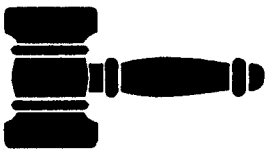
LEHIGH VALLEY
HOSPITAL

Medical Staff Progress Notes

Volume 7, Number 4
May, 1995

In This Issue...



From the President

The quarterly meeting of the medical staff took place in the Lehigh Valley Hospital auditorium, Monday, March 13. Many of you had the opportunity to attend, but for those who didn't, let me briefly summarize some of the important points covered. I gave a brief presentation on patient centered care, "where we are" and "where we are going." In addition, I presented to the medical staff the goals, as assembled by TROIKA after brief interviews with the chairs of departments, the chiefs of various divisions and sections, and past presidents of the medical staff. These were aligned as seven "things the medical staff should do" and five "things the medical staff should not do." They were as follows:

Things the Medical Staff Should Do

1. Work together as a team in a spirit of openness and cooperation toward shared goals.
2. Develop a sense of mutual respect, truthfulness, and trust.
3. Empower the PHO to work on our behalf in the arenas of managed care, quality assurance, and protocol development.
4. Develop vibrant citizenship requirements for hospital and physician which foster mutual growth, participation and interest.
5. Improve timely communication with medical staff at all levels.
6. Enhance educational leadership opportunities for physicians to ensure the best patient care.
7. Recognize, respect and protect pluralistic models of health care in our hospital.

Things the Medical Staff Should Not Do

1. Let the medical staff be governed by hallway rumor.
2. Stray from patient care as our central focus.
3. Polarize and splinter the medical staff from each other and from the hospital.
4. Lose our identity as a medical staff.
5. Hesitate to speak the truth when necessary, no matter how difficult.

These words of counsel, along with a TROIKA "wish list" for 1995, which was compiled from various personal goals of the chairs, chiefs, and past presidents will be discussed at length at a brief mini-retreat on June 3, 1995, which will be held for the medical staff. Invited to that retreat will be members of Med Exec, President and

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CEO, Chief Operating Officer, Senior Vice President of Clinical Services, chairs of our departments, chiefs of our division, key medical staff committee chairmen, past presidents of the medical staff, and physicians who have been on active staff for over 10 years. The work of that retreat will be to develop the top three priority goals that we should target for the next two years and to pound out the best mechanism of obtaining those goals.

Institutional advances included opening of the hospital-based transitional skilled nursing unit (TSU) on March 8 on the 5th floor of 17th & Chew. Jane Dorval is the medical director of the new TSU, and we look forward to working with her in making this unit a great success for our patients.

The ribbon cutting ceremony for the opening of the new GI/Endoscopy Laboratory was held on April 6. We anticipate the new laboratory to greatly enhance the quality and level of patient care for those who require gastroenterological procedures.

I'd like to welcome Linda Lapos as the newly elected member to the Medical Executive Committee in the at-large seat vacated by Bob Murphy's move to the President-Elect position. I'd like to thank Linda for her willingness to volunteer her time, energy and expertise in this capacity.

The third Medical Staff/ Administrative Exchange Session took place on Thursday, March 16. Issues discussed included the hospitals position on the Fairgrounds Surgical Center and reports by Drs. Klasko and White regarding LVPG negotiations with members of obstetrics and family practice. An upcoming meeting on April 20 will be dedicated to the medical oncologists and the John and Dorothy Morgan Cancer Center. The medical staff leadership encourages your participation in this frank and open exchange regarding this very volatile issue. In general, I believe all of these sessions are important if not vital as a mechanism for improving communication. I look forward to as many of you attending as possible.

The Lehigh Valley Physician Hospital Organization (LVPHO) continues to actively recruit new health care business for the hospital. Recently B. Braun Medical joined Valley Preferred, bringing the total number of covered lives to 15,400. Since the beginning of this year, LVPHO has made available to members a number of important management services organization (MSO) programs including the ability to obtain medical malpractice and health insurance for physician employees at a reduced rate through the organization. On March 30, over 70 office practices were represented at a special presentation to introduce MSO services to members of the LVPHO. Benefits offered at this time include group purchasing discounts for office supplies, medical/surgical supplies, facsimile machines, infectious waste disposal, and temporary employment service discounts. A number of additional services are being planned for the future. I congratulate John Jaffe and Greg Kile for their efforts to date and encourage them in their efforts to market a a small business insured program by July 1.

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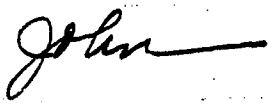
Congratulations are in order for the departments of medicine, surgery, and obstetrics for their excellent results in the recent residency match which occurred in mid-March of this year. Obtaining a high-quality, energetic residency staff for our hospital and its departments is a process which requires hundreds of hours of interviews, phone communications and active marketing by our chairs and the residency directors. We are pleased to see that effort has been fruitful again this year and look forward to meeting the new residents who will come on board in June of 1995.

Lastly, so many changes have been occurring in the area of information services that I would like to dedicate virtually all of my next progress note to describing them. A joint commission chaired by Harry Lukens and vice chaired by Chris Wohlberg has been designed to assist I/S in improving clinical services for physicians and nurses. Paperchase and Micromedics have been acquired for our PHAMIS terminals and have greatly improved our ability to search the medical literature and review drug interactions at any one of the 2,500 PHAMIS terminals currently available. Information management, data collation and transmission on patient laboratory medical records coupled with improved systems of scheduling appointments and follow-ups for patients throughout our hospital and ultimately the integrated delivery network are all critical due to the efficient functioning of the hospital of the future. With administration's support and funding and physician and nursing input and counsel, coupled with the expertise of Harry Lukens and his team at I/S, that hospital of the future may be no more than a year or two away. I look forward to describing some of that to you in detail in my next report.

Sincerely,



John E. Castaldo, MD
Medical Staff President

Newsletter Change

In order to provide you with information in the most timely manner, Medical Staff Progress Notes will now be distributed prior to the month published on each edition. For instance, this issue -- Volume 7, Number 4 - May, 1995 -- was distributed at the end of April. Please note, therefore, that there was no April issue.

Lehigh Valley Hospital Honors Physicians at Second Recognition Dinner

Over 300 physicians, board members, hospital administrators, and guests were in attendance at the Second Physician Recognition Dinner sponsored by Lehigh Valley Hospital and its medical staff, which was held on April 1 at the Holiday Inn Conference Center, Fogelsville.

The evening's festivities began with a welcome by John E. Castaldo, MD, Medical Staff President. In his welcome, Dr. Castaldo indicated that "we are here tonight to welcome, appreciate, and thank each other as physicians. Patient care is often a stress filled, demanding, and intense occupation. It is an environment that requires much talent, time, and teamwork... and sometimes we take each other for granted. This occasion is to make sure that we do not."

Serving as Master of Ceremonies for the event was Rev. Daniel G. Gambet, OSFS, President, Allentown College of St. Francis de Sales and a member of the LVH Board of Trustees, who also gave the invocation.

Receiving special recognition at the dinner were past presidents of the medical staff, who received a personally engraved Heritage Captain's Chair made by Standard Chair of Gardner. Also recognized at the dinner were physicians who actively served 50 and 25 years on the medical staff. Each physician in these categories received a beautifully designed crystal bowl made by Orrefors.

Past presidents who were honored include: Joseph A. Candio, MD, general internist; and John Jaffe, MD, urologist.

Honored for 50 years of service was E. Eugene Cleaver, MD, family practitioner.

Those honored for 25 years of service include: Judith N. Barrett, MD, family practitioner; Stephen J. Barrett, MD, psychiatrist; Jeffrey E. Burtaine, MD, family practitioner; Samuel W. Criswell, Sr., MD, family practitioner; Walter J. Dex, MD, radiologist; Dean F. Dimick, MD, endocrinologist; John P. Hentosh, MD, pediatrician; Earl S. Jefferis, Jr., MD, obstetrician/gynecologist; Peter A. Keblish, Jr., MD, orthopedic surgeon; Chetan D. Khindri, MD, cardio-thoracic surgeon; Indru T. Khubchandani, MD, colon-rectal surgeon; James E. Kintzel, MD, nephrologist; Elmer C. Long, MD, pediatrician; Joseph N. Nader, MD, cardiologist; Walter J. Okunski, MD, plastic and reconstructive surgeon; Antonio C. Panebianco, MD, cardio-thoracic surgeon; Joseph J. Prorok, MD, general surgeon; Joseph T. Sembrot, MD, endocrinologist; James A. Sheets, MD, colon-rectal surgeon; Javad Sholehvar, MD, otolaryngologist; Jere P. Smith, MD, pediatrician; Richard N. Stein, MD, pediatrician; Michael H. Ufberg, MD, gastroenterologist; Concepcion T. Yen, MD, obstetrician/gynecologist; and John S. Ziegler, DDS, dentist.

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Following the presentation of awards for each category, a special presentation of a giant wall clock was made by Elliot J. Sussman, MD, President and CEO, and Irwin Greenberg, Chairman, Board of Trustees, to Dr. Castaldo for the entire medical staff.

According to Mr. Greenberg, "This clock will dedicate the newly redesigned Lehigh Valley Hospital lobby to you the members of the medical staff who have made this hospital great. This living recognition is appropriate for the lobby where all of the public who come to this hospital may see, recognize, and appreciate the efforts of the past, as well as the ongoing efforts to build our hospital into a vibrant, community health organization of the future."

The inscription below the clock reads, "To the Medical Staff of Lehigh Valley Hospital in sincere appreciation for their exemplary teaching, service, and health care for our community. Elliot J. Sussman, MD, President and CEO, and Irwin Greenberg, Chairman of the Board. April 1, 1995."

Following the presentation, entertainment was provided by Mixed Nuts, a six-person comedy troupe; and for dancing and listening pleasure, The Frank Michael Orchestra provided the music.

Transitional Skilled Unit Gets Green Light

On March 23, the Transitional Skilled Unit (TSU) completed its final inspection by the Pennsylvania Department of Health. As of that date, the unit was certified for full occupancy. The unit is now able to accept your patients who require the special environment of the TSU and who meet the specific criteria.

Those criteria include:

⌘ An inpatient stay of three or more days in the acute care setting;
⌘ The need for skilled nursing and/or rehabilitation services; and
⌘ A well-defined discharge plan exists for the resident to return home or to another level of care within the approximate length of stay period of 20 days.

If you wish to admit or refer a patient to the TSU, please contact the Discharge Planner or the TSU Skilled Care Coordinator at 402-3300, who will facilitate the transfer of appropriate patients.

If you have any questions or concerns about the TSU, please contact Jane Dorval, MD, Medical Director, at 776-3340, or Terry Tressler, TSU Administrator, at 402-9725.

Orders for Inpatient MRI and MRA Procedures to be Available through PHAMIS

Effective April 24, orders may be placed on PHAMIS for inpatient MRI and MRA procedures. However, the existing manual process for scheduling an MRI and/or MRA procedure should be followed prior to placing an order on the system. This process includes completion of Lehigh Magnetic Imaging Center's (LMIC) Inpatient Intake Sheet and a phone call to LMIC to schedule a magnet (740-9500).

LMIC will use PHAMIS to enter diagnostic results for inpatient procedures. **You may access results for MRI and MRA studies via ancillary results review within the MPI command**. Although plans are being looked at to include outpatient procedures at some time in the future, outpatient MRI and/or MRA orders or results are not currently available.

Please note that inpatient implementation is scheduled for noon on April 24. After that time, you should be able to enter orders or find results on PHAMIS for inpatient MRI or MRA procedures.

If you have any questions regarding access to inpatient MRI reports on PHAMIS, please contact Nancy Fredericks, LMIC Business Director, at 740-9731.

News from Research

A call for abstracts have been issued by the following:

- The International Society for Pharmacoepidemiology for the 11th International Conference to be held on August 27 in Montreal, Canada. Submission due date is May 15.

- The Society for Medical Decision Making for the 16th Annual Meeting to be held on October 14 in Tempe, Ariz. Submission due date is May 24.

For instructions, forms, and further information, contact Kathleen Moser in the Research Department at 402-8747.

Reminder from Risk Management

The legally acceptable way to make a change to a patient's medical record is to draw a line through the incorrect verbiage, initial and date/time the correction. DO NOT obliterate what you are changing. You are permitted to correct only your own documentation. If you are concerned about an inaccuracy with another individual's charting, you must discuss the question with that individual. Do not attempt to "correct" another's charting.

Legal Briefings by Janine Fiesta

Implementation of New Requirements for "Physician Ownership and Referral"

According to Section 1877 of the Social Security Act [42 U.S.C. Section 1395nn], effective January 1, 1995, physicians cannot make self-referrals for certain designated health services. The designated health care services include any of the following items or services:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Radiology services, including MRI, CAT scans, and ultrasound services
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

The law prohibits a physician who has a financial relationship with an entity from referring Medicare patients to that entity to receive a designated health care service. The prohibition also applies if a physician's immediate family member has a financial relationship with an entity. A financial relationship can exist as an ownership or investment interest or in a compensation arrangement with an entity. **The law is triggered by the mere fact that a financial relationship exists; it does not matter what the physician intends when he or she makes a referral.**

The law requires physicians and entities to comply with the prohibition on referrals for designated health care services beginning on January 1, 1995. If a person collects any amount for services billed in violation of the law, he or she must make a refund. In addition, significant civil money penalties or even exclusion from Medicare, Medicaid, and other programs could occur. The law also prohibits a physician or entity from entering into a circumvention scheme (such as a cross referral arrangement), which the physician or entity knows or should know has a principal purpose of assuring referrals to a particular entity that would be prohibited if made directly.

The law does contain a number of exceptions to the general prohibition. It is important to seek legal advice in accessing your individual circumstances in order to assure that your business relationships meet the requirements of this law.

If you have questions regarding this or other legal issues, please contact Legal Services/Risk Management at 402-5210.

Library News

Through e-mail, there is now an LVH form that allows you to request a photocopy or interlibrary from the Health Sciences Library.

Multiple Sclerosis Bike Tour

Lehigh Valley Hospital is forming a team of riders for the annual Multiple Sclerosis fundraiser -- the MS150 PA Dutch Bike Tour, a weekend biking excursion from the Trexlertown Velodrome to Lancaster on June 10 and 11.

Early registration is recommended to guarantee overnight accommodations. Registrations are due by May 26, and pledges of at least $150 must be turned in prior to the event by June 2.

Lehigh Valley Hospital will pay the registration fee and provide a fanny pack for each team rider.

To be part of the team or to sponsor a rider, contact Gail Pitsko in Public Relations at 402-3001. For more information about the event, contact the Multiple Sclerosis Society at 395-7230.

Congratulations!

Raymond A. Fritz, Jr., DPM, podiatrist, recently completed a second board certification which is recognized by the American Podiatric Medical Association. Dr. Fritz is now a Diplomate of the American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

Peter H. Goldman, MD, family practitioner, was one of the principal reviewers of the new National Safety Council "Oxygen Administration" manual. The curriculum is directed at basic first aid trained responders in the workplace and athletes.

Ellen M. Joyce, MD, obstetrician/gynecologist, recently fulfilled all the requirements for certification and is now a certified Diplomate of the American Board of Obstetrics and Gynecology.

Richard M. Lieberman, MD, chief, Division of Urology, recently received recertification as a Diplomate of the American Board of Urology.

Larry N. Merkle, MD, chief, Endocrinology/Metabolism, was selected by the Pennsylvania Medical Society to serve as the Endocrinology Representative to the Interspecialty Section.

Oscar A. Morffi, MD, pediatrician, was recently elected to the position of Vice President of the Allentown Board of Health.

Howard A. Silverman, MD, family practitioner, was elected to the position of President of the Allentown Board of Health. Dr. Silverman previously served as the Board's Vice President.

Meetings of the Physician Well-Being Group have been cancelled until further notice.

Papers, Publications and Presentations

John P. Fitzgibbons, MD, Chairperson, Department of Medicine, served on the faculty of the Association of Program Directors in Internal Medicine meeting in Atlanta, Ga., on March 22 and 23. He ran two workshops dealing with "The Issue of Decreasing Numbers of Fellows in Medicine" and "Clinical Work Redesign with Residents Moving to Ambulatory Training."

Indru T. Khubchandani, MD, colon and rectal surgeon, was the principal speaker at the 23rd Congress of the Venezuelan Society of Surgery in Caracas, Venezuela from March 14 to 17. His address was titled "Complex Problems in Anorectal Surgery." He also participated on two panels -- "Recurrent Cancer Detection and Management" and "Benign Diseases of the Anorectum."

Thomas D. Meade, MD, orthopedic surgeon, was an invited lecturer at the Annual Primary Care Sports Medicine Symposium at the Milton S. Hershey Medical Center on March 10 and 11. His talk was titled "Elbow-Tenosynovitis Medial and Lateral."

In addition, Dr. Meade held a spring board diving clinic at the West End Racquet Club on March 18 which was attended by 30 future high school and collegiate divers.

Glen L. Oliver, MD, ophthalmologist, attended the Schepens International Retinal Society Meeting from March 1 to 5 in Mexico City, where he presented a paper on "Idiopathic Retinal Vasculitis, Aneurysms and Neuroretinitis." The ocular findings in 11 cases of this rare syndrome were presented along with a discussion of the possible etiology and management of its complications.

Lester Rosen, MD, Program Director, Colon and Rectal Surgery Residency, was a member of the faculty at the Cleveland Clinic's annual symposium, Colorectal Disease in 1995, held from February 23 to 25 in Ft. Lauderdale, Fla. He presented lectures on three topics during the conference: "Condylomata Acuminata," "Rectocele Repair," and "C. Difficile and Other Antibiotic Induced Colitides," and served on three panel discussions representing a variety of colorectal topics.

Alexander M. Rosenau, DO, emergency medicine physician, participated in the paramedic training lecture series at the Lehigh Valley Hospital Emergency Medicine Institute on March 25. His presentations included: "Near Drowning," "Arthropod and Snake Envenomation," and Hyper and Hypothermia."

On March 27, the ***Medical Command Base Station Course*** was presented by the Eastern Pennsylvania Regional EMS Council at Lehigh Valley Hospital. Dr. Rosenau's presentations included: "Medical Legal Aspects of Pre-hospital Care," "Pitfalls of On-line Command, Off-line Medical Control," and "Quality Assessment and Improvement." **John F. McCarthy, DO,** emergency medicine physician, was also a participant and presented "Triage and Special Transport." The Base Station course served the needs of participants from five hospitals. In addition, the course introduced the Emergency Medicine Residency of the Lehigh Valley's residents to the principles of pre-hospital medical command through case simulations.

Upcoming Seminars, Conferences and Meetings

Medical Staff/Administrative Exchange Session

The May **Medical Staff/ Administrative Exchange Session** will be held on Thursday, May 18, beginning at 5:30 p.m., in Conference Room 1, Side B, of the John and Dorothy Morgan Center.

It is of paramount importance that as many physicians as possible attend these sessions to participate in the exchange of information about important topics in a timely manner.

Topics to be discussed will be posted throughout the hospital prior to the session.

For more information, contact John E. Castaldo, MD, Medical Staff President, through Physician Relations at 402-9853.

Mitchell F. Katz, MD Lecture Series Postponed

The Fourth Mitchell F. Katz, MD Lecture Series, which was scheduled for May 24, has been postponed due to scheduling conflicts. The lecture series will be rescheduled later this year. Please watch ***Medical Staff Progress Notes*** for an update.

If you have any questions, please contact Marcia Shaffer in the Department of Family Practice at 402-4955.

Regional Symposium Series VI

Fifteenth Annual Update in Cardiology will be held on Thursday, May 4, from 7:45 a.m. to 12:30 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Physicians and other health care professionals interested in the latest breakthroughs in selected aspects in cardiology will benefit from this program.

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

- discuss the current clinical usefulness of cardiac transplant in treating heart disease
- describe the role of endothelial factors in coronary events
- explain the use of anti-thrombotic and anti-platelet agents in coronary syndromes
- explain the economic and ethical feasibility of heart transplants in the current medical climate.

Fourth Annual Wilderness Medicine Symposium will be held on Saturday, May 13, from 7:30 a.m. to 4:45 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Physicians, nurses, pre-hospital personnel, and others interested in wilderness medicine will benefit from the program.

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At the completion of the program, participants should be able to:
- discuss the signs, symptoms, and treatment of medical problems which may occur in wilderness situations
- recognize and treat traveler's diarrhea
- explain techniques for prevention and treatment of eye problems in the wilderness
- describe appropriate packaging of patients for rough terrain transport
- describe the prevention and management of injuries while mountain biking

Third Annual Obstetrics and Gynecology Joseph A. Miller, MD, Resident Research Day will be held on Friday, June 2, from 8 a.m. to 3 p.m. , in the hospital's Auditorium at 17th 7 Chew.

Obstetricians, gynecologists, family practitioners, nurses, residents, students, and other health care professionals interested in an update in obstetrics and gynecology will benefit from this program.

At the completion of the program, participants should be able to:
- discuss the management of diabetes during pregnancy
- describe the indications for endoscopic surgery in the pediatric and adolescent patient

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

Department of Pediatrics

Craniosynostosis will be presented by Luis Schut, MD, Director of Neurosurgery, Children's Hospital of Philadelphia, on Friday, May 12.

Hypoglycemia in Newborns and How it Relates to Mom and Sequelae will be presented by Dennis Mujsce, MD, Division of Newborn Medicine, Hershey Medical Center, on Friday, June 9.

Both programs will be held on noon in the Auditorium at 17th & Chew.

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

Psychiatry Grand Rounds

Attention Deficit Hyperactivity Disorder in Adults will be presented by George J. DuPaul, PhD, Associate Professor of School Psychology, Department of Counseling Psychology, School Psychology, and Special Education, Lehigh University, on Thursday, May 18, 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.

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

Sangeeta Agrawala, MD
ABC Pediatrics
Allentown Medical Center
401 N. 17th Street, #203
Allentown, PA 18104-6805
(610) 821-8033
Department of Pediatrics
Division of General Pediatrics
Provisional Active

Saralee Funke, MD
Forensic Pathology Associates, Inc.
Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556
(610) 402-8140
Department of Pathology
Division of Forensic Pathology
Provisional Active

Robert J. Laskowski, MD
Senior Vice President of Clinical Services
Lehigh Valley Hospital
Cedar Crest & I-78
Allentown, PA 18105-1556
(610) 402-7502
Department of Medicine
Division of General Internal Medicine
Provisional Active

Additional Privileges

J. Patrick Kleaveland, MD
Department of Medicine
Division of Cardiology
Active
Stent Placement Privileges

Change of Status

Joseph A. Habig II, MD
(J. Wolf, MD & Mark Kender, MD)
Department of Family Practice
From Courtesy to Provisional Active

Practice Changes

Michael F. Busch, MD
No longer associated with
Charles R. Levine, MD
Now associated with
Coordinated Health Systems
451 Chew Street
Suite 400
Allentown, PA 18102-3424
(610) 821-2822
FAX: (610) 432-6262

Robert J. Coni, DO
No longer associated with
Neurological Services, Inc.
New address:
728 Delaware Avenue
Bethlehem, PA 18015-1135
(610) 882-0280
FAX: (610) 882-0218

Ellen M. Field-Munves, MD
Has now joined
Coordinated Health Systems
2775 Schoenersville Road
Bethlehem, PA 18017-7327
(610) 861-8080
FAX: (610) 861-0258

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Charles R. Levine, MD
No longer associated with
Michael F. Busch, MD
Now associated with
Lehigh Valley Orthopedics
ROMA Corporate Center
1605 N. Cedar Crest Blvd., #111
Allentown, PA 18104-2304
(610) 821-4848
FAX: (610) 821-1129

Louis E. Spikol, MD
No longer associated with
Drs. McGorry and Neumann
Now associated with
Southside Family Medicine
141 E. Emaus Avenue
Allentown, PA 18103
(610) 791-5930
FAX: (610) 791-2157

Raymond L. Weiand, DO
Now associated with
Lehigh Valley Orthopedics
ROMA Corporate Center
1605 N. Cedar Crest Blvd., #111
Allentown, PA 18104-2304
(610) 821-4848
FAX: (610) 821-1129

Address Changes

Lehigh Valley Orthopedics
Peter M. Anson, MD
Randy Jaeger, MD
Charles R. Levine, MD
Barry A. Ruht, MD
Leo J. Scarpino, MD
Thomas Ward, MD
Raymond L. Weiand, DO
ROMA Corporate Center
1605 N. Cedar Crest Blvd., #111
(610) 821-4848

Mertztown Community Medical Center
Chandrakant C. Shah, MD
Michael G. Sidarous, MD
506 Woodside Avenue
Mertztown, PA 19539-9723

Maheshwer B. Verma, MD
21 Corporate Drive
Suite 4
Easton, PA 18045-2664

M. Bruce Viechnicki, MD
1611 Pond Road
Allentown, PA 18104-2256
(610) 366-7000
FAX: (610) 366-0255

Resignations

C. Theodore Blaisdall, MD
(Valley Anesthesia, Inc.)
Department of Anesthesiology
Active

Wayne A. Moyer, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Podiatry
Courtesy

Allied Health Professionals

Appointment

Mary Ellen Lynch, CNM
Physician Extender
Professional - CNM
(Hospital - Dr. Balducci)

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Additional Privileges

Barbara Fadale, RN
Linda Gorman, RN
Kathy Leiby, RN
Sue Nabhan, RN
(Cardiovascular Associates)
Margery A. Fettig, RN
(John Cassel, MD)
Physician Extender
Professional - RN
May record the progress notes for the physicians as long as the physician is on the nursing unit and signs the progress note immediately after it is written.

Address Change

Christopher A. Fry, PA-C
(Charles R. Levine, MD)
ROMA Corporate Center
1605 N. Cedar Crest Blvd., #111
Allentown, PA 18104-2304

Resignation

Mary M. Conaway, RN
Physician Extender
Professional - RN
(Yasin Khan, MD)

HEALTH NETWORK LABORATORIES

A Service of LEHIGH VALLEY HOSPITAL

Immunology Methods for the Rapid Diagnosis of Acute Infections

The major objective of most immunology laboratories is to make a tentative identification of infecting organisms rapidly enough that attending physicians can institute therapy or offer advice to eliminate potential spread of disease. In some cases, isolation and identification of an infectious agent may be slow and information obtained is used retrospectively, serving only to confirm the clinical diagnosis of the physician. Immunological techniques, when available, offer an alternative to a traditional culture in the diagnosis of infectious disease. In the past few years, most efforts for rapid diagnosis have been directed toward the development of methods permitting direct detection of antigens in a clinical specimen, thus circumventing the wait for culture results.

Antigen detection assays vary in design but usually involve incubation of the patient's specimen with a labeled antibody. These are designated by the type of label used and the most common are:

- RIA (Radioimmunoassay) - uses an isotope labeled conjugate usually in a noncompetitive solid phase assay. RIA, while quite sensitive, runs into problems because of expense and safety issues.

- DFA/IFA (Immunofluorescence) - uses an antibody tagged with FITC or fluorescein isothiacyanate with microscopic examination under UV illumination. Fluorescent techniques are limited with regard to expense, quality, specificity, and standardization of reagent.

- EIA/ELISA (Enzyme Immunoassay) - uses an enzyme that catalyzes a chemical reaction in a substrate. The end product of the reaction is measured visually, spectrophotometrically, or fluoremetrically. EIA has proven to be a significant alternative to the previously listed traditional immunologic methodologies and is becoming the method of choice.

DNA/RNA probes and PCR (polymerase chain reaction). Although many of these procedures have not yet been approved for in vitro diagnostic use, they are becoming more available and more accepted. At present, they are a costly service to provide, since dedicated work space and highly trained personnel are required. As a highly sensitive technique, PCR also has its drawbacks. The DNA sequence must be known for the particular fragment to be amplified and must be in a region of DNA that does not vary among known isolates. Also because of the amplification sensitivity, false positives may occur.

The immunologic protocol readily available for rapid diagnosis of infectious disease used the assessment of antibody response to a specific infectious agent. Traditionally this involved obtaining an acute and convalescent blood specimen 2 weeks apart. A positive result was to observe a four-fold increase in IgG antibody titer over the course of the infection. The serodiagnosis of infectious diseases can be enhanced by determination of specific antibodies of the IgM class. In general, IgM antibodies characteristically appear the first 7-10 days after primary infection.

Maximum titers are reached in 2-3 weeks, declining to undetectable levels in about 3 months. The presence of a specific IgM

antibody is consistent with a current or recent infection and provides a rapid diagnosis based on a single serum specimen. In pregnancy, maternal IgM antibody does not cross the placenta. Therefore the detection of specific IgM antibodies in the serum of a neonate can be assumed to be the result of a congenital infection.

In the past, a number of procedures had been developed for detecting specific antibodies of the IgM class. Unfortunately, experience with these methods revealed that the procedures were not sufficiently specific or sensitive. Newer assays now available address most of these problem issues, thereby improving the reliability of the results. The most common limitations to IgM testing are:

1) Interference by IgG antibodies, especially in high titer as they compete with IgM antibodies for binding sites on the antigen, causing false negative results.

2) Interference by RF, an IgM anti-IgG antibody which in the presence of specific IgG antibodies can produce false positive results.

Current methodology is to employ two distinct alternatives for reducing the effects of these interferences.

1) Separation or absorption steps prior to assay performance

- ♦ IgM may be isolated by sucrose gradient centrifugation
- ♦ IgG may be removed by absorption with Staph A and Streptococci
- ♦ IgG & RF may be removed by absorption with precipitating anti-IgG

2) IgM capture assay using anti-human IgM as a "capture" antibody.

- ♦ Anti IgM captures patient IgM antibodies
- ♦ Antigen specific conjugate is added
- ♦ Substrate detects complex

To summarize, once interferences to IgM testing have been minimized, the specific IgM assay routinely exhibits increased sensitivity allowing for the rapid diagnosis of an acute infection. This is the testing wave of the future. The following list of available IgM assays will be continually expanding to provide more tests with improved diagnostic efficiency. The acute and convalescent specimen approach of the past has been replaced by these specific IgM assays of the future.

As with all laboratory tests clinical judgment must be employed to interpret an IgM test result. For example false negatives can occur when the specimen is obtained too early in the infection process, or in situations with early intervention with anti-microbial or viral therapy or in the immune compromised patient. The intensity of the IgM antibody response varies with the virus. Finally interpretation of positive results must consider cross reaction to related virus or prolonged IgM responses in relation to latent virus especially with the herpes group.

The following Specific IgM antibody assays are available in-house for the rapid diagnosis of the acute infectious state representing both types of the separation processes.

Mycoplasma pneumoniae Ab, IgM
Lyme (Borrelia borgdorferi) Ab, IgM
Epstein Barr Virus, VCA IgM
Hepatitis A Ab, IgM
Hepatitis B Core Ab, IgM
Toxoplasma gondii, IgM
CMV, IgM
HSV 1 & 2
Rubella (german measles) IgM
Rubeola (measles), IgM
Varicella Zoster (Herpes Zoster), IgM

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LEHIGH VALLEY
HOSPITAL

Issues In Medical Ethics

Spring 1995

Editorial:

Editor
A.D. Rae-Grant, M.D.

Contributor
J. Vincent, M.D.

This time last year we were all talking about the Clinton reform plan, the 1500 page manifesto, the coming changes. Hillary's name was on everyone's lips, and 'nervous' concern was the word for physicians and health care workers. Since then, the Clinton plan has fallen into ruins, and the insurers have taken the field. Where is health care reform? Is it a reform in an ethical sense, or an overhaul in a fiscal fashion? On April 6th at Lehigh Valley Hospital in the auditorium (7:30 pm) Dr.Willard Gaylin will talk on "Health care reform: who dropped the ball?". Please consider coming to this important lecture and its companion panel discussion the next morning from 9-11:30 am in the auditorium. Health care is too important to be left to the bean counters. It requires reformation, not repackaging.

In this "Issues", we are reprinting in part the new withdrawing and withholding policy presented to the Medical Executive Committee. Dr.Joe Vincent and a subcommittee worked hard and long to put together a comprehensive statement on the ethics in this area. In addition, examples of some of the kinds of ethical decisions which occur are included, under the title "Parables and Pearls". Approximately 80% of the cases the ethics committee sees come under this heading. Perhaps you can all put us out of business by reading the policy and cases, and applying this knowledge at the bedside.

Finally, the Krank returns with some griping about medical ethicists. The editors remind you, the readers, that the views of the Krank are expressly not representative of the institution, the editors, or of Hillary Clinton.

Withdrawing and Withholding Policy.

A subcommittee of the Ethics Committee was formed to develop a withdrawing and withholding policy for the Lehigh Valley Hospital. Reprinted below is the text of part of this document. In addition, a copy of the proposed Withholding of therapy ordersheet is also reprinted. Thanks go to Dr. Joe Vincent for chairing this group and bringing this task to fruition.

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Purpose:

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

Types of Treatments

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

A. Cardiopulmonary resuscitation
B. Mechanical Ventilation
C. Dialysis
D. Artificial hydration and nutrition
E. Antibiotic therapy and other life-sustaining medications
F. Administration of blood and blood products
G. Surgery

Policy:

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

Presumptions:

A. Patients may accept or refuse recommended medical care even when life-threatening conditions are present, whether or not they are terminally ill. This is the principle of **autonomy** or self-determination which has been upheld by the courts and ethical scrutiny.
B. Self-determination requires the patient with capacity (competent) to have adequate information which he/she can understand and accept or reject without coercion. **Informed consent/ refusal** is a requirement of the legal and ethical systems for the person who has capacity (is competent).
C. When a patient does not have the capacity to make decisions about medical treatment, it is appropriate for a person who has either legal standing (guardian or durable power of attorney) or a loving, caring familial relationship with the patient to make medical decisions regarding his/her treatment. This person is called a **surrogate decision-maker** and is a person (usually a family member) who knows and has a caring relationship with the patient.
D. Professional health care clinicians have duties toward the patient which are part of the provider-patient relationship. The **principle of beneficence** or doing good for the patient must be balanced with the patient's wishes and decisions. Informing and convincing without coercion are part of that duty, trying to avoid the patient making bad decisions for him or herself.
E. **WITHHOLDING AND WITHDRAWING MEDICAL TREATMENTS** are equivalent acts from both a legal and ethical point of view. The conditions which make withholding medical treatment legitimate also justify withdrawing similar treatments. It is recognized that the two concepts practice often feel different and may elicit different emotional responses in carrying out the decisions.
F. When comfort care is needed in withholding and withdrawing situations, the **principle of double effect** is generally recognized and accepted. This principle states that

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actions may have two effects and one of these effects is unintended. These actions meant for comfort may hasten death but are not intended for that end and have no acceptable alternatives. Pain and dyspnea control with adequate analgesics, usually narcotics, become part of the treatment but may also hasten death, the double effect.

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

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

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

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

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

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

M. In Pennsylvania there is living will legislation which, if executed and

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

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

Withholding Of Therapy Ordersheet

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

- ☐ No CPR-cardiopulmonary resuscitation, code blue, ACLS Protocol
- ☐ No electrical defibrillation
- ☐ No Tracheal intubation for any reason
- ☐ No Mechanical ventilation for any reason
- ☐ No Vasopressors/ionotropic agents
- ☐ No Antiarrhythmics
- ☐ No Dialysis
- ☐ No Hyperalimentation
- ☐ No Tube feedings
- ☐ No Blood or blood products
- ☐ No Antibiotics
- ☐ No Electrolytes or acid/base corrective measures
- ☐ No Treatment for low urine output
- ☐ No transfer to ICU or monitored bed

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

_____

_____

_____

_____

_____

I have discussed this with the patient/patient surrogate

_____
NAME

_____
PHYSICIAN'S SIGNATURE

_____
PRINTED NAME

_____ _____
DATE TIME

☐ **Discontinue the above order(s) immediately.** (See next order sheet for specific orders)

Also, write order to discontinue withholding status on regular order sheet)

Case Records of the Lehigh Valley Hospital: Pearls and Parables of Withdrawing and Withholding Care.

A.D. Rae-Grant, M.D.,F.R.C.P.(C.)

The following case scenarios illustrate some but by no means all of the ethical issues involved in withdrawing and withholding care. These cases and others were presented at Medical Grand Rounds December 13th, 1994.

Parable 1:

Mrs.Butterbur, in the advanced stages of Alzheimer's disease, suffers from deep decubitus ulcers and infections in the bone, neither of which have responded to treatment efforts, including skin grafts. During the past month, the patient has been admitted to the intensive care unit three times with generalized infections and has required a ventilator. Four days after her most recent discharge, she is brought to the emergency room by the paramedics. She is septic, with a BP of 60/40 (Normal 120/80), and arterial pH of 6.92 (Normal 7.40), and is hardly breathing. Should she receive a tube to help her breath?

Pearl 1:

"Know when the fat lady sings"

Issues: Medical indications for therapy and medical futility.

Summary: Moribund patients are those whose death will occur in a few hours no matter what is done. None of the major goals of medicine can be met in such cases (Cure, Caring, Coping). There is no independent overriding goal. You should not continue therapy in this situation.

Parable 2:

Mr.Baggins is a 74 year old male with endstage congestive heart failure. He is on maximal therapy and is on 100% oxygen by mask. He is alert and capable and not depressed. He has already refused intubation and resuscitation. He asks that you let him remove his oxygen, knowing he will die without it. What do you do?

Pearl 2:

"You do not own your patient."

Issues: Capacity, autonomy, and lack of "countervailing" harms

Summary: In the 90's patient preferences have both ethical and legal force. They make explicit the values of self-determination and personal autonomy that are deeply rooted in the ethics of our culture. A variety of legal decisions have made it clear that there is a fiduciary relationship between the physician and his/her patient, and that following the patients wishes if they are competent and rational is the legally appropriate action.

Parable 3:

Mrs.Brandybuck is a 54 year old female with terminal cancer metastatic to the liver, bowel and lung. She is in excruciating pain. You initiate a morphine drip. You tell her this may alter her breathing, possibly hastening death. Do you increase the drip until pain is controlled even if there is a risk of hastening her death? If she becomes unconscious and shows no sign of pain, should you continue to increase her drip?

Pearl 3:

"If it feels good, do it. If it doesn't, don't."

Issues: Beneficence, "Double Effect" versus Active Euthanasia.

Summary: On occasion, it is difficult to manage pain medications so that palliative effects and depressant effects are balanced. In these situation, relief of pain and suffering become paramount over saving life, i.e. there are countervailing goals of medicine. When the goal of prolonging life can no longer be attained, the relief of pain becomes the primary goal to be sought during the remaining time of the patient's life. This is called the "double effect." Proponents of this, including the Catholic Church, argue that effects can be ethi-

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cally permissible under the following conditions;

a. the action is ethically good or at least indifferent, that is neither good nor evil in itself,
b. The agent must intend the good effects, not the evil ones , even though these are foreseen, (i.e. intention is to relieve pain, not cause respiratory compromise),
c. The morally objectionable effect cannot be a means to the morally permissible one (i.e. the respiratory compromise is not the means of relief of pain).

In the second situation, it is clearly the intention to hasten death, which is an 'evil' effect, and not a goal of medicine in and of itself. It's a good idea with Morphine drips to document why the drip is instituted, and why increases in the drip occur.

Parable 4:

Mr. Shelob is an 64 year old male on dialysis for 5 years. The yearly cost of his dialysis is $50,000 which is paid by Medicaid. He has a stroke which leaves him unable to move his left side. He can talk and is fully aware of what is going on around him. Your partners get together and come to you. They tell you they think his dialysis should be stopped. They feel that it is not right for him to be getting dialysis, and feel this is contributing to health care costs. What do you say to them?

Pearl 4:

"You are still your patient's advocate."

Issues: Fiduciary contract with the patient, distributive justice, "Futility".

Summary: Medical ethicists have reached consensus that social worth is not a criteria for fair distribution of health care. Lottery, queue, and other systems may be better, but biases in terms of social worth are wrong. However, potential for benefit may be an important variable in this equation. In cultures or situations where a limited number of patients can receive this service, some component of the expected ability to thrive, the longevity with the treatment, etc, is rational to consider. If the patient perceives some quality of life, futility is not the issue. Our perception of what is good and bad is not germane to the practice of medicine. Health care allocation decisions should be made on a societal or institutional basis, and not case-by-case at the bedside.

Parable 5:

Arwen Evenstar, a 36 year old female, has been in a nursing home for 12 years since a devastating car accident. She has not awakened since the accident, except to open and close her eyes. She doesn't respond to pain, nor does she respond to her family. Her family feels she died in the car accident and that a "corpse" is all that is left. They wish to stop her tube feeds, since they feel these are futile. She never had any discussion about this issue with friends or family. What do you call this state of consciousness? What should you do?

Pearl 5:

Some ethical questions do not have easy answers. The persistent vegetative state is a problem where ethics and law intersect.

Principles: Futility, Autonomy, Best Interest Judgements

Summary: At present, where there is a clear and convincingly presented statement of prior wishes in persistent vegetative state, decision making is relatively easy. This is the case with living wills or with patients where a pattern of discussions or written documents chronicle their wishes. However, what to do about the 50,000 or so patients in the United States in nursing homes and hospitals without such statements? No clear answers have yet been given for this dilemma.

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Parable 6:

You are caring for Mr. Boromir, a 32 year old male with AIDS who has a resistant strain of tuberculosis. He is in the later stages of AIDS and will probably not live longer than a year or two. He is having trouble breathing and requires a ventilator. The nurses and respirologists at the hospital are against starting a ventilator, arguing that this is futile treatment, and that it puts health care workers at risk of contracting the AIDS virus from him. The patient is able to speak and is fully competent. He wishes you to start the ventilator and is aware that he may not be able ever to come off it. What do you do?

Pearl 6:

"Beauty is in the eye of the beholder"

Issues: Duty to treat, profession, not commerce, real "Risk versus benefit"

Summary: In terms of the hierarchy, ours is a higher calling, and the patient's interests should and must come first. Though we perceive that there is a limited outcome in such a patient's case, this is not our decision to make, on the basis of our fiduciary contract and on the basis of autonomy.

Parable 7:

Mr. Sauron, a 42 year old male with a headache, stiff neck and high fever enters the emergency room. He is drowsy but arousable. White count is elevated, and his spinal fluid shows 2,000 white cells consistent with acute bacterial meningitis. He refuses antibiotics, and will die within 24 hours without them. What should the intern do?

Pearl 7: "Go for the win"

Issues: Medical indications, capacity and rationality.

Summary: In this case there is a question of the rationality of the decision. If the decision is held to be inconsistent with the mass of regular decisions of others, then it may be deemed irrational. This is a dangerous ethical argument. It was held that a stand against slavery was irrational in antibellum south, or that a stand against segregation in the pre-Brown versus board of education was held as bad. We have to be constantly on the lookout for trends which in time will be shown to be false. In this case, since the chance of death is great (100%) and the chance of cure is also great (95%), the weight of the ethical argument is to treat the patient and hope that he will be happy when he is cured.

Parable 8:

Mrs. Gollum is an 83 year old female who comes into the hospital with pneumonia and difficulty breathing. You tell her you need to use a ventilator to help her breath temporarily while the antibiotics take effect, and she agrees. Later that night her daughter calls, threatening to sue you for starting the ventilator. She tells you that the patient has a living will and she has durable power of attorney, and the patient should not have had the ventilator started. Do you call your lawyer? Were you wrong in what you did?

Pearl 8:

"The patient knows best."

Summary: The living will is a document to allow the patient to clearly state their wishes in writing. This is in preparation for a time when and if they cannot speak for themselves. The living will does not come into effect if the patient is capable of speaking for themselves. This patient was asked and agreed to the ventilator. The living will does not affect this decision at all. In law in Pennsylvania, living wills only have legal authority if a patient is in a persistent vegetative state or is brain dead, not in other circumstances. A durable power of attorney grants the right to make medical decisions to another person. This also does not come into effect if the patient can speak for themselves.

Announcement:

On April 6th at 7:30 PM in the Lehigh Valley Hospital auditorium, Dr.Willard Gaylin will present an address on "The ethics of health care reform: who dropped the ball?". This lecture is organized by the Ethics Committee of LVH and supported by the Dorothy Rider Pool Health Care Trust.

On April 7th from 9 AM until 11:30 AM a panel discussion on the ethics of health care reform will be chaired by Dr.Gaylin. The panelists will include Dr.Elliot Sussman, CEO of Lehigh Valley Hospital, Dr.Sam Bub, Medical Director Cedarbrook, Aaron Whitlock, Benefits Analyst, Air Products, incorporated, Lori Gruen, Professor of Philosophy, Lafayette College, Barbara Stader, Medical Director, Allentown Health Bureau, and Alan Jennings, Director, Community Action Center of the Lehigh Valley. Look forward to a lively and informative discussion. Your input is requested and anticipated.

Kranks Korner

I'm tired of roasting politicians, physicians and insurance empire builders. Its time to grind a new axe, add grist to a new mill, make a new mountain out of a molehill. Today, my gripe is professional ethicists. Who, you ask, am I talking about? Well, the Krank has noticed that over the past few years a new breed has crept into the medical literature; in fact, the breed seems to be mutating into media darlings, spreading into the newspapers and onto 20/20. This breed is a heretofore unknown professional group which has taken the area of bioethics under their wing. Bioethics, the study of the ethics and morals of medical care. Once upon a time physicians, perhaps nurses, and rarely other people directly involved with the untidy practice of caring for patients used to be in charge of these things. Who else could understand what was going on in the hospital, at the bedside, in physicians' offices? As medicine has become complex, professional bioethicists, complete with the requisite complex degrees, have taken over the ethics of health care from the practitioner.

Oh, the Krank is all for intellectual pursuits and unbiased ivory-towerism. No sweeping midwestern populist anti-elitism here. BUT, he/she wonders, do we need a professional cadre, a GROWING professional cadre, to ever expand the complexity of the issues in medical care that we face? Seems to me (says the Krank, gripping her/his red suspenders fervently and spitting a chaw of baccy out), seems to me that mebby we don't need all these here people yakking it up over a bunch of chicken scratch! Get out, says the Krank. Shouldn't the people who practice the medicine be the ones who monitor the ethics? Don't get into the oven if you can't stand the heat, says the Krank.

Sure, there is a place for professionals guiding the major discussions, jumping into new important, previously unheard of areas of concern. Witness the genetics debate (how many double helices can dance on the head of a pin, for example). But the Krank questions whether this needs to be a growth area. The crop of new publications look thinner and thinner, with more pedantic periodical spinning off of more established generalist ones. Coming to your town soon, the Journal of the Ethics of Plantar Wart Removal: should the entire gym be informed? Its just the thin edge of the wedge, says the Krank. A word to the wise: start with a splinter, you end up with a splinter group!

P & T HIGHLIGHTS

The following action were taken at the March 15, 1995 Pharmacy and Therapeutics Committee Meeting - Maria Barr, Pharm.D., Barbara Leri, Pharm.D., Richard Townsend, R.Ph.

THE WINNER IS.... PROCARDIA XL!

After contract negotiations, the sole extended release nifedipine product for Lehigh Valley Hospital will be Procardia XL^{R}. The Pharmacy Department will automatically substitute Procardia XL^{R} for all Adalat CC^{R} orders as per the Pharmacy and Therapeutics Committee's decision.

ZZZ-ZOLPIDEM, A SECOND-LINE AGENT FOR SLEEP

Zolpidem (Ambiem^{R}, Searle), a non-benzodiazepine sedative is indicated for short-term treatment of insomnia. It has been added to the formulary for use in selective patients. Zolpidem is structurally unrelated to benzodiazepine, selectively binding to the same GABA benzodiazepine omega$_1$ receptor site. The omega$_1$ receptor site is one of the three omega receptor sites bound by benzodiazepines. Selective binding to omega$_1$, may explain the absence of muscle relaxant and anticonvulsant effects as well as preservation of stage 3 through 4 sleep. Zolpidem is hepatically metabolized to inactive metabolites that are renally eliminated. Therefore, use with caution in patients with hepatic dysfunction.

Other sedative-hypnotics agents such as: oxazepam (Serax^{R}) or temazepam (Restoril^{R}) should be used as first-line agents for sleep in most patients based on their safety, efficacy, and low cost. Zolpidem (Ambiem^{R}) may be considered for use in selective patients based on the approved criteria for use:

1. Patient's age 55 or greater;
2. Prior history of hypersensitivity to benzodiazepines;
3. Renal impairment or renal failure requiring hemodialysis; or
4. COPD patient with CO_2 retention;
5. Continuation of home therapy.

Judicious use of this new and unique agent is anticipated. The cost impact on the pharmacy alone based on replacing 50% of our current benzodiazepine sleeping aide use with Zolpidem is estimated to be an increase of at least $13,500.

ANTIMICROBIAL USAGE - THINK PROMPT NARROWING AND EARLY PO CONVERSIONS

The January antimicrobial drug expenditure was $103,934. Oral agents comprise $8,300 of our total drug cost. The goal for narrowing empiric therapy is within 3 days or as soon as culture results are available. Early oral conversion with IV Ciprofloxacin and IV Fluconazole has been successful. A substantial cost difference is realized with oral versus parenteral therapies. A cost comparison illustrates this difference.

Antimicrobial IV to PO Cost Comparisons

Agent*	Usual IV $/Day **	Usual PO $/Day **
Ampicillin	$1.72-$3.20	$0.36
Ampicillin/SB (Unasyn®)	$20.80-$40.00	$4.47-$6.21 Amp/clav. (Augmentin®)
Cefazolin (Ancef®)	$4.50	$0.68
Cefuroxime (Zinacef®)	$15.90-$31.65	$4.66-$9.08
Chloramphenicol	$12.00	$0.72
Ciprofloxacin (Cipro®)	$26.00-$50.00	$4.80
Clindamycin (Cleocin®)	$4.80	$2.64
Doxycycline	$4.40	$0.14
Metronidazole (Flagyl®)	$4.80	$0.21
Penicillin	$5.20	$0.68
Trimethoprim/Sulfa (Bactrim)	$4.20	$0.08

* Only agents with available oral formulations are listed.
** $ data based on Lehigh Valley Hospital acquisition cost only for usual adult dosages

VANCOMYCIN-HELP STOP THE RESISTANCE!

Appropriate and limited use of both IV and oral vancomycin is crucial during this time of increasing resistance of enterococcus. The CDC has published guidelines for the judicious use of vancomycin. All vancomycin use will be reviewed according to the following guidelines.

1. Treatment of documented or suspected serious infections due to a beta-lactam resistant gram-positive organism, i.e. MRSA.
2. Treatment of infections due to gram-positive microorganisms in patients with SERIOUS ALLERGY to beta- lactam antibiotics.
3. When antibiotic-associated colitis (AAC) fails to respond to metronidazole therapy or if AAC is severe and potentially life-threatening.

Keep in mind, vancomycin should NOT be used as routine surgical prophylaxis; continued as empiric use in patients with cultures negative for resistant gram-positive organisms; selective decontamination of the digestive tract; or first line therapy for AAC.

DO YOU KNOW YOUR PATIENT'S CREATININE CLEARANCE? PHARMACISTS DO!

In efforts to improve patient care and working toward patient centered care, the pharmacists are becoming more clinically involved throughout the hospital. The first area being addressed is the appropriate renal dose adjusting of medications. You may have already noticed chart memos recommending dosage adjustments on renally eliminated drugs on your patient charts. This is one mechanism approved by the Pharmacy and Therapeutics Committee for the pharmacists to utilize. Another mechanism is automatic renally-dosed substitution for the equi-effective dosage of nizatidine (Axid®), our primary oral histamine$_2$ antagonist for other H_2antagonist. Any questions regarding renal dosing may be forwarded to the Pharmacy Department Ext. 8887 (CC site) and Ext. 2250 (17 site).

MEDICATION USE - ALL FOR ONE AND ONE FOR ALL

Currently, several department-specific policy and procedure manuals exist throughout the hospital system causing confusion and unnecessary duplication regarding medication use. The Pharmacy and Therapeutics Committee, with the assistance of Nursing/Pharmacy Committee, will merge all current policy and procedures involving medication use into one Medication Administration Policy and Procedure Manual.

FYI CORNER

Warfarin Dosing Sliding Scale

An orthopedic group is successfully piloting a Warfarin Sliding Scale in select post-op patients. Data is continuously being collected for safety and efficacy.

Drug Unavailability

The shortage of ***albumin*** continues nationwide. Prescribers are encouraged to consider crystalloids and other colloid alternatives when possible.

Parenteral prednisolone (Hydeltrasol®) is also unavailable with a return date unknown at this time. Prescribers are encouraged to consider alternative parenteral corticosteroid preparations or oral agents when feasible.

A national raw material shortage of ***meperidine (Demerol®)*** will deplete the hospital's supply shortly. Please consider the use of morphine sulfate as an alternative whenever possible and reserve meperidine for cases where other options are not available. Equivalent parenteral doses of meperidine to morphine are 75mg to 10mg, respectively administered at the same schedule.

LEHIGH VALLEY
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M/F/H/V