. Patients are not being denied care with this bill, just incalculable payments which amount to a lottery, not an appropriate recompense for damages. Juries receive little or no guidance on how to value non-economic damages like pain and suffering, and have no quantitative standards to guide their determination of these awards. These non-economic damages vary widely for cases of similar severity. This is not at all just; it is just capricious.

From 1975 to 2000, medical liability insurance premiums rose 167 percent in California, 505 percent in the nation, and 1400 percent in Pennsylvania. More than one-half of Pennsylvania's hospitals report having trouble filling vacant physician positions. More than one-third of Pennsylvania's hospitals report that services have had to be closed, curtailed, or limited due to physician leaving or reducing their practices. California's medical liability system, which includes a $250,000 dollar cap on 'pain and suffering', has effectively contained medical liability costs. In 2000, patient medical liability payments per capita in California were $5.95. In Pennsylvania, these payments were over seven times this amount.

Now is the time to contact Senators Specter and Santorum. Encourage your patients, friends and colleagues to follow suit. Calls from constituents count and are counted. Please refer to the handy phone number reference list provided for your convenience.

In the long run, this is a long run. We need to be politically active and on target with our action. We need to emphasize the risk to access to care for the politicians' constituents. We need to hammer the point home to politicians at different levels, over a long period of time. We need to donate to their campaigns to emphasize our commitments to this cause.

Handy Telephone Reference

AHA Liability Reform Hotline:
1-800-826-9658

U.S. Senator Arlen Specter

Philadelphia District Office:
215-597-7200
Washington, DC Office:
202-224-4254
Email:
arlen_specter@specter.senate.gov

U.S. Senator Rick Santorum

Philadelphia Office:
215-864-6900
Washington, DC Office:
202-224-6324
Website:
www.senate.gov/~santorum/

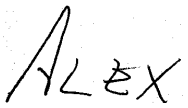
We should also think of what other ways our patients' needs should be represented politically. We should be advocating for some kind of insurance coverage for uninsured patients. We should be arguing for a reduction in prescription drug costs, better long-term care, and a reduction of catastrophic payouts for patients with prolonged illnesses. We need to emphasize that our political interest extends beyond our pocketbooks.

We should not consider walking out or joining organized job actions. We should not withhold care for political reasons. All actions that reduce or remove services are counter productive to the political message that access to patient care is our concern. If I were the public, I would wonder how a physician who cannot afford to pay malpractice premiums has enough money to close his or her office to protest paying premiums. If I were the public, it just wouldn't add up to me.

On a personal note, I will reflect on a physician strike that I was involved in while in my residency in Ontario. The attending physicians walked out for two months to support a reasonable cause, that of being able to 'opt out' of the Ontario Health Insurance Plan (the single payer system of care). Initially, public opinion was with the doctors, but as days turned into weeks, the public and media turned against the physicians, characterizing them as greedy and disinterested in the needs of their patients. Ultimately the strike was a dismal failure, physicians returned to work and lost forever their right to work outside of the governmental insurance scheme. I had the opportunity to keep working while the staff physicians walked out. I tried to do my best, but I'm sure many patients went uncared for during the long two-month strike. Not only am I against striking and job actions on the grounds that withdrawing care is counter to the message and spirit of our political battle, but I am also arguing that these actions are counterproductive and very likely to turn our present allies, our patients, against us. Think before you leap, let the messy political process play out, speak up and let your voices be heard.

Throw away, in the first place, the ambition beyond doing the day's work well. Preserving the ability to do the day's work well, that's what this is all about.

A special thanks to Brent Ennis, Director of Government Relations, for background information and suggestions.



Alexander D. Rae-Grant, MD
Medical Staff President

Spotlight on . . .

Daniel E. Ray, MD

Born in Bowling Green, Ohio, Dr. Daniel Ray completed his undergraduate education at Boston College where he earned a Bachelor of Arts degree. He received his medical degree from Ohio State University College of Medicine. He completed a three-year Internal Medicine residency at the Medical College of Wisconsin Affiliated Hospitals where he also completed a three-year Pulmonary and Critical Care Medicine Fellowship.

Dr. Ray is certified by the American Board of Internal Medicine in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. In addition, Dr. Ray was recently notified by the American Board of Hospice and Palliative Medicine that he has received certification in Hospice and Palliative Medicine. Dr. Ray joins more than 1,200 fellow physicians in North America who have achieved this certification; however, he is one of only 30 in Pennsylvania, and one of only three in the Lehigh Valley.

Dr. Ray joined the hospital's Medical Staff in 1998. He is a member of the Divisions of Pulmonary and Critical Care Medicine, and is in practice with Pulmonary Associates.

Dr. Ray is the Fellowship Director of the Pulmonary-Critical Care Program, the Medical Director of the Special Care Unit, the Medical Director of Respiratory Therapy, and Assistant Medical Director of the Medical Intensive Care Unit. He is an Assistant Professor of Clinical Medicine at Pennsylvania State University College of Medicine.

In addition to being published and involved in numerous research activities, Dr. Ray is the principal investigator for a grant funded initiative in palliative care (see article on Pages 8 & 9).

On a more personal note, Dr. Ray and his wife, Amy, have two daughters -- Gretchen and Abigail. In his spare time, he enjoys restoring an 1804 stone farmhouse and raising chickens, dairy goats, and miniature donkeys. He is also an avid skier.

In conclusion, Dr. Ray has the following comment to share with his colleagues on the Medical Staff: “Caring is state of mind, not additional work”.

At-Large Members Needed for Medical Executive Committee

The Lehigh Valley Hospital Medical Staff Nominating Committee is soliciting nominations for six at-large seats, each for a three-year term beginning July 1, 2003, on the Medical Executive Committee.

Nominations should be submitted in writing to Donald L. Levick, MD, Chairman of the Nominating Committee, via the Medical Staff Services Office, Cedar Crest & I-78, or verbally to John W. Hart, Vice President, Medical Staff Services.

All nominations must be submitted by Thursday, May 15, 2003.

If you have any questions regarding this issue, please contact Dr. Levick or Mr. Hart at (610) 402-8980.

EAU vs. ECU

Confusion seems to set in when referring to the EAU and the ECU. To help clarify the difference in these units, following is a brief overview of both.

The EAU, or **Express Admit Unit**, is a 6-bed unit located on the second floor in the area previously occupied by SICU. This unit is designed for any direct admit patients coming in from physician offices or directly from home. Patients here are admitted to the floors.

The ECU, or **Express Care Unit**, is a 5-bed area adjacent to the Emergency Department that is used specifically for patients who have minor injuries such as sprains, strains, simple lacerations, etc. Patients here do NOT get admitted. This area is staffed by Physician Assistants and Registered Nurses.

News from CAPOE Central

Communication to Nursing Order -- Because You Asked For It

In response to requests from the CAPOE users, a new order -- "Communication to Nurse" -- has been created. Users have requested a generic order to communicate with the nursing staff, and for patient care orders that either do not exist in the system or cannot be easily found. The "Communication to Nurse" order is located under the "NURSING" button in the "NOTIFY" list. This order is NOT to be used to order medications or diagnostic tests. Medication and diagnostic orders require specific detail and must interface with other systems. The "Communication to Nurse" order should be used for special circumstances in which detail is required to clarify an order or instruction to the nursing staff. The use of this order will be monitored for appropriate usage. If you are unsure about the use of this order, please contact someone from the CAPOE Support Team.

A Hearty Welcome to 4C and TOHU as they join the CAPOE ranks

Late in April, 4C and TOHU went live with on-line charting of vital signs, I&O's and medications. The nursing staff handled the training exceptionally well, and was eager to begin using the system. Early in May, these two units will be turned on as CAPOE units. Thus, all CAPOE trained physicians will be able to enter all their orders on-line while on 4C and TOHU. A date is being finalized to bring 4A live. Please look for notices regarding when this unit will go live.

More About Care and Feeding of Your LifeBooks

Several calls have been received about the LifeBooks losing connectivity in various areas of the hospital. The wireless network is constantly monitored for activity. The ongoing construction at Cedar Crest & I-78 has created some intermittent 'dead zones.' However, these have been actively resolved once they are reported. Please continue to contact the CAPOE team if you find any dead spots. Another reason that the LifeBooks lose connectivity is related to inactivity. When the LifeBook is inactive or in sleep mode for more than 20 minutes, the connectivity to the wireless server may be lost. To reconnect, the user needs to log all the way out of NeonSecure, close and reopen NEON. Logging out of Lastword is not adequate for the hardware to reconnect. Proper shutdown of the LifeBook is also essential. To shut the device off properly, use the START>Shutdown options from Windows. Do not use the power button that turns the device on. Pressing this button only places the device in a suspend mode and will cause a connection error if left idle for more than 20 minutes.

If you want your meds given ASAP -- Check the Box

Please remember that when ordering meds, it is important to let the Pharmacy know that you would like a dose given right away. If you type in the comment field to "give first dose right away" then the system will not know to time the first dose appropriately. Pharmacy can re-time the order, but this may cause delays in the administration of the first dose. The better (and easier) way is to click the "START ASAP" checkbox, located in the lower left portion of the med detail screen. By checking this box, a dose will be ordered right away, and the remaining doses will be scheduled appropriately. Please look for and use this button when ordering medications to be given right away.

Don Levick, MD, MBA
Physician Liaison, Information Services
Phone: (610) 402-1426
Pager: (610) 402-5100 7481

Coding Tip of the Month

Guidelines for coding the excision of a lesion have changed effective January 2003. CPT coding guidelines for the excision of lesions have previously been based on the size of the lesion that was excised. New guidelines include the size of the lesion (at greatest diameter) plus the size of the margin that was required for complete excision.

Therefore, it is important for the physician to document in the operative note the size of the lesion that is being excised **and** the size of the margins that are excised in order for the appropriate CPT code to be assigned.

Changes in Medical Staff Services

On March 31, **Brenda E. Lehr** began her new position as Director of Medical Staff Services. Brenda has been a part of the larger LVHHN family for the past 24 years. In 1979, she began her career as practice manager for Cardiovascular Associates (now The Heart Care Group). For the past five years, Brenda has been with LVPG, first as practice manager for Oncology Specialists, and most recently as operation manager for nine specialty practices located on the Cedar Crest & I-78 campus.

Brenda received her Bachelor's degree in Business Administration-Management from Bloomsburg University. She is active in the Medical Group Management Association, PMGMA, and other professional organizations.

In her new position, Brenda will be responsible for overseeing the credentialing and privileging of over 1,100 physicians, dentists, and podiatrists on the Medical Staff and over 350 members of the Allied Health Staff. In addition, Brenda will provide support to the Medical Staff leadership and oversee the administrative support for various Medical Staff functions and committees, including Bylaws, General Medical Staff, and Medical Executive Committee.

Brenda is located in the Medical Staff Services office on the first floor of Lehigh Valley Hospital, Cedar Crest & I-78. She may be reached by e-mail at brenda.lehr@lvh.com or by phone at (610) 402-8975.

Pat Skrovanek, who has served in the role of Director for the past nine months, has returned to her first love as a Physician Liaison in the Physician Network Development Department under the direction of Edward Dougherty. She has joined Andrea Parry and Kathleen Leto who also serve as Physician Liaisons.

Pat is located in Physician Network Development on the first floor of 1770 Bathgate on the LVH-M campus. She is available by e-mail at patricia.skrovanek@lvh.com, by phone at (484) 884-9293, or by page at (610) 402-5100 3089. Her fax number is (484) 884-4913. The main number for Physician Network Development is (484) 884-2020.

Smallpox Update

In mid- to late March, LVHHN began contacting 50+ individuals who identified themselves as potential volunteers for the smallpox vaccine to receive their pre-vaccination counseling/screening. At the same time, tension in the vaccination program was building with the notification of heart attacks and death in individuals who were recently vaccinated. None of the deaths was clearly tied to the vaccine; each of the individuals had defined risk factors for coronary artery disease known in their medical history. However, the Centers for Disease Control and the Advisory Committee on Immunization Practices took quick and decisive action -- additional screening criteria was added to enhance the safety of the smallpox vaccination program. LVHHN Employee Health Service reacted immediately to update pre-vaccination counseling information.

Pennsylvania continues to move forward with its program reporting 83 vaccinated statewide as of Friday, April 4. In mid-April, 12 individuals working for the Suburban General Hospital in Pittsburgh were the first health care workers vaccinated in Pennsylvania; county and hospital representatives were very generous in sharing processes and experiences with LVHHN. Vaccination of volunteer LVHHN employees will occur in early May. The exact numbers will be unknown until that point as individuals have been screened out for medical contraindications and are making self-determinations as to whether the vaccine and associated lifestyle changes are right for them. Employees who do receive the smallpox vaccination require fit-for-duty evaluation/dressing check prior to their duty shifts. ***Non-employee providers who are vaccinated will also be required to participate in the evaluation/dressing check any day they will be seeing LVHHN patients.*** This information will be covered with them at the time of vaccination.

If you have any questions related to the smallpox vaccination program, please contact Debra Geiger, Project Manager, at (610) 402-4589.

Pennsylvania Act 13 (MCARE)

Over the past several months, educational sessions regarding Pennsylvania Act 13, Medical Care Availability and Reduction of Errors (MCARE), were held as part of clinical departmental meetings. For your information, following is a list of the most frequently asked questions related to Act 13.

1. ***What is a Serious Event?***
   A serious event is an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death OR compromises patient safety AND results in UNANTICIPATIED injury REQUIRING the delivery of ADDITIONAL health care services to the patient.

2. ***What are examples of Serious Events?***
   Wrong site surgery and medication errors that result in harm are obvious examples. However, many situations are not as easily definable and will require careful and individual analysis. For example, the law is NOT an attempt to collect a database of potentially ANTICIPATED complication. Therefore if a patient is harmed due to an anticipated complication, it is not a reportable serious event.

3. ***Who determines that the event is serious within the definition of the Act?***
   The licensed health care provider has the initial responsibility of identifying that a serious event has occurred and notifying the Patient Safety Officer through the 24 hour hotline, (610) 402-2830. The Patient Safety Officer, in consultation with the Vice President of Legal Services, will verify for the health care provider whether the event is serious.

4. ***What happens once an event is defined as serious?***
   Defining an event as serious triggers a series of responsibilities under ACT 13. The event must be disclosed to the patient, the disclosure discussion must be documented on the patient's medical record; the patient must be provided with a letter documenting that the discussion has occurred. In addition, a report must be provided to the State Department of Health within 24 hours of the event. This report is for data collection purposes only and has no identifiers such as patient's name, medical record number or health care providers' name.

5. ***Who discloses the event to the patient?***
   Under the Act, it is the licensed health care provider's responsibility to fulfill the requirements. Failure to meet the requirements of the Act for either notification to the facility (Patient Safety Officer) or disclosure to the patient will result in licensure consequences for the doctor or nurse.

6. ***What is the institution's responsibility?***
   The institution is responsible for monitoring compliance with the Act and for reporting to the State. The Patient Safety Officer will accompany the health care provider to assist in the discussion with the patient, if requested by the health care provider. Documentation by the Patient Safety Officer will be done in the Medical Record. The Patient Safety Officer, together with the physician, will provide a letter to the patient, if appropriate.

7. ***What is the role of the Patient Safety Council?***
   The Patient Safety Council, under Act 13, is composed of the Patient Safety Officer, health care workers, a member of the Board of Trustees, and community members. The Council is required to review all serious events and evaluate recommendations to eliminate future serious events. Information reviewed by this Council receives specific protection under the Law from discovery and admissibility in legal proceedings.

8. ***What is the purpose of the Patient Safety Act?***
   The purpose of the Act is to mandate reporting obligations in order to improve the safety of patient care.

If you have any questions regarding this issue, please contact Fran Miranda, Risk Manager/Patient Safety Officer, at (610) 402-2803.

Safety Pearl of the Month

Watch Out for Complacency!!

Complacency, which occurs when we let our experiences guide our expectations, diminishes our caution when participating in the medication use process and allows errors to get through the system. We are especially vulnerable to complacency when technology is used.

Palliative Care Initiative in the Medical Critical Care Unit

On March 1, 2003, the Medical Critical Care Program of LVHHN was awarded a grant through The Robert Wood Johnson Foundation to fund a demonstration project integrating the principles of palliative medicine into the ICU. The award was extraordinarily competitive with 242 submitted proposals and only four recipients.

Palliative medicine is *not* equivalent to hospice or end-of-life care. It is the management of patients with far-advanced diseases for which the prognosis is limited and the focus of care is quality of life. It recognizes the multi-dimensional nature of suffering and conveys mutuality, respect, and interdependence. Integrating basic premises of palliative medicine will be a compliment to the technology-driven rescue therapy found in the ICU. The goal of this project is to support a model in which patient's preferences and quality of life values are directly incorporated into the multi-disciplinary care plan. The culture will emphasize a patient/family-centered process that provides for the relief of suffering arising from emotional, social, and spiritual sources.

Medical Staff Progress Notes has committed to an ongoing column dedicated to the Palliative Care Initiative in the ICU. It is anticipated that the progress of this initiative will be shared as well as brief informational reviews of selected topics in palliative medicine and end-of-life care. Many of these topics will be obtained from the National Residency End-of-Life Curriculum Project sponsored by the Medical College of Wisconsin, Inc. These *Fast Facts and Concepts* can be downloaded from their website at www.eperc.mcw.edu

Title: Fast Fact and Concept #23: DNR Orders in the Hospital--Part 1

Author(s): Weissman, D.; von Gunten, C.

*This **Fast Fact & Concept** reviews the basic steps in discussing DNR (do not resuscitate) orders in the hospital setting. This could be used during ward rounds or in a conference discussing goal setting and DNR orders.*

Educational Objective(s): Review the steps in conducting a DNR discussion with a seriously ill patient in the hospital.

DNR discussions with seriously ill patients in the hospital should always take place in the context of the larger goals of care, using a step-wise approach[1]. Prior to any DNR discussions, physicians must know the data defining outcomes and morbidity of CPR in different patient populations[2].

1. Establish the setting
Ensure comfort and privacy; sit down next to the patient. Ask if family members or others should be present. Introduce the subject with a phrase such as: *I'd like to talk with you about possible health care decisions in the future.*

2. What does the patient understand?
Ask an open-ended question to elicit patient understanding about their current health situation. It is important to get the patient talking--if the doctor is doing all the talking, it is unlikely that the rest of the conversation will go well. Consider starting with phrases such as: *What do you understand about your current health situation?* or *What have the doctors told you about your condition?* If the patient does not know/appreciate their current status, this is time to review that information. An informed decision about DNR status is only possible if the patient has a clear understanding of his/her illness and prognosis.

3. What does the patient expect?
Next, ask the patient to consider the future. Examples of ways to start this discussion are: *What do you expect in the future?* or *What goals do you have for the time you have left-what is important to you?* This step allows you to listen while the patient describes a real or imagined future. Most patients with advanced disease use this opening to voice their thoughts about dying -- typically mentioning comfort, family, and home, as their goals of care. If there is a sharp discontinuity between what you expect and what the patient expects, this is the time to clarify. Listen carefully to the patient's responses; most patients have thought a lot about dying, they only need permission to talk about what they have been thinking. Setting up the conversation in this way permits the physician to respond with clarifying and confirming comments such as: *So what you're saying is, you want to be as comfortable as possible when the time comes,* or *What you've said is, you want us to do everything we can to fight, but when the time comes, you want to die peacefully.* Whenever possible, ask patients to explain the values that underlie their decisions: *can you explain why you feel that way?*

Continued on next page

4. Discuss a DNR order
Use language that the patient will understand, give information in small pieces. Don't introduce CPR in mechanistic terms (e.g. "starting the heart" or "putting on a breathing machine"). Never say, *"Do you want us to do everything?"* "Everything" is euphemistic and easily misinterpreted. Using the word "die" helps to clarify that CPR is a treatment that tries to reverse death. To a layman, when the heart and/or lungs stop, the patient dies.

If the patient and doctor mutually recognize that death is approaching and the goals of care are comfort, then CPR is not an appropriate medical intervention and a clear recommendation against CPR should be made. You can say: *We have agreed that the goals of care are to keep you comfortable and get you home. With this in mind, I do not recommend the use of artificial or heroic means to keep you alive. If you agree with this, I will write an order in the chart that if you die, no attempt to resuscitate you will be made.*

If the clinical situation is more ambiguous in terms of prognosis and goals of care, and you have no clear recommendation, the issue of DNR can be raised by asking: *If you should die in spite of all of our efforts, do you want us to use heroic measures to attempt to bring you back?* or *How do you want things to be when you die?* If you are asked to explain "heroic measures", then describe the purpose, risks and benefits of CPR in greater detail. The clinical pearl here is to start general and become specific later in the conversation.

5. Respond to emotions
Strong emotions are common when discussing death. Typically the emotional response is brief. The most profound initial response a physician can make may be silence, providing a reassuring touch, and offering facial tissues. (see future Fast Fact on responding to emotions).

6. Establish a plan
Clarify the orders and plans that will accomplish the overall goals you have discussed, not just the DNR order. A DNR order does not address any aspect of care other than preventing the use of CPR. It is unwise and poor practice to use DNR status as a proxy for other life-sustaining therapies. Consider using words: *We will continue maximal medical therapy to meet your goals. However, if you die in spite of everything, we won't use CPR to bring you back,* or *It sounds like we should move to a plan that maximizes your comfort. Therefore, in addition to a DNR order, I'd like to ask my hospice/palliative care colleagues to give you some information.*

If you have any questions regarding palliative care, please contact Daniel E. Ray, MD, Division of Pulmonary/Critical Care Medicine, at (610) 439-8856 or page him at (610) 776-5554.

References

[1]Buckman, R. How to break bad news: a guide for health care professionals. 1992, Baltimore: Johns Hopkins University Press.

[2]Junkerman, Charles and Schiedermayer, David. Practical Ethics for Students, Interns and Residents, 2nd Ed. University Publishing Group ISBN 1-55572-054-4

Patient Safety Video

Over the course of the past six months, the Patient Safety staff has worked with a local production company to complete a patient safety video. The purpose of the video is to educate physicians, staff and patients regarding Pennsylvania Act 13, Medical Care Availability and Reduction of Errors (MCARE).

The patient safety video is approximately 11 minutes long and covers the following patient safety goals: individual treatment plan, medication administration, surgical site identification, fall prevention, hand washing and discharge planning. The video is currently available for inpatients to view on Channel 50. In addition, plans are being evaluated to address video viewing for outpatients.

A copy of the video, titled “Patient Safety at LVHHN,” will be available for all physician practices. To receive your copy, please call Kelly Beauchamps, Patient Safety Analyst, at (610) 402-2787. Physicians are encouraged to offer the video during office visits for patient education to assist in promoting a patient safe environment.

Stay tuned for a campaign to adopt a patient safety slogan for the organization. In the meantime, remember PATIENT SAFETY benefits everyone!

If you have any questions regarding this issue, please contact Fran Miranda, Risk Manager/Patient Safety Officer, at (610) 402-2803.

News from the HIM Department

Electronic Signature – Effective April 14, 2003, ability to electronically sign Home Care orders and consultations was been added to the EHRM (Electronic Historical Medical Record) signature deficiency module, consistent with the goal to provide efficiency in document processing as well as a single source of electronic signature for the physicians.

Ongoing Medical Record Review – A multidisciplinary team composed of physicians, clinicians and Health Information Management (HIM) staff perform ongoing medical record reviews to assure that (1) patient care is appropriately documented and (2) documentation meets regulatory agency requirement.

The compliance standard established through the Medical Record Committee is 97%. Third quarter 2002 review identified the following opportunities for improvement:

	LVH	LVH-M	PI Initiative
History and Physical	**Compliance**	**Compliance**	
Medical history, including ♦ Chief complaint ♦ Details of present illness ♦ Relevant past, social and family histories Inventory of body systems	50%	52%	Opportunity: Documentation of family and social history and inventory of body
Report of relevant physical examination	88%	88%	Opportunity: Documentation of vital signs
Statement on conclusions or impressions drawn from the admission history and physical	96%	96%	
Statement on course of action planned for this episode of care and its periodic review as appropriate	100%	100%	
Consultations			
♦ Date ♦ Referring physician ♦ Consultant	50%	40%	Opportunity: Documentation of referring physician
Operative Reports			
♦ Primary surgeon and assistants ♦ Findings ♦ Technical procedures used ♦ Specimens removed ♦ Post-operative diagnosis	86%	84%	Opportunity: Documentation of pre-op diagnosis, post-op diagnosis, findings
Discharge Summaries			
♦ Diagnoses/procedures ♦ Reason for hospitalization ♦ Significant findings ♦ Procedures performed, treatment rendered ♦ Condition on discharge ♦ Instructions to patient/family ♦ Follow-up care	76%	88%	Opportunity: Documentation of final diagnoses

Following first quarter 2003 data collection, HIM will contact individual physicians regarding documentation improvement opportunities.

Documentation and Authentication in the Medical Record – Medical record documentation serves as a means of (1) communication between physicians and other members of the health care team, (2) evaluating adequacy and appropriateness of care, (3) substantiating insurance claims, (4) protecting legal interests of the patient and facility, and (5) providing data for research and education.

Documentation and authentication must:

- Be legible
- Include the caregiver's name and credentials

If you have any questions regarding this issue, please contact Zelda B. Greene, Director, Health Information Management, at (610) 402-8330.

Perioperative Services Performance Improvement Team Identifies Key Step to Improving First Case Start

For the last eight months, a dedicated team consisting of staff in the operating room, surgical staging unit, PACU, anesthesia, and surgery have focused performance improvements on reducing the turnaround time between cases and improving the number of first cases that go to the operating room on time. Up until now, this effort has been focused on the Cedar Crest & I-78 operating room, understanding that lessons learned will be easily translated to the other sites.

The team concentrated initially on first case time starts, mapped out the process, identified barriers to efficiency, and developed nearly 100 potential solutions. The potential solutions were evaluated based on five criteria, the most important of which was the effectiveness of the solution.

As it turns out, one of the major causes for delay in starting first cases on time is incomplete preoperative paperwork including: history and physical, surgical and anesthesia consent forms, and incomplete or inadequate pre-operative testing. Ultimately, one strong recommendation of the Perioperative Services Performance Improve Team is to schedule patients for a pre-admission testing (PAT) appointment at Lehigh Valley Hospital **even if, in the physician's opinion, no actual testing is necessary**. The purpose of this appointment is to begin the necessary nursing assessment process and for the patient to meet with a member of the Department of Anesthesiology. This appointment will avoid last minute "scrambling" that can occur as the patient is prepared for the operating room.

Please also note that the operating room regulations state that cases that do not have all complete paperwork cannot be scheduled as the first case in the room. The Central Document Processing department (CDP) contacts physician offices 48 and 24 hours in advance to collect any paperwork that is missing or incomplete.

If you have any questions regarding this issue, please contact Mark Holtz, Vice President of Operations, at (484) 884-4710, or Herbert C. Hoover, Jr., MD, Chair, Department of Surgery, at (610) 402-8338.

News from the Blood Bank

On April 16, 2003, the Blood Bank began phasing in the use of **Pre Storage** Leukoreduced Red Cells instead of using the bedside leukoreduction filter. These leukoreduced red cells are **prefiltered at the blood center and therefore, only require a routine blood filter at the bedside.**

This change is being made to provide a leukoreduced red cell product which has a better degree of quality control. Additionally, there have been problems with the bedside filter such as clogging and slow infusion rates.

Orders for leukoreduced red cells should **continue** to be written as "**red cells leukoreduced**". Either prestorage or a bedside filter (as a back up) will be issued. Bedside leukoreduction will generally be used in emergency situations or for patients with alloantibodies, when the prestorage red cells are not readily available.

All orders for blood transfusions should continue to specify whether Leukoreduced or Irradiated is needed as per LVHHN Leukoreduction & Irradiation Indications, approved by the Hematology/ Oncology Division in January and again in July 2002.

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

A Reminder from the Emergency Department

When admitting patients through the Emergency Department, to improve communication and enhance patient safety, please remember to designate all orders that require immediate attention as **STAT**, and ***verbally*** communicate this need to the ER nurses.

News from the Libraries

Ovid Training

To arrange for instruction in the use of OVID's MEDLINE and its other databases, please contact Barbara Iobst at (610) 402-8408.

Recently Acquired Publications

Library at 17th & Chew

- Handsfield. Color Atlas and Synopsis of Sexually Transmitted Diseases. 2001.
- Coulehan. Medical Interview. 2001

Library at Cedar Crest & I-78

- Delanty. Seizures. 2002
- Rucker. Low Back Pain. 2001

Library at LVH-Muhlenberg

- Physicians' Desk Reference. 2003
- Arndt. Manual of Dermatologic Therapeutics. 2002

If you have any suggestions for new books, please send them to Barbara Iobst in the Library at Cedar Crest & I-78.

"Partners in Your Care"©

"Partners in Your Care"© is strictly voluntary for the patient and non-punitive to the health care worker.

The Infection Control Department is launching an exciting new hand hygiene program, "Partners in Your Care"©. Patients will be educated by a member of the Infection Control team on hand hygiene and invited to become "Partners in Your Care"© by asking all health care workers who have direct contact with them the question, "Did you wash your hands?" The patient empowerment program is strictly voluntary for the patient and non-punitive to the health care worker. "Partners in your Care"© is scheduled to begin in May 2003 on TTU, 5B and 5C at Cedar Crest & I-78 and 4S at LVH-Muhlenberg.

Most studies on hand hygiene compliance show that health care workers wash their hands only about 48% of the time prior to patient contact. "Partners in Your Care" ©, was developed by the University of Pennsylvania where studies demonstrated a 35-40% **sustained increase** in hand hygiene compliance. "Partners in Your Care"© uses the patient as a continuous prompter for health care workers to improve their hand hygiene compliance. Participation in this patient empowerment program is consistent with the National Patient Safety Plan.

The amount of soap and alcohol hand sanitizer consumed on each of the designated floors will be measured to determine the success of the program in increasing the frequency of hand hygiene. It is expected that the program will be expanded throughout the inpatient facilities after the pilot phase is completed.

This program gives us, as health care workers, a great opportunity to partner with our patients to increase hand hygiene compliance.

If you have questions or for more information, contact Deborah Fry in Infection Control at (610) 402-0680.

Congratulations!

Karen E. Senft, MD, Division of Pediatric Subspecialties, Section of Developmental-Rehabilitation, was recently notified by the American Board of Pediatrics that she successfully passed the certifying examination and has become certified in Developmental-Behavioral Pediatrics.

Dr. Senft has been a member of the Medical Staff since October of 1986.

Papers, Publications and Presentations

✏ In late March, **Indru T. Khubchandani, MD**, Division of Colon and Rectal Surgery, was an invited speaker/surgeon at the University of San Martino, Genoa, Italy, where he performed Transanal Repair of Rectocele which was telecast to the auditorium. Other surgeons performed the repair by alternative approaches including transvaginal.

In addition, Dr. Khubchandani was a guest speaker at the meeting of the Italian Society of Colon and Rectal Surgeons on Cancer of the Rectum where he spoke on "Surgeons as a Factor in Prognosis." Dr. Khubchandani is a Visiting Professor at the University of Genoa.

✏ **Patrick J. McDaid, MD**, Division of Orthopedic Surgery/Hand Surgery, Section of Ortho Trauma, co-authored a book chapter for ***Current Clinical Neurology: Clinical Evaluation and Management of Spasticity***. The chapter is titled "Orthopaedic Interventions for the Management of Limb Deformities in Upper Motoneuron Syndromes."

✏ **Robert X. Murphy, Jr., MD**, Division of Plastic Surgery/Hand Surgery, Section of Burn; **Samina Wahhab, MD**, Division of Plastic Surgery; **Peter F. Rovito, MD**, Division of General Surgery; **Gregory R. Harper, MD, PhD**, Physician in Chief, Cancer Services; **Mark J. Young, MD**, Chair, Department of Community Health and Health Studies; and **Sharon R. Kimmel, PhD**, Senior Research Scientist, Community Health and Health Studies, co-authored the article, "Impact of Immediate Reconstruction on the Local Recurrence of Breast Cancer after Mastectomy," which was published in the April issue of ***Annals of Plastic Surgery***.

✏ **Michael D. Pasquale, MD**, Chief, Division of Trauma-Surgical Critical Care, and **William Bromberg, MD**, former Trauma Fellow, co-authored the chapter, "Applications of Tonometry in Critical Care," which appeared in ***Advances in Anesthesia***.

✏ **Paul F. Pollice, MD**, Division of Orthopedic Surgery, Section of Ortho Trauma, co-authored a book chapter for ***The Adult Knee: Volume II***. The chapter is titled "Principles of Instrumentation and Component Alignment."

✏ **Michael C. Sinclair, MD**, Chief, Section of Cardiac Surgery, **Raymond L. Singer, MD**, Chief, Section of Thoracic Surgery, and **Norman J. Manley, CCP**, and **Ralph Montesano, CCP**, Perfusionists, co-authored the paper, "Cannulation of the Axillary Artery for Cardiopulmonary Bypass: Safeguards and Pitfalls," which appeared in the March issue of the ***Annals of Thoracic Surgery***.

✏ **Craig J. Sobolewski, MD**, Chief, Division of Gynecology, and **Larry R. Glazerman, MD**, Division of Primary Obstetrics and Gynecology, attended Beyond Hysterectomy: The Contemporary Management of Uterine Fibroids -- An International Congress held April 11 to 13 in Scottsdale, Arizona. Dr. Sobolewski and Dr. Glazerman co-authored "In Situ Morcellation of the Uterine Body and Fundus During Laparoscopic Supracervical Hysterectomy," which was presented to the Congress by Dr. Sobolewski. In addition, Dr. Glazerman and Dr. Sobolewski co-chaired a luncheon roundtable at the Congress titled "Alternative Approaches to Removing Intra-abdominal Pathology - Morcellation vs. Colpotomy."

Upcoming Seminars, Conferences and Meetings

Computer-Based Training (CBT)

The Information Services department has computer-based training (CBT) programs available for Lehigh Valley Hospital (LVH) staff. CBT programs replace the instructor-led classes previously held at LVH. 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.

Topics covered by the CBT programs include:

Access 97	Windows NT 4	Excel 97
Word 97	GUI Email	
PowerPoint 97	PowerPoint 4.0	

Computer-based training takes place in **Information Services (Educational Room)** at **1245 S. Cedar Crest Blvd., First Floor** and in the **Lehigh Valley Hospital-Muhlenberg I/S training room** (*off the front lobby*). The schedule of upcoming classes is as follows:

2003 CBT Sessions for 1245SCC (Educational Room): *(All sessions will be held from 8 a.m. to noon)*

May 27 June 24 July 22 August 26

2003 CBT Sessions for LVH-Muhlenberg, I/S Training Room: *(All sessions will be held from noon to 4 p.m.)*

May 15 June 19 July 17 August 21

Twelve slots are available for each session. To register for a session in email, go to either the **Forms_/LVH** or **Forms_/MHC** bulletin board, (based on your choice of site and training room). The form has all the available information in an easy to choose format, detailing titles, dates, times and locations. Simply do a "Use Form" (a right mouse option) on the **I/S Computer Educ Request** form. Complete the form indicating your desired session selection and mail the form. Shortly thereafter, you will receive a confirmation notice.

If you have any questions, please contact Information Services by calling the Help Desk at (610) 402-8303 and press option "1." Tell the representative that you need assistance with I/S education.

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 LVH-Muhlenberg. Topics to be discussed in May will include:

- May 6 - "An Update on Cardiology"
- May 13 - "Cardiovascular Manifestations of Thyroid Disease"
- May 20 - **Stahler-Rex Symposium** - "Patient Safety - A Systems Approach"
- May 27 - "Hypertension Update: The ALLHAT Study"

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

Department of Pediatrics

Pediatric conferences are held every Tuesday beginning at 8 a.m. Pediatric conferences are held in the Education Conference Room 1 at Lehigh Valley Hospital, Cedar Crest & I-78, unless otherwise noted. Topics to be discussed in May will include:

- May 6 - "Constipation"
- May 13 - "Child Maltreatment: The Legal and Community Response" (Location Change -- Auditorium, Cedar Crest & I-78)
- May 20 - Case Presentation
- May 27 - Senior Resident Presentation

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

Surgical Grand Rounds

Surgical Grand Rounds are held every Tuesday at 7 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed in May will include:

- May 6 - "Evaluation and Treatment of Vocal Cord Paralysis"
- May 13 - "The Metamorphosis of Abdominal Aortic Aneurysm Repair in the Endovascular Era"
- May 20 - **Stahler-Rex Symposium** - "Patient Safety - A Systems Approach"
- May 27 - Cardiothoracic Division - TBA

Topics are also posted on the Auditorium and OR Lounge doors and in the LVH_LIST bulletin board in email.

For more information, please contact Cathy Glenn in the Department of Surgery at (610) 402-7839.

Who's New

This section contains an update of new appointments, address changes, status changes, resignations, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

New Appointment

Jeffrey R. McConnell, MD
Orthopaedic Associates of Allentown
1243 S. Cedar Crest Blvd., Second Floor
Allentown, PA 18103
(610) 433-6045
Fax: (610) 433-3605
Department of Surgery
Division of Orthopedic Surgery
Section of Ortho Trauma
Provisional Active

Status Changes

Hugh S. Gallagher, MD
Department of Medicine
Division of Cardiology
From: Honorary
To: Provisional Active

John J. Scaffidi, Jr., MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology
From: Provisional Active
To: Affiliate

Practice Name Change

John A. Altobelli, MD
Robert B. Kevitch, MD
W. Michael Morrissey, Jr., DMD, MD
From: Kevitch Altobelli Center for Aesthetic Surgery
To: Aesthetic Surgery Associates

Practice Changes

France Bourget, MD
(No longer with OBGYN Associates of the Lehigh Valley)
Center for Women's Medicine
Lehigh Valley Hospital
17th & Chew Streets, First Floor
P.O. Box 7017
Allentown, PA 18105-7017
(610) 402-1600
Fax: (610) 402-9688

Wayne E. Dubov, MD
(No longer with Good Shepherd Physician Group)
Orthopaedic Associates of Allentown
1243 S. Cedar Crest Blvd., Second Floor
Allentown, PA 18103-6268
(610) 433-6045
Fax: (610) 433-3605

Joseph V. Episcopio, MD
(No longer with Bethlehem Medical Associates)
2912 Kenwick Drive
Bethlehem, PA 18017-3042
(610) 867-2155
Fax: (610) 867-0875

Mark A. Kender, MD
(No longer with Drs. Wolf and Habig)
LVPG-Medicine
1210 S. Cedar Crest Blvd., Suite 3600
Allentown, PA 18103-6208
(610) 402-1150
Fax: (610) 402-1153

Robert J. Laskowski, MD
(No longer with LVPG-Medicine)
President and Chief Executive Officer
Christiana Care Health System
Wilmington Hospital
P.O. Box 1668
Wilmington, DE 19899
(302) 428-2570

Clifford H. Lyons, MD
Hamburg Family Practice Center
700 Hawk Ridge Drive
Hamburg, PA 19526-9219
(610) 562-3066
Fax: (610) 562-3125

Robin A. Skrine, MD
(No longer with Breast Care Specialists, PC)
Lehigh Valley Women's Cancer Center
Paragon Centre
1611 Pond Road, Suite 101
Allentown, PA 18104-2256
(610) 366-8555
Fax: (610) 366-8550

Resignation

Nick S. Garg, MD
Department of Psychiatry
Section of Child-Adolescent Psychiatry

Allied Health Staff

New Appointments

Lorraine O. Dillon, PA-C
Physician Assistant-Certified
(Oncology Specialists of Lehigh Valley - Herbert C. Hoover, Jr., MD)

Mei MacHarrie, RN
Registered Nurse
(The Heart Care Group, PC - Donald J. Belmont, MD)

Luis A. Martinez, PA-C
Physician Assistant-Certified
(The Heart Care Group, PC - Gary W. Szydlowski, MD)

Resignations

Jeffrey B. Biondi
Pacemaker/ICD Technician
(Medtronic USA Inc)

Deborah A. Burris, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC)

Robert F. Danges, PA-C
Physician Assistant-Certified
(The Heart Care Group, PC)

Holly Gaugler
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC)

Marcel Knotek, PA-C
Physician Assistant-Certified
(Lehigh Valley Orthopedic Group, PC)

Amy L. McConaughy, PA-C
Physician Assistant-Certified
(Lehigh Valley Hospital-Muhlenberg)

Jane Z. Pile, PhD
Psychologist

Beth A. Schoch, LPN
Licensed Practical Nurse

Barry M. Tice, PA-C
Physician Assistant-Certified
(Drs. Bub and Young Family Medical Center)

Karen L. Voorhees, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC)

George M. Walton, PA-C
Physician Assistant-Certified
(The Heart Care Group, PC)

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

Phone: 610-402-8590
Fax: 610-402-8938
Email: janet.seifert@lvh.com

Non-Profit Org.
U.S. Postage
PAID
Allentown, PA
Permit No. 1922

We're on the Web!

If you have access to the Lehigh Valley Hospital intranet, you can find us on the LVH homepage under What's New — Medical Staff Services

Medical Staff Progress Notes *is published monthly to inform the Medical Staff and employees of Lehigh Valley Hospital of important issues concerning the Medical Staff.*

Articles should be submitted by e-mail to janet.seifert@lvh.com or sent to Janet M. Seifert, Medical Staff Services, 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 contact Mrs. Seifert by e-mail or phone at (610) 402-8590.