

# Medical Staff Progress Notes

Volume 7, Number 1  
January, 1995



## *From the President*

The turn of a new year is a time for renewal. For all of us, it is a time to recall our achievements of the past year, recount our blessings, reaffirm our vocation as teachers, healers and caregivers to our community of patients. The year 1995 marks the halfway point of the decade of the nineties which in neurology circles has been called the "decade of the brain." While no one can predict what changes this year will bring to us, a Medical Staff, one thing is for certain; we will need more than ever to harness our collective wisdom, share information openly and honestly, and develop strategies to work with the hospital as a team to meet the challenges of the changing health care environment. We will need innovation, energy and optimism. Over the next two years, I hope to represent the Medical Staff to the Administration and the Board of Trustees of Lehigh Valley Hospital in a positive and proactive light, and I hope to bring forward many suggestions to make our hospital better over the next two years. It is clear that the successful hospital of the future will be one where physicians, administrators and board members work together as a team.

I would like to welcome to our Medical Staff Bob Laskowski who has accepted the position of Senior Vice President of Clinical Services and will be joining us in mid-January. Dr. Laskowski is a Board Certified General Internist with additional certification in Geriatric Medicine. He was previously Group Medical Director and President of Northeast Permanente Medical Group in Farmington, Conn., and Clinical Assistant Professor of Medicine at the University of Connecticut.

I would like to welcome Bob Murphy once again as the new President-Elect and the newest member of TROIKA. I look forward to Bob's energy, enthusiasm, and counsel in the years to come.

He is a graduate of New York University, New York, N.Y. Dr. Murphy completed a general surgery internship followed by a two-year general surgery junior residency at Beth Israel Hospital, Boston, Mass. Dr. Murphy was Chief Resident, Plastic and Reconstructive Surgery, in 1987-88, Montefiore Medical Center and Albert Einstein College of Medicine, Bronx, New York.

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In 1988-89, he did his Clinical Fellowship in Hand Surgery, Bellevue Hospital and New York University Medical Center, New York. He is certified by the American Board of Plastic Surgery with certification of Added Qualifications in Surgery of the Hand. He has authored more than a dozen articles published in peer review journals of his specialty. Dr. Murphy is presently Clinical Senior Instructor, Department of Surgery, Medical College of Pennsylvania and Hahnemann University, Philadelphia, Pa., and Clinical Assistant Professor of Surgery, Department of Surgery, Temple University School of Medicine, Philadelphia. His Penn State appointment is pending.

Lastly, I would especially like to thank Joe Candio, for his countless hours of selfless service, who over the past four years served as President-Elect and President of the Medical Staff. Joe's even-tempered demeanor, tenacity to purpose, and quiet but persistent leadership skills will not soon be forgotten.

And finally, let me wish us all a peaceful, prosperous, healthy and Happy New Year in 1995.

Sincerely,



John E. Castaldo, M.D.  
President, Medical Staff

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## *Medical Staff Loyalty Survey*

Our recent survey concerning physician-hospital expectations has been tabulated and is presented here for your review. Many thanks to those who responded by completing the survey or discussing it with us.

Some unintended furor arose over the survey, but may support some of the intended objectives of the survey which originated at the Board-Senior Management Council Retreat in June, 1994. One of the discussion points centered on physician practices and one of us discussed LVPG; the other reviewed the majority practice format of the Medical Staff at Lehigh Valley Hospital. Both presentations were well received and generated further discussion. Rather than only discussions at a committee level

though, we sought the opinions of the physicians "in the trenches." In particular, Lehigh Valley Hospital has grown over the years with the significant contributions of our non-salaried Medical Staff as well as the salaried Medical Staff. Many physicians enhance healthcare delivery via activities in providing care to the indigent in clinics, develop new programs, engage in research, diligently serve on committees and lead divisions, actively participate in teaching programs, among many other activities. Importantly, the voluntary commitment of physicians to enhance and improve patient care at Lehigh Valley Hospital should be recognized. But how?

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Bruce Gresh, Director, Management Systems, and his staff have done the considerable work required to compile the results of the survey. Consider that before even beginning the task, they had to deal with handwritten responses from physicians. What follows is a brief overview of results. For a more complete summary, contact Bruce Gresh at 402-3061.

1. The issue of "loyalty" is one of high interest and importance to physicians.

One hundred forty physicians completed the survey. On the scale of 1 (no significance) to 7 (great significance): 79% rates the topic as a 6 (24%) or 7 (54%).

Many physicians provided extensive comments, both written and verbal. Several encouraged a formal opportunity for follow-up discussion and wanted to participate in that process.

2. "Loyalty" to the hospital is a troubling concept to some physicians.

A small subgroup searched for some other agenda than the stated objective of simply defining a concept commonly used but variously defined by physicians. A more common response was to suggest that a physician's loyalty to patients eclipsed any loyalty to institutions. More than one physician expressed the concept that the most essential way a physician demonstrates loyalty to the hospital is in maintaining a central focus on providing the best care for each individual patient.

3. The majority response characterized a loyal physician in one or more of the following contexts:

- Participates in teaching, research and administrative activities
- Works cooperatively
- Represents the hospital favorably to internal and external constituencies
- Uses the hospital or its affiliates as a primary or exclusive site of care

4. Five main factors were identified as encouraging loyalty:

- Reward and recognition of physicians' efforts and contributions
- Provision of an environment conducive to high quality patient care
- Honest and direct two-way communication with the hospital
- Support and protection of physician practices
- Reciprocal loyalty from the hospital

The importance of these five factors to successful physician-hospital relationships was the most consistent result of the survey. Characterization of a loyal hospital echoed these themes. A loyal hospital was characterized as:

- Rewards and recognizes physician efforts and contributions
- Responsive to physician needs

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- Engages in honest and direct communication and consultation with physicians
  - Supports, protects and does not compete with physicians
5. Most respondents described themselves as loyal to the hospital. On a scale of 1 (not at all loyal) to 7 (totally loyal): 6% were between 1 and 3, 6% were 4, and 88% were between 5 and 7.
6. Colleagues were described as generally loyal, but not as loyal as respondents. On the above scale: 14% were between 1 and 3, 20% were 4, and 66% were between 5 and 7.
7. A good physician-hospital working relationship was characterized by one

where both parties work together toward common goals with honest and direct two-way communication and mutual trust and respect.

From a personal perspective, the survey was tremendously helpful in clarifying issues critical to building collaborative physician-hospital relationships. We were struck by the high level of feeling and diversity of response. One message is that many physicians feel a lack of appreciation for past efforts. It is clear that the perspective of the Medical Staff in how to better recognize individuals, divisions, and departmental efforts would be of great value. Our plan is to carry the discussion forward to the Medical Executive Committee with specific suggestions for follow-up.

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## *Site & Facilities Update*

### **Cedar Crest & I-78**

#### **Work Continues on GI Lab**

To facilitate the construction of the new GI Lab, in the area previously occupied by administrative offices, a temporary wall has been erected parallel to and approximately 12 feet in front of the existing west wall.

The temporary wall does not limit access to the admissions office, elevators or to the Anderson Wing; however, it has affected the lobby's seating capacity -- the built-in seats have been replaced with freestanding chairs.

The construction of the GI Lab, with a capacity for up to six treatment rooms, will continue through March.

As work proceeds on the new GI Lab, renovations of the main lobby will begin. Tentatively scheduled for mid-January, the project will be completed in phases to allow uninterrupted access to admissions and other areas of the hospital. As a result, the lobby will, at times, resemble a series of tunnels. However, this was considered a more practical alternative to re-routing patients and visitors to other hospital entrances. The end-result will be a bright, airy and modern lobby featuring comfortable new furnishings and other attractive decor.

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### **Traffic Signals, Signage Reflect New Traffic Patterns**

New operational traffic signals and signage have been installed to reflect the changes in traffic patterns along Cedar Crest Boulevard and the hospital's main access road. The changes result from an extensive road construction project initiated by the hospital to ease the flow of traffic and improve automotive safety inside and adjacent to the hospital campus.

### **Trees to Line Hospital Entrance**

About 12 large trees will be planted behind the hospital's new entrance sign (which will be installed near the ballfield) while an additional 10 ornamental trees will be planted in the median strip at the entrance to the hospital's main access road. Planting has been postponed until ground conditions improve.

### **Pneumatic Tube System Installed**

Contractors have completed the installation of a pneumatic tube system for sending lab specimens, test results and supplies from one part of the hospital to another. The system, similar to the compressed air chutes used in drive-through banks, connects the Emergency Department with the Laboratory and Microlab, Shock/Trauma and the Medical and Surgical Intensive Care Units. Employees are now being trained in the use of the pneumatic tube system which will be operational in late January.

### **Cafeteria Upgrades Planned**

A series of minor projects are planned to enhance cafeteria and food service functions. To avoid disruptions in service, the projects will be completed during evening hours beginning with improvements to the tray drop area.

### **Sprinkler System Installation Continues**

A riser is being installed in Stairwell #4 for a wet sprinkler system that will service the new GI Lab. Other risers will serve 7A, 5C, 4B and eventually the entire hospital.

### **Cardiac Cath Lab #1 to be Upgraded**

The renovation of Cardiac Cath Lab #1 has begun and will include an expansion of the lab and equipment replacement.

### **17th & Chew**

#### **Work to Begin on Antepartum Unit**

Work is about to begin on a new high-risk Antepartum Unit in the area previously occupied by the Labor and Delivery Unit. The antepartum unit will serve women who require hospitalization during pregnancy.

#### **Kitchen Exhaust to be Upgraded**

Several exhaust and supply air projects are being planned to improve the temperature and ventilation in the food preparation and tray make-up areas.

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### **Air Conditioning Improvement Planned**

A new chilled water distribution system and 800 ton chiller project is ready to begin and is designed to improve air conditioning for newly-remodeled areas.

### **Elsewhere**

#### **Health Promotion and Disease Prevention Department Moves**

The Health Promotion and Disease Prevention Department has relocated from the Wellness Center to Suite 3209 on the third floor of the 1243 building. Staff members based at the department's new quarters include:

**Jane Nester, Director, Health Promotion and Disease Prevention**  
**David Zimmerman, Coordinator, Nicotine Dependence and Stress Management**

**Greg Salem, Coordinator, Fitness and Exercise**

**Judith Thieme, Coordinator, Nutrition and Weight Control**

**Sandra Barillo, Health Educator**

**Christina Kobylinski, Staff Assistant**

**Terri Kraft, Office Coordinator**

The telephone number for the department is (610) 402-5960; the fax number is (610) 402-5966. Mail should be addressed to 1243 S. Cedar Crest Blvd., Suite 3209, Allentown, PA 18103-7982.

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### ***Cath Tray Gloves***

Work is underway to actively incorporate cost containment ideas submitted by the Medical Staff and the Care Management Committee of the PHO with the Hospital's on-going Operation Improvement initiatives. One of the ideas recently evaluated involved the gloves supplied with cath trays. Currently, a majority of the physicians using the tray find the gloves too small, and discard them in favor of a larger, separate pair of gloves. It seemed reasonable that replacing the gloves on the tray with a larger glove would reduce waste and cost. The hospital utilizes about 25,000 trays annually at a cost of \$43,000.

Employees from Nursing and Material Management reviewed several tray configuration options. They followed the process of value analysis, which, in short, means obtaining needed supplies and services at the lowest total-in-cost. Total-in-cost takes into account all costs associated with the use of an item ranging from its functionality in relation to the intended use to the cost of disposal, if applicable. The group's finding was somewhat surprising -- the suggested change would be more costly.

The explanation for this unexpected outcome is rooted in economics and market dynamics. The current

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"standard" configuration is routinely produced and sold in large quantities to health care providers nationwide. Universally, about 80% of the trays are used by nurses who generally have smaller hands. The high volume allows the manufacturer to spread its fixed costs and sell the tray at a very low unit cost. The current manufacturer and others which were approached are willing to produce basically any tray configuration requested. However, these alternative configurations represent custom trays to the manufacturer. Because of much lower volume expectations, the same economies of scale are not available, and therefore the alternative trays carry a higher unit cost. A number of options were explored, including a tray with no gloves at all, and in each case, the price per tray would be higher by an amount that exceeds the cost of continuing the current practice. Accordingly, the recommendation is to stay with the current tray.

The hospital management recognizes the potential ongoing inconvenience associated with having to exchange gloves; however, please be assured that larger gloves will be readily available. In addition, through the hospital's Products Review Committee, other options are continuously being researched. Ideally, a manufacturer will be found that has a "one size fits all" glove to incorporate into a standard tray configuration.

The cath tray review has provided an opportunity for collaboration on cost containment. Work is in progress on the many other ideas offered by the Medical Staff, and all hospital personnel are committed to integrating their efforts with those of the physicians as a team.

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## *Laboratory Update*

In order to understand the local incidence of E. Coli 0157:H7, Microbiology has been routinely culturing stool specimens for E. Coli 0157:H7 since April, 1994. During that time, 640 stools were looked at, and the following significant stool pathogens were uncovered: 46 Campylobacter, 26 Salmonella, 7 Aeromonas, 2 Yersinia, 1 Shigella, 0 E. Coli 0157.

Microbiology will no longer routinely culture for E. Coli 0157. If you

suspect that a patient has an E. Coli 0157 infection, please note this as a special request on the microbiology request slip and the specimen will be processed for E. Coli 0157.

If you have any questions regarding this issue, please contact Georgia Colasante, Microbiology Supervisor, at 402-8190.

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## *Hospice News*

### **Dedicated Inpatient Beds**

Lehigh Valley Hospice is pleased to announce that beginning January 16 it will have three dedicated beds on 4S (rooms 36, 38, and 41) at 17th & Chew. The beds will be available to Hospice patients in need of inpatient care for symptom management. This is the first step in Hospice's plan to establish a Hospice inpatient unit. Through the use of these dedicated beds and other similar arrangements in the future, Lehigh Valley Hospice hopes to continue the continuity of care for terminally ill patients.

The understanding and cooperation of the Medical Staff is crucial to the success of Lehigh Valley Hospice's inpatient program. For your information, to be eligible for admittance to the Hospice's inpatient program, the patient must sign a "Do Not Resuscitate" order, which is a requirement of the Medicare Hospice Benefit.

#### **Criteria for Admission to the Hospice Inpatient Unit**

A patient who meets the criteria for hospice care under the Medicare Hospice Benefit is eligible for admission to the Hospice Inpatient Unit if:

- The patient/family agrees to admission to the center;
- The patient/family signs a consent to hospice care, including acceptance of the **Do Not Resuscitate** policy in the Hospice Inpatient Unit;

- The physician and hospice team agree the admission is appropriate for acute pain and symptom control, not able to be managed at home;
- The primary physician agrees to manage the medical care of the patient admitted for symptom management and/or requests the Medical Director to do so.

If you have any questions regarding this issue, please contact one of the following individuals: William V. Dunstan, Administrator, at 402-7394 (beeper - 309-0935); Kathi Straubinger, Director, Inpatient and Patient Care, at 402-7400 (beeper - 907-0445); or Donna Meridith, Hospice Coordinator, at 402-8604 (beeper - 2081).



### **Attention Physicians Prescribing Home Care or Hospice**

Beginning January 1, 1995, HCFA will compensate physicians for the management of home health and hospice patients.

To bill for care plan oversight, please have your billing personnel use **CPT Code 99375**. A reimbursement of \$58.58 will be paid for each month of home health care plan supervision.

If you have any questions regarding this issue, please contact Lehigh Valley Home Care at 402-7300 or Lehigh Valley Hospice at 402-7400.



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## *News from Affinity*

Carmine J. Pellosie, D.O., Medical Director of Affinity, recently announced the appointment of Charles T. Bonos, M.D., as a staff physician in Occupational Medicine. Affinity, a joint venture of Lehigh Valley and Good Shepherd Hospitals, provides both occupational medicine and outpatient rehabilitation. The addition of Dr. Bonos compliments the existing staff of four full-time and three part-time physicians, one of whom is dedicated to the rehabilitation area.

In February, Affinity will launch the Diabetic Foot and Comprehensive Wound Care Program. This multi-

disciplinary program is dedicated to the treatment and prevention of diabetic foot disease and wound care difficulties associated with the diabetic patient. The referral based program offers consultative, treatment and preventive services. The program is comprised of specialty physicians and therapists providing diagnostic consultation and alternative treatment options for patients with diabetic feet and chronic wound problems.

For more information regarding Affinity, please call 402-9200. To schedule an appointment, please call 402-9292.

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## *Transplant Patient Accommodations*

Patient care accommodations for transplant/immunosuppressed patients were recently reviewed by Craig R. Reckard, M.D., chief, Transplant Services, and Luther V. Rhodes III, M.D., chief, Division of Infectious Diseases. The recommendations for care of the transplant patient were based on a review of the literature and survey of transplant programs in central and northeastern Pennsylvania, and were effective as of November 2, 1994.

Patient care accommodations for transplant/immunosuppressed patients are as follows:

- Insure patient is in a private room on transplant/immunosuppressed precautions when a) patient undergoes renal transplant; b) if admitted during

first three months post-transplant; c) when readmitted for treatment of acute rejection.

- Insure patient is in a semi-private room with a non-infected patient if admitted beyond the first three months for treatment other than acute rejection.

If you have any questions regarding this issue, please contact Patricia A. Campbell, R.N., M.S.N., Transplant Nurse Coordinator, at 402-8506.

**Reminder - When looking at the census, please note that SU = Surgical ICU (second floor) and SC = Special Care Unit (sixth floor).**

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## ***Peripherally Inserted Central Catheter Nurses Appointed***

Charlotte Buckenmyer, R.N., and Mari Driscoll, R.N., were recently appointed to Peripherally Inserted Central Catheter (PICC) nurse positions. Their responsibilities include PICC insertion and care coordination.

Ms. Buckenmyer has 17 years experience as an Emergency Department staff nurse and most recently as the IV Clinician for Spectrum Apothecary Services.

Ms. Driscoll has 13 years experience as an Emergency Department staff nurse, five years here at Lehigh Valley Hospital.

Both nurses are PICC certified and have attended/participated in PICC seminars and workshops.

They will be available for PICC insertion routinely Monday through Friday, from 8 a.m. to 6 p.m., and on Saturday and Sunday, from 10 a.m. to 4 p.m. These individuals will be supported by members of the current PICC Team, nursing staff, and supervisors.

Ms. Buckenmyer and Ms. Driscoll are available on beeper 4303. Please direct all mail and correspondence c/o Susan Pool, Patient Care Services (Nursing Administration), Cedar Crest & I-78.

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## ***Research Advisory Committee - Request for Proposals***

The Research Advisory Committee (RAC) meets bi-monthly to review clinical/epidemiological research proposals (requests for funding) submitted by the Medical and Professional staff of Lehigh Valley Hospital. All proposals must be submitted to the Research Department for review three weeks before the next scheduled RAC meeting.

The next meeting of the RAC is **Wednesday, February 15, 1995**. All proposals submitted by **January 25** will be reviewed by the Research Department before being placed on the RAC agenda.

For more information or proposal guidelines, please contact James F. Reed III, Ph.D., Director of Research, at 402-8889.

**A Support Group for Survivors of Sudden and Traumatic Loss** has been formed and meets on the fourth Tuesday of the month from 7 to 8:30 p.m., in Room 115 of First Presbyterian Church, Cedar Crest Boulevard and Tilghman Street, Allentown.

For more information, contact Karen Peterson at 402-8260.

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## ***Are Physician Assistance Program Services Really Confidential?***

Sure, the Physician Assistance Program says that its services are private and confidential, but are they really?

The Physician Assistance Program employs the following measures to ensure that services provided to clients remain private and confidential:

- Physicians and family members may access the Program anonymously. There is never a need for program providers to identify users except via an assigned control number. In fact, the identify of most of the 20 plus program users is unknown except to the actual service providers (i.e., Drs. Kaufmann and Turoczi).
- Only a client can authorize release of any information concerning visits to a program provider. To date, there has not been a need to even ask a client to authorize disclosures of any sort – neither the Hospital nor the Medical Staff leadership have asked!
- The Medical Staff is billed according to the number of visits. Bills do not include client names or any other identifying information on them.
- All client records are owned, maintained and secured by the service provider.
- While Hospital personnel have a responsibility to report impaired physicians to the state licensing authority, the Physician Assistance Program providers operate independently of the Hospital and have

no such mandate. Indeed, confidentiality and privilege preclude program providers reporting potentially impaired physicians.

Confidentiality plays an integral part of the Physician Assistance Program. It is hoped that you feel comfortable with this issue. If you have any concerns or questions, please call Oliver D. Neith, Program Director of The Counseling Program, at 433-8550.

**You Don't Have to go it Alone...When You Need to Talk, the Physician Assistance Program is There to Listen.**

To use the Physician Assistance Program during normal working hours, call The Counseling Program at (610) 433-8550 or 1-800-327-8878, identify yourself **ONLY** as an active member of the Lehigh Valley Hospital Medical Staff (or a family member), and ask to speak to Oliver Neith or Gary Goodwin.

**Outpatient Diabetes Education Services are available to your patients.**

**For more information, contact the Helwig Diabetes Center at 402-9885.**

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## ***Drive Alert -- Arrive Alive***

Last month, John P. Galgon, M.D., co-director of the hospital's Sleep Disorder Center, attended the National Sleep Foundation's Drive Alert -- Arrive Alive National Forum in Washington, D.C.

The focus of the forum was to keep drivers alert while driving and prevent crashes caused by the sleepy driver or one who actually falls asleep.

Although progress has been made with drunk driving (accidents caused by DUI are down), the accidents caused by the sleepy driver are not.

Following is a summary of the findings reported at the forum, including recommendations for driving alert and arriving alive.

### **The Major Causes of Drowsiness in Drivers:**

- Insufficient sleep - the average American gets 5 to 6 hours of sleep but needs 8.4 hours
- Alcohol in and of itself causes sleepiness, but the combination of insufficient sleep with alcohol can be devastating. It should be noted that with a blood alcohol level of only 0.8 (not legally drunk), performance is markedly reduced even if the driver doesn't feel sleepy. If one measures the sleepiness of a driver with only 5 hours of sleep and a blood alcohol level of 0.8, it is similar to that of a patient with narcolepsy.
- Sleep disorders such as sleep apnea, narcolepsy and chronic insomnia which affect about 50% of the population
- Shift work - 25% of these workers report crashes

- Medications, many which cause sleepiness
- Age - nearly 55% of accidents are caused by drivers under age 25 (the peak age being 20) usually due to insufficient sleep. Seventy percent of the drivers are males. People over 65 have sleep disruption due to many causes, all of which cause sleepiness
- Commercial drivers who spend a large number of hours driving frequently at night
- Circadian influences - there is a normal dip in alertness from 2 to 4 p.m. (siesta time) and a much greater dip from midnight to 6 a.m. (the time we are supposed to be sleeping).

### **To Avoid Drowsiness While Driving:**

- Plan for eight hours of sleep nightly to avoid sleep debt, at least on the night before a long trip
- Don't drink and drive; at the very least, avoid alcohol 4 to 5 hours prior to driving. Don't assume coffee will counteract the effect of alcohol; you may feel more alert but have "microsleeps."
- Drive during the time of day when you are normally most awake and avoid dips in alertness
- Take mid-afternoon breaks or a nap if you are sleepy
- Don't drive after midnight; either you will fall asleep or the driver of the other car will
- Stay overnight in a motel rather than driving straight through
- If you are traveling with passengers, talk with them; they'll be quick to note any signs that you are becoming drowsy

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- Take a break every two hours or 100 miles. Stop sooner if you become sleepy and take a nap
- When you take a break, walk around, and wash your face with cold water. Walking around may also prevent deep vein thrombosis and pulmonary emboli (Dan Quayle may have had pulmonary emboli from sitting for long periods on airplanes)
- Keep your car temperature cool and open windows at intervals
- Eat lightly. It is better to feel a little hungry than "stuffed." There is evidence that a high-fat diet actually

causes sleepiness. So, instead of having a burger, fries, and a shake, have a salad, a cup of coffee, and maybe a veggie whopper (Burger King)

- Don't depend on coffee; the effects of a cup of coffee last about 40 minutes and may be associated with microsleeps. Sipping coffee over a two hour period may be better but will probably not help you avoid "microsleeps"

- Listen to news or talk shows rather than music on the radio. But, remember that turning the radio up doesn't work.
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## ***Congratulations!***

**Bala B. Carver, M.D.**, Director, Transfusion Medicine and HLA, recently passed a rigorous certification exam given by the American Board of Histocompatibility and Immunogenetics (ABHI). This was the first exam of its kind conducted for certification of directors of Transplantation Laboratories. Of the 45 individuals who took the exam, Dr. Carver was one of 32 who successfully passed the exam. She is, therefore, one of only 32 Diplomates of the ABHI nationwide.

**Louis W. Hansrote, M.D.**, chief, Division of Pediatric Cardiology, was informed that he successfully passed the 1994 Pediatric Cardiology certifying exam and is now certified by the American Board of Pediatrics in Pediatric Cardiology.

**Alexander M. Rosenau, D.O.**, Department of Emergency Medicine, was recently appointed co-medical director of the Eastern Pennsylvania Regional EMS Council which provides medical oversight to the six-county area.

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## ***Papers, Publications and Presentations***

**John D. Harwick, M.D.**, and **John S. Papola, M.D.**, chief and associate chief, Division of Otolaryngology, respectively, were recent participants in the National Conference on Sinusitis sponsored by the University of Pennsylvania, Department of

Otorhinolaryngology-Head and Neck Surgery. Symposium participants contributed to the establishment of guidelines for medical and surgical treatment of sinusitis, including functional endoscopic sinus surgery.

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**Thomas O. Burkholder, M.D., and Alan B. Leahey, M.D.,** Division of Ophthalmology, recently authored a paper titled, **Infectious Keratitis One Day After Radial Keratotomy.** This is the first case reported in the literature of a severe corneal infection that developed one day after a common type of refractive surgery. The importance of the article was that it is the first that strongly recommends that these individuals be seen on the first post-operative day so that a site threatening infection, if developing, can be treated appropriately. The article was published in the December 1994 issue, Volume 112, of the *Archive of Ophthalmology.*

**Jenni Levy, M.D.,** Division of General Internal Medicine, developed a precourse, **Addiction Medicine in Primary Care: Clinical and Teaching Skills,** which was presented at the 1994 Annual Meeting of the Society of General Internal Medicine. Independent peer reviewers of the session ranked it one of the highest precourses presented.

**William L. Miller, M.D.,** vice chairperson, Department of Family Practice, authored two chapters and helped edit a research book titled **Exploring Collaborative Research in Primary Care.** Dr. Miller's chapters were **Researching Primary Care Practice Organizations and Common Space: Creating a Collaborative Research Conversation.**

Dr. Miller also co-authored Chapter 21 - **Clinical Research in Handbook of Qualitative Research,** a book which examines models and strategies for collecting, analyzing, interpreting, and

reporting findings of qualitative research.

As principle investigator for a research contract on colon/rectal cancer screening through the Agency for Health Care Policy and Research, **Lester Rosen, M.D.,** Division of Colon/Rectal Surgery, has been appointed to a government-sponsored panel designed to create national guidelines for screening. The panel's first meeting was held December 3 and 4 in Washington, D.C.

The 25-member panel is composed of digestive specialists, family practitioners, internists, radiologists, behavioral and statistical experts, consumers, and government advisors. Within the year, guidelines will be recommended that cover the rationale for fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema to promote early detection of colon/rectal polyps and cancer, thereby reducing colon/rectal mortality.

**Alexander M. Rosenau, D.O.,** site coordinator for the Emergency Medicine Residency of the Lehigh Valley, recently lectured on a number of topics. In September, he was a member of the faculty at the **EM/EMS Convergence: Hazards of the Profession** conference held in Baltimore, Md. His topic was **Electrical/Radiation Emergencies.**

Also in September, Dr. Rosenau presented **Hypothermia** at the annual Lehigh Valley Hospital **Overcoming the Odds** symposium. In November, to kick off the skiing season, Dr. Rosenau lectured to the Camelback Ski Patrol on **Closed Head Injury.**

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## ***Upcoming Seminars, Conferences and Meetings***

### **Medical Staff/ Administrative Exchange Session**

The February Medical Staff/  
Administrative Exchange Session will  
be held on Thursday, February 16,  
from 5:30 to 7:30 p.m., in Conference  
Room 1, Side B, of the John and  
Dorothy Morgan Cancer Center.

The goal of the Exchange Sessions is  
to encourage the mutual exchange of  
information between members of the  
Medical Staff and senior management  
in an informal, relaxed atmosphere.

As space is limited to 40 people,  
registration will be taken on a first-  
come, first-serve basis.

For more information or to register,  
please contact Janet M. Seifert in  
Physician Relations at 402-9853.

### **Medicare Professional Services Rep**

To help ease the transition of the  
Medicare Physician payment system,  
Lehigh County Medical Society has  
arranged to Peggy Blue, Medicare  
Professional Services Representative,  
to meet with Medical Society members  
or their staff on a one on one  
consultation basis to discuss Medicare  
questions, concerns, or "nagging  
payment problems."

Mrs. Blue will be available for  
consultation at Lehigh Valley Hospital  
on Tuesday, February 21, and

Tuesday, March 21, from 9:30 a.m. to  
2 p.m., in Classroom 4 at Cedar Crest  
& I-78.

To schedule an appointment with Mrs.  
Blue, please call Lehigh County  
Medical Society at 437-2288.

### **Regional Symposium Series VI**

**Sixth Annual Symposium in  
Geriatrics** will be held on Saturday,  
January 28, from 8 a.m. to 3 p.m., in  
the Auditorium of Lehigh Valley  
Hospital, Cedar Crest & I-78.

Physicians, nurses, medical residents,  
pharmacists, social workers, and other  
health professionals interested in an  
update in geriatrics will benefit from  
the program.

At the completion of this program,  
participants should be able to:

- identify current approaches to the  
care of the elderly including treatment  
for osteoporosis and benefits of  
geriatric research
- identify the impact of  
pharmacokinetic and pharmacodynamic  
changes in the elderly on drug therapy  
compliance and apply strategies to  
prevent or minimize adverse treatment  
outcomes
- identify and incorporate a variety of  
community resources and placement  
options for elderly patients and their  
caregivers
- describe the changes in the eye  
which occur with aging and  
differentiate normal changes from  
disease process

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- identify common causes of urinary incontinence, describe factors affecting continence, and identify three approaches to the management of urinary incontinence in the elderly.

**Second Annual Current Trends in Cancer Care** will be held on Saturday, February 11, from 8 a.m. to 1 p.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78.

Medical and radiation oncologists, surgeons, urologists, internists, family practitioners, nurses, radiation technologists, and other health professionals interested in current trends in cancer care will benefit from the program.

At the completion of the program, participants should be able to:

- discuss current treatment modalities for breast cancer
- discuss current treatment modalities for prostate cancer
- identify the current guidelines for cancer pain control as identified by the Agency for Health Care Policy and Research
- discuss the impact cancer pain has on the quality of life of the person with cancer.

**Fifth Annual Critical Care Symposium** will be held on Friday, February 24, from 7:20 a.m. to 12:15 p.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78.

Physicians, nurses, and other health care professionals interested in an update in critical care medicine will benefit from the program.

At the completion of the program, participants should be able to:

- discuss diagnosis of pulmonary thromboembolic disease and the role of low molecular weight heparin in prevention and treatment
- describe the developments leading to limited critical care services and methods for limiting care
- explain the diagnosis and most current treatment of candida in surgical patients
- describe various treatment modalities for patients with ventilator-associated pneumonia.

For more information about the above programs, please contact Human Resource Development at 402-1210.

## Department of Pediatrics

**Transfusion Support for Infants and Children – Case Presentation** will be presented by Bala B. Carver, M.D., Director, Transfusion Medicine, on Friday, January 27, beginning at noon, in the Auditorium at 17th & Chew.

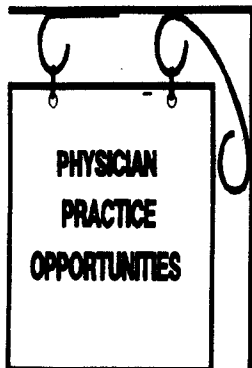
For more information, contact Beverly Humphrey in the Department of Pediatrics at 402-2410.

## Psychiatry Grand Rounds

**Anatomy of Psychological Trauma** will be presented by Ann Wolbert Burgess, R.N., D.N.Sc., Chairperson and van Ameringen Professor of Psychiatric Mental Health Nursing, University of Pennsylvania, School of Nursing, Philadelphia, Pa., on Thursday, February 16, at noon in the Auditorium at 17th & Chew.

As lunch will be provided, pre-registration is requested. For more information or to register, contact Lisa Frick in the Department of Psychiatry at 402-2810.





- **Wanted -- Medical Director, Skilled Nursing Facility, Lehigh Valley Hospital, 17th & Chew -- Primary care physician sought as Medical Director for Lehigh Valley Hospital's hospital-based, interim care skilled nursing facility. Will oversee operations of new 52-bed unit and participate in medical management of patients. Board certification required. Experience working in skilled nursing facility preferred. Position is part-time (.25 FTE). Interested candidates please send CV, in confidence, to Francis Salerno, M.D., Chair, Search Committee, c/o Carol Voorhees, Physician Recruitment Department, 1243 S. Cedar Crest Boulevard, Allentown, PA 18103, 402-3090, fax - 402-9858.**
- **For Sale or Lease -- Springhouse Professional Center, 1575 Pond Road. Ideal for physician's office. Approximately 2,500 sq. ft.**
- **For Sale -- Office building at Northeast corner of 19th and Turner Streets in Allentown. Upper level - 2,400+ sq. ft., large waiting room, two large consultation rooms, five exam rooms, etc. Lower level - 2,300+ sq. ft. Parking lot for 16 cars.**
- **For Sale -- Medical office suite in the 1230 S. Cedar Crest Boulevard Medical Office Building. 1,225 sq. ft.**
- **For Lease -- Office to sublet on Monday, Tuesday, Thursday, and Friday. 950 sq. ft. Common waiting area. Lakeside Professional Building, Quakertown.**
- **For Lease -- Slots are currently available for the Brown Bag suite at Kutztown Professional Center. Ideal for satellite location.**
- **For Lease -- Several time slots are available in the medical office building on the campus of Gnadon Huetten Memorial Hospital in Lehighton.**
- **For Lease -- Medical-professional office space located on Route 222 in Wescosville. Two 1,000 sq. ft. offices available or combine to form larger suite.**
- **For Lease -- Medical office space located in Peachtree Office Plaza in Whitehall. One suite with 1,500 sq. ft. (unfinished - allowance available), and one 1,000 sq. ft. finished suite.**
- **For Lease -- Specialty practice time-share space available in a comprehensive health care facility. Riverside Professional Center, 4019 Wynnewood Drive, Laurys Station. Half- or full-day slots immediately available.**
- **For Lease -- Professional office space available in an established psychology and psychotherapy practice at 45 N. 13th Street, Allentown. Large, warm Victorian building in a relaxed atmosphere. Secretary and billing available and included in some leases. Furnished or unfurnished full offices and sublets available. Utilities included.**

For more information or for assistance in finding appropriate office space to meet your needs, contact Janet M. Seifert, Physician Relations Rep, at 402-9853.

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## WHO'S NEW

The Who's New section of *Medical Staff Progress Notes* contains an update of new appointments, address changes, newly approved privileges, etc. Please remember that each department or unit is responsible for updating its directory, rolodexes, and approved privilege rosters.

### Medical Staff

#### Appointments

**Deborah A. Bren, DO**  
Christine & Bren  
1365 Blue Mountain Drive  
Danielsville, PA 18038-9738  
(610) 767-4315  
Department of Family Practice  
Provisional Referring

**Gary M. Pryblich, DO**  
19th Street Family Health Care, PC  
1901 Hamilton Street  
Suite 2  
Allentown, PA 18104-6413  
(610) 437-7181  
Department of Family Practice  
Provisional Referring

#### Additional Privileges

**Bryan W. Kluck, DO**  
Department of Medicine  
Division of Cardiology  
Active  
Coronary Rotablator Privileges

#### Change of Status

**Brian L. Fellechner, DO**  
Department of Medicine  
Division of Physical  
Medicine/Rehabilitation  
From Active to Consulting

### Appointment of Medical Directors for Newly-Named Units

**Jay H. Kaufman, MD**  
Medical Director  
Medical Intensive Care Unit (MICU)

**Michael D. Pasquale, MD**  
Medical Director  
Surgical Intensive Care Unit (SICU)

### Practice and Address Changes

● Effective January 14, 1995, Charles T. Bonos III, MD, will no longer be associated with Trexlertown Medical Center. He has accepted a position with Affinity.

**Charles T. Bonos III, MD**  
Affinity  
1243 S. Cedar Crest Blvd.  
Allentown, PA 18103  
(610) 402-9200

● Effective January 2, 1995, Joseph A. Habig II, MD, is no longer in practice with Southside Family Medicine. He has joined the practice of Mark A. Kender, MD and John F. Wolf, MD.

**Joseph A. Habig II, MD**  
John Wolf, MD & Mark Kender, MD  
3131 College Heights Blvd.  
Suite 2200  
Allentown, PA 18104  
(610) 437-9007  
Fax - 437-1731

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- Effective January 1, 1995, the following individuals have all become members of

**Allentown Anesthesia Associates, Inc.**  
1251 S. Cedar Crest Blvd.  
Suite 212C  
Allentown, PA 18103  
(610) 402-8810

Karen A. Bretz, MD  
In-Ho Chang, MD  
J. John Collins, MD  
Edgardo S. Cruz, MD  
Ramon J. Deeb, MD  
Domenico Falcone, MD  
Dorothy Hartman, MD  
Howard E. Hudson, MD  
Jay Soo Jung, MD  
Jin Il Kim, MD  
Samuel M. Lerner, MD  
Alphonse A. Maffeo, MD  
Carmen G. Montaner, MD  
Toeruna Widge, MD  
Wen-Shiong Yang, MD

- Effective January 1, 1995, the members of the Ronald A. Stein, MD cardiology practice and the Syed A. Subzposh, MD cardiology practice merged to form **InterValley Cardiology**. The members of the new practice along with the primary office location include:

**InterValley Cardiology**  
Kenneth Bernhard, MD  
William A. Markson, MD  
Eugene E. Ordway, MD  
Ronald A. Stein, MD  
Syed A. Subzposh, MD  
451 Chew Street  
Suite 302  
Allentown, PA 18102-3423  
(610) 821-2810  
Fax - 821-6952

- Effective January 1, 1995, the members of **Advanced Dermatology and Dermatology Associates of Allentown, Ltd.** merged to form **Advanced Dermatology Associates, Ltd.** The members of the new practice along with their appropriate addresses include:

**Advanced Dermatology Associates, Ltd.**

Alan H. Schragger, MD  
Arthur C. Sosis, MD  
Robert J. Thompson, MD  
1317 Hamilton Street  
Allentown, PA 18102

**Advanced Dermatology Associates, Ltd.**

J. Greg Brady, DO  
Marc W. Levin, MD  
Stephen M. Purcell, DO  
2200 Hamilton Street  
Allentown, PA 18104

### Address Changes

**Gazi Abdulhay, MD**  
Gynecologic Oncology Associates of Lehigh Valley, Inc.  
1611 Pond Road  
Allentown, PA 18104-2256  
(610) 366-8555  
Fax - 366-8550

**Mark B. Farin, MD**  
**Louis W. Hansrote, MD**  
401 N. 17th Street  
Suite 309  
Allentown, PA 18104

**Milton J. Friedberg, MD**  
1240 S. Cedar Crest Blvd.  
Suite 305  
Allentown, PA 18103

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**Yasin N. Khan, MD**  
Lehigh Valley Pain Management, Inc.  
4825 Tilghman Street  
Allentown, PA 18104

**Christopher G. Lynch, MD**  
Allentown Rehabilitation Center  
4825 Tilghman Street  
Allentown, PA 18104-9374  
(610) 398-9747  
Fax - 398-2067

**Wendy J. Rush Spinosa, MD**  
Mauch Chunk Medical Center  
1580 Center Avenue  
Jim Thorpe, PA 18229-1099  
(717) 325-2705  
Fax - (717) 325-8310

**Surgical Associates of the Lehigh Valley, Inc.**

William W. Frailey, MD  
Charles J. Scagliotti, MD  
Gerald P. Sherwin, MD  
Barry H. Slaven, MD  
1240 S. Cedar Crest Blvd.  
Suite 305  
Allentown, PA 18103

**Resignations**

**Richard J. Angelico, MD**  
Department of Surgery  
Division of Cardio-thoracic Surgery  
Courtesy

**Thelma Quiogue, MD**  
Department of Radiology/Diagnostic  
Medical Imaging  
Division of Diagnostic Radiology  
Consulting

**Allied Health Professionals**

**Reinstatement of Privileges**

**Cynthia L. Ward, RN**  
Physician Extender  
Professional - RN  
(Cardiology Care Specialists)

**Address Change**

**David S. Glosser, Sc.D.**  
Neuropsychology & Behavioral  
Medicine  
3420 Walbert Avenue  
Suite 100  
Allentown, PA 18104

# HEALTH NETWORK LABORATORIES

A Service of **LEHIGH VALLEY**  
HOSPITAL



## *Opportunities for Operational Improvement: Recommendations for the Use of Blood Cultures*

Over the years, improvements in the methods used to detect bacteremia have increased the yield of positive blood cultures per each sampling event and reduced the time to detect bacteria and yeasts in blood. The system we are currently using in our laboratory is the *Bacti-Alert (TM) system*. This is a continuous monitoring, totally closed, high volume, automated system. This means that once a laboratorian places the bottles on the system they are not reentered unless they register as positive. The bottles are incubated and read every 10 minutes by a system which detects the production of carbon dioxide from microbial metabolism. The recommended volume of blood per blood culture bottle to detect adult bacteremia is 10 ml per bottle or 10 me per set of two blood culture bottles (aerobic and anaerobic). Recent papers have reaffirmed earlier observations that increasing the volume of blood on any sampling event increases the likelihood of detecting microbial agents of sepsis. Because most septic events are intermittent, it is preferable to adequately sample the bloodstream at a well chosen time when sepsis is likely and before antibiotic administration than to inadequately sample multiple times and compromise the probability of isolating the causative agent due to

antibiotic therapy, low sample volume, or poor timing. Performing too many blood cultures costs more, runs the risk of iatrogenic blood loss, and produces no greater yield than a well planned blood culture protocol. Our system requires a minimum of 5 ml per bottle to detect adult sepsis but volumes less than 10 ml per bottle compromise the yield on any single sampling event. This is different in infants and young children where the bacterial load per milliliter of blood is higher and 0.5 to 1.0 ml of blood have been reported to provide acceptable detection of neonatal sepsis. The bacterial load per ml of blood in adult sepsis is usually around 1 CFU (colony-forming unit) of bacterial per ml. Only 20% of cases of adult sepsis demonstrate bacterial loads of less than 0.1 CFU/ml when quantitative cultures have been done.

Our experience at Lehigh Valley Hospital suggest we may either perform more adult blood cultures than necessary or inadequately sample the bloodstream on each testing event. We base this premise on the fact that our positive rate per blood culture is less than would be expected comparing ourselves to other hospitals with the same technology and types of patients.

We would expect a positive rate of about 8-10% but our current experience is a positive rate of around 5% and sometimes less. Although blood volume per test influences these outcomes our internal lab QC indicates that this is not the major problem. We believe we perform to many cultures when the timing is poor, we have already collected enough blood to reasonably detect sepsis, or there is inadequate reason to suspect sepsis clinically. The reflex order that includes a blood culture every time a fever is reported at night or the frequency with which blood cultures are ordered on admission through the emergency department are special areas that warrant review.

Practice which we believe could improve our yield of positive adult blood cultures and reduce the unit cost per positive blood culture are as follows:

1. Setting: The acutely ill patient with a high suspicion of clinical septicemia in need of STAT antibiotics.

Order: "Two blood cultures, STAT, one from each arm or (less desirable) one from an arm and one from a line".

Comment: Not to exceed two in 24 hours; cultures *must be labeled* line to vein origin.

2. Setting: The most common blood culture order; useful for the febrile patient where urgent antibiotic use is not anticipated.

Order: "Two blood cultures, one hour apart."

Comment: Routinely not to exceed two in 24 hours unless special circumstances arise and are documented on an order sheet.

3. Setting: The relatively uncommon FUO patients where the clinical suspicion of acute septicemia or fungemia is not the leading impression.

Order: "Three blood cultures, one hour apart."

Comment: This order should be relatively uncommon for most of our staff since most bacteremias are detected with two cultures.

We believe that, most importantly, adherence to these recommendations would improve the clinical utility of the blood culture as a diagnostic test in our hospital. Secondly, if we increase the positive rate per blood culture to rates comparable with other institutions and national statistics, the cost to provide this service will also decrease. A 5% reduction in blood cultures, which equates to about 85 per month, would cut our costs by about \$20,000 a year.

Luther V. Rhodes III, MD  
David G. Beckwith, Ph.D., ABMM  
Georgia Colasante, MS, SM, (AAM)

# a minute for the medical staff

## The ABCs of medical records documentation

This column is the first of a three-part series intended to help fellow physicians with a critical activity that's often uncomfortable—accurate medical records documentation.

In this day of managed care and multiple payer requirements, it's amazing that there are any common threads of knowledge that will help the physician receive proper reimbursement regardless of the patient or payer. But there are: It doesn't matter if it's Medicare, Medicaid, Blue Cross, modified fee-for-service insurance, or staff model HMOs, if you know the important concepts of Part A documentation (ICD-9-CM coding) and Part B documentation (CPT coding), you'll be in an advantageous position when what I call Part C arrives—the computerized medical record.

Hence the title of this series—the ABCs of medical records documentation. This one focuses on

Part A (documentation for ICD-9-CM coding).

### Ten documentation rules for proper Part A (ICD-9-CM) coding

1. The definition of the principal diagnosis for any inpatient under ICD-9-CM is officially defined as "the condition which after study occasioned the admission of the patient to the hospital for care." This means the principal diagnosis for a patient who is admitted because of a CVA is still CVA, even if the patient has a major MI four hours after admission and spends three weeks in the CCU in cardiogenic shock.

2. A complication or comorbid condition can change the patient's DRG; it is defined statistically as a diagnosis that extends the length-of-stay by one hospital day in 75% of the cases in which it occurs. It does not have to extend the length-of-stay in your

particular case for it to be counted as a complication or comorbid condition.

3. Frequently, more than one diagnosis is present at the time of admission of a Medicare patient, any of which would result in the decision to admit—and therefore could be considered the principal diagnosis. For example, an elderly patient from a nursing home with a fever is admitted with both significant urinary tract infection and aspiration pneumonitis. The more resource-intensive diagnosis can and should be chosen as the principal diagnosis; in this case, the aspiration pneumonitis.

4. To use ICD-9-CM properly, coders must code *possible, probable, likely, suspected, and to be ruled out* diagnoses as though the conditions exist, unless of course the conditions are ruled out prior to discharge. (This is a complete contradiction to CPT coding rules

used in your office, which state that a condition should be coded only to the level of symptomatology until a diagnosis has been made.)

This ICD-9-CM rule results in much greater specificity in inpatient coding. For example, the patient mentioned above can be coded as aspiration pneumonitis if the physician feels that, clinically, the aspiration was the source of the pneumonitis and is treating the patient for that condition.

5. Remember to use "history of" correctly. This phrase refers to past medical conditions or procedures that are no longer active problems. For example, it is incorrect to document "history of hypothyroidism, taking Synthroid 0.15 mg QD," but it is correct to document "history of erysipelas as a child" or "10 years status post TAH, BS&O."

6. Just because a condition is "routine" to you, it doesn't mean that it should be omitted as a complication. For example, it's often the case that patients are hypokalemic after cardiac surgery. Even if you have standing orders and the other professionals routinely care for this problem without calling the surgeon or post-op care physician, it is still a "complication."

7. Some physician is always the attending physician at the time of discharge and must sign the attestation. It doesn't matter whether that physician was the one who took care of the patient's brittle diabetes or COPD, he or she still should sign an attestation with these diagnoses recorded if they were present and treated, even though the care may have been given by other physicians.

8. The prospective payment system is a reimbursement system based on averages

over time. Hospitals will make money in some cases and lose money in others. It is not your job as the attending physician to determine one or the other, but rather to be certain that all appropriate diagnoses requiring resource consumption during the hospitalization are recorded.

9. Legitimate specificity is critical. If you know or suspect that a patient's anemia is due to iron deficiency secondary to chronic GI blood loss, say so. We're still allowed to have working diagnoses!

10. Remember that you as a physician are being profiled for the level of quality and care you render your inpatients just as hospitals are. You have a "case-mix index" and a "provider report card" just as the hospital does. Such utilization information, based on the clinical data you provide, will be used to determine your level of participation in managed care.

**Dean R. Backstrom, MD, is the author of *A Minute for the Medical Staff*. He is a physician consultant for Healthcare Management Advisors in Atlanta, GA.**

**A Minute for the Medical Staff is an exclusive service for subscribers to Medical Records Briefing. Reproduction of A Minute for the Medical Staff is encouraged.**

**MRB, P.O. Box 1168, Marblehead, MA 01945. Telephone 617/639-1872. Fax 617/639-2982.**



# ACLS COURSES 1995

## COURSE DIRECTOR/STATE AFFILIATE FACULTY

Ronald A. Lutz, M.D., F.A.C.E.P.  
Chairman, Emergency Medicine  
Interim Director, Emergency Medicine Institute  
Lehigh Valley Hospital  
Allentown, Pennsylvania

## ASSISTANT COURSE DIRECTOR

Richard T. Cook, Jr., M.D., F.A.C.E.P.  
Assistant Director, Emergency Medicine Institute  
Lehigh Valley Hospital  
Allentown, Pennsylvania

## ASSOCIATE COURSE DIRECTOR

Edith J. Gray, R.N., M.S.N., C.E.N.,  
Health Professional R.N.  
Clinical Coordinator  
Emergency Medicine Institute  
Lehigh Valley Hospital  
Allentown, Pennsylvania

## FACULTY

The faculty is composed of ACLS certified instructors, physicians, and other health professionals.

## PURPOSE

The ACLS course provides training for medical personnel actively involved in emergency cardiac care. All courses are taught to the standards of the American Heart Association. The Emergency Medicine Institute sponsors ACLS provider and renewal as well as ACLS instructor courses.

## COMPUTER ASSISTED INSTRUCTIONAL PROGRAM

The EMI is pleased to offer the Actronics, Inc. Video Learning System. This self-paced, user-friendly, computer assisted instructional program is available to students in both BLS and ACLS courses before, during, or remedial study after enrolled courses. The program augments the following materials within the ACLS textbook: Airway Management, Basic Life Support, Dysrhythmia Recognition (static/dynamic and therapeutic modalities), Electrical Therapy, Automated External Defibrillation, Mega Code, Circulatory Adjuncts and Resuscitation Pharmacology. To schedule the use of the (CAI) Learning System, please contact the EMI at (610) 402-5944 or (610) 402-5943.

## ACLS PROVIDER RENEWAL COURSE

### Course Pre-requisites:

Current ACLS Provider status and Basic Life Support (BLS). A copy of your current ACLS and BLS card with expiration date shown must accompany registration form.

A specific course for the reappointment of those who have previously completed the full ACLS Provider Course. Participants will be given the opportunity to refresh practical skills prior to demonstrating cognitive and practical expertise through a written examination and performance at skill testing stations.

## ACLS PROVIDER COURSE

### Course Pre-requisites:

Current provider status in Basic Life Support (BLS). A copy of current BLS card with expiration date shown must accompany registration form.

### Course Content:

- ▶ Advanced Cardiac Life Support in Perspective
- ▶ Adjuncts for Airway Control, Ventilation & Supplemental Oxygen
- ▶ Intraosseous and Invasive Techniques
- ▶ Monitoring for Dysrhythmia Recognition
- ▶ Electrical Therapy in Malignant Dysrhythmias
- ▶ Automated External Defibrillation
- ▶ Cardiovascular Pharmacology I and II
- ▶ Myocardial Infarction
- ▶ Acid Base Balance
- ▶ Resuscitation of Infants & Children & Other Special Resuscitation Situations
- ▶ Medicolegal Aspects of CPR and Emergency Cardiac Care
- ▶ BLS Review

Lecture sessions and practical work at skill stations are used to emphasize course content. The course materials will be mailed to the registrants prior to the beginning of the course.

## ACLS "SLOW TRACK" PROVIDER COURSE

This (10) week course is offered for those participants who feel that they may benefit from a slower paced ACLS course.

## LOCATION OF COURSES

ACLS courses will be held at the 1243 Building which is located across the street from the hospital.

## REGISTRATION

Please Print or Type

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Position/Occupation \_\_\_\_\_

Social Security # \_\_\_\_\_

Please register me for the course indicated below.  
(Tuition fee and course pre-requisite documentation must be enclosed.)

Make checks payable to the Emergency Medicine Institute.

## COURSES

**ACLS Provider**  
(Weekday Courses)  
• May 4 & 5, 1995  
• December 4 & 5, 1995

**ACLS Provider**  
(Weekend Courses)  
• February 3 & 4, 1995  
• April 21 & 22, 1995  
• October 27 & 28, 1995

**ACLS Renewal**  
(Weekday Courses)  
• January 13, 1995  
• March 24, 1995  
• September 22, 1995  
• October 30, 1995  
• November 17, 1995

**ACLS Renewal**  
(Weekend Courses)  
• May 6, 1995  
• September 23, 1995  
• December 2, 1995

**ACLS "Slow Track"**  
• January 9, 1995 through March 13, 1995

Please return completed form, along with tuition and course registration to:

**EMERGENCY MEDICINE INSTITUTE**  
Lehigh Valley Hospital  
1243 South Cedar Crest Boulevard  
Allentown, PA 18103  
(610) 402-5944 or (610) 402-5943

## GENERAL INFORMATION

### **Registration**

Advanced registration is requested no later than three (3) weeks prior to the first day of the course. Early registration is advised to allow time to receive pre-course materials. Registration will be closed when maximum enrollment is reached. Course pre-requisites must be met by all applicants.

### **Tuition**

Includes cost of instruction, course and handout materials, nutritional breaks, and the use of the Actronics, Inc. Computerized Interactive Video Learning System with the AHA: CPR ACLS course ware.

### **Renewal Course**

\$75.00 for physicians and nurses  
\$40.00 for paramedics and paraprofessionals

### **Provider Course**

\$100.00 for physicians and nurses  
\$60.00 for paramedics and paraprofessionals

### **Cancellation Policy**

Tuition minus \$25.00 administration fee is fully refundable if cancellation is received (10) business days prior to the course. No refund if cancellation notice is not received (10) business days before the course.

### **Lodging**

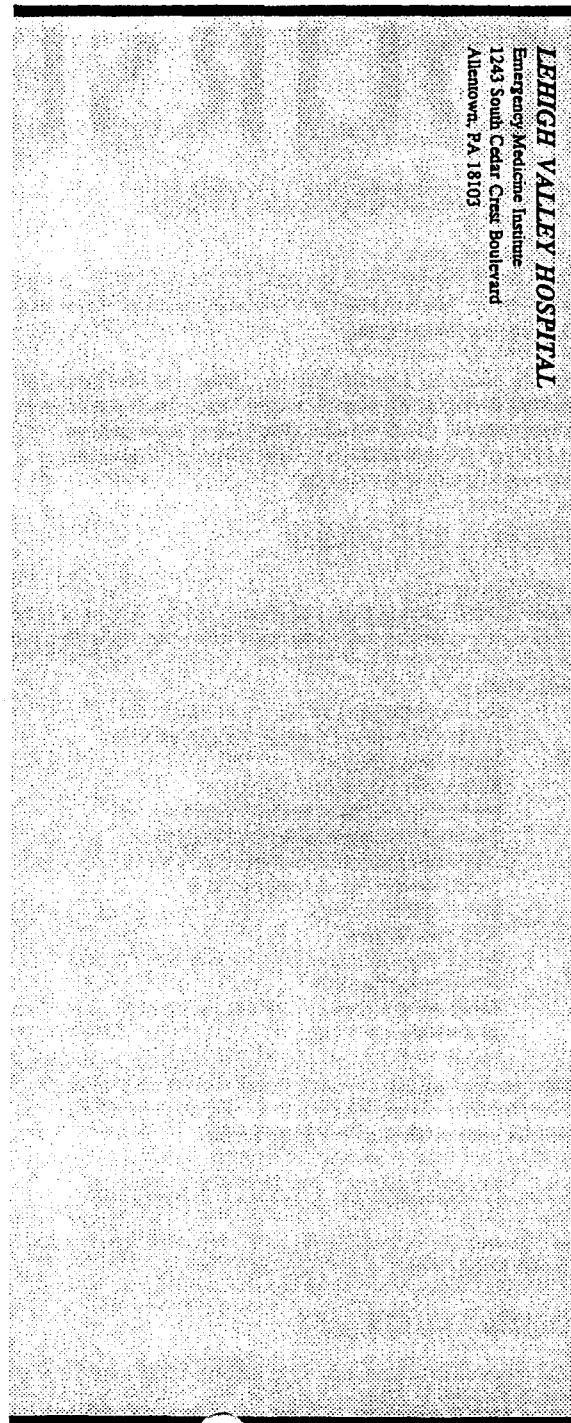
Overnight accommodations are the responsibility of the program participant. Lodging is available near the hospital.

### **Appointment**

Participants successfully completing the ACLS Provider or Renewal Course shall be valid in ACLS according to the American Heart Association standards for a maximum of two years.

### **Accreditation**

- The ACLS courses have been approved for Category I credit of the Physician's Recognition award of the American Medical Association and the Pennsylvania Medical Society membership requirement by the Lehigh Valley Area Health Education Center.
- Lehigh Valley Hospital is an approved PNA provider for Continuing Education credits.
- Pennsylvania Nurses Association Contact hours will be awarded.
- Paramedic continuing education credits

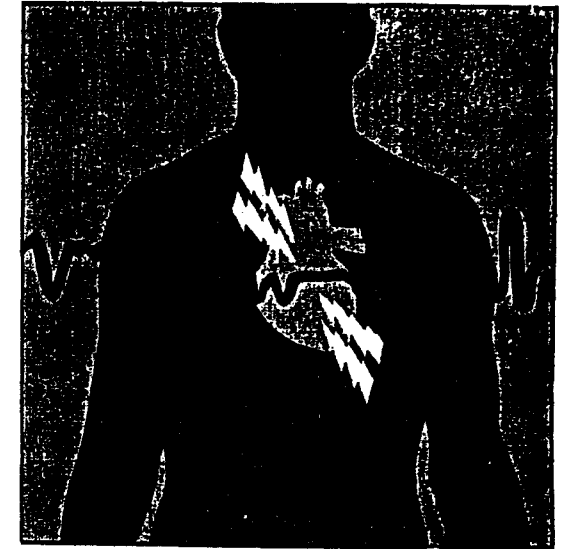


**LEHIGH VALLEY HOSPITAL**  
Emergency Medicine Institute  
1243 South Cedar Crest Boulevard  
Allentown, PA 18103

# **LEHIGH VALLEY HOSPITAL**

## **Emergency Medicine Institute**

*presents*



**A.C.L.S.**  
**ADVANCED**  
**CARDIAC**  
**LIFE SUPPORT**  
**COURSES**

**1995**

# CPR COURSES 1995

## INTRODUCTION

The EMERGENCY MEDICINE INSTITUTE of the Lehigh Valley Hospital is offering courses to adults interested in obtaining or maintaining certification in cardiopulmonary resuscitation (CPR) and foreign body airway obstruction (FBAO).

## LOCATION

Lehigh Valley Hospital  
1243 South Cedar Crest Boulevard  
Allentown, Pennsylvania 18103

Classes are held at the 1243 Building of the hospital which is located across the street from the main hospital grounds on the third floor.

The course will begin promptly at 7:00 P.M. and end at 10:00 P.M.

## PARKING

Parking is available in the parking deck which is located along side the building.

## CANCELLATION POLICY

If you must cancel the course you are registered for, it must be done no later than 72 hours prior to the first night of the course.

Please call (610) 402-5945 to cancel and/or reschedule the course you have registered for. An administrative \$5.00 processing fee and cost of books, will be deducted from your refund if you cancel the course.

## COURSE C

Participants in this course will learn to administer adult 1 and 2 man, child, and infant CPR. Instruction will also be provided in utilization of mouth to mask ventilation and removing an item blocking the airway for conscious and unconscious adults, infants, and children. You must attend all 3 evenings to be eligible for provider status. Written and practical examinations are given. The course fee is \$30.00

## COURSE C - RENEWAL

This course reviews all of the material covered in the provider course. To be eligible for this course, you must have a current course C card or a card that has expired within 1 month. The course fee is \$15.00.

## COURSE A

Participants in this course will learn to administer one-man adult heart-saver CPR and instruction on removing an item blocking the airway for conscious and unconscious adults. The course fee is \$20.00

## COURSE D

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February 13, 20, & 27, 1995  
March 13, 20, & 27, 1995  
April 10, 17, & 24, 1995  
May 8, 15, & 22, 1995  
June 12, 19, & 26, 1995  
July 31, August 7, & 14, 1995  
September 11, 18, & 25, 1995  
October 16, 23, & 30, 1995  
November 6, 13, & 20, 1995  
December 4, 11, & 18, 1995

### COURSE C - RENEWAL

January 9, 1995  
March 6, 1995  
June 5, 1995  
July 10, 1995  
August 21, 1995  
October 9, 1995

### COURSE A

April 3, 1995  
July 24, 1995  
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### COURSE D

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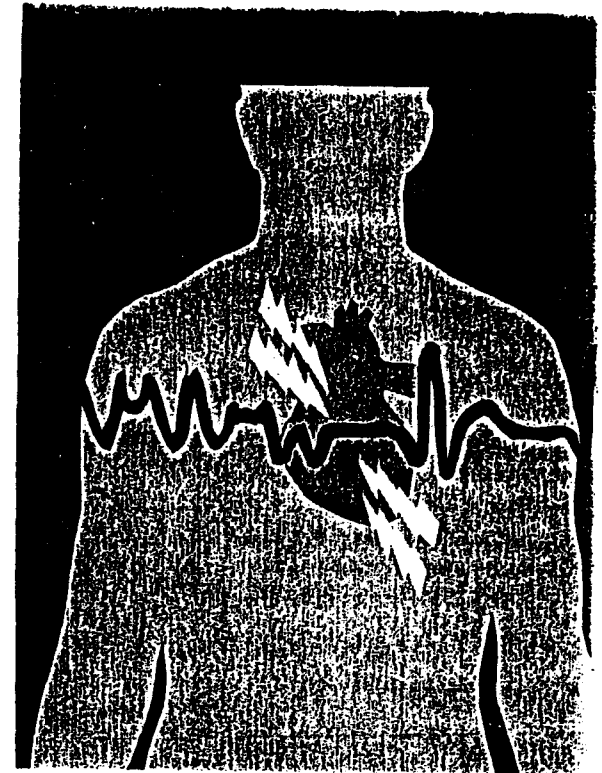
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# *Issues In Medical Ethics*

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Winter 1994

## **Editor's comments:**

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Anonymous

**W**ith this, our fourth edition, we take another step into the future of 'desktop publishing'. This edition will be going out to members of the ethics community beyond the hospital walls. Who knows; perhaps someday a network of people interested in medical ethics will be linked electronically, colleagues on the internet!

In this edition, we publish a summary of talks on the ethics of transplantation that were presented this summer to the LVH ethics committee. A variety of ethical issues are emerging in the important area of organ procurement and transplantation. Not all the answers are clear yet and perhaps there will never be a consensus on who should receive these valuable resources. Searching for local and national solutions is really the answer; an ongoing 'operations improvement' to refine the process.

Finally, the krank is back at work. In reply to our local rabble rouser, let me state that we plan a conference on the Ethics of Health Care Reform in the spring. Watch for announcements on this event. We look forward to a cast of excellent speakers on this timely topic. There, that should satisfy the scoundrel.

-The Editors

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## **Transplantation Ethics, selected topics**

### **Ethical Issues In Organ Distribution**

Because the number of patients waiting for life-saving organ or tissue transplants is increasing exponentially and the donor supply lags far behind, the ethics of organ distribution has received increasing attention in the transplant and public community. Current organ allocation policies are based upon an attempt to balance equally the ethical principles of medical utility and justice. The specific areas that would fall under medical utility include the number of successful transplants, patient and graft survival data, quality of life and the cost/benefit ratio when a specific allocation

policy is implemented. Specific areas falling under medical justice include the patient's degree of medical urgency, the actual waiting time and also a consideration of the medical disadvantages that may be found in certain categories of patients. These would include such conditions as high level of pre-existing anti-HLA antibodies, blood group or racial factors which may tend to exclude or appear or deny a "fair share" or organs to a subset of patients.

The present policies of organ distribution can be grouped into two broad systems. The first system is based upon strictly objective criteria that cover kidney or

**Continued on Page 2**

kidney/pancreas distribution. Kidneys are distributed on the basis of four objective criteria which include ABO status, degree of match with the donor, waiting time and degree of prior sensitization (i.e., pre-existing anti-HLA antibodies). Based upon these four criteria, a point system has been developed wherein the patient with the highest number of points is offered the organ.

There are several circumstances where this point system is superseded. First, a kidney initially must first be offered nationally to any patient who matches the donor perfectly based on the HLA system. Secondly, recipients of combined pancreas/kidney transplants take priority over kidney alone recipients if the donor is a suitable pancreas donor. This particular variance has led to an inequity in the waiting time for kidney only recipients in that they wait two to three times longer than patients awaiting combined grafts.

The second system governs distribution of "vital" organs where the transplant is absolutely necessary for the patient's long-term survival (i.e., liver, heart and lung transplantation). For these extra-renal organs, the system is based on less objective criteria which places great emphasis on medical urgency. Consequently, the recipient list for these organs is divided into categories based upon the medical status of the patient. Waiting time and geography also tend to play a role because of shortened preservation times associated with certain of the "vital" organ transplants.

There are a number of ethical issues with both kidney and extra-renal organs that have been the focus of many national organizations and the topic of national forums over the past two to three years. Certain issues tend to overlap with all organs. The first of these is the issue of multiple listing. Presently, there is no rule that prohibits a patient, if they have the means and the energy, to list on the waiting list at several transplant centers around the country. This offers the possible

advantage of shortening the wait time for an organ. However, it tends to disadvantage those patients who cannot afford the extra time and effort involved in multiple listing.

A second major ethical issue which crosses all organs relates to the issue of multiple transplants. This particular topic falls into both the area of medical utility and justice. Should a patient who has already had an organ transplant be placed ahead of someone who has not yet had their opportunity at a transplant? In the face of extremely limited resource availability, is it fair or cost effective to give a single patient several organs of the same type?

Ethical issues in kidney distribution include a discussion of whether or not matching of kidneys as a criterion for distribution tends to disenfranchise certain groups of patients because of the known disparities in antigen frequencies in various subpopulations (i.e., Caucasian vs. Oriental vs. African-American, etc.). The role of matching in the outcome of kidney transplantation tends to be emotionally charged with a variety of data which both support and refute the utility of matching. The African-American population, which has almost one-third of the patients on chronic hemodialysis, tends to receive only 10-20% of the kidneys available. Minority access proponents claim that this relates to the genetic differences between African-Americans who supply very few donors vs. Caucasians from whom the majority of donor organs are obtained. In the current matching system, of interest is the fact that only 20% of the points at the time of allocation are based upon match whereas most points are based upon waiting times.

There are other ethical issues in kidney distribution which include the definition of "waiting time". It appears that some centers will tend to place patients on the waiting list long before they are truly in need of a renal transplant to allow the patient to accumulate waiting time points

Continued on Page 2

which ultimately play a major role in the distribution of kidneys. There have been discussions regarding the standardization of the timing of placement on the waiting list for a kidney but there have been no decisions regarding this.

One of the ethical dilemmas under discussion regarding the extra-renal "vital" organs relates to the high priority given to the sickest patient. Because of the limited number of extra-renal organs available, there are concerns that perhaps the sickest patient, who will most likely have the worst outcome, unjustly "consumes" too many organs and that patients who are waiting longer periods but who are less ill would have much better outcomes with these limited resources.

In summary, while the current system attempts to create a framework allowing the equitable distribution of organs, there are many areas that may require re-thinking and perhaps modification of the current rules.

Dr. C. Reckard, Transplantation Surgeon, Lehigh Valley Hospital

## Ethical Issues In Anencephalic Organ Donation

Current law and public policy in the United States prohibits the use of anencephalics as organ donors. This prohibition is based on (1) the "dead donor" rule in the Uniform Anatomical Gift Act, which holds that vital organs may not be taken from the living for the benefit of others and (2) the whole-brain statutory definition of death, which holds that all brain functions, including those of the brain stem, must cease before death can be declared.

One strategy for transplanting organs from anencephalics consistent with current law was tested in 1987 by Loma Linda University Medical Center. (Peabody, Emory, and Ashwal 1989; Walters and Ashwal 1988) Anencephalics were placed on life support until whole brain death occurred at which time they became

suitable organ donors. Although this strategy does not involve tampering with the current definition of death or the dead donor rule, it raises an ethical issue from its apparent treatment of the anencephalic simply as a means to benefit a potential recipient of organ transplantation. Intubating and resuscitating the infant immediately and aggressively at birth solely in order to determine brain death and salvage organs is viewed by some as a violation of the dignity of the child and the Kantian rule against treating others simply as means. (Meilaender 1986; Shewmon, Capron, and Peacock 1989). However, others point out that there are ample precedents for maintaining life-support systems in patients in order to salvage their organs, particularly in cases of trauma, and that anencephalic infants, while clearly human beings, are not full-fledged "persons" in the Kantian sense and will not be harmed by extending their lives by a few days. (Robertson 1988; Veatch 1988; Walters and Ashwal 1988; Cefalo and Engelhardt 1989) While the Loma Linda experiment may be a workable compromise, Loma Linda stopped doing transplants from anencephalics because it was "medically unfeasible."

A second strategy for allowing anencephalic organ donation is to change the definition of "donor" in the Uniform Anatomical Gift Act to include at least one category of living human being. (Caplan 1987, 1988; Robertson 1988) Proponents of this strategy hold that because of their severe deficits, anencephalics do not have any interests, and therefore cannot be either benefited or harmed. Taking their vital organs does not violate their interests or rights. Since the purpose of the dead donor rule is to protect vulnerable, dying patients from harm, it does not apply to anencephalics.

Proponents of this argument further contend that the debate over this issue should be resolved by weighing the effects of the procedure on others. (Caplan 1987,

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1988; Cranford and Roberts 1989; Cranford and Smith 1987; Harrison 1986) The benefits to dying children in need of vital organs and the consolation to the parents of anencephalics that some good can come out of their tragedy are two of the benefits that outweigh what advocates claim are merely symbolic concerns of the general public: that there is an appearance of violating the dignity of persons and using others simply as means to further the good of others.

Opponents of amending the dead donor rule claim that consistency would require similar treatment of other individuals who lack the capacity for consciousness and therefore lack any interests whatever, e.g., individuals in persistent vegetative state (PVS). (Arras and Shinnar 1988; Capron 1987; Fost 1988; Willke and Andruski 1988) More significantly, they claim that it will lead to taking organs from individuals who can be harmed and who do have rights, e.g., infants with microencephaly or hydranencephaly and patients with end-stage Alzheimer's disease. Such slippery-slope consequences can occur through the possibility of misdiagnosis by less than competent physicians or by means of a gradual erosion of respect for human life.

Opponents cite other moral and social costs. Even if anencephalics are beyond harming, the practice of removing organs from anencephalics would nonetheless involve the direct killing of human life. (Shinnar and Arras 1989) Not only would this violate the traditional moral and medical ethical prohibition against killing, it would likely inflict a heavy emotional toll on health care professionals. (Peabody, Emory, and Ashwal 1989; Shewmon, Capron, and Peacock 1989) The effect on parents is also unclear. Although some may derive satisfaction from donating their infants organs, there will be many others who will be disappointed when their infant cannot be used as a donor because of organ malformations or lack of a suitable recipient. Conceivably, parents may experience remorse at having "killed"

their infant. (Shinnar and Arras 1989)

Finally, opponents worry that tinkering with the dead donor rule would have serious consequences for organ transplantation. (Capron 1987; Fost 1988; Freedman 1988; Shewmon, Capron, and Peacock 1989) It has taken enormous efforts at public education to reassure ordinary people of the rightness of taking organs from whole-brain dead bodies. Using anencephalics as organ donors would revive a public fear that doctors were abusing some patients for the benefit of others and science. Regardless of whether this public perception is rational, opponents claim that it would undermine public confidence in organ transplantation.

A third argument in support of anencephalic organ donation is to amend the laws defining death in such a way that anencephalics would count as "dead." Critics of the current whole-brain definition of death argue that brain stem functions alone lack any moral importance. (Cefalo and Engelhardt 1989; Cranford 1987; Engelhardt 1986; Gervais 1986; Green and Wikler 1980; Lizza 1993; Veatch 1988; Zener 1988, 1989) The capacity for cognitive function, including consciousness, is viewed as a necessary condition of personhood, and that when there is no longer a potential for cognitive function, as in anencephaly and individuals in PVS, death has occurred. A breathing human body is not itself a person, and without a functioning neocortex, anencephalics and individuals in PVS are merely breathing bodies. By revising our current statutory definition of death from a whole-brain to a higher-brain definition, anencephalics would be categorized as morally and legally dead, and thus could be used as a source of organ donation without violating the dead donor rule.

Opponents of this argument contend that there is no broad public consensus for the higher-brain definition of death as there is for the whole-brain definition, and that such a consensus is needed before any

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redefinition of death should or could take place. (Arras and Shinnar 1988; Capron 1987; Fost 1988; Freedman 1988) Despite whatever philosophical plausibility there is to the higher brain definition, anencephalics and individuals in persistent vegetative state do not look "dead" to the average person. Moreover, the higher-brain definition of death may be inconsistent with religious value systems that have accepted the whole-brain standard. Critics also

worry that amending the definition of death would threaten the severely senile and severely retarded, since the boundary between marginal personhood and unequivocal death would be a matter of degree. (Shinnar and Arras 1989)

References available upon request from Gale Brunst, Critical Care Office.

John P. Lizza, Ph.D., Professor of Philosophy, Kutztown University

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## Ethical Issues In Bone Marrow Transplantation

Bone marrow transplantation has become an important life-saving therapy for the 90's. Potential recipients of such transplants include patients with immunodeficiencies, non-malignant blood disorders, enzyme disorders, and patients with malignancies. Donors are selected from twins, allogenic (matched donors), or related donors, and sometimes from mismatched, unrelated donors. Complications for the donors relate to discomfort from the procedure and a temporary anemia. Complications from the transplantation includes graft failures, graft versus host diseases, infections, and the toxicity of the

attendant chemotherapy and radiotherapy. Ethical issues relate to the quality of life (i.e. does the transplantation improve quality of life sufficient to warrant the procedure and attendant treatment), cost/benefit ratio, reimbursement issues (i.e. should insurers have to pay for such therapies, are they still experimental), donor risk (relatively minimal), and breeding of children to act as donors (ie having a child for the specific purpose of donating bone marrow to a sibling.).

Robert Post, M.D. Oncologist, Medical Director, Hospice

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## Ethical Issues In Cardiac Transplantation

Heart transplantation was first described in a canine to canine transplant in 1905, with a two hour survival of the recipient. The 'patient' developed massive clotting causing its death. Advances in surgical technique by the 1950's allowed surgeons to place patients on cardiopulmonary bypass, opening the way for open heart procedures. The University of Mississippi in 1964 transplanted the first xenograft (primate donor to human). The

patient survived one hour.

In 1967 Dr. Christian Barnard of South Africa transplanted a heart into a 58 year old patient. This patient survived 18 days and died of pneumonia. From 1970 to 1980 heart transplantation saw major progress with the development of long-distance organ procurement, the development of the concept of brain death, and use of immunosuppressants for treatment

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of rejection.

Selection of patients for heart transplantation differs somewhat from renal transplantation in that local patients are given preference over distant patients, due to problems of organ maintenance. The average waiting time on the transplant list is increasing, but at present is about 8 months. Up to 25% of patients die while waiting for an organ. The age for recipients ranges from neonates up to patients in their 60's.

For those who do receive a heart, the survival for one year is >85%, for 5 years it is 60-75%. Quality of life is good to excellent for 80-90%, 85% are capable of returning to work. Financially 38% are worse off after the transplant, due to the

high cost of the procedure (between 50 and 100,000 dollars). Complications of the procedure include rejection of the transplanted organ, infection, coronary artery disease, malignancy, renal failure, an hypertension. The United States has about 110 transplant centers, whereas the rest of the world has about 90 centers.

Ethical issues have to do with prioritization of recipients, the issue of transplantation to patients with self-induced cardiac disease (for example, patients with alcoholic cardiac injury), and with the right of patients to undergo a second transplant. To date these issues remain unresolved.

Jeffrey Snyder, M.D. Cardiologist,  
Lehigh Valley Hospital

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## Brain Implants In Parkinson's; An Exercise In Theory.

Parkinson's disease is a common, progressive, disabling disorder of the nervous system of unknown cause. In it there is a degeneration and loss of nerve cells in deep portions of the brain, cells which make a chemical called dopamine vital to the movements which we all enjoy. With the inexorable loss of dopamine from the brain, patients show progressive slowing of movement, loss of balance, tremor of the limbs, hesitancy of speech, and worsening disability.

In the 1950's neurosurgical treatments for this disorder outstripped medical therapy. Surgeons would cause small lesions in the brain at critical areas for movement. These operations would improve certain aspects of the Parkinsonian syndrome, including tremor and rigidity. When L-dopa was developed in the late 1960's and found to be effective in Parkinson's disease, these operations fell into disuse.

Unfortunately, it became apparent that L-dopa and the other dopamine type medications which followed it were only tem-

porarily effective in this progressive disease. After 5-7 years many patients developed episodes where their system would shut off, causing them to freeze in their tracks. The brain could no longer 'buffer' the effect of the dopamine, and the patients developed wild swings in their ability to function, increasing their disability.

In the 1970's animal models of Parkinson's disease were developed. There was evidence from the studies that improvements in the symptoms could be achieved by implanting either adrenal gland tissue or fetal tissue into the animals. Though the number of experiments in this area were small, these results encouraged physicians in a number of countries to use these techniques in patients with the disease.

Initial trials in a handful of patients in Sweden were a dismal failure. This seemed to signal the end of transplantation in this area, until in 1987 Madrazo et al from

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Mexico described dramatic results in adrenal medulla autotransplantation into the brains of two patients with Parkinson's disease. Further experimentation in China and Mexico provided more striking examples, this time captured on videotape.

As a result of these preliminary results, a series of operations was undertaken, and in 3 years 200 additional patients were operated on around the world. At all major US centers results fell far short of the initial findings. At the Mayo Clinic, 8 patients underwent adrenal transplantation. At 6 months after operation moderate improvement was seen in only one patient, and no improvement was present in the others. Several US centers reported their combined results. There was statistically significant improvement in this group at 6 months, but by 18 months after surgery this had largely reversed. Two major registries of Parkinson's operations were developed, compiling the results of adrenal medullary transplants in the USA. This analysis showed inconsistent results, few patients with impressive results, and a large morbidity including some mortality. Adrenal Medullary transplantation was stopped in the USA in 1990. A large part of the problem may have been that the transplants rarely survived the graft process, producing nonvital tissue with no dopamine producing potential.

The ethics of autotransplantation of adrenal medulla (I.E. transplanting the patient's own glandular material to the brain) lie in whether there is proof that this is better or safer than presently accepted procedures. The author contends that this is still an experimental treatment and should only be provided within carefully documented and supported research protocols.

Concurrent with the use of autologous adrenal tissue, fetal transplantation of mid-brain (The area of the brain lacking in dopamine cells in Parkinson's) began to be utilized. More than 100 Parkinson's patients have undergone transplantation of human fetal midbrain, documented in

published articles from Sweden, USA, Mexico, Great Britain, Czechoslovakia, and Cuba. In some of the patients improvements were sustained with decreased clinical fluctuations. However, dosages of antiparkinsonian medications were rarely reduced. At the University of Colorado Freed and associates reported the first US patient in 1990. They more recently reviewed 7 cases, who at four years showed improvement. At Yale Spencer et al. reported moderate improvement in three patients. A fourth patient died 4 months after transplant. Post-mortem there was survival of the graft and vascular and synaptic integration of the graft. However, there was no staining indicating activity of dopamine forming cells.

The overall results from multiple countries were thus positive. However, there are significant authorities (including Landau, 1994) who doubt the effect of these operations, making the point that placebo effect, as well as the effect of the surgical injury rather than the transplantation may have caused the improvement. There continue to be major issues in the medical efficacy of this procedure, as well as changes in technical features of placement and graft processing which need working out in animal models. In addition, patients with fetal transplantation require immunosuppression, usually with cyclosporine, which has significant side effects of hypertension and renal dysfunction. This also raises the issue of whether the immunosuppression itself affects the disease.

The ethical issues in this area fall into the following categories:

1. There are concerns that human experimentation in this area has outstripped the experimentation in animals, which runs counter to usual methods of introducing surgical techniques into human treatment.
2. There continue to be concerns as to whether this therapy works, and

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there are significant risks of morbidity and death.

3. There is a question of the ethics of using fetal donations. These 'patients' have no ability to formulate prior wishes. In some of the studies it is unclear what kind of consent format is used for the parents.
4. There is a question as to whether use of fetal tissue from abortions supports or legitimizes abortion. This is sometimes argued by those who state that women who have elective abortions are ambivalent, and that additional justifications may sway them.

In 1989 Ronald Reagan imposed a ban on the use of federal funds for fetal transplantation of tissue obtained from elective abortion. Subsequently a panel of 21 experts concluded by a vote of 18-3 that such research was acceptable for public funding. Guidelines were set up to try to prevent linkages between the decision to

have an abortion and the decision to donate fetal tissue. They suggested that the possibility of donating fetal tissue not be mentioned to a pregnant woman until after she had decided to have an abortion. In addition, they suggested that tissue not be donated for a specific or related patient. Finally, there should be no financial incentive for a woman to donate fetal tissue, or for her clinical staff to encourage her to do so.

In summary, fetal transplantation remains a research technique with continuing questions as to efficacy, and some continuing ethical dilemmas.

References available upon request from Dr. Rae-Grant, 1210 S. Cedar Crest Blvd., Allentown, Pa., 18103

Alex Rae-Grant, M.D., F.R.C.P.(C.)  
Chairman,  
Lehigh Valley Ethics Committee

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## Krank's Corner:

Seasons greetings to one and all! The new year brings us the defeat of health care reform in America; with the new season, Hillary's disappeared from the scene and the shady 500 have all gone back to their think tanks. Lest we go back to "business as usual", this krank would like to remind you that huge corporations continue to coalesce into major 'pseudo-alliances', with power over entire regions. The question will be, does this power invest the profit-seeking insurers and for-profit entrepreneurs with haloes of virtue? When the buck stops, will the patient be at the bottom line?

The krank's message reads; stop cheering the end of Clintonemia. Health care reform, governmental or not, 'reform' or not, is here to stay. We can't afford to ignore it or assume that it will pass around us and flow on either side innocuously. No matter where WE draw the line, the

health care system will mutate dramatically in the next 10 years. Restraints on spending, restrictions on physician access, closure of hospitals, tightening of belts; the halcyon days of caring for the patient and disregarding the rest appear to be gone.

To the present time, the krank has noticed that the debate of health care has taken the ethical framework of medicine for granted. It appears to be assumed that if the structure of medicine changes, that the 'ethics' will remain intact. This cynic notes that most of the time, when your boss says push this product or cut corners here, you at least consider the option, especially when your economic job performance is on the line. In fee for service medicine the big ethical problem, one which frankly has helped to sink this system, is the potential for self-serving refer-

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ral and testing. In managed care, the opposite problem exists. The physician, potentially, becomes adversarial to the patient. As a gatekeeper, charged with cutting costs, the doctor's job becomes in essence saying no to an ill and needy population. I've been told by friends working in HMOs that this is not a problem. Patients in the HMO systems tell me otherwise. Nothing is a bed of roses, in either

fee-for service or HMO medicine. What we need to do it expose the assumptions underlying health care delivery for the present systems and for proposed systems. If we are going to become health care workers in the millennial realpolitik, we have to log onto the virtual reality which is health care reform; there will be no time for anyone out there fooling themselves. Take two aspirin, and beam me up, Scotty.

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