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Great victories are rarely achieved by individuals acting alone. It is unity of effort which is bringing down the regimes of Eastern Europe. And unity will arm physicians for the struggles of the '90s.

Physicians working together: that was the premise behind the formation of PMSLIC 11 years ago. Abandoned by commercial carriers, physicians forged ahead to create their own solution to the professional liability crisis. The company they established honored the role of medical judgment in the insurance process... and stood staunchly with physicians in defending against frivolous claims.

Now, the field of conflict is widening—from county courtrooms to the halls of Congress. As unification with the AMA moves forward, PMSLIC-insured physicians face a historic opportunity, to join forces with their peers across the country, to fight the threatening inroads of government, and to preserve the integrity and independence of medical practice.

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HOSPITAL PERFORMANCE DATA NEED FURTHER REFINEMENT

PMS President J. Joseph Danyo, MD, said further refinement is needed on the hospital performance statistics released in the second report by the Health Care Cost Containment Council (HC4). The reports released January 12 cover three months of data for hospitals in the Lehigh Valley and six months of data for hospitals in south central Pennsylvania. Dr. Danyo said, "The reports are intended to provide data on cost and quality for purchasers of health care, to help them make informed decisions and to encourage competition in the health care marketplace. For the system to work, however, the data must be accurate and understandable." PMS has persuaded the Council to implement a number of improvements in the report, but Dr. Danyo said other flaws still need to be remedied.

PMS MEMBERSHIP CONTINUES GROWTH

In 1989 PMS recorded a net increase of 534 members over 1988 figures. This included the addition of 99 new active members, 175 members in first year of practice, 6 residents, 19 members on disability, 63 associate members, and 257 student members. Total PMS membership for 1989 is 20,876. The major priority in 1990 is retention of existing membership. A membership unification kit, including a videotape made during the AMA meeting, has been prepared to assist leaders in answering questions on unified membership.

PENNSYLVANIA RESOLUTIONS CONSIDERED BY AMA HOUSE

Pennsylvania delegates submitted six resolutions to the December AMA House of Delegates meeting in Hawaii. The AMA: adopted a recommendation to restructure nursing education to ease the nursing shortage; agreed that the impact of quality analysis of medical care on physicians' treatment methods should be examined and evaluated; acknowledged concerns about Peer Review Organizations and fair hearings for physicians; referred to the board suggestions that AMA specialty coding be revised to include new clinically accepted specialties and subspecialties; referred to the board a recommendation that the AMA develop computer protocols for continuing medical education software and require these protocols for AMA accreditation. Details on the meeting will appear in February.

LIMITS ON ABORTION BLOCKED BY RULING

On January 11, a federal judge blocked several controversial provisions of Pennsylvania's 1989 abortion control law. Enjoined were requirements of a 24-hour waiting period; spousal notification; age determination of the fetus prior to abortion; and the recommendations of two physicians that an abortion is necessary to save the life of the mother for it to be performed after 24 weeks. Other provisions, including bans on sex-selection abortions and abortions after six months of pregnancy, took effect as scheduled on January 16.

OUTLOOK FOR PMS-BACKED AIDS BILL LOOKS BRIGHT

PMS and its coalition are optimistic for House approval of the AIDS confidentiality bill, SB 1163. It passed unanimously in the Senate, and has been the subject of intense negotiations in the House. Changes requested by the health department and the insurance federation have been made, eliminating some opposition.

FETUS' RIGHTS QUESTION MOVES THROUGH COURTS

Slowly progressing through the Pennsylvania court system is the question of fetuses' rights. A state appellate court panel, ruling in a Lycoming County wrongful death case, recently said that the question of whether a fetus has constitutional rights should be decided by the legislature. Broad interpretations of the ruling upheld by the appellate court could have significant implications, because the courts and the legislature have yet to address at what point a fetus becomes a person.

PMS CREDIT UNION HAS NEW TOLL-FREE NUMBER

The toll-free phone number of the Pennsylvania Central Federal Credit Union has been changed to: 1-800-356-3875.
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ABOUT DIABETES

Diabetes is a chronic condition that affects about 11 million people in the United States. Health care professionals should know that continuing medical care and education of diabetic patients is essential in preventing acute complications and reducing the risk of longterm complications.

Physicians should be especially mindful of the diabetic's eye care, kidney function, blood pressure, and cardiovascular fitness. Diabetes is the leading cause of new cases of blindness in adults. It accounts for about 30 percent of new cases of end-stage renal disease and an estimated 50 percent of all nontraumatic amputations occur in persons with diabetes. Heart disease, hypertension, and loss of nerve function are among the many other disabilities associated with diabetes.

As can be expected with any chronic disease, the costs associated with diabetes care are considerable. Annual costs attributable to diabetes are approximately $13.8 billion. The total economic impact of this disorder, however, is even greater because additional medical expenses are frequently assigned to specific complications of diabetes rather than to diabetes itself.

To reduce the morbidity and mortality of this disease, emphasis is placed on improving the care diabetic patients receive from health care providers. The American Diabetes Association recently published a position statement on “Standards of Medical Care for Patients with Diabetes Mellitus” to achieve this goal. (See the standards elsewhere in this issue.) The standards outline elements of specific concern in the diabetic patient’s initial visit, including medical history, physical examination, laboratory evaluation, and management plan. They address continuing care and evaluation in follow-up visits and list possible intercurrent illnesses and special considerations.

The intent of these standards is to define basic medical care for individuals with diabetes. The standards can serve as a model against which health care providers can assess and improve their clinical practice. Because the standards define only minimal level of quality, health care professionals should feel free to go beyond these standards.

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Dr. Braddom is known as Man of the Year due to his founding the Ecco Family Health Center in Ohio. He’s praised for his work in creating the Providence Hospital Rehabilitation Unit as well as the St. Francis-St. George Hospital Rehabilitation Unit. And he’s applauded for his participation in founding Total Living Concepts, Inc. in Cincinnati, a group which built accessible housing for the disabled. He’s president of the Association of Academic Physiatrists and he’s tops in the field of physical medicine and rehabilitation. And now he’s tops at MossRehab.

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Among my most serious concerns as your president is physicians' freedom to exercise their medical judgment in meeting patients' needs and the attempts of third and fourth parties to intrude on that judgment.

More and more, third-party payers are using utilization review, pre-authorization, and other mechanisms to limit the cost of care. Sometimes this review is performed by the payer by an outside organization, the "fourth party."

It's one matter to use proper review procedures to address health care costs; it's quite another when these procedures prevent a patient from getting needed care by employing what I consider harassment and intimidation by untrained personnel.

Third and fourth parties claim they make only a payment decision, not a treatment decision. As a practical reality, however, a payment denial often leaves the patient with no choice but to forego the treatment. That is the crux of the problem.

Particularly onerous, in my view, is review performed by individuals who may lack the necessary expertise, or even by computer programs rather than thinking human beings.

It's time for us to assume the offensive on behalf of our patients, to tell third and fourth parties we won't permit them to intimidate us into denying our patients medically necessary care.

Professionally, morally, and legally, physicians have a duty to provide the generally accepted standard of medical care, if not the highest standard of care they can give. Our training prepared us for this responsibility; our Hippocratic oath binds us to it; our patients expect us to live up to it; and no insurer's rules can relieve us from it.

Whether a payer will be held legally responsible for its review decisions is unsettled in Pennsylvania. While that question remains open, the responsibility of the treating physician is absolutely clear: He always has a duty to provide care to the patient.

Physicians must never allow their medical decisions to be influenced by whether or not reimbursement will be made. If they do, they will be held accountable regardless of whether a third or fourth party contributed to the wrong.

Third and fourth parties believe they're on a roll with doctor-bashing. I strongly believe we should say "no" to their efforts to harass us into providing less care than we deem necessary.

When an insurer insists on pre-authorization for a recommended treatment, the doctor should firmly tell that carrier: "Read my lips: this patient needs this treatment." If pre-authorization is denied, help your patient exhaust all available appeals. But don't give in on your medical recommendations!

Because of my concern about this issue, I'm asking the Pennsylvania Medical Society to study it carefully. Among other avenues, this topic will be discussed by an ad hoc group of members, one of several we are organizing to encourage more Society involvement by local physicians.

You are the captain of the ship. Our patients need us to act as their advocates to the fullest extent possible. It's my hope that your State Society can find ways to support you as you struggle to fulfill that role, and I will keep you informed about developments in the coming months.
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An integral part of the Wood Center is the Children’s Hospital Diagnostic Center, a resource for community physicians who refer patients with complex or hard-to-diagnose illnesses or disorders. With a single telephone call to the Center, a referring physician can obtain information about available services, schedule consultations with specialists and arrange testing.

Another highlight of the Wood Center is a Magnetic Resonance Imaging (MRI) machine. Unlike MRI machines located at other hospitals, Children’s Hospital’s MRI provides instrumentation tailored specifically for children.

All of these resources help make Children’s Hospital a leader in pediatric health care. The next time you refer a patient, choose The Children’s Hospital of Philadelphia—there’s no place like it.
MEDICINE IN TRANSITION—CONFERENCE THEME

The Leadership Conference Committee has announced that “Medicine in Transition” is the theme for the 1990 conference scheduled for the Hershey Lodge and Convention Center, May 1 and 2.

Keynoting the two-day meeting will be Lawrence S. Lewin, president of ICF Incorporated, a health care consulting firm in Washington D.C. Lewin will preview the health care marketplace of the 90s and describe the actions physicians can take to maintain positions of leadership.

Other major areas to be covered in the “Medicine in Transition” theme are: The Changing Demographics of Medical Practice; The Movement for National Health Care, and Governmental Transitions in Medical Care.

Endorsed insurer, Bethalon Rowland Agencies, will sponsor the Tuesday evening reception. The Pennsylvania Medical Political Action Committee (PaMPAC) will sponsor the banquet and guest speaker, political satirist, Dick Flavin, star of the Sunday Today Show.

Wednesday morning’s activities begin with a breakfast meeting sponsored by PMSLIC. Their speaker will be Edward R. Amis, MD, a past president of the AMA whose topic is “The Doctor Patient Relationship.”

A series of workshops follows the breakfast. The subjects are: Risk Management, the New PRO Scope of Work, the Health Care Cost Containment Council Data Reports, and a session on How to Handle Personal Stress.

Frederick G. Brown, MD, Fourth District Trustee, is chairman of the Leadership Conference Committee. Committee members are: J. Joseph Danyo, MD, PMS president; Victor F. Greco, MD; Herbert C. Perlman, MD; Jonathon E. Rhoads Jr., MD; and Ferdinand L. Soisson Jr., MD.

The conference registration fee is $35. Those interested in attending may call PMS Communications at 1-800-228-7823.

PMS AUXILIARY TARGETS DRUG ABUSE EDUCATION

Pennsylvania Medical Society Auxiliary members from 28 counties attended the Auxiliary’s November workshop on drug abuse education at State College.

The workshop prepared Auxiliary members to coordinate a statewide education program for children in kindergarten through third grade.

Local physicians and their spouses will visit classrooms and use videotapes, coloring books and activity books to teach youngsters about the dangers of drugs. The program focuses on countering peer pressures and informing very young children on the limits of the human body. With materials tailored to the needs of each local school district, the Pennsylvania Department of Education introduced the program to all 501 school districts in Pennsylvania.

Featured speakers at the workshop were presidential physician Burton L. Lee, MD; addiction expert Karl Gallegos, MD; and “Kids Saving Kids” director Katie True. Also speaking were Roger L. Pilotti of the Bureau of Narcotics Investigations and Drug Control, state Office of Attorney General; J. Joseph Danyo, MD, orthopedic surgeon from York and president of PMS; and James G. Pitcavage, MD, a Pittsburgh pediatrician and adviser to the Auxiliary’s drug education program.

PMS/RPS ELECTS NEW LEADERSHIP

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AMA/Burroughs Wellcome Leadership Award and is currently a clinical fellow in the Department of Medicine at the University of Pittsburgh.

Frederick Hellman, MD, a pathology fellow at the University of Pennsylvania, was elected vice-chairman of the RPS, and Jack A. Yanovski, MD, a fellow at the National Institutes of Health, was elected secretary/treasurer.

Carl Sirio, MD, a fellow in critical care at the National Institutes of Health, was selected as the representative on the board of trustees for the RPS.

DATA BANK BEGINS OPERATION IN 1990

With the publication of final regulations in October, the Public Health Service’s “Data Bank” may begin operation by spring of this year. Authorized by the Health Care Quality Improvement Act of 1986, the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners will compile nationwide information on malpractice.

The Data Bank is intended to improve quality of medical care and restrict state-to-state movement of incompetent physicians and other practitioners.

Physicians and dentists are encouraged to identify colleagues who engage in unprofessional behavior or incompetent practices. State medical and dental boards will be required to report any licensure actions against health professionals, and hospitals and other health care entities must report actions to remove physicians’ or dentists’ clinical privileges. Professional societies will be required to report any adverse actions against members. Insurance companies will also be required to report any payments on malpractice claims.

Final regulations require hospitals to request information from the data bank every two years about licensed health care practitioners on staff or holding clinical privileges. Hospitals must also request information on practitioners who apply for staff positions or clinical privileges.

Practitioners also are authorized to request information from the data bank. Of concern to health care organizations is the authorization of plaintiff’s attorneys to obtain information in malpractice actions. Regulations were tightened, but attorneys can obtain access to the Data Bank if they have evidence that the hospital failed to obtain prior information on a practitioner as mandated.

An information systems firm in Blue Bell, Pennsylvania has been contracted to run the Data Bank.

DRUG ABUSE CONFERENCE REFINES GOALS

A plan to fight drug abuse in Pennsylvania was the goal of a November conference sponsored by the Pennsylvania Medical Society Task Force on Drug Abuse. Leaders from the state’s medical, legislative, law enforcement, education and media communities met in Hershey to solidify general recommendations into a plan for the future.

The recommendations had been developed in May, when a group of more than 150 people gathered for the
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first phase of the conference. The Task Force's concept is to use "networking" among leaders from various concerned groups to spark ideas and develop unified missions.

Attorney General Ernest Preate addressed the group's November meeting. Expert panelists then brought the audience into discussions about aspects of drug abuse prevention. Lee H. McCormick, MD, chairman of the Task Force on Drug Abuse, was moderator.

Panelists included Donald Garnett, director of Concept 90, Gaudenzia; Eva Kepp, executive director of the Youth and Aging Committee of the House of Representatives; Ronald Minard, editor of The Patriot News, Harrisburg; Robert L. Schneider, MD, task force vice chairman and senior associate director for clinical development of Merck Sharp & Dohme; Oscar Vance Jr., chief county detective of Montgomery County; Deborah Beck, president of the Drug and Alcohol Service Providers Organization of Pennsylvania; Louise Brookins, executive director of Welfare Rights Organization; Major James Hazen, Pennsylvania State Police; and Fred Woscoff, creative services manager for WGAL-TV, Lancaster.

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Five distinguished physicians from the U.S. and Canada who received all or part of their postgraduate medical training at Graduate gave scientific presentations and participated in a commemorative ceremony honoring Graduate's role in modern medicine and medical education.

Featured guest speaker was Henry T. Bahnson, MD, professor of surgery and chairman emeritus of the Department of Surgery in the University of Pittsburgh School of Medicine.

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**ALLERGISTS FACE ANTITRUST PROBE**

The Massachusetts Allergy Society and a number of its members are currently subject to a grand jury investigation being conducted by the antitrust division of the Department of Justice. The inquiry concerns the conduct of the MAS and its members in connection with discussions with third-party payors such as health maintenance organizations and insurance companies.

As their defense fund is drained, the MAS has appealed to all physicians for $100 contributions. The MAS says it is aware of no wrongdoing, and it concerned about the suppression of free and open communication between physicians and third-party payors which the investigation could cause.

Contributions to the Massachusetts Allergy Society Legal Defense Fund should be made payable and sent to: c/o Daniel L. Goldberg, Esq., Bingham Dana & Gould, 150 Federal Street, Boston, MA 02110.
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KEPRO WINS NEW CONTRACT

Donald E. Harrop, MD

On November 30, 1989, the last day of the contract extension under which KEPRO had been operating, we were notified that the contract with the Health Care Financing Administration would be renewed for three years. The new contract, which was signed and became effective December 1, is for approximately $42.5 million over the three-year period ending November 30, 1992.

In my November report, the significant changes under the new Scope of Work were reviewed and, at the time, we expected that all changes would be effective December 1. However, because the contract was not signed until that date, there will be some delay in implementation of certain requirements of the contract. The most important of these is the preprocedure review of the ten surgical procedures reported in the November issue. The effective date for this review is for procedures performed on and after January 4, 1990. Therefore, we began to accept telephone requests starting December 15 and FAX and written requests for precertification of these procedures earlier in December. I strongly suggest that, if you perform any of these procedures, you become familiar with the requirements and contact the PRO contact person at your hospital or ambulatory surgery center to coordinate the methodology for requesting prior certification. The reason for this is that our past experience with preadmission review is that some facilities do the precertification request while others expect it to be done by the physician or the physician's office staff. It is also because only one approval is needed for both the physician and the hospital claims.

Keep in mind that when these procedures are not precertified, they must be approved retrospectively before payment will be made to the facility or to the physician. This can result in a delay in reimbursement for as much as 90 days. Not seeking prior review, therefore, can have an effect on your cash flow as well as that of the hospital.

The ten procedures requiring KEPRO preapproval are: carotid endarterectomy; cataract extraction; major joint replacement; coronary artery bypass with graft; complex peripheral revascularization; hysterectomy; prostatectomy; pacemaker insertion; laminectomy; and, percutaneous transluminal coronary angioplasty.

Dr. Harrop is president of the Keystone Peer Review Organization and a past president of the Pennsylvania Medical Society. He is a family physician in Phoenixville.
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Generic Drugs: Potential Public Health Threat

Gordon K. MacLeod, MD, FACP

The Pennsylvania Medical Society has become increasingly concerned about adverse effects upon patients from generic drugs when substituted for prescribed brand name drugs. Even though PMS favors generic drug use in principle because it lowers the cost of medical care, many questions have arisen giving physicians legitimate concerns about their efficacy and tolerance. These concerns focus on therapeutic and clinical equivalence in testing, quality assessment, and monitoring of generic drugs (see attached bibliography prepared by the American Academy of Family Physicians.) The variation in generic drug equivalency has become a major public health problem in Pennsylvania and elsewhere, not yet fully appreciated by the government and the public alike.

On the one hand, PMS is aware that generic drugs are being promoted in an effort to contain health care costs by government agencies, health insurers, and corporate employers without ever seeing a patient. On the other hand, physicians are being placed in the awkward position of having to defend their role as the patient's advocate when faced with manifest problems involving the effectiveness of generic drugs.

Governmentally mandated changes in the use of generic drugs have contributed to many problems faced by physicians in addition to the fraud and abuse currently being reported about the generic drug industry. In Pennsylvania, Act 154 passed in 1988 mandates changing prescription blanks encouraging increased generic prescribing. This has created serious obstacles in controlling the use of generic drugs by physicians. At the national level, the Pennsylvania Medical Society urges the federal government to allocate the necessary resources for the FDA to perform its charge adequately. It also urges the Food and Drug Administration (FDA) to institute reforms to prevent fraud and abuse in the approval and ongoing monitoring of generics. Until these remedies are instituted, PMS feels obligated to alert physicians to the potential pitfalls in the patients' use of generic medications.

A recent change in FDA drug testing procedures has contributed to the pitfalls in dispensing generic medications. Traditionally, randomized clinical trials were required to demonstrate substantial evidence of safety and efficacy before a drug was approved for marketing. Since the 1970s clinical trials were no longer required by the FDA to approve a product that was chemically the same as an approved product. In 1984, the Drug Price Competition and Patent Term Restoration Act facilitated FDA approval of generic drugs even further, simply by showing the generic drug to be bioequivalent to the brand name product. The FDA uses two tests to establish bioequivalence of the generic medication to the brand name drug. Even using the FDAs own definition, these two tests do not require proof of therapeutic equivalence.

One test measures drug blood levels by a single dose crossover study in 18 to 24 healthy volunteers between the ages of 21 and 35 who are within 10 percent of their ideal body weight. Following the single dose of the drug to the volunteers, serum concentration of the generic drug is determined after overnight fasting. Bioequivalence is thus determined by a single dose crossover study even though certain drugs may require multiple dose blood level studies. Bioequivalence, rather than therapeutic equivalence, is purportedly established based upon a statistical analysis of the average readings for rate and extent of absorption, if they are found to be less than 20 percent above or below that of the reference drug. If by chance, however, one generic drug is substituted for another, the variation between generic drugs could conceivably be 40 percent. (Although Pennsylvania law does not permit the same pharmacy to substitute a second generic drug for the first, it is entirely possible for the patient to have a subsequent prescription filled at another pharmacy.)
The other test uses the so-called 75/75 rule in which the plasma level of the generic drug is compared to the brand name product in each experimental subject. This test is supposed to evaluate the variability of the drug in each individual in the crossover study. The 75/75 rule simply requires that the ratio of generic drug to the brand name product be between 0.75 and 1.25 in at least 75 percent of the subjects tested. (JAMA September 4, 1987, Vol 258, No. 9, pp 1200–1204). This test provides some measure of intraindividual variability in the bioavailability of the products but it is neither a rigorous scientific nor statistically valid test.

This past summer the American Academy of Family Physicians released a white paper based on a 2-year study of generic products. The Academy observed that certain generic drugs do not have the same rates or extent of absorption as brand name products. Even when the generic drug undergoes complete absorption, a change in the rate of absorption could affect dosing schedules. The authors of the white paper concluded in no uncertain terms that "bioavailability does not necessarily equal therapeutic equivalence." (JAMA September 22/29, 1989 - Vol 262, No. 12, pp 1566–1567).

Studies of drug bioequivalence in healthy young persons frequently may not apply to children nor to chronically ill or elderly debilitated patients. In fact, a normal dose in the healthy adult may be an overdose for an elderly patient. Moreover, changes in blood levels in certain clinical conditions may produce toxicity or significant changes in clinical outcome. When generic drugs are substituted for brand name products with a narrow therapeutic index, even minor changes in the plasma level may have a dramatic effect on the clinical outcome. The problem can be further compounded when multiple therapeutic agents have to be used by elderly patients.

In a recent case report, a fully compliant epileptic patient was switched from brand name Mysoline (primidone) to generic primidone on two separate occasions. In both episodes, the seizure frequency increased. (JAMA Sept 4, 1987 - Vol 258 No. 9, pp 1216–1217.) Similar problems have been reported in other epilepsies because of the narrow therapeutic index of antiepileptic drugs. Because epilepsy makes such a dramatic clinical presentation, it is easy to identify variability in generic drugs used for this condition. Less dramatic presentations might well be missed when using generics for other conditions.

While many drugs, whether generic or brand name, have broad therapeutic indices, Strom has pointed out that the only way to ensure appropriate therapy after generic substitution is to retitrate the patient. (Italics mine.) Strom has suggested that perhaps the FDA or the manufacturers of generic drugs should be expected to fund studies in a random sample of drugs approved by the FDA on the basis of bioavailability data in order to validate the bioequivalence which can obviously affect clinical outcome. On the other hand, he argues that when brand name manufacturers claim therapeutic inequivalence, perhaps they should be asked to fund such studies before making such a claim. Eventually perhaps, Strom concludes, clinical equivalence can be based on data rather than supposition. (NEJM June 4, 1987, Vol 316, No. 23 pp 1456–1461)

The Pennsylvania Medical Society will not allow these public health transgressions to continue unaddressed. Pennsylvania's physicians do not want their patients to risk adverse drug reactions because the government has not satisfactorily evaluated the clinical effects of generic drugs. Physicians do not believe that the government should sacrifice drug efficacy and tolerance to cost containment without full disclosure of this policy to the public.

Bibliography
2. Suleiman MS, Najib NM, el-Sayed YM, Abdulhammed ME. A Bioequivalence study of six brands of cephalixin.


**CLINICAL INFORMATION:** This is a 69-year-old male who is unable to abduct his right arm and who has difficulty extending his arm. This is associated with right shoulder pain.

**FINDINGS:** Figure 1 is a proton density image in the coronal plane of the right shoulder. There is degenerative hypertrophy of the right acromioclavicular joint with a prominent inferior projecting osteophyte (A). A roughly linear area of low signal intensity inferior to the right distal clavicle represents the medial aspect of the rotator cuff (labeled B). A thin linear structure of low signal intensity superior to the right humeral head (labeled C) represents the lateral portion of the rotator cuff. Figure 2 is a T2-weighted image again demonstrating the inferior projecting osteophyte from the acromioclavicular joint (A) and the components of the torn rotator cuff (labeled B and C) as previously described. Increased signal intensity material between the torn portions of the rotator cuff represents joint fluid lying both within the joint space and in the subacromial bursa. Image 3 is a partial flip angle image which is sensitive for T2-weighting. This exhibits increased signal intensity in the immediate region of the rotator cuff tear as well as extending lateral over the right humeral head. The level of this slice is slightly anterior to figures 1 and 2 and the increased signal intensity material represents joint fluid extending over the right humeral head into the subdeltoid bursa.

The MR images demonstrate complete disruption of the rotator cuff which may be due to an acute injury or possibly due to chronic entrapment of the rotator cuff by the degenerated right acromioclavicular joint.

**COMMENT:** MR imaging is the only modality capable of directly visualizing and differentiating the various soft tissue components of the musculoskeletal system. Only CT arthrography approaches this degree of accuracy in the detection of rotator cuff tears, however CT arthrography like its cousin, routine shoulder arthrography, is invasive and requires injection of contrast into the shoulder joint. MR imaging is the imaging modality of choice in the initial evaluation of soft tissue injuries of the shoulder joint with routine or CT arthrography reserved for those patients on whom the MR study was indeterminate.
STANDARDS OF MEDICAL CARE FOR PATIENTS WITH DIABETES MELLITUS

Diabetes is a chronic illness that requires continuing medical care and education to prevent acute complications and to reduce the risk of longterm complications. People with diabetes should receive their treatment and care from physicians with expertise and a special interest in diabetes. The following standards define basic medical care for people with diabetes. These standards are not intended to preclude more extensive evaluation and management of the patient.

Initial visit
Medical history. The comprehensive medical history can uncover symptoms that will help establish the diagnosis in the patient with previously unrecognized diabetes. If the diagnosis of diabetes has already been made the history should confirm the diagnosis, review the previous treatment, help evaluate the present degree of glycemic control, determine the presence or absence of the chronic complications of diabetes, assist in formulating a management plan, and provide a basis for continuing care. Elements of the medical history of particular concern in patients with diabetes include:

- Symptoms and laboratory test results related to the diagnosis of diabetes;
- Dietary habits, nutritional status, and weight history; growth and development in children;
- Details of previous treatment programs, including diabetes education;
- Current treatment of diabetes, including medications, diet, and results of glucose monitoring;
- Exercise history;
- Frequency, severity, and cause of acute complications such as ketoacidosis and hypoglycemia;
- Prior or current infections, particularly skin, foot, dental, and genitourinary;
- Symptoms and treatment of chronic complications associated with diabetes: eye, heart, kidney, nerve, sexual function, peripheral vascular, and cerebral vascular;
- Other medications that may affect blood glucose concentration;
- Risk factors for atherosclerosis: smoking, hypertension, obesity, hyperlipidemia, and family history;
- Psychosocial and economic factors that might influence the management of diabetes;
- Family history of diabetes and other endocrine disorders;
- Gestational history: hyperglycemia, delivery of an infant weighing more than 9 lbs., toxemia, stillbirth, polyhydramnios, or other complications of pregnancy.

Physical examination. A complete physical examination should be performed during the initial evaluation. Individuals with diabetes are at high risk of developing eye, kidney, nerve, cardiac, and vascular complications. Patients with type I (insulin-dependent) diabetes also have an increased frequency of thyroid disease, and all individuals with diabetes are at increased risk of infections. Children may have delayed growth and maturation. Therefore, certain aspects of the physical examination require special attention. These include:

- Height and weight measurement (and comparison to norms in children);
- Sexual maturation staging;
- Blood pressure determination (with orthostatic measurements);
- Ophthalmoscopic examination, if possible with dilation;
- Thyroid palpation;
- Cardiac examination;
- Evaluation of pulses (with auscultation);
- Foot examination;
- Skin examination (including insulin-injection sites);
- Neurologic examination;
- Dental and periodontal examination.

The examiner should also be alert for signs of diseases that can cause secondary diabetes, e.g., hemochromatosis,
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5:00 p.m. Carotid Disease in Cardiac Surgical Patients
A. Charles Winkelmann, MD
Michael D. Strong, MD

6:00 p.m. Refreshments

Thursday, March 15, 1990
Moderator: Eric L. Michelson, MD
Director, Division of Cardiology
Professor of Medicine

4:00 p.m. Case Presentation
5:00 p.m. Cardiac Problems in Renal Failure
Ronald S. Pennock, MD

5:30 p.m. Dialysis in Cardiac Patients
Charles D. Swartz, MD

6:00 p.m. Refreshments

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pancreatic disease, and endocrine disorders such as acromegaly and Cushing's syndrome.

**Laboratory evaluation.** Each patient should undergo laboratory tests that are appropriate to the evaluation of the individual's general medication condition. In addition, certain tests should be obtained to establish the diagnosis of diabetes, determine the degree of glycemic control, and define associated complications and risk factors. These include:

- **Fasting plasma glucose:** a random plasma glucose may be obtained in an undiagnosed symptomatic patient for diagnostic purposes;
- **Glycosylated hemoglobin (HbA, or HbA1c);**
- **Fasting lipid profile:** total cholesterol, high-density lipoprotein (HDL) cholesterol, low-density lipoprotein (LDL) cholesterol, and triglycerides;
- **Serum creatinine in adults or if proteinuria is present;**
- **Urinalysis:** ketones, glucose, protein, microscopic if indicated; after five years of diabetes or after puberty, total urinary protein excretion should be measured by a microalbuminuria method if available;
- **Urine culture:** if microscopic is abnormal or symptoms are present;
- **Thyroid function tests (T4 or thyroid-stimulating hormone);**
- **ECG (in adults).**

**Management plan.** The management plan should be formulated as an individualized therapeutic alliance between the patient/family, the physician, and other members of the health care team (e.g., RN, RD) to achieve the desired level of diabetes control. Consideration must be given to the age of the patient, school or work schedules and conditions, physical activity, eating habits, social situation and personality, and presence of complications of diabetes or other medical conditions.

Implementation of the management plan requires that each aspect be understood by the patient and the care provider and that the goals and means be considered realistic. Instructions and plans should be reinforced by providing written material appropriate to the

---

**COMPARING CARE OF PENNSYLVANIA PATIENTS WITH DIABETES TO NATIONAL STANDARDS**

C.H.M. Jacques, MD, PhD  
Robert L. Jones, DEd  
Kathleen M. Dwyer, PhD, RD

In 1988 the Pennsylvania Diabetes Academy conducted a random stratified telephone survey of over 600 primary care physicians in Pennsylvania to determine attitudes and care patterns for diabetic patients. The survey included physicians in active practice who listed their primary specialty as either internal medicine, family practice, or general practice. A survey response rate of 73 percent was obtained.

The chart below presents survey results on six important aspects of patient care compared to the standards of care for diabetic patients recently recommended by the American Diabetes Association. Nearly all physicians surveyed indicated that they measured the blood pressure and weight at every visit and provided patient education. Only 71 percent of the physicians routinely referred diabetic patients to an eye doctor, with 56 percent referring to ophthalmologists and 15 percent to optometrists. About one third of physicians indicated that they examine the feet at every visit and 61 percent indicated they examine the feet more often than once a year.

The greatest deviation from the standards was for the use of glycosylated hemoglobin measurements. Pennsylvania physicians reported using this test 1.8 times per year compared to a recommended frequency of four times per year.

When individual groupings of physicians were examined, several patterns emerged. The greatest differences occurred with physician age. Younger physicians were much more likely to use newer technologies such as self glucose monitoring and glycosylated hemoglobin than their older colleagues. Younger physicians were also more likely to refer to eye doctors and examine feet more frequently. There also was a consistent difference in reported care patterns for the different primary care specialties in the use of self-glucose monitoring, glycosylated hemoglobin measurements, referrals to eye doctors, and the frequency of foot examination. Internists consistently reported the highest frequency of these behaviors. Rural physicians had fewer referrals to eye doctors than urban doctors and were less likely to perform glycosylated hemoglobin measurements. In each instance, these differences were statistically significant after adjusting for confounding variables.

Drs. Jacques and Jones are assistant professors in the Department of Family and Community Medicine at PennState College of Medicine, Hershey. Dr. Dwyer is executive director of the Pennsylvania Diabetes Academy.

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**Care Patterns of Pennsylvania Physicians For Type I Diabetic Patients Compared to Recommended Standards of Care**

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<tr>
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<th>Percent of Recommended Standard</th>
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<tr>
<td><strong>Patient Education</strong></td>
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<td><strong>Weight and BP</strong></td>
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<td><strong>Routine Eye Referral</strong></td>
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<td><strong>Routine Foot Exam</strong></td>
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<td><strong>Glycosylated Hb</strong></td>
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<td><strong>Glucose Monitoring</strong></td>
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<table>
<thead>
<tr>
<th>Time</th>
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<td>8:30-9:00</td>
<td>Registration and Coffee</td>
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<td>9:00-10:30</td>
<td><strong>INFLAMMATORY BOWEL DISEASE</strong></td>
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<td>Moderator: Harris R. Clearfield, MD</td>
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<td>Microscopic Colitis—A.J. DiMarino</td>
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<td>Toxic Megacolon—L.S. Friedman</td>
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<td>New Rx—R. McDermott</td>
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<td>Surgical Advances—M. Nusbaum</td>
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<td>Indications &amp; Results—P. Malet</td>
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<td>Newer RX PBC &amp; S. Chol.—C. O'Brien</td>
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<td>12:15-1:15</td>
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<td>Moderator: Walter Rubin, MD</td>
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<td>Motor Disorders—D.O. Castell</td>
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<td>Chest Pain (an overview)—S. Cohen</td>
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<td>Peptic esophag. &amp; Ulcer—W. Lipshutz</td>
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<td>2:45-3:00</td>
<td>Coffee and Soft Drinks</td>
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<td>3:00-4:30</td>
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<td>Insertion of scope—V.P. Dinoso</td>
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<td>Preparation of Patient—B. Frank</td>
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<td>Representative Path.—H.B. Lefton</td>
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The frequency of patient visits depends on the type of diabetes, degree of blood glucose control achieved, changes in the treatment regimen, and presence of complications of diabetes or other medical conditions.

Patients starting insulin or having a major change in their insulin program may need to be in contact with their care provider as often as daily until glucose control is achieved, the risk of hypoglycemia is low, and the patient is competent to conduct the treatment program. Some patients may require hospitalization for initiation or change of therapy. Contact with the patient after a major modification of the treatment plan should not be delayed more than one week.

Patients beginning treatment by diet or oral glucose-lowering agents may need to be contacted weekly until reasonable glucose control is achieved and the patient is competent to conduct the treatment program. Contact with these patients after a major modification of the treatment plan should be no more than one month later.

Regular visits should be scheduled for insulin-treated patients at least quarterly and for other patients at least semiannually. All patients must be taught some method of monitoring glycemic control. In insulin-treated patients, and in non-insulin-treated patients with poor metabolic control, this should be blood glucose testing; in other patients, blood glucose testing may be useful. Patients must be taught to recognize problems with their glucose control and to report problems to the health care team. They also should be taught to recognize early signs and symptoms of acute and chronic complications and to report these promptly.

Elements of continuing care

Medical history. An interim history should assess 1) frequency causes, and severity of hypoglycemia or hyperglycemia; 2) results of regular glucose monitoring; 3) adjustments by the patient of the therapeutic regimen; 4) problems with adherence; 5) symptoms suggesting development of the complications of diabetes; 6) psychosocial status; 7) other medical illnesses; and 8) current medications.

Physical exam. A comprehensive physical examination should be performed annually. A complete eye and visual examination by an eye doctor should be performed at least annually in all patients over 30 years old and in patients between 12 and 30 years of age with a diagnosis of diabetes of at least five years in duration.

At every regular visit, the following should be measured: height (until maturity), weight, sexual maturation in adolescents, and blood pressure. Portions of the physical examination that were found to be abnormal on previous visits should be repeated. The feet should be examined routinely. The examination also should be extended to include areas indicated by the interim history.

Laboratory. A glycosylated hemoglobin determination should be performed at least semiannually in all patients and preferably quarterly in insulin-treated patients and in non-insulin-treated patients with poor metabolic control. A fasting plasma glucose test may be useful to judge glycemic control in patients with type II (non-insulin-dependent) diabetes. The value obtained from a random plasma glucose test may be useful for comparison with the value obtained simultaneously by the patient using his/her own monitoring system.

Triglycerides, total cholesterol, and HDL cholesterol should be tested annually in adults and every two years in children.

Routine urinalysis should be performed yearly. After five years in duration of diabetes, or after puberty, total urinary protein excretion should be measured yearly, by a microalbuminuria method if possible. If proteinuria is detected, serum creatinine or urea nitrogen concentrations should be measured and glomerular filtration assessed.

Management plan. The plan should be reviewed at each regular visit to determine progress in meeting goals and to identify problems. This review should include nutritional evaluation and weight control, the exercise regimen, the control of blood glucose and desired lipid levels, frequency of hypoglycemia, adherence to all aspects of self-care, assessment of complications, follow-up of referrals, and psychological adjustment. In addition, knowledge of diabetes and self-management skills should be reassessed at least annually.

Intercurrent illness

The stress of illness frequently aggravates the hyperglycemia of diabetes, and during such illness, blood glucose and urine ketones should be monitored frequently. Marked hyperglycemia requires temporary adjustment of the treatment program, and the patient treated with oral hypoglycemic agents or diet alone may temporarily require insulin. Infection or dehydration is more
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likely to necessitate hospitalization in the person with diabetes than in the person without diabetes. If possible, the hospitalized patient should be treated by a physician with expertise in the management of diabetes.

**Special considerations**

**Diabetic ketoacidosis and hyperosmolar coma.** These conditions represent decompensation in diabetic control and require immediate treatment. Depending on the severity of the illness and available resources, treatment can be undertaken in the physician’s office, emergency room, hospital room, or medical intensive care unit. Recurrence demands a detailed psychosocial and educational evaluation by a diabetes specialist.

**Severe or frequent hypoglycemia.** The occurrence of severe, frequent, or unexplained episodes of hypoglycemia requires evaluation of both the management plan and its execution by the patient and may indicate a need to revise the plan or reeducate the patient. The accomplishment of these goals generally requires more frequent patient visits during adjustment of the treatment program.

**Pregnancy.** To reduce the risk of fetal malformations and maternal and fetal complications, pregnant women and women planning pregnancy require excellent blood glucose control. These women need to be seen by a physician frequently, must be trained in self-monitoring of blood glucose, and may require specialized laboratory and diagnostic tests. Consultation with an obstetrician and medical specialist in diabetes is indicated before pregnancy.

**Hypertension.** Hypertension contributes to the development and progression of chronic complications of diabetes. Hypertension should be treated aggressively to achieve and maintain blood pressure in the normal range. The selection of an antihypertensive drug should be individualized to minimize the number and severity of side effects. For example, beta-blockers should be used with caution in insulin-treated individuals because these drugs may mask early symptoms of hypoglycemia and prolong recovery from hypoglycemia.

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**Retinopathy.** Diabetic retinopathy or other visual abnormalities require care by an ophthalmologist experienced in the management of people with diabetes.

**Nephropathy.** The patient with abnormal renal function (proteinuria or elevated serum creatinine) requires heightened attention and control of other risk factors (e.g., hypertension, smoking) and requires consultation with a specialist in diabetic renal disease.

**Cardiovascular disease.** Patients with cardiovascular risk factors should be carefully monitored. Evidence of cardiovascular disease such as angina, decreased pulses, and ECG abnormalities requires efforts aimed at correction of contributing risk factors (e.g., obesity, smoking, hypertension, sedentary lifestyle, hyperlipidemia, poorly regulated diabetes) in addition to specific treatment of the cardiovascular problem.

**Neuropathy.** Diabetic neuropathy may result in painful paresthesias, muscle weakness, and loss of sensation. Autonomic involvement can affect the function of various organ systems (gastrointestinal, cardiovascular, genitourinary) and may require consultation with an appropriate medical specialist.

**Foot care.** Problems involving the feet may require care by a podiatrist or other medical professional experienced in the management of people with diabetes. Patients with evidence of sensory neuropathy should be educated about the risk and prevention of foot problems.

**Children and adolescents.** Children and adolescents with diabetes, especially preschoolers and teenagers, should be managed in consultation with a physician who has expertise in treating children with diabetes.

**References**

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I believe that my remarks as your president should inform you about the state of the union—the Federation of Medicine—the AMA.

I hear it said as I travel around the country that our profession is on a road to change. It is important to remember that we have always been on a road to change. We were on the road to change when we approved the Flexner report and drove out the diploma mills a century ago. We were on the road to change when we built community hospitals all over the country after World War II using government money authorized by Hill-Burton. We were on the road to change when the Health Planning and Resource Development Act was passed. And surely we were on the road to change when we warned the American people of the restrictions HSA would put on the availability of medical services and facilities, and the people said they would not accept that change and the bureaucracy HSA would impose.

We are used to change. The AMA functions in a configuration that permits us to adapt to change and to guide change. That is the nature of our organization, with its policy planning and strategic management capabilities.

So we are not intimidated by the prospect of confronting new challenges. And while we expect change, we do not expect to lose the fundamental values traditional to our profession. Just as we will not give up the pluralism and free choice that has made our health care system what it is at its very best.

The times are not easy for us. Society distrusts institutions, and the professions are not above attack. Medicine, law, the clergy—the historic learned professions are targets of criticism reminiscent of the days of Hogarth. I have joked that if your think things are hard for physicians, how would you like to be a TV evangelist?

But doctor-bashing is not a laughing matter, and we must consciously and with great intensity work to maintain the confidence of the public in medicine as an institution, and in the AMA as its lead organization. This cannot be done easily, or by edict, or by emanations from a central headquarters. Preserving trust in medicine depends on deeds as well as words and, it is a task that must build a message from the grassroots, as well as from Chicago or Washington.

The need for us to counter the antimedicine currents—whether they come from the media or from business or local government or national political power bases—has never been greater, not even in 1964. The process by which we must...
Description: Yohimbine is a 3a,15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocen® is indicated as a sympathicomimetic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warnings: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardiovascular patients with cardiac or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as anxiolytics, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diabetes, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.1,2 Also dizziness, headache, skin flushing reported when used orally.1,3

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence: 1.2-4 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

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accomplish this begins right here, right now, and with an examination of what is RIGHT with the AMA.

Stormy Johnson and I were invited to visit with caucuses in Pennsylvania during their October meeting where their brilliant and united State Society leadership successfully carried the unification issue of their House of Delegates for ratification and bylaws change. We were asked the same question there that each of you is asked regularly—particularly those of you who have earned blazers because of your dedication to member recruitment. The question: What does the AMA do for me?

It is this question I want to address today.

Let us, then, look only briefly at the environment of medicine, because that is a subject which the other AMA officers and I have discussed with many of you in your states, and which we will continue to discuss as we visit more of you over the coming six months. And it is a subject where we will tell it as we see it, and we will listen carefully to what you tell us.

For this report, suffice it to say that medicine is very much affected by our information-driven society; by a budget-driven government policy; by the potential for fragmentation over the changes in physician payment; by the threat of conversion of our profession into a public utility; and by increased frustration due to loss of professional freedom and the imposition of the terror of the courts. So my state of the union message today is a report on what the AMA is doing for every physician and patient in America, not a report on what others are trying to do to us.

Neither do I wish to cite a litany of AMA accomplishments about which you are already well informed—as important as they are—because they are in the handbook as part of your business, or because they are a part of a proud but familiar record.

Therefore, I will not tell you in detail how we have defeated mandatory assignments four times in the past three Congresses. But it is important for our membership to know we have done this for them. And tell our members that we beat Pete Stark and ETs in the budget bill, after they said we were beaten.

Nor do I wish to tell you all that goes into making AMA the world's largest publisher of scientific information, or the largest source of physician demographic information—so much so that when the government wants this kind of information, it often comes to us. At least, we know our numbers are accurate.

Nor will I dwell on the fact that our members receive three dollars worth of services for each dollar because dues income accounts for only thirty-eight percent of our revenue. That is important information, but you know it already.

Instead, in the time allotted to my Interim Report, I want to focus on some of the less well-known projects and activities of the AMA. Some of it is the work of outstanding people whose valuable work doesn't get noticed very often. Some of it represents innovation and preparation for the future. And some of it is simply the glue that binds us into an organization that, if it did not exist, we would have to create.

Did you know that our White Paper on the use of animals in research is the definitive work on the subject, and that we have received thanks and high praise from NIH and the academic community for taking a courageous lead in this area? Tell your basic science colleagues about that, and maybe more MD-PhD's will join AMA. Tell them, too, that our consistent support for NIH funding and efforts to protect the NIH agenda from political pressure is an important AMA contribution to the stability and integrity of medical research in the U.S.

Did you know that in this year alone we have held flagship conferences on adolescent health, animals in research, injuries and accidents in American society, family violence, who pays for medical education, and the future implications the Human Genome Project has for the practice of medicine? The national movers and shakers attended these conferences and recognized the contributions of AMA, even though our average member might not have even noticed the ads and announcements that heralded these events. Sometimes our light burns just as brightly even if it is underneath a bushel.

Did you know the AMA is the leader of the world medical community? Not only do we publish JAMA in thirteen languages, but we lead the world, through the World Medical Association, in developing statements of ethics, guidance in the use of technology, manpower issues, medical education standards and quality assurance. The world is now small, and our global leadership responsibility to our profession is important. For instance, did you know we helped organize the Thai Medical Association in a program for infant survival, and that we presented that program to the director of the World Health Organization, as well as the World Medical Association?

Of course, our number one mission is representation. I said two years ago in a speech at our leadership conference that in order to represent medicine, we must be organized into an AMA that is strong, that is united, that is a triple threat in response to government intervention, that is willing to take risk, and that is capable of rapid response. To represent all of medicine, we must exert both strength and stability in finance, in membership, in our staff capability, and in our ability to communicate the fact that we have the greatest health care system in the world—and that the public will lose if we convert it into a public utility.

On the communications front, did you know that our Division of Communications answers over one thousand requests for information and interviews—each month? That three thousand reporters receive our packet of daily newspapers regularly, adding up to some fifty-five this year? That AMA spokespeople make hundreds of national and local appearances on electronic media each year? That American Medical Radio News is used by five hundred fifty radio stations daily and is broadcast on the Voice of America in Europe? That in 1989, AMAs consumer film “First Comes Caring” had twenty-nine hundred telecasts to an audience of over twenty-one million people? Or that American Medical Television reaches over fifty thousand physicians and eight hundred thousand lay people each month on the Discovery Channel, and that it will become an increasingly important tool to get out our message in the media decade ahead?

Did you know that we hold conferences for science reporters and seminars for physician media communicators each year, so that our message can be communicated by a network system at the local level?

Is all we are doing enough? Of course not.

Must we do more? Certainly.

What is the best way? To network with the communications capability of hundreds of state and county societies.

I said that the AMA must be triple-
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Moderator: William J. Untereker, MD

3:00-3:30  Yes—William J. Untereker, MD
3:30-4:00  No—Gary J. Vigilante, MD
4:00-5:00  Case presentations—Interesting patients with valvular heart disease—Marie-Noelle Langan, MD
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What about representation to our other publics? Many of us officers have addressed major business groups in Seattle, New Orleans, Boston, Detroit, and we are planning visits to other major cities, to highlight our plan to strengthen the U.S. health care system rather than to adopt a foreign model.

And we are constantly seeking ways to coordinate better our legislative activities with national specialty societies. We hold regular briefing sessions for information exchange and tactical planning. Our Washington staff was named by Congressional staffs as one of the five most effective Washington lobbies. They achieved this ranking because our people are experienced, knowledgeable, tough and professional. Just look at what they have accomplished with RBRVS. And when the Federation puts on a full-court press, as it did on E Ts, it is wonderful to behold. We had a magnificent win on physician payment last month, and we can all be proud of it.

We work at establishing the best possible relations with organized consumer groups. For instance, we have frequent staff-to-staff meetings with AARP to identify areas of joint cooperation. We have lobbied with them against unreasonable Medicare cuts. And we held a joint conference on quality of care for the elderly.

We also keep the lines of communication open with other professions. As an example, I have carried our preliminary discussions with the president of the American Bar Association, Mr. Stanley Chauvin, with respect to a joint AMA-ABA project to put together teams of a doctor and an attorney to go into local schools and present a program on the medical and legal aspects of drug use. This great idea is Stan's, and originated with his concern about how little risk-taking teenagers understand the lifelong impact of a felony conviction, and how they underestimate the medical consequences of drug use. We are jointly developing talking points and handouts, and Stan and I will pilot the lawyer-doctor drug prevention team teaching in Salt Lake City in January, with a program that will be replicable for use all around the U.S. In the months ahead, I ask each of you to work with your local bar association to implement this important and needed effort.

Another area where the law and medicine often meet is ethics. As our science becomes more complex, as society insists on being more engaged in medical decisions that affect it, as entrepreneurial trends force questions never before asked, AMAs responsibility as the source of ethical guidance becomes even more important. Our Council on Ethical and Judicial Affairs will be on top of the issues, with studies and opinions relating to financial incentives to limit care; ethical implications for HMOs and IPAs; racial and gender disparities in receipt of medical care; prenatal screening for genetic defects, just to name a few.

These, then, are some answers to the question so many of you are asked so often: What does the AMA do for me?

What do I have to report to you about the future state of our union, our AMA?

I am cautiously optimistic—optimistic because the current leadership and staff of the Association is so capable. I am impressed, for instance, with the excellence of the Council and Board reports, the directions the AMA is taking in reaching out to the formation of coalitions, and joint activities with specialty societies and other organizations. We are able to leverage our strength when we do so. We must and will optimize these opportunities.

My note of caution comes from a concern that the frustration and disillusionment being expressed by physicians in America will lead them to throw up their hands in despair rather than raise up their arms in support. We must have membership to succeed. And to get and keep members, we must tell America's physicians how well AMA functions, and all that it is doing for them. We must tell them that we need their involvement if medicine is to successfully confront the challenges of the decade ahead.

To the uninvolved, I say: join us with confidence, and not out of desperation.

To our critics, I say: we welcome your ideas; we are always open to better ways of doing things. But give the AMA credit for what is right when you criticize the AMA for what is wrong.

To nonmembers, I say: your future is at stake. AMA membership is your best investment in that future.

To our superb staff at all of its many levels, I say: thank you—we know of your loyalty and the excellence of your work.

To you, the leaders of American medicine, I say two things: First, thanks for the extraordinary personal kindness you extend to Gwen and me and for your letters, and your input, and your help. Second, I say: lift up your heads, be proud. You are the linchpin of the work of the AMA.

And the AMA works.
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Symposia

Clinical Challenges for General Ophthalmologists
Peter Savino, M.D., moderator

Governmental Policies and Political Trends of Importance to Ophthalmologists
Hunter Stokes, M.D., moderator

Gettes Memorial Symposium on Cataract and IOL Surgery
Stephen Lichtenstein, M.D., moderator

Scientific and Technical Papers
to be presented by Members of Wills Eye Hospital Society of Ex-Residents

moderators and participants (partial list)
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January 10, 1990
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Myron H. Weinberger, MD
Professor of Medicine
Director, Hypertension Research Center
Indiana University School of Medicine

January 17, 1990
RHEUMATOLOGY & IMMUNOLOGY
NEWER ADVANCES
Raphael J. DeHoratius, MD
Professor of Medicine
Director, Division of Clinical Immunology
and Rheumatology

January 24, 1990
SKIN CANCER (NON-MELANOMA)
Gary R. Kantor, MD
Associate Professor of Medicine
and Dermatology
Department of Medicine

January 31, 1990
SPACE MEDICINE: CARDIOVASCULAR,
BONE, FLUID SHIFTS AFFECTS OF SPACE
G. John DiGregorio, MD, PhD
Professor of Pharmacology and Medicine
Director, Division of Toxicology
Consultant to NASA

FEBRUARY 1990
February 7, 1990
SOMATOSTATIN, CARCINOID SYNDROME
John Oates, MD
Professor & Chairman
Department of Medicine
Vanderbilt University, Nashville, TN

February 14, 1990
LYME DISEASE
Steven Billstein, MD, MPH
Associate Professor of Medicine
Columbia Presbyterian Medical Center

February 21, 1990
NEOPLASTIC DISEASE ADVANCES IN THERAPY
Isadore Brodsky, MD
Professor of Medicine
Department of Neoplastic Diseases
Director, Institute of Cancer & Blood Diseases

February 28, 1990
CLINICAL PATHOLOGIC CONFERENCE
Chief Residents:
Michael DeAngelis, MD
Ana Nunez, MD
Ralph McKibbon, MD
Matthew Sandler, MD

WEDNESDAYS
MEDICAL SEMINAR SERIES
8:30 A.M.–3:00 P.M.

MARCH 1990
March 7, 1990
IMMUNE INTERVENTION IN TYPE I DIABETES MELLITUS
Jay S. Skylar, MD
Professor of Medicine
Director, Diabetes Mellitus
University of Miami, Miami, FL

March 14, 1990
COPD: PATHOGENESIS AND TREATMENT ADVANCES
Mark J. Utell, MD
Professor of Medicine and Toxicology
University of Rochester, Rochester, NY

March 21, 1990
CLINICAL PHARMACOLOGY
Vincent J. Zarro, MD, PhD
Associate Professor of Pharmacology
& Medicine
Director, Division of Clinical Pharmacology

March 28, 1990
DERMATOLOGIC TREATMENT WITH RETINOIDS AND CYCLOSPORINE
Richard L. Spielvogel, MD
Professor of Medicine and Dermatology
Director, Division of Dermatology

MARCH 1990
March 7, 1990
Diabetes Mellitus: Immune Mechanisms & Insulin Therapy Innovations
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BACK SCHOOL RELIEVES PATIENTS' PAIN

Back pain is widely accepted as the cause of more lost work time than any medical condition but the common cold. Virtually 80 percent of the United States population will suffer from serious back pain at least once in their lives.1 Unfortunately, medical science has not yet been able to identify all the causes of back pain—nor to cure all cases in which the cause has been identified—despite recent advances in spinal diagnostic technology such as the computerized axial tomogram and magnetic resonance imaging. For the foreseeable future, patients will have to learn to cope with their back pain to continue to be productive members of society. The concept of back school education may be the best method of handling this problem.

The concept of education as a treatment and preventive modality for spinal pathology began in Scandinavia, a country with an impressive history of investigation into the pathophysiology of back pain.2,3 Canada's entry into this arena since Dr. Fahimi's first back school in Vancouver in 1958, likewise has produced a wealth of information concerning the value of the back school.4 The United States, a latecomer in the area has produced a number of back schools across the country that are just now producing data as to the efficacy of this approach.5,6,7,8,9

The Graduate Hospital Back School, an outpatient facility in Philadelphia, has provided educational information, physical medicine, and nutritional and psychological support to well over 100 sufferers of back pain during the last three years (1985–1987). The following article provides the results of this training for the first 100 patients. The goals of the program are: to increase the patients' knowledge as to the cause of their pain and disability; to increase self-care and the ability to cope with life situations at home and at work; to decrease pain-related behavior such as the taking of medication and the need for physical therapy or physician visits; and to establish a lifelong pattern of exercise and physical fitness. The effectiveness of the program was measured by comparing

---

Figure 1
Back Pain at Follow-up

<table>
<thead>
<tr>
<th>Pre Back School</th>
<th>Post Back School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 51</td>
</tr>
<tr>
<td>31.4% Upper Back</td>
<td>31.4%</td>
</tr>
<tr>
<td>56.9% Lower Back</td>
<td>64.7%</td>
</tr>
<tr>
<td>15.7% Buttocks</td>
<td>9.8%</td>
</tr>
<tr>
<td>Posterior Thigh</td>
<td>41.2% 23.5%</td>
</tr>
<tr>
<td>Anterior Thigh</td>
<td>23.5% 35.3%</td>
</tr>
<tr>
<td>Posterior Calf</td>
<td>29.4%</td>
</tr>
<tr>
<td>Shin</td>
<td>5.9%</td>
</tr>
<tr>
<td>Posterior Ankle</td>
<td>13.7%</td>
</tr>
<tr>
<td>Dorsum of Foot</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

---

William H. Simon, MD, FACS
Sharon J. Gates, MSN, CRNP
Albert G. Crawford, PhD
Doreen Robinson, RPT

Dr. Simon is clinical associate professor of orthopaedic surgery at the University of Pennsylvania School of Medicine.
Ms. Gates is director of the Back Program at Graduate Hospital, Dr. Crawford and Ms. Robinson are affiliated with Graduate Hospital. This study was supported by a grant from the Department of Orthopaedic Surgery at Graduate Hospital. The findings from this study were presented to the Pennsylvania Orthopaedic Society in Pittsburgh in November 1988. Send reprint requests to William H. Simon, MD, 255 S. 17th St., 11th Floor, Philadelphia, PA 19103.
Table 1
Overview of Back School

<table>
<thead>
<tr>
<th>Problem</th>
<th>Acute (&lt;3 months duration) and Chronic (&gt;3 months duration) lower back pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>Increase knowledge concerning the form and function of the lower back</td>
</tr>
<tr>
<td>Goals</td>
<td>Improve functional ability</td>
</tr>
<tr>
<td>Instructions</td>
<td>Promote methods of self-care</td>
</tr>
<tr>
<td>Frequency</td>
<td>Two evening sessions in the first week</td>
</tr>
<tr>
<td>Group Size</td>
<td>Six to eight participants per session</td>
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Table 2
Demographic Characteristics

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<tr>
<th>Sex</th>
<th>Number</th>
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<tr>
<td>Female</td>
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<tr>
<td>Age</td>
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<tr>
<td>25-29</td>
<td>6</td>
<td>13.6</td>
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<tr>
<td>30-39</td>
<td>18</td>
<td>41.0</td>
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<tr>
<td>40-49</td>
<td>6</td>
<td>13.6</td>
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<td>50-59</td>
<td>7</td>
<td>15.9</td>
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<td>60-69</td>
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<td>9.1</td>
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<tr>
<td>70-79</td>
<td>3</td>
<td>6.8</td>
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<td>Total Responding</td>
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<td>Education</td>
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<td>High School Education</td>
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<td>Total Responding</td>
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<td>100.0</td>
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<tr>
<td>Occupation</td>
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<td></td>
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<td>Blue Collar</td>
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<td>29.4</td>
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<tr>
<td>White Collar</td>
<td>36</td>
<td>70.6</td>
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<td>Total Responding</td>
<td>51</td>
<td>100.0</td>
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<tr>
<td>Employment Status</td>
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<tr>
<td>Employed</td>
<td>33</td>
<td>71.7</td>
</tr>
<tr>
<td>Unemployed</td>
<td>13</td>
<td>28.3</td>
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<tr>
<td>Total Responding</td>
<td>46</td>
<td>100.0</td>
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Geisinger Clinic

1989–1990 Continuing Education Programs

Advanced Trauma Life Support Provider Course
January 12 & 13 or March 9 & 10, 1990

Advanced Cardiac Life Support Instructor Course
Friday & Saturday, February 2 & 3, 1990

15th Annual Concepts in Clinical Practice
Saturday & Sunday, February 10 & 11, 1990
Sheraton Lancaster Resort, Lancaster

Advanced Cardiac Life Support Provider Course
Friday–Sunday, February 23–25, 1990

Emergency Medicine Update: 1990
Wednesday, March 7, 1990

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Saturday, March 10, 1990

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Saturday, March 17, 1990

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Wednesday, April 4, 1990

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Wednesday, April 18, 1990

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3rd Annual Orthopaedic Trauma Update
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Tuesday–Friday, June 19–22, 1990
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Geisinger Medical Center Logo
scores on pre-school and post-school written questionnaires and pain drawings.

Methods
Back school is the outpatient component of the comprehensive spinal care program in a 300-bed tertiary care facility located in Philadelphia. A series of five, 90-minute consecutive evening classes are held each month for adults over the age of 18 years who have a history of back pain for at least three months. The classes are taught by a nurse practitioner, a physical therapist, a clinical psychologist, and an orthopedic surgeon (via videotape). The curriculum focuses on self-care (Table 1). Participants are physician- or self-referred.

The first session consists of a physician narrated videotape describing the anatomy and function of the spine. The second session focuses on the importance of regular aerobic exercise. Each student participates in flexibility and strengthening classroom exercises. The third session helps participants identify and relieve everyday stressors and provides an atmosphere that promotes progressive relaxation. The fourth session allows participants to practice good posture and body mechanics through the activities of a daily living obstacle course. The fifth session provides time for review of previous learning and a discussion of nutrition, medications, sexual activity, and back first aid.

During the first class session, participants complete a 10-item multiple choice questionnaire to evaluate their current knowledge of the causes of back pain and methods to reduce pain. Also covered are the Mooney pain drawing to assess current levels of pain and a demographic questionnaire to determine individual characteristics. Upon completion of the five sessions, participants complete a 10-item questionnaire to determine current knowledge. The subjects are informed that they will be contacted by mail six weeks later to answer a series of questions.

The present study is based upon a review of the first 100 consecutive subjects who completed the Graduate Hospital Back School program between April 1985 and April 1986. Six weeks following completion of their back school education, questionnaires were mailed to all subjects. Participants were asked to rate the back school by completing 13 close-ended questions, to rate their current level of pain by completing the Mooney pain-diagram, and to assess their current knowledge level by completing a 10-item test.

Participants were assumed to have minimal knowledge of back care at the start of back school. It was expected that test scores would change over time and that the effectiveness of the teaching could be determined by comparing pre- and post-course scores.

Results
Fifty-one of the 100 patients returned completed follow-up questionnaires in pre-addressed stamped envelopes. The patient sample characteristics are shown in Table 2. Forty of the 51 patients knew their diagnoses. These included two patients with herniated disc at L4-5, three with herniated disc at L5-S1, and six with degenerative joint disease. Three patients reported having lumbar spinal surgery prior to back school and one patient underwent spinal surgery between back school and the follow-up period.

Because all 51 patients did not answer all pre- and post-test questions, percent-ages stated in the results are those of re-

![Table 3](image)

<table>
<thead>
<tr>
<th>Known Causes of Back Pain</th>
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<tbody>
<tr>
<td>Total Responding: Males = 13, Females = 16</td>
</tr>
<tr>
<td>N=29</td>
</tr>
<tr>
<td>Work</td>
</tr>
<tr>
<td>7</td>
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<td></td>
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![Table 4](image)

<table>
<thead>
<tr>
<th>Employment Status</th>
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</thead>
<tbody>
<tr>
<td>Total Responding = 46</td>
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<tr>
<td>Pre Back School</td>
</tr>
<tr>
<td>13</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

![Graph](image)
Twenty of the 49 nonresponders were contacted by telephone and completed a short verbal questionnaire. Their responses were not considered in the statistical analysis.

For the 51 individuals completing the follow-up questionnaire, the mean duration of back pain prior to back school was 14 months.

Fifty-six percent (9/16) of the responding female participants attributed their back pain to a motor vehicle accident, while 54 percent (7/13) of the males cited work as the reason for their back pain (Table 3).

Eighty-four percent (42/50) stated that, overall, back school helped them understand the nature of back pain. Sixty percent (24/40) had reduced their pain medication. Fifty-seven percent (27/47) stated they understood about back care and were able to manage without physical therapy or physician visits. While there was a noted decrease in radiating leg pain, 65 percent (33/51) of the participants continued to have back pain at follow-up examination (Figure 1).

Following back school instruction, 80 percent (35/44) stated that back school helped them work more comfortably. At follow-up, 38 percent (5/13) of previously unemployed patients had returned to their former jobs (Table 4).

Fifty-six percent of the participants (28/50) continued to perform their flexion and extension back exercises following back school and 68 percent (34/50) followed a regular weekly exercise regimen of 30 minutes of aerobic exercise five times a week (Table 5).

Sixty-five percent (31/48) of patients reported that they were better able to manage everyday stressors, after taking the course.

One hundred percent of the telephone respondents stated that back school helped them in general, reduced their back pain, and helped them cope better with stress. Eighty-two percent continued to perform a regular exercise program.

Table 6 shows the results of the analysis of educational differences in test scores in the pre-school, immediate post-school, and follow-up phases. Grading was on a scale of zero to 10 with the highest score being 10. The students with a high school education or less had a mean pre-school score of 4.75, which rose significantly (t = 6.5, df = 11, p < .001) to an immediate post-school score of 6.55, through the follow-up. On the other hand, the students with a college education or more started with scores as high as those that the less well-educated students achieved over time, 6.5, a mean which is significantly (t = 4.28, df = 43, p < .001) higher than that of the less well-educated students. Nevertheless, the college-educated group improved their performance only slightly, to 7.0, during the course of the back school, and declined in performance, to 6.67, between the immediate post-school and follow-up phases.

An analysis of the test results revealed that this change in results depended mainly on answers to questions 8 and 9, concerning exercises for abdominal muscle strengthening, and factors that reduce back strain while on a long car trip (Figure 2).

One interpretation of these findings is the hypothesis that there is a "ceiling effect," such that more highly educated students cannot perform any better, while less highly educated students can. While there may be some truth to this interpretation, it does not account for the decline in scores among the college educated group between the post-school and follow-up phases, coupled with a slight continued improvement among the high school educated students.

Discussion

Those who have criticized the concept of a back school in the past have done so on the basis of a lack of an objective study showing efficacy of such endeavors. The patient is not cured. Spinal mobility does not improve. Subjectively, however, past studies

---

**Figure 2**

**Pre- and Post-Back School Test Questions**

Instructions: Where indicated, either complete the blank or circle the appropriate answer.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

1. Back pain may be caused by:
   - a. emotions
   - b. diet
   - c. occupations
   - d. posture
   - e. a, c, d
   - f. all of the above

2. True or False? There are three main curves in the side view of the human spine.

3. True or False? Abdominal muscles are not important in taking the load off of the lower back.

4. True or False? A herniated disc in the lower back is the same thing as degenerative disc disease.

5. Choose from below the major principles involved when lifting an object from the floor.
   - a. bend your knees
   - b. arch your back
   - c. hold the object close to your body
   - d. all of the above

6. True or False? Emotional stress can aggravate physical pain just as physical disability can generate emotional stress.

7. True or False? When a physical disability strikes a family member, the entire family feels the stress and both the disabled and their families must make difficult emotional adjustments.

8. Choose from the list those exercises that strengthen the abdominal muscles.
   - a. sit-ups
   - b. straight leg raises
   - c. pelvic lift
   - d. a & c only
   - e. a only

9. If you are going on a long car trip, what things listed below could help you to reduce back strain?
   - a. stop the car, get out and walk around
   - b. put a small towel behind your back
   - c. keep your car seat closed
   - d. a & c
   - e. all of the above

10. Which of these exercises protect the back from injury?
    - a. brisk walking
    - b. bicycling
    - c. swimming
    - d. a & c
    - e. all of the above
have agreed with the present study that the patient benefited significantly.4,5,6,7,8 The subjective phenomenon of a general improvement in the quality of life (decrease in the use of medication, increased ability to cope with pain, increased ability to work and return to normal daily activities) are benefits of the back school that must not be overlooked or underestimated in the quest for objectivity.

The reduction in medical costs (physicians' fees, physical therapy costs, medication costs, medical equipment costs) provided by this educational modality could conceivably make the back school the most cost-effective medical treatment program presently available in the United States.

Many authors have recognized that the program itself is less expensive than an equivalent period of physical therapy.5,6,7 In addition, the value of self awareness gained in the back school continues to aid the patient long after the subjective effects of therapy have worn off.7 According to our study, the educational value of the program is long-lasting. Interestingly, the lower education level patients appear to gain and retain more from the program than patients with higher educations. In a similar study in 1983, Hall et al. found a positive correlation between subjective improvement and the amount of information retained.4 This is important in returning patients to unskilled work—even though it is universally acknowledged that patients receiving workers' compensation generally respond less well to any modality of treatment than other similarly affected patients.8

The psychological impact of the back school also must be appreciated. The patient realizes that, as a member of a group with similar problems, he or she is not alone. Group support and individual attention given by members of the back school faculty to the patients helps dispel frustration, depression, and the anxiety of chronic pain. Patients realize that their referring physicians do believe them and are trying to help relieve their symptoms. In addition, they have a whole new support group to contact should they need help with problems that arise in the future.

While the results of the present study support previous studies in noting a significant improvement in subjective complaints,4,5,6,7,8 there are differences. Our level of response to the post-test questionnaire was better than found in most studies (51%).3 Our study also tests for comprehension and long-term retention of material presented at the Graduate Hospital Back School. Many past studies have not provided this data.7

The information gained from the present study confirms the value of back school in dealing with patients with subacute or chronic back pain. The program is inexpensive and relatively easy to administer and should be available to every eligible patient anywhere in the United States.

Table 5
Exercise Regimen

<table>
<thead>
<tr>
<th>Total Responding</th>
<th>49/50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Back School</td>
<td>24</td>
</tr>
<tr>
<td>Post Back School</td>
<td>34</td>
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Table 6
Analysis of Educational Differences

<table>
<thead>
<tr>
<th>Education</th>
<th>Pre-School Phase</th>
<th>Immediate Post-School</th>
<th>Follow-up Phase</th>
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<tr>
<td>High school or less</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>4.75 (sd=1.22, N=12)</td>
<td>6.42 (sd=1.62, N=12)</td>
<td>6.55 (sd=1.92, N=11)</td>
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<tr>
<td>College or more</td>
<td>6.60 (sd=1.73, N=12)</td>
<td>7.00 (sd=1.74, N=12)</td>
<td>6.67 (sd=1.23, N=12)</td>
</tr>
</tbody>
</table>

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Proceedings 140th Annual Meeting of the House of Delegates

Opening Session
October 20, 1989

James A. Raub, MD, Speaker of the House, called the opening session of the House of Delegates to order at 10:06 a.m. in the Grand Ballroom of the Pittsburgh Westin William Penn Hotel.

Invocation
Reverend Stuart P. Boehmig of Orchard Hill Church, Wexford, Pennsylvania, offered the invocation.

Credentials Committee
Bradford K. Strock, MD, Dauphin County, chairman of the Credentials Committee, presented the following report:

Mr. Speaker, there is a quorum of 196 delegates registered and in attendance.

Speaker's announcements
Dr. Raub announced that delegates should be aware of Resolution 72-6 prohibiting smoking in the House of Delegates and reference committee hearings.

Dr. Raub also announced that anyone encountering an individual who should dial 5108 on the hotel phones and assistance would be provided.

Dr. Raub called to the attention of the House of Delegates that The Educational and Scientific Trust had available PMS ties and golf shirts.

Presentation of memorial resolution
D. Ernest Witt, MD, Columbia County, presented the following memorial resolution for George A. Rowland, MD:

WHEREAS, George A. Rowland, MD worked as a family physician for over 40 years in Danville and Millville, Pennsylvania, serving his large group of patients as he would family and friends with kindness, true concern, and gentleness and, by doing so, also served these communities; and

WHEREAS, He also served on the staffs of Danville State and Bloomsburg Hospitals with a term as Chief of Staff on the latter, as well as being on the teaching staff of Geisinger Medical Center and Hershey Medical School; and

WHEREAS, He served his fellow physicians locally as long-time secretary-treasurer of Columbia County Medical Society, as well as a term as president, and long-time delegate to the Pennsylvania Medical Society; and

WHEREAS, He served medicine statewide on many Pennsylvania Medical Society committees and councils, and as a long-time Board member and finally chairman of the Board, and also as president of the Pennsylvania Academy of Family Physicians, also, as a charter member and eleven year member of the PMSLIC Board of Directors and corporate member of Pennsylvania Blue Shield; and

WHEREAS, He served medicine nationally as delegate, Board member, and vice-president of the American Academy of Family Physicians and delegate and Board member of the American Medical Association; and

WHEREAS, He passed away suddenly in August 1989 after an acute, short-term illness but will be remembered by us for his true wit, great sense of humor, and genuine friendliness; therefore be it

RESOLVED, That we pause for a moment to reflect on this; and be it further

RESOLVED, To enter these remarks in our minutes and a copy thereof be sent to the surviving family members.

Address of the president
Gerald L. Androtle, MD, Luzerne County, addressed the House. Dr. Androtle's address, which contained no recommendations, was referred to Reference Committee F.

Committee on Rules
Presented by:
Robert W. Ford, MD

Mr. Speaker, members of the House of Delegates, the Committee on Rules met and reviewed Standing Rules 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 of the House of Delegates of the Pennsylvania Medical Society as published in the 1989 Official Reports Book.

The committee reviewed the Board of Trustees Report Q: Ad Hoc Committee to Study AMA Delegate Electoral Process and Resolution 89-1: Elimination of the Bullet Ballot in Elections for AMA Delegates.

Mr. Speaker, the Committee on Rules recommends that Standing Rules 1, 2, 3, 4, 5, 8, 9, and 10 be adopted.

The House adopted Standing Rules 1, 2, 3, 4, 5, 8, 9, and 10.

Mr. Speaker, the Committee on Rules reviewed Report Q of the Board of Trustees: Ad Hoc Committee to Study AMA Delegate Electoral Process that addresses Standing Rule 6 and recommends that Standing Rule 6 be reaffirmed as it presently reads.

The Committee on Rules heard testimony favoring the present process for nominating alternate delegates and determined to leave Standing Rule 6 unchanged.

The House reaffirmed Standing Rule 6 as it presently reads.

Mr. Speaker, the Committee on Rules also recommends that Standing Rule 7 be changed to disallow use of the bullet ballot.

The Committee on Rules recommends that the following language be adopted for Standing Rule 7:

'This means that if several nominees for equal office are voted for in a group, a ballot containing fewer votes than the number of positions to be filled is invalid. A ballot containing votes for more than the number of positions to be filled is also invalid.'

The committee cited Section 6.9012 of the AMA's Constitution and Bylaws which mandates that a ballot contain no fewer or no more votes than the number of members to be elected.

It was moved and seconded from the floor of the House to postpone voting on this recommendation until the caucuses had the opportunity to meet, but prior to the time of the elections. The House rejected this motion. The House rejected the recommendation to change Standing Rule 7 to disallow the use of the bullet ballot.

Mr. Speaker, the Committee on Rules recommends that Resolution 89-1 be filed. RESOLVED, That the Pennsylvania Medical Society amend its Standing Rules to no longer permit the use of the bullet ballot.

The House approved filing Resolution 89-1.

Approval of proceedings
The proceedings of the 139th Annual Business Meeting of the Pennsylvania Medical Society, held in Philadelphia, October 21-23, 1988, and found on pages 65-83 in the January 1989 issue of PENNSYLVANIA MEDICINE, were approved.

Address of the president elect
J. Joseph Danyo, MD, York County, addressed the House, during which he made the following recommendations:

1. The Pennsylvania Medical Society consider creating regional medical societies to better serve our membership and use available resources more effectively (referred to Reference Committee F).

2. The Pennsylvania Medical Society adopt the policy that federal funding for approval and continued monitoring of generic drugs must be the same as that for brand name drugs; in the meantime, PMS should withdraw its support of generic drugs (referred to Reference Committee B).

Remarks on AMA representative
Robert N. Moyer, MD, chairman of the Board of Trustees, introduced Daniel H. Johnson Jr., MD, vice speaker of the AMA House of Delegates, and Alan R. Nelson, MD, president of the American Medical Association, who briefly addressed the House.

Report of the AMA Delegation
Dr. Roehl reminded the House of its policy requiring the AMA Delegation to deliver an annual report to the House and called attention to the report of the AMA Delegation, which had been referred to Reference Committee F.

Official Reports Book
The Official Reports Book, containing the 1989 annual reports and Resolutions 89-1 through 89-51, was accepted as business of the House.

Please refer to the index of these proceedings for the subject, author, introducer, and referral of all resolutions.

Additional reports
The following report was received after the mailing of the Official Reports Book:
Late resolutions

Late resolutions, Resolutions 89-52 through 89-56 and 89-67 through 89-69, were received after the mailing of the Official Reports Book and required a two-thirds vote to become business of the House. Standing Rule 2, revised by the 1981 House of Delegates, requires that the Rules Committee review each late resolution and make a recommendation to the House as to whether it should be accepted or rejected as business of the House. Standing Rule 2, as revised by the 1987 House of Delegates, states that resolutions emanating from a business meeting of an officially recognized section of the Pennsylvania Medical Society may be presented for consideration by the House of Delegates at any time before the close of business at the opening session of the House and, therefore, does not require review by the Rules Committee. Resolutions 89-57 through 89-66 were submitted by special sections.

Committee on Rules

Presented by:
Robert W. Ford, MD

Mr. Speaker, members of the House of Delegates, the Committee on Rules has considered all of the items in the index.

Mr. Speaker, the Committee on Rules recommends that the following resolutions be accepted as business:

RESOLUTION 89-52: REPRESENTATION ON THE PENNSYLVANIA MEDICAL SOCIETY BOARD OF TRUSTEES

RESOLUTION 89-54: ELIMINATION OF PARTICIPATING AND NONPARTICIPATING PHYSICIAN CLASSIFICATION

RESOLUTION 89-56: LICENSE SUSPENSION OF IMPAIRED PHYSICIANS

RESOLUTION 89-67: DISASTER RELIEF EFFORTS FOR THE SAN FRANCISCO EARTHQUAKE AND HURRICANE HUGO VICTIMS

RESOLUTION 89-68: ELECTION OF FUND TO AID HURRICANE HUGO AND CALIFORNIA EARTHQUAKE PHYSICIAN VICTIMS

The House accepted as business Resolutions 89-52, 89-54, 89-56, 89-67, and 89-68.

RESOLUTION 89-55: HEALTH CARE COST CONTAINMENT COUNCIL

Mr. Speaker, the Committee on Rules recommends that Resolution 89-55 be rejected as business.

Resolution 89-55 asks that the PMS petition the Health Care Cost Containment Council to survey the hospitals in our state to determine the actual expenses in securing the information that Council demands and that the value of the information obtained thus far be estimated so that either:
1. The costs are justified and, therefore, hospitals will be reimbursed or,
2. The costs are not justified, and the Health Care Cost Containment Council self-destructs (because it is not effective).

The committee determined to reject this resolution because there is a similar resolution to be considered as business for the House of Delegates.

The House rejected as business Resolution 89-55.

RESOLUTION 89-69: EVALUATION OF KEPRO

Mr. Speaker, the Committee on Rules recommends that Resolution 89-69 be rejected as business.

Resolution 89-69 asks that the president of the PMS and the speaker of the House of Delegates appoint a committee of five members of the House of Delegates to investigate fully the operations of KePRO and the interaction with the Board of Trustees of PMS; and that the committee report its findings and recommendations to the 1990 House of Delegates or, if it appears appropriate, a special meeting of the House of Delegates; and that the committee report its findings to the Board of Trustees as soon as possible to allow appropriate action to be taken expeditiously; and that no member of the committee shall be serving in any capacity on the Board of Trustees of PMS, as an officer of PMS, as an officer or trustee in KePRO, or as an officer or trustee in PMSLIC.

The Committee on Rules determined to reject this resolution due to its lateness.

The House rejected as business Resolution 89-69.

Presentation of honorary resolution

Do it G. Bartuska, MD, Philadelphia County, presented the following resolution honoring C. Everett Koop, MD:

WHEREAS, C. Everett Koop, MD, has been a long time citizen of Philadelphia County and the Commonwealth of Pennsylvania; and

WHEREAS, He is widely acknowledged as a foremost medical educator, scientist, and surgeon; and

WHEREAS, He assumed the office of Surgeon General under terms of great duress and was forced to deal with many major health problems, including AIDS; and

WHEREAS, He rose to the occasion in extraordinary fashion and has had a great impact on the good of the citizens of the United States being the advocate of the nation’s public health; therefore be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society representing the entire medical community of the Commonwealth publicly commend and honor Dr. Koop for his distinguished service.

Introduction of Auxiliary presidents

Mrs. Earle R. Davis, president, Pennsylvania Medical Society Auxiliary, briefly addressed the House. Mrs. Davis’ report, which was contained in the Official Reports Book, was referred to Reference Committee F. Mrs. Davis then introduced Mrs. J. Edward Hill, the American Medical Association Auxiliary president, who briefly addressed the House.

Presentation on Forbes Report

Robert N. Moyers, MD, chairman of the Board of Trustees, introduced Ferdinand L. Soisson Jr., MD, chairman of the Committee on Long Range Strategy and Communications, who gave a presentation on the Forbes Report.

Reference committees

Reference committees for the 1989 Annual Business Meeting of the House of Delegates are listed below:

Reference Committee A: Roberta L. Schreiber, MD (Montgomery), chairman; James L. Cristol, MD (Philadelphia); Norman L. Eckberg, MD (Montour); Robert G. Heisey, MD (Lebanon); Robert L. Lasher, MD (Erie); and James B. Hayden, MD (Huntingdon), alternate.

Reference Committee B: Carol E. Rose, MD (Allegheny), chairman; Paul D. Drinkall, MD (Montgomery); Robert Marvin, MD (Delaware); Athole M. Nechel-Jacobi, MD (Medical School Section); Carl A. Sirio, MD (Resident Physician Section); and William D. Calley, MD (Clearfield), alternate.

Reference Committee C: John W. Lehman, MD (Beaver), chairman; Richard M. Gash, MD (Philadelphia); Virginia E. Hall, MD (Dauphin); Richard W. Hemphill, MD (Allegheny); Richard R. Ratner, MD (Delaware); and Edward A. Lottick, MD (Luzerne), alternate.

Reference Committee D: Edward J. Resnik, MD (Philadelphia), chairman; Richard D. Baltz, MD (Dauphin); Richard E. Dugan, MD (Allegheny); John D. Lawton, MD (Bucks); Edward J. Owens, DO (Crawford); and Spencer G. Weig, MD (Bradford), alternate.

Reference Committee E: Alan H. Schragger, MD (Lemhi), chairman; David W. Dunn, MD (Crawford); Ronald A. Dietrick, MD (Blair); Norman A. Godstein, MD (Chester); J. Walter Valenteen, MD (Delaware); and Paul J. Poinard, MD (Philadelphia), alternate.

Reference Committee F: John W. Mills, MD (Indiana), chairman; David L. Cohen, MD (York); Jay L. Funkhouser, MD (Beaver); Lewis T. Patterson, MD (Dauphin); Milton A. Wohl, MD (Philadelphia); and R. L. Furigay, MD (Cambridge), alternate.

Rules: Robert W. Ford, MD (Allegheny), chairman; Ronald J. Clearfield, MD (Radiology); Robert J. Foglietti, MD (Family Practice); Elmer H. Funk Jr., MD (Philadelphia); Donald E. Parlee, MD (Bucks); and Robert M. Pilewski, MD (Venango), alternate.

Credentials: Bradford K. Strock, MD (Dauphin), chairman; Daniel H. Gregory, MD (Allegheny); Gladys M. Miller, MD

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REPORT A, COMMITTEE ON BY-LAWS, SUBJECT 2: DELETION OF REFERENCES TO ALLOPATHIC AND OSTEOPATHIC

Mr. Speaker, your reference committee recommends that the bylaws change appearing in the Official Call and providing for the deletion of references to allopathic and osteopathic in the PMS bylaws be adopted.

In accordance with a recommendation approved by the House of Delegates in 1988, the proposed deletion of the references to allopathic and osteopathic is consistent with previous deletions in language relating to the hospital medical staff and medical student sections completed last year. There was no discussion on this subject.

The House adopted the bylaws change as presented in Subject Two of the Official Call.

REPORT A, COMMITTEE ON BY-LAWS, SUBJECT 3: REQUIREMENT OF 30 YEARS CONTINUOUS MEMBERSHIP FOR ASSOCIATE STATUS

RESOLUTION 89-3: REQUIREMENT TO 30 YEARS CONTINUOUS MEMBERSHIP FOR ASSOCIATE STATUS

RESOLVED, That the Pennsylvania Medical Society amend its bylaws to require a total of thirty (30), not necessarily consecutive, years of membership to qualify for associate status.

Mr. Speaker, your reference committee recommends that the bylaws change appearing in the Official Call and providing for eligibility as an Associate member of PMS for physicians 70 years of age or older who have a total of 30 years membership of this Society or of a constituent association of the AMA, be adopted.

Mr. Speaker, your reference committee recommends that Resolution 89-3 be filed.

The intent of both the report of the Bylaws Committee and of Resolution 89-3 are to liberalize the requirement for physicians 70 years of age or older to qualify as an Associate member of this Society. Associate members do not pay an annual membership fee unless they choose to receive regular PMS mailings. The current requirement is for 30 years of continuous membership in this Society or in a constituent association to the AMA. This bylaws change would permit the 30 years of membership in the Society to be noncontinuous. There was no discussion on this subject.

The House adopted the bylaws change as presented in Subject Three of the Official Call. The House approved filing Resolution 89-3.

REPORT A, COMMITTEE ON BY-LAWS, SUBJECT 4: UNIFIED MEMBERSHIP WITH THE AMA

Mr. Speaker, your reference committee recommends that the bylaws change appearing in the Official Call and providing for unified membership with the AMA be adopted.

Your reference committee heard speakers thoughtfully address both sides of this critical issue. Overall, a majority of those we heard favored unification.

Negative testimony focused primarily on four points. First was the perception that unification would result in the loss of a "freedom to choose." Second was that data from polls conducted by numerous component societies which appeared to oppose unification. Third was the fear that unification would bring a significant loss of members. And, fourth was a challenge to the AMA to expand its educational efforts regarding the importance and benefits of membership.

However, the committee heard extensive positive testimony and counter arguments to most of the objections that were raised. For example, the committee believes that the threat of coercion from the government and other outside forces poses a more significant threat to our membership and our practice of medicine than does unification.

The committee also believes that this important decision should not be based on unscientific polling. There was great concern about the size of the samples, the validity of the respondent population and the potential bias in the wording of the polls.

In contrast, the data from the statistically valid survey of nearly 1,300 PMS members and delegates this summer would seem to endorse strong arguments for unification. Most notably, governmental representation and third-party payment advocacy led the list of issues thought to be "very important" by those responding.

The committee wishes to point out that the unified membership incentive program anticipates and addresses the problems of early membership losses. The committee also acknowledges available historical information from other states which predicts long-term membership stabilization and growth.

Other positive testimony highlighted the fact that Pennsylvania already has a unified county and state membership program. We believe building on that foundation and unifying with the AMA could only serve to strengthen the Pennsylvania Medical Society.

The committee noted that during the past year the AMA has offered PMS an incentive package tied to unification. Although that package offers attractive benefits, the committee believes that other reasons for unification were more persuasive.

On the other hand, we would like to stress that there would be significant positive benefits from continuing and expanding the educational program begun by the AMA for Pennsylvania physicians this year.

Finally, your reference committee believes that as delegates to this House, our responsibility to our constituents can best be fulfilled by voting for this proposal which in the long term is in their best interests. The overwhelming positive testimony heard from the leaders of this Society, including the Board of Trustees, the Delegation to the AMA, and board members from many component county and specialty societies convinced us that unification with the AMA deserves to be the policy of the Pennsylvania Medical Society.
It was moved and seconded from the floor of the House to postpone the vote on unification until the next day; the House rejected this motion.

Joseph N. Denko, MD, chairman-elect of the Pennsylvania Delegation to the AMA, stated from the floor of the House that if unification was adopted, he planned to recommend that it be reviewed in three years to determine the status of PMS and county medical society membership and the overall health of the organizations.

It was moved and seconded from the floor of the House to postpone action on unification for one year. The House rejected this recommendation.

It was moved and seconded from the floor of the House to add an amendment to the current motion for unification to state: "The Pennsylvania Medical Society, by action today, is recommending that the AMA use the model of its work in the Pennsylvania unification effort to encourage other states to take action similar to that taken by Pennsylvania today." After further discussion, this amendment was withdrawn.

The delegates voted by secret ballot on the unification issue. The House adopted the bylaws change as presented in Subject Four of the Official Call. Dr. Denko presented his recommendation that unification be reviewed in three years to determine the status of PMS and county medical society membership and the overall health of the organizations. The speaker stated this recommendation was not necessary since it was not of an immediate nature, but suggested Dr. Denko submit a resolution to the 1990 House of Delegates if he so wished.

It was moved and seconded from the floor that the following resolution be adopted, "RESOLVED, That the PMS and AMA continue their efforts to educate the physicians of Pennsylvania to the benefits of unified membership until they deem this activity no longer necessary." The House adopted this resolution.

REPORT GG, BOARD OF TRUSTEES, UNIFIED MEMBERSHIP WITH THE AMA

Mr. Speaker, your reference committee recommends that Report GG, Board of Trustees, be filed.

The House approved filing Board Report GG.

RESOLUTION 89-11: PMSLIC—PMS RELATIONSHIP

RESOLVED, That the Pennsylvania Medical Society develop a policy that will allow 1989 members of PMS that have insurance through PMSLIC to retain their coverage without having to maintain PMS/AMA unified membership; and be it further

RESOLVED, That the Pennsylvania Medical Society use all means at its disposal to accomplish this end.

Mr. Speaker, your reference committee recommends that Resolution 89-11 be rejected.

The requirement for PMSLIC insureds to hold membership in this Society arises from Resolution 76-5-1 and appears in the PMSLIC Underwriting Manual which is on file with, and has been approved by, the Pennsylvania Department of Insurance. Your reference committee believes that this resolution would inappropriately create a special interest group.

It was moved and seconded from the floor of the House to adopt the following substitute resolution, "RESOLVED, That the Pennsylvania Medical Society develop a policy which will allow licensed physicians in Pennsylvania to apply for PMSLIC insurance through a mechanism which involves an annual payment of a $1,000 application fee to PMS." It was moved and seconded to refer substitute Resolution 89-11 to the Board of Trustees. The House approved referring substitute Resolution 89-11 to the Board.

Presentation of memorial resolution

Doris G. Bartuska, MD, Philadelphia County, presented the following memorial resolution for William J. Erdman II, MD:

WHEREAS, On Wednesday, September 27, 1989, almighty God called from among us Dr. William J. Erdman II, expert in rehabilitation medicine from Philadelphia, Pennsylvania and delegate to the Pennsylvania Medical Society; and

WHEREAS, Dr. Erdman was a native of Philadelphia, having graduated from Germantown Friends School, Swarthmore College, and the University of Pennsylvania School of Medicine; and

WHEREAS, Dr. Erdman, after training under George M. Piersal, MD, at the University of Pennsylvania, at age 32, succeeded Dr. Piersal as professor and chairman of the department of physical medicine and rehabilitation; and

WHEREAS, During 34 years in that post, Dr. Erdman trained hundreds of residents in his specialty and wrote many professional papers; and

WHEREAS, Dr. Erdman also held concurrent positions as the hospital's medical director from 1968 to 1978 and as assistant dean of the medical school from 1960 to 1968; and

WHEREAS, Dr. Erdman, working with industry, established pilot programs for employment of the disabled, particularly with computers; and

WHEREAS, As a pioneer in electromyography, Dr. Erdman held leadership posts in international and national organizations of physical medicine and rehabilitation; and

WHEREAS, Dr. Erdman faithfully served the Philadelphia County and Pennsylvania Medical Societies; therefore be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society record its deep appreciation for Dr. William J. Erdman II, and his remarkable record of service to mankind and the medical profession, and that the House observe a moment of silence in his honor; and be it further

RESOLVED, That the House convey this resolution to his wife of 32 years, Betty, and his daughters Mary Belle Patton and Jane Elizabeth Erdman.

Reference Committee C
Presented by: John W. Lehman, MD

Mr. Speaker, members of the House of Delegates, Reference Committee C has considered all of the items in the index.

RESOLUTION 89-31: REPEAL OF LONG TERM CARE ASSESSMENT AND MANAGEMENT PLAN (LAMP) PROGRAM

RESOLVED, That the Pennsylvania Medical Society join with the Osteopathic Medical Association and The Hospital Association of Pennsylvania to repeal the LAMP Program.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-31 be adopted.

RESOLVED, That the Pennsylvania Medical Society work with other interested associations to seek a comprehensive evaluation of the effectiveness of the Long Term Care Assessment and Management Plan (LAMP) Program; and be it further RESOLVED, That the Pennsylvania Department of Aging be requested to take immediate action to avoid future untimely delays in the assessment process.

The reference committee head considerable testimony regarding the effectiveness of the LAMP Program, both pro and con. In some instances, the program provides funds for alternative care sources which facilitate placement. In other instances, untimely delays in the assessment process result in unacceptable economic losses to hospitals from which the patients are awaiting discharge. The committee believes, therefore, that efforts should be made to evaluate the effectiveness of the program prior to calling for its elimination and, at the same time, to address the immediate concern over costly delays resulting from the assessment process.

The House adopted substitute Resolution 89-31.

RESOLUTION 89-30: PROBLEMS WITH THE STATE OF PENNSYLVANIA PRE-ADMISSION QUESTIONNAIRE FORM PA-376

RESOLVED, That the Pennsylvania Medical Society, in cooperation with the nursing home organization, seek modification of the pre-admission questionnaire form PA-376 to clarify the questions incomprehensible to both physicians and nursing home personnel.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-30 be adopted.

RESOLVED, That the Pennsylvania Medical Society join with the statewide nursing home associations to request that the Pennsylvania Department of Public Welfare simplify the questions contained in form PA-376.

All testimony heard confirmed the difficulty experienced by physicians and nursing home personnel in completing PA-376. The House adopted substitute Resolution 89-30.

RESOLUTION 89-32: CREDENTIAL VERIFICATION DATA BANK

RESOLVED, That the Pennsylvania Medical Society...
Medical Society study the feasibility of starting a credential data bank which would primarily verify a physician’s credentials and would now be acceptable as a primary source for all hospitals.

Mr. Speaker, your reference committee recommends that Resolution 89-32 be adopted.

The Committee heard only favorable testimony regarding the recommendation to study the feasibility of PMS establishing a primary verification credential data bank. It was suggested that the study include an investigation of the scope of such a data bank, whether or not the data verification should extend beyond Pennsylvania physicians. A suggestion was also made to investigate the possibility of modifying the AMA made to investigate the possibility of modifying the AMA Physician Masterfile to serve as a primary verification source.

The House adopted Resolution 89-32.

RESOLUTION 89-34: PMS PHYSICIAN CONFLICT OF INTEREST GUIDELINES
RESOLVED, That the Pennsylvania Medical Society study and develop conflict of interest guidelines for its officers, trustees, and members.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-34 be adopted.

RESOLVED, That the Pennsylvania Medical Society study and develop conflict of interest guidelines for its officers and other leadership.

Testimony heard by the reference committee suggested that the intent of the resolution was to address potential conflict of interest situations within the Society framework, not among all physician members. While the committee is aware that PMS, KePRO, and PMSLIC Board members are presently required to complete a conflict of interest disclosure statement annually, it is believed a more comprehensive set of guidelines for physician leaders should be developed.

The House adopted substitute Resolution 89-34.

RESOLUTION 89-36: EVALUATION OF JCAHO
RESOLVED, That the Pennsylvania Medical Society seek the cooperation of The Hospital Association of Pennsylvania in developing a questionnaire to be directed to a statistically significant number of Pennsylvania hospitals so that the president, medical staffs and chief executive officers may evaluate the JCAHO and, in so doing, create justifiable approval or constructive criticism which may be directed through appropriate channels.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-36 be adopted.

RESOLVED, That the appropriate PMS unit be charged with indentifying the concerns of medical staffs in Pennsylvania regarding the JCAHO accreditation survey process and determining how those concerns can be most appropriately addressed.

Various problems associated with the JCAHO survey process were reported to the committee. To define more concisely the specific concerns held by medical staffs in Pennsylvania, the committee believes PMS should first investigate those concerns prior to requesting The Hospital Association of Pennsylvania to participate in a joint survey.

The House adopted substitute Resolution 89-36.

RESOLUTION 89-59: COMPILATION OF DECK RESEARCH ON REGULATIONS AFFECTING MEDICAL PRACTICE
RESOLVED, That the Pennsylvania Medical Society issue a continually updated desk research of third-party payor and government health regulations at a reasonable cost.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-59 be adopted.

RESOLVED, That the Pennsylvania Medical Society make available at a reasonable cost a periodically updated desk reference of state and federal health law affecting medical practice.

The committee heard only favorable testimony regarding this resolution. The original resolution recommended that third party payor policies also be included in the reference manual. However, to include rules of third party payors in such a reference would be both costly and impractical due to the volume of and constantly changing third party payor policies.

The House adopted substitute Resolution 89-59.

ADDRESS OF THE VICE-PRESIDENT, GORDON K. MACLEOD, MD, RECOMMENDATION 1: TASK FORCE ON QUALITY OR ON PRACTICE PARAMETERS

Mr. Speaker, your reference committee recommends that Recommendation 1 of the vice president be referred to the Board of Trustees to monitor and coordinate PMS activities with those of the American Medical Association and national medical specialty societies.

The committee agrees that the medical profession must take a leadership role in the development of practice parameters. Further, it is the consensus of the committee that PMS can best serve the interests of Pennsylvania physicians by working with the AMA in such efforts.

The House approved referring to the Board of Trustees Recommendation 1 of the vice president.

ADDRESS OF THE VICE-PRESIDENT, GORDON K. MACLEOD, MD, RECOMMENDATION 2: COMMISSION ON PHYSICIAN CAREERS

Mr. Speaker, your reference committee recommends that Recommendation 2 of the vice president be referred to the Board of Trustees.

The committee believes there is merit in PMS defining and promoting new careers for physicians, and that the Board of Trustees is best suited to determine the most appropriate means to accomplish these objectives.

The House approved referring to the Board of Trustees Recommendation 2 of the vice president.

Waiver of Debate List

The following items have been grouped together in a waiver of debate list; little or no testimony was heard, and the committee feels the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends filing:

REPORT X, BOARD OF TRUSTEES: HOUSE ACTION 7.07, RECOMMENDATION V OF THE PRESIDENT-ELECT, COMMITTEE ON PROFESSIONALISM

REPORT A, COUNCIL ON MEDICAL PRACTICE

REPORT A, HOSPITAL MEDICAL STAFF SECTION (HMSS)

The House approved filing the waiver of debate items.

Special Presentation

Daniel H. Gregory, MD, president of the Allegheny County Medical Society, presented a special commemorative plate to Dr. Raub.

Reference Committee D

Presented by:

Edward J. Resnick, MD
Mr. Speaker, members of the House of Delegates, Reference Committee D has considered all of the items in the index.

REPORT A, COUNCIL ON GOVERNMENTAL RELATIONS

Mr. Speaker, your reference committee recommends that Report A, Council on Governmental Relations be filed.

There was discussion concerning Resolution 88-4 as outlined in this report. Your reference committee notes the renewed interest of the Society in generic drug evaluation and monitoring. Evidence of this was given in the discussion on Resolution 88-4 and the president elect’s recommendation concerning generic drugs.

The House approved filing Report A.

REPORT II, BOARD OF TRUSTEES: RESOLUTION 87-27: PATIENT’S BILL OF OBLIGATIONS

Mr. Speaker, your reference committee recommends that Report II, Board of Trustees be filed.

The committee heard more discussion concerning the patient’s responsibilities than the patient’s obligations. It was noted, however, that the testimony presented to the reference committee appeared to agree with the opinions of the Council on Education and Science and the Board of Trustees.

It was moved and seconded from the floor of the House to refer Board Report II back to the Board of Trustees. The House approved referring Report II back to the Board.

RESOLUTION 89-27: TORT REFORM
RESOLVED, That the Pennsylvania Medical Society continue its high priority efforts to promote meaningful tort reform in Pennsylvania.
Mr. Speaker, your reference committee recommends that Resolution 89-27 be adopted.

Your reference committee heard enthusiastic support for this resolution.

The House adopted Resolution 89-27.

RESOLUTION 89-28: ESTABLISHING A MEDICAL OMBUDSMAN TO SERVE STATE LEGISLATORS
RESOLVED, That the Pennsylvania Medical Society form a coalition of medical societies, medical schools, and other scientific and professional organizations to establish a medical ombudsman dedicated to serving the state legislators as a source of reliable, trustworthy medical and scientific information. It was noted that the new mission statement of the Society supports this concept. Testimony was generally in favor of the present actividades and future plans of the Society in this area.

The House rejected Resolution 89-28.

RESOLUTION 89-60: ADVERTISEMENT ENCOURAGING THE FILING OF MALPRACTICE LAWSUITS
RESOLVED, That the Pennsylvania Medical Society use all suitable resources, including cooperation with the Pennsylvania Bar Association, to discourage attorneys' advertisements which inappropriately encourage and solicit the filing of malpractice suits against physicians.

Mr. Speaker, your reference committee recommends that Resolution 89-60 be referred to the Board of Trustees.

Due to the complexity of the issues involved, your reference committee recommends further study by the Board of Trustees.

The House approved referring Resolution 89-60 to the Board of Trustees.

Waiver of Debate List
The following items have been grouped together in a waiver of debate list; little or no testimony was heard, and the committee feels the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends the following reports be filed:
REPORT B. COUNCIL ON GOVERNMENT RELATIONS
REPORT K. BOARD OF TRUSTEES: TAXING DEFENSE
REPORT A. PENNSYLVANIA MEDICAL POLITICAL ACTION COMMITTEE

The House approved filing the waiver of debate items.

Nominations and elections
In accordance with Standing Rule 10 (adopted October 22, 1982), nominations of delegates to the AMA were held Friday morning, October 20, 1989. Nominations were also held on Friday, October 20 for AMA alternate delegates, vice president, speaker of the House of Delegates, vice speaker of the House of Delegates, and trustees. Nominations for one member to serve on the Committee to Nominate Delegates and Alternates to the AMA, and one member to serve on the PMS Judicial Council were held on Saturday, October 21. Voting for those offices contested was held Sunday morning, October 22, 1989. As mandated by Resolution 89-2, Publishing the Results of Elections, the following is an account of those elections. The new officers for 1989-90 are:
President: J. Joseph Danyo, MD (York) was installed as president.
President Elect: Gordon K. MacLeod, MD (Allegheny) acceded to the office of president elect.
Vice President: Robert N. Moyer, MD (Crawford) was elected to the office of vice president with 140 votes; William H. Maood, MD (Montgomery) received 128 votes.
Speaker: Jonathon E. Rhoads Jr., MD (York) was elected as speaker with 192 votes; Charles A. Heisterkamp III, MD (Lancaster) received 77 votes.
Vice Speaker: Howard A. Richter, MD (Delaware) was elected as vice speaker with 183 votes; Donald C. Brown, MD (Westmoreland) received 85 votes.

The following trustees were elected by acclamation:
First District: George Ross Fisher, III, MD (Philadelphia);
Third District: John H. Hobart, MD (Northampton);
Eleventh District: Robert L. Lasher, MD (Erie);
Ninth District: John W. Mills, MD (Indiana);
Resident Physicians: Carl A. Sirio, MD; Hospital Medical Staff: Lee H. McCormick, MD;
Medical Students: Steven F. Nemerson.

One member was elected to serve a three-year term on the Committee to Nominate Delegates and Alternates to the AMA: Wilma C. Light, MD (Westmoreland) was elected with 139 votes; John D. Lane, MD (Bucks) received 123 votes.

Kenneth L. Cooper, MD (Lycoming) was reelected to a three-year term on the PMS Judicial Council with 128 votes; Leo J. Corazzo, MD (Luzerne) received 35 votes and Carol N. Maurer, MD (Venango) received 84 votes.

Report of the Committee to Nominate Delegates and Alternates to the AMA
The nominations of the Committee to Nominate Delegates and Alternates to the American Medical Association were published on page 1 of the Officials Report Book. Nine delegates elected by acclamation on Friday, October 20 to two-year terms commencing January 1, 1990 were: Gerald L. Andriole, MD (Luzerne); Donald C. Brown, MD (Westmoreland); Joseph N. Demko, MD (Lackawanna); George Ross Fisher III, MD (Philadelphia); Gordon K. MacLeod, MD (Allegheny); William H. Mahood, MD (Monongahela); Robert D. Moyer, MD (Crawford); Jonathan E. Rhoads Jr., MD (York); and Barbara A. Shelton, MD (Philadelphia). Nine alternate delegates elected by acclamation on Friday, October 20 to two-year terms commencing January 1, 1990 were: George F. Buerger Jr., MD (Allegheny); Ronald J. Clearfield, MD (Westmoreland); James L. Cristol, MD (Philadelphia); Jay L. Funkhouser, MD (Beaver); Joseph A.C. Girone, MD (Bucks); Lee H. McCormick, MD (Allegheny); Lewisk T. Patterson, MD (Dawhin); Michael J. Prendergast, MD (York); and Robert D. Reimncke, MD (Philadelphia).

Due to the action taken by the House of Delegates approving unification with the AMA, Pennsylvania became entitled to two additional delegates and alternates to the AMA. The speaker recognized Richard P. Kennedy, MD, Monroe County, chairman of the Committee to Nominate Delegates and Alternates to the AMA, who presented the following report.

Mr. Speaker and members of the House of Delegates, due to the action just taken by this House, approving unification with the AMA, Pennsylvania is entitled to two additional delegates to the AMA beginning January 1, 1990. The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations:
1. Ronald J. Clearfield, MD (Westmoreland County)
2. Robert L. Lasher, MD (Erie County)
3. Lee H. McCormick, MD (Allegheny County)

The Committee to Nominate Delegates and Alternates to the AMA further recommends that the nominee not elected to one of those two delegates' terms be returned to the alternate delegate term he held prior to this election, and the four alternate delegate vacancies that exist not be filled at this time.

It was moved and seconded from the floor of the House that voting for the delegate positions be held on Saturday, October 21, and voting for the alternate delegate positions be held on Sunday morning, October 22. Following further discussion, this motion was withdrawn.

It was moved and seconded from the floor of the House that nominations for delegate and alternate delegate positions also be made from the floor of the House; the House approved this motion. Nominations were held on Saturday, October 21, and the elections were held Sunday morning, October 22.

The following were nominated for one of the two additional AMA delegate positions:

Robert L. Lasher, MD (Erie) was elected to a two-year term as delegate beginning January 1, 1990 with 119 votes; Lee H. McCormick, MD (Allegheny) was elected to a one-year AMA delegate term beginning January 1, 1990.
with 109 votes; Ronald J. Cleafird, MD (Westmoreland) received 94 votes; John S. Parker, MD (Westmoreland) received 55 votes; and Robert D. Reinecke, MD (Philadelphia) received 97 votes.

The following were nominated for the seven AMA alternate delegate positions (two due to unification, and five resigned alternate delegate positions nominated for delegate positions); the persons receiving the four highest number of votes were elected to the four two-year terms beginning January 1, 1990, and the persons receiving the three highest number of votes were elected to the three one-year terms beginning January 1, 1990: Charles J. Cattano, MD (Allegheny); David L. Cohen, MD (York); Ronald J. Cleafird, MD (Westmoreland); Itendra M. Desai, MD (Allegheny); John E. Devenney, MD (Montgomery); Carl A. Frankel, MD (Dauphin); Donald Kaye, MD (Philadelphia); John W. Lehman, MD (Beaver); Phillip R. Levine, MD (Allegheny); Edward A. Lottick, MD (Luzerne); John S. Parker, MD (Westmoreland); Robert D. Reinecke, MD (Philadelphia); and Carl A. Sirio, MD (Dauphin). Elected as alternate delegate for two-year terms were: Ronald J. Clearfield, MD (172 votes); John W. Lehman, MD (143 votes); John S. Parker, MD (122 votes); and Robert D. Reinecke, MD (142 votes). The following were elected as AMA alternate delegates for one-year terms: Charles J. Cattano, MD (Philadelphia); Donald Kaye, MD (Dauphin); and Carl A. Sirio, MD (88 votes). The following is an account of the votes received by those not elected to AMA alternate delegate positions: David L. Cohen, MD (73 votes); Carl A. Frankel, MD (71 votes); Phillip R. Levine, MD (55 votes); and Edward A. Lottick, MD (54 votes). Drs. Desai and Devenney withdrew their names as nominees prior to the election.

Reference Committee E
Presented by:
Alan H. Schragger, MD
Mr. Speaker, members of the House of Delegates, Reference Committee E has considered all of the items in the index.

RESOLUTION 89-16: REIMBURSEMENT FOR AUTOPSIES
RESOLVED, That the PMS Council on Medical Economics study the issue of autopsy reimbursement by third parties and its value for quality assurance; and be it further
RESOLVED, That PMS subsequently request that the AMA Council on Medical Service consider performing comparable activities on a national basis.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-16 be adopted.

RESOLVED, That the PMS study the issue of autopsy reimbursement by third parties, for nonpatient and nonmedical examiners, and its value for quality assurance.

The House adopted substitute Resolution 89-16.

RESOLUTION 89-24: MANDATED APPEALS MECHANISM FOR PHYSICIANS PARTICIPATING IN MANAGED HEALTH CARE SYSTEMS
RESOLVED, That the PMS Council on Medical Economics study the following proposal: "All physicians participating in managed health care systems must be afforded an appeals mechanism if payment for a specific medically-necessary test or therapy is denied by the insurer/employer."

Mr. Speaker, your reference committee recommends that substitute Resolution 89-24 be adopted.

RESOLVED, That the PMS study the following proposal: "All physicians participating in managed health care systems must be afforded an appeals mechanism for a specific medically-necessary test or therapy if denied by the insurer/employer."

Mr. Speaker, your reference committee recommends that substitute Resolution 89-24 be adopted.

RESOLUTION 89-44: DEPARTMENT OF PUBLIC WELFARE SECOND OPINION PROGRAM
RESOLVED, That the Pennsylvania Medical Society urge the Department of Public Welfare to drop the Second Opinion Program requirement from the Place of Service Review process.

Mr. Speaker, your reference committee recommends that Resolution 89-44 be adopted.

Your reference committee heard mixed testimony on this resolution; however, the mandatory nature of the program and the administrative costs of the program are such that the Department of Public Welfare would better serve the Medical Assistance recipients by eliminating the program and increasing benefits with the dollars saved.

It was moved and seconded from the floor of the House that Resolution 89-44 be amended as follows: "RESOLVED, That the Pennsylvania Medical Society urge the Department of Public Welfare to drop the Second Opinion Program requirement from the Place of Service Review process with a voluntary program based on the patient's wishes." The House approved the amendment. The House adopted Resolution 89-44 as amended.

RESOLUTION 89-38: DEVELOPMENT OF SPECIFIC CPT-4 CODES FOR NUTRITIONAL SUPPORT
RESOLVED, That the Pennsylvania Medical Society recommend that Blue Shield seek changes in the coding process from the CPT Editorial Board to provide a specific series of codes for nutritional support; and be it further
RESOLVED, That the Pennsylvania Medical Society recommend that Blue Shield seek changes in the coding process from the CPT Editorial Board to provide a specific series of codes for nutritional support.

Mr. Speaker, your reference committee recommends that Resolution 89-38 be referred to the Board of Trustees.

Your reference committee heard considerable testimony on this resolution, most of it positive. However, it was felt that some additional development was needed, particularly the delineation of specific nutritional diagnoses.

The House approved referring Resolution 89-38 to the Board.

RESOLUTION 89-58: PHYSICIAN REVIEWER RESPONSIBILITY
RESOLVED, That the Pennsylvania Medical Society recommend that the attending physician be given the name, medical license number, state in which licensed, specialty, and board certification, if such exists, of the concurrent reviewing physician; and be it further
RESOLVED, That the Pennsylvania Medical Society adopt the above-stated policy and seek legislation requiring that this information be made available; and be it further
RESOLVED, That the Pennsylvania Medical Society will seek legislation to regulate concurrent non-hospital-based utilization review.

Mr. Speaker, your reference committee recommends that Resolution 89-58 be adopted.

Your reference committee heard considerable testimony on this resolution. The proliferation of utilization review and managed care firms is a national problem. More than 100 such organizations operate within the Commonwealth, and there is a need for regulation to curtail alleged abuses that have the potential to adversely affect patient care.

The House adopted Resolution 89-58.

RESOLUTION 89-54: ELIMINATION OF PARTICIPATING AND NON-PARTICIPATING PHYSICIAN CLASSIFICATION
RESOLVED, That the Pennsylvania Medical Society Delegation to the AMA seek that body's help in urging HCFA to eliminate "participating" and "non-participating" classification, and to substitute instead: "contracted" and "non-contracted" physician classification; and be it further
RESOLVED, That the Pennsylvania Medical Society Delegation to the AMA seek that body's help in urging HCFA to cease and desist from further harassment, intimidation, and discriminatory acts towards non-contracted physician providers.

Mr. Speaker, your reference committee recommends that Resolution 89-54 be adopted.

Your reference committee heard limited testimony on this resolution. The terms participating and nonparticipating are confusing to the Medicare patient. The fact that more than 90 percent of Medicare claims were on an assigned basis in 1988, while only 37 percent of Pennsylvania physicians were "participating," was difficult to get across to the public. The terms "contracted" and "non-contracted" are more relevant.

It was moved and seconded from the floor of the House to refer Resolution 89-54 to the Board of Trustees. The House approved referring Resolution 89-54.
Waiver of Debate List
The following items have been grouped together in a waiver of debate list; little or no testimony was heard and your reference committee feels the items are of a noncontroversial nature.
Mr. Speaker, your reference committee recommends adoption of the following:
RESOLUTION 89-20: PHYSICIAN/PATIENT DISCUSSION OF THIRD PARTY COVERAGE OF ESTIMATED CHARGES PRIOR TO SERVICE
RESOLVED, That the Pennsylvania Medical Society publicize the existence of this "participating physician" policy to the public through the public relations department; and be it further RESOLVED, That the Pennsylvania Medical Society encourage constituent county medical societies to publicize the existence of this policy to the public; and be it further RESOLVED, That the Pennsylvania Medical Society ask that the AMA consider adopting this policy.
RESOLUTION 89-39: MANDATED UNIVERSAL CLAIM FORM FOR MEDICAID
RESOLVED, That the Pennsylvania Medical Society seek a legislative solution to mandate that the Department of Public Welfare use the universal claim form that other insurance carriers accept.
RESOLUTION 89-46: CARE OF THE ELDERLY INDIGENT
RESOLVED, That the Pennsylvania Medical Society and affiliated county medical societies seek, in cooperation with senior citizen groups, to create an organized voluntary program in which such senior citizens groups also participate to address the needs of these patients; and be it further RESOLVED, That the Pennsylvania Medical Society study similar programs such as that sponsored by the Medical Society of the State of New York.
RESOLUTION 89-19: KEPRO’S SMALL ANALYSIS FEEDBACK MEDICAL ASSESSMENT PILOT (MAP)
RESOLVED, That The Pennsylvania Medical Society request of KePRO a report regarding the activities of the Small Area Analysis Feedback MAP Program.
RESOLUTION 89-42: KEYSTONE PREMIE REVIEW ORGANIZATION (KEPRO)
RESOLVED, That the Pennsylvania Medical Society or the American Medical Association initiate whatever action is necessary, including court action, to establish a fair and impartial appeals process for all actions brought against physicians by PROS.
RESOLUTION 89-51: ENHANCED QUALITY REVIEW
RESOLVED, That the Pennsylvania Medical Society become more actively involved in physician reviewer recruitment, education, and; and be it further RESOLVED, That all members of the Pennsylvania Medical Society actively involve themselves in quality utilization and

quality review.

RESOLUTION 89-64: MINIMIZING PURCHASE OF DUPLICATE MEDIGAP INSURANCE PLANS
RESOLVED, That the Pennsylvania Medical Society study the issue of duplicate Medigap insurance plans in order to determine whether specific initiatives should be promulgated; and be it further RESOLVED, That such initiatives to minimize the purchase of duplicate Medigap insurance plans may include laws which deal with: (a) mandated categorization of insurance policies; and (b) prohibition or sale of duplicate insurance policies; and be it further RESOLVED, That such initiatives to minimize the purchase of duplicate Medigap insurance plans may include non-legislative actions which may include: (a) requesting that the American Association of Retired Persons warn its members not to purchase duplicate insurance policies; and (b) requesting that the American Association of Retired Persons and Blue Cross/Blue Shield voluntarily refrain from selling duplicate insurance policies.

It was moved and seconded from the floor of the House to extract Resolution 89-20 from the waiver of debate list. The House approved this motion. It was moved and seconded from the floor of the House to amend Resolution 89-20 by deleting the final resolved. The House approved this amendment. The House adopted Resolution 89-20 as amended. The House adopted the waiver of debate items.

Mr. Speaker, your reference committee recommends that the following items be filed:

REPORT A, COUNCIL ON MEDICAL ECONOMICS

REPORT B, COUNCIL ON MEDICAL ECONOMICS (RBRVS)

REPORT JJ, BOARD OF TRUSTEES (CAT FUND)

REPORT G, BOARD OF TRUSTEES (MEDICAL CARE FOR THE UNDER-SERVED AND UNINSURED—RESOLUTION 88-26)

REPORT N, BOARD OF TRUSTEES (H莫斯)

REPORT O, BOARD OF TRUSTEES (MEDISGROUPS)

REPORT CC, BOARD OF TRUSTEES (HEALTH CARE COST CONTAINMENT)

REPORT FF, BOARD OF TRUSTEES (HAP/PPS/POMA JOINT COMMITTEE)

REPORT T, BOARD OF TRUSTEES (KEPRO OVERSIGHT)

REPORT KK, BOARD OF TRUSTEES (KEPRO)

REPORT, KEPRO (ANNUAL REPORT)

REPORT MM, BOARD OF TRUSTEES (THIRD PARTY/FRAUD ABUSE)

The House approved filing the waiver of debate items.

Mr. Speaker, your reference committee recommends that the following two items be referred to the Board of Trustees:

RESOLUTION 89-23: COST EFFECTIVENESS OF HEALTH CARE COST CONTAINMENT COUNCIL ACTIVITIES

RESOLVED, That the Pennsylvania Medical Society search for ways such as lobbying for legislation which will mandate that the Health Care Cost Containment Council will include in its reports an analysis of how much it cost (both the taxpayers and the hospitals) to generate the report.

RESOLUTION 89-43: UNAUTHORIZED LAB STUDIES PERFORMED BY INDEPENDENT LABORATORIES AND HOSPITALS

RESOLVED, That the Pennsylvania Medical Society study this issue of unauthorized laboratory services performed by independent laboratories and hospitals, and formulate and recommend guidelines for physicians concerning responsibility and liability, and report back to the House of Delegates at its next meeting.

The House approved referring to the Board of Trustees Resolutions 89-23 and 89-43.

Reference Committee F
Presented by: John W. Mills, MD
Mr. Speaker, members of the House of Delegates, Reference Committee F has considered all of the items in the index.

REPORT E, BOARD OF TRUSTEES: RESOLUTION 88-19, AUGUST ISSUE OF PENNSYLVANIA MEDICINE

Mr. Speaker, your reference committee recommends that Report E, Board of Trustees, dealing with Resolution 88-19, August issue of Pennsylvania Medicine, be referred back to the Board for further study.

Your reference committee heard testimony supporting the idea of publishing physician telephone numbers in the August issue of Pennsylvania Medicine. It was also suggested that consideration be given to including physician provider number as an added member benefit.

The House approved referring back to the Board for further study Board Report E.

REPORT BB, BOARD OF TRUSTEES: COMMITTEE ON LONG RANGE STRATEGY AND COMMUNICATIONS (FORBES REPORT)

Mr. Speaker, your reference committee recommends that Report BB, Board of Trustees dealing with the Forbes Report, be filed.

Your reference committee heard considerable testimony on this extensive report. Most of the comments were positive and your reference committee commends the Board on its efforts to address this complicating issue. However, the Board of Trustees is urged to move ahead as expeditiously as possible. Also, your reference committee heard suggestions that additional consideration be given to: (1) the content of
the mission statement; (2) the issue of the combined office of the president and chairman of the Board; and (3) development of health issues that will help improve the public perception of the profession. Your reference committee suggests that the Board also make every effort to adequately inform members of progress on this important project.

It was moved and seconded from the floor of the House to refer back to the Board of Trustees for further study and implementation, with report back to the 1990 House of Delegates, its Report BB. The House approved referring Report BB back to the Board.

**RESOLUTION 89-29: FORBES REPORT**

RESOLVED, That the Forbes Report become the business of the Pennsylvania Medical Society House of Delegates in October 1989 through a special reference committee and for discussion in the House of Delegates.

Mr. Speaker, your reference committee recommends that Resolution 89-29, dealing with the Forbes Report, be rejected.

Your reference committee strongly suggests that consideration be given to having a reference committee devoted to long range planning at future House meetings.

It was moved and seconded from the floor of the House to adopt the following substitute resolution: "WHEREAS, The Forbes Report deserves further study and discussion by the Society and the House of Delegates; and WHEREAS, The Long Range Planning Committee of the Board of Trustees will generate related concepts and recommendations; therefore be it RESOLVED, That the Pennsylvania Medical Society convene a special reference committee for the 1990 House of Delegates to further discuss the Forbes Report and Long Range Planning with an agenda to be sent to the delegates prior to the Annual Meeting."

The House adopted substitute Resolution 89-29.

**RESOLUTION 89-9: TEN YEAR SUNSET PROVISION FOR PMS POLICY**

RESOLVED, That commencing in 1990, all policies of the Pennsylvania Medical Society adopted prior to 1981 be reviewed and presented to the House of Delegates for readoption; and be it further

RESOLVED, That in subsequent years, all policies adopted by PMS on the tenth anniversary of their adoption be reviewed and presented to the House of Delegates for readoption; and be it further

RESOLVED, That all policies reviewed but not readopted will automatically expire at the end of the then current session of the House of Delegates.

**RESOLUTION 89-10: DIGEST OF PMS POLICY ACTIONS**

RESOLVED, That the Pennsylvania Medical Society annually compile and update a digest of policy actions; and be it further

RESOLVED, That each policy action be identified as coming from the PMS House of Delegates or the Board of Trustees; and be it further

RESOLVED, That this policy digest have integrated with it the Digest of Policy Actions of the American Medical Association.

**RESOLUTION 89-21: DISSEMINATION OF ORGANIZED MEDICINE POLICY TO PHYSICIAN MEMBERS**

RESOLVED, That the Pennsylvania Medical Society study ways to improve its ability to provide its membership a comprehensive report of the results of House of Delegates and Board of Trustees activities in a highly-readable format in a timely fashion; and be it further

RESOLVED, That the Pennsylvania Medical Society ask the AMA to study ways to improve its ability to provide to its membership a comprehensive report of the results of House of Delegates and Board of Trustees activities in a highly-readable format in a timely fashion.

**RESOLUTION 89-22: ACCESS TO PREVIOUSLY-ESTABLISHED POLICIES OF ORGANIZED MEDICINE**

RESOLVED, That the Pennsylvania Medical Society study the feasibility of developing a computer-based compendium of policies and/or policy topics previously addressed by the Pennsylvania Medical Society; and be it further

RESOLVED, That the Pennsylvania Medical Society ask the AMA to consider adopting a comparable policy and procedure regarding the dissemination of established policies.

Mr. Speaker, your reference committee recommends that: (1) Resolution 89-9: Ten Year Sunset Provision for PMS Policy; (2) Resolution 89-10: Digest of PMS Policy Actions; (3) Resolution 89-21: Dissemination of Organized Medicine Policy; and (4) Resolution 89-22: Access to Previously-Established Policies of Organized Medicine, be referred to the Board of Trustees for study.

Your reference committee heard only positive testimony and agrees with the intent of the four resolutions. Progress has already been made in this area with the computerization of policy back into the 60s. However, additional study and cost analysis is required before implementation should proceed.

It was moved and seconded from the floor of the House to extract Resolution 89-22. The House approved this motion. It was moved and seconded from the floor of the House to amend Resolution 89-22 as follows: "RESOLVED, That all new resolutions be reviewed prior to becoming business of the PMS House to ascertain whether or not they are repetitive of previously adopted policies of the House." During the discussion and from the amendment of the second order was moved and seconded from the floor of the House, "If such resolution is found, it be sent to the author." The House rejected this amendment.

The following amendment of the second order was then moved and seconded from the floor of the House, "...and to include this information in the handbook prior to the meeting of the House." It was moved and seconded from the floor of the House to refer the amendment and original Resolution 89-22 to the Board of Trustees for further study. The House rejected this motion.

It was moved and seconded from the floor of the House to refer Resolution 89-22 to the Board. The House approved referring Resolution 89-22 to the Board.

It was moved and seconded from the floor of the House to extract Resolution 89-9. The House approved this motion. It was moved and seconded from the floor of the House that Resolution 89-10 be rejected. The House rejected Resolution 89-10.

It was moved and seconded from the floor of the House to refer Resolution 89-21 to the Board of Trustees. The House approved referring Resolution 89-21 to the Board.

It was moved and seconded to reconsider Resolution 89-10. The House approved this motion. It was moved and seconded from the floor of the House to refer Resolution 89-10 to the Board of Trustees. The House approved referring Resolution 89-10 to the Board.

**RESOLUTION 89-12: REDISTRICTING**

RESOLVED, That an ad hoc committee of the House of Delegates of the Pennsylvania Medical Society be appointed to draft a comprehensive redistricting plan to ensure that representation at the Board level will be based more equitably on the overall distribution of Society membership throughout the state; and be it further

RESOLVED, That the ad hoc committee of the House of Delegates of the Pennsylvania Medical Society submit a report of its redistricting plan at the Society’s 1990 Annual Business Meeting.

**RESOLUTION 89-52: REPRESENTATION ON THE PENNSYLVANIA MEDICAL SOCIETY BOARD OF TRUSTEES**

RESOLVED, That the Pennsylvania Medical Society amend the composition of the Board of Trustees to allow one district trustee for each district with up to 1,500 members and one additional district trustee for each additional 1,500 members in the district.

Mr. Speaker, your reference committee recommends that the following substitute resolution be adopted in lieu of Resolution 89-12 and Resolution 89-52.

RESOLVED, That an ad hoc committee of the House of Delegates of the Pennsylvania Medical Society be appointed to draft a comprehensive redistricting plan to ensure that representation at the Board level will be based more equitably on the overall distribution of Society membership throughout the state; and be it further

RESOLVED, That the ad hoc committee of the House of Delegates of the Pennsylvania Medical Society submit a report of its redistricting plan at the Society’s 1990 Annual Business Meeting.
distribution of Society membership throughout the state; and be it further.

RESOLVED, That the ad hoc committee of the House of Delegates of the Pennsylvania Medical Society submit a report of its restructuring plan at the Society's 1990 Annual Business Meeting.

Your reference committee heard considerable testimony about the imbalance of trustee representation and believes this matter should be fully studied and the issue be brought back to the 1990 House of Delegates.

An editorial revision was offered from the floor of the House to insert in the first resolved the words, "... by the speaker of the House ..." after the words, "RESOLVED, That an ad hoc committee of the House of Delegates of the Pennsylvania Medical Society be appointed ..." The House approved this editorial revision.

It was moved and seconded from the floor of the House to postpone action temporarily on Resolutions 89-12 and 89-42; the House rejected this motion.

It was moved and seconded from the floor of the House to delete the word "more" in the first resolved of the substitute resolution. The House approved the amendment. The House adopted the substitute resolution in lieu of Resolutions 89-12 and 89-52.

Recess

The House of Delegates was recessed at 4:53 p.m. for the inaugural program and reception.

Inaugural program and reception

The inaugural program was held at 6:30 p.m. in the Pittsburgh Room of the Pittsburgh Westin William Penn Hotel.

Opening remarks—James A. Raub, MD, speaker of the House of Delegates, presented opening remarks.

Master of Ceremonies—Robert N. Meyers, MD, chairman of the PMS Board of Trustees, presided as the master of ceremonies.

Invocation—The invocation was presented by the Very Reverend John Kowalczyk of St. Michaels Russian Orthodox Church.

Presentation of Colors—Navy Sea Cadets.

Pledge of Allegiance—Robert N. Meyers, MD, led the attendees of the program in the pledge of allegiance.

Singing of "God Bless America"—Larry Lee Jones.

Introductions—Robert N. Meyers, MD, made the following introductions: Pennsylvania Medical Society officers and trustees; Pennsylvania Medical Society past presidents; Pennsylvania Medical Society Auxiliary president and immediate past president; Auxiliary dignitaries and Board of Directors; and visiting dignitaries.

Presentation of Plaques to Retiring Leaders—Robert N. Meyers, MD, presented plaques to James A. Raub, MD; David L. Miller, MD; Jeaninne R. Hahn, MD; and called attention to John Helwig Jr., MD, who was retiring from the Board but was unable to be present. Gerald L. Andriele, MD, presented a plaque to Robert N. Meyers, MD, retiring Board chairman.

Presentation of Past President's Medallion—Robert N. Meyers, MD, presented the past president's medallion to Gerald L. Andriele, MD, Luzerne County, in tribute to his great efforts on behalf of the Pennsylvania Medical Society as its 139th president. Following the presentation, Dr. Andriele briefly addressed the attendees.

Installation of the President—Robert N. Meyers, MD, installed J. Joseph Danyo, MD, York County, as the 140th president of the Pennsylvania Medical Society. After taking the oath of office, Dr. Danyo introduced his family and special guests and delivered brief remarks.

Closing remarks—James A. Raub, MD, presented closing remarks. Following the program, a reception was held in the Urban and Grand Ballrooms.

Final session

October 22, 1989

The final session of the 1989 House of Delegates was called to order at 9:35 a.m. in the Grand Ballroom of the Pittsburgh Westin William Penn Hotel, Sunday, October 22, 1989.

Credentials Committee

Braddock J. Strock, MD, Dauphin County, chairman of the Credentials Committee, presented the following report:

Mr. Speaker, there is a quorum of 290 delegates registered in attendance today.

A round of applause and thanks was made from the floor of the House of Delegates for the Pennsylvania Medical Society staff.

Reference Committee F Present by:

John W. Mills, MD

RESOLUTION 89-26: PRESIDENT, CHAIRMAN OF THE BOARD, SPEAKER OF THE HOUSE AS ALTERNATE DELEGATES TO THE AMA

RESOLVED, That the chairman of the Board of Trustees, the president, and the speaker of the House be ex officio members of the PMS AMA Delegation and have positions as alternate delegates.

Mr. Speaker, your reference committee recommends that the following substitute Resolution be adopted in lieu of Resolution 89-26.

RESOLVED, That the chairman of the Board of Trustees, the president, and the speaker of the House be ex officio members of the PMS AMA delegation.

Your reference committee is in favor of the intent of the resolution, but heard testimony against taking alternate delegate positions.

The House rejected Resolution 89-26.

RESOLUTION 89-65: MEDICAL STUDENT REPRESENTATION ON THE PMS DELEGATION TO THE AMA HOUSE OF DELEGATES

RESOLVED, That the PMS establish a medical student delegate and alternate delegate position upon the PMS Delegation to the AMA House of Delegates; and be it further

RESOLVED, That the student delegate and alternate delegate be nominated by the PMS-MSS and approved by the Nominating Committee of the PMS; and be it further

RESOLVED, That the student delegate and alternate delegate serve one-year terms, beginning at the conclusion of the annual meeting of the PMS in October, and ending at the conclusion of the next annual meeting of the PMS, with maximum tenure for these positions being two years.

Mr. Speaker, your reference committee recommends that Resolution 89-65, dealing with the student representation on the PMS delegation to the AMA House of Delegates be rejected.

Your reference committee does not favor slotting of AMA delegate positions. However, students are encouraged to run for positions on the AMA delegation if they so wish.

It was moved and seconded from the floor of the House that the following substitute resolution be adopted. "RESOLVED, That the PMS establish a medical student alternate delegate position upon the PMS Delegation to the AMA House of Delegates; and be it further RESOLVED, That the student alternate delegate be nominated by the PMS-MSS and approved by the Nominating Committee of the PMS; and be it further RESOLVED, That the student alternate delegate serve a one-year term beginning at the conclusion of the Annual Meeting of the PMS in October, and ending at the conclusion of the next Annual Meeting of the PMS, with maximum tenure for these positions being two years."

It was moved and seconded from the floor of the House to refer substitute Resolution 89-65 to the Board of Trustees with report back to the 1990 House of Delegates. The House approved referring substitute Resolution 89-65.

RESOLUTION 89-68: ESTABLISHMENT OF FUND TO AID HURRICANE HUGO AND CALIFORNIA EARTHQUAKE PHYSICIAN VICTIMS

RESOLVED, That the Pennsylvania Medical Society Board of Trustees be instructed to establish a fund to aid physicians who suffered from the effects of Hurricane Hugo and from the recent California earthquake.

Mr. Speaker, your reference committee recommends that Resolution 89-68 dealing with the establishment of a fund to aid Hurricane Hugo and California earthquake physician victims be rejected.

your reference committee heard that the AMA and the South Carolina Medical Society have already contributed $1 million for physician victims of Hugo. It is believed that the AMA and California Medi-
al Association will do likewise, if necessary, for earthquake physician victims.

The House rejected Resolution 89-68.

RESOLUTION 89-67: DISASTER RELIEF EFFORTS FOR THE SAN FRANCISCO EARTHQUAKE AND HURRICANE HUGO VICTIMS

RESOLVED, That the PMS contribute $10,000 to the disaster relief efforts for the San Francisco Earthquake and Hurricane Hugo victims.

Mr. Speaker, your reference committee recommends that Resolution 89-67, dealing with disaster relief efforts for the San Francisco Earthquake and Hurricane Hugo victims, be adopted.

Your reference committee heard only positive testimony on this resolution.

It was moved and seconded from the floor of the House that the following substitute resolution be adopted, "RESOLVED, That PMS physicians be urged to voluntarily contribute to disaster relief efforts." The House adopted substitute Resolution 89-67.

ADDRESS OF THE PRESIDENT ELECT, J. JOSEPH DANYO, MD, RECOMMENDATION 1: CREATING REGIONAL MEDICAL SOCIETIES

Mr. Speaker, your reference committee recommends that the address of the PMS president elect, J. Joseph Danyo, MD, Recommendation 1 dealing with the creation of regional medical societies be referred to the Board.

Your reference committee believes that this recommendation has merit, but needs further clarification.

The House approved referring Recommendation 1 of the president elect.

Waiver of Debate List

The following items have been grouped together in a waiver of debate list; little or no testimony was heard, and the committee feels that the items are of noncontroversial nature.

Mr. Speaker, your reference committee recommends the following items be adopted:

REPORT DD, BOARD OF TRUSTEES: ALLOCATION TO SUPPORT STUDENT LOAN PROGRAM

REPORT A, COMMITTEE ON AID TO EDUCATION: ANNUAL REPORT OF THE ACTIVITIES OF THE COMMITTEE ON AID TO EDUCATION

REPORT EE, BOARD OF TRUSTEES: ANNUAL ASSESSMENT FOR STUDENTS

REPORT F, BOARD OF TRUSTEES: RESOLUTION 88-24, RETIRED PHYSICIANS SECTION

REPORT P, BOARD OF TRUSTEES: AD HOC COMMITTEE TO STUDY AMA DELEGATE ELECTORAL PROCESS AND RECOMMENDATION 2 OF THE PRESIDENT

REPORT A, SPEAKER, HOUSE OF DELEGATES: SUBSTITUTE RESOLUTION 88-12, PMS ELECTION CAMPAIGNS

RESOLUTION 89-2: PUBLISHING THE RESULTS OF ELECTIONS

RESOLVED, That the speaker of the House of Delegates publish the vote tally received by all candidates in the official Proceedings, in addition to announcing the victors at the time of election.

RESOLUTION 89-8: PARLIAMENTARY PROCEDURES

RESOLVED, That the speaker and vice speaker of the PMS House annually prepare a current policy manual for all delegates and alternate delegates, outlining the operation of the PMS House and outlining the parliamentary procedure used in the House of Delegates; and be it further RESOLVED, That the speaker and vice speaker arrange an introductory session prior to the opening session of the House of Delegates to meet with and instruct new delegates and alternate delegates.

RESOLUTION 89-45: AMA SPECIALTY CODING

RESOLVED, That the Pennsylvania Medical Society compile a more complete listing of currently omitted practice specialties and subspecialties and request the AMA, through resolution at the December 1989 AMA interim meeting, to officially endorse and incorporate such practice specialties in its officially recognized specialty listing.

RESOLUTION 89-62: EMPLOYEE ASSISTANCE PROGRAM (EAP)

RESOLVED, That the Pennsylvania Medical Society study whether the provision of an employee assistance program would be desirable as a membership benefit.

The House adopted the waiver of debate items.

Mr. Speaker, your reference committee recommends that the following items be filed:


REPORT A, COUNCIL ON MEMBERSHIP

REPORT A, YOUNG PHYSICIANS SECTION

REPORT A, MEDICAL STUDENT SECTION

REPORT A, RESIDENT PHYSICIAN SECTION

REPORT A, PENNSYLVANIA DELEGATION TO THE AMA

REPORT A, EDUCATIONAL AND SCIENTIFIC TRUST

REPORT A, ADVISORY COMMITTEE ON PROFESSIONALISM

REPORT A, COMMITTEE ON MEDICAL BENEVOLENCE

REPORT A, SECRETARY

REPORT A, TREASURER

REPORT A, EXECUTIVE VICE PRESIDENT

REPORT A, AUDITOR

REPORT A, PMS AUXILIARY PRESIDENT

TRUSTEE REPORTS, FIRST THROUGH TWELFTH DISTRICT, SPECIALTY, HOSPITAL MEDICAL STAFF SECTION, MEDICAL STUDENT SECTION

ADDRESS OF THE PMSA PRESIDENT, MRS. EARLE R. DAVIS

ADDRESS OF THE PRESIDENT, GERALD L. ANDRIOLE, MD

ADDRESS OF THE PRESIDENT ELECT, J. JOSEPH DANYO, MD

ADDRESS OF THE VICE PRESIDENT, GORDON K. MACLEOD, MD

The House approved filing the waiver of debate items.

Reference Committee B

Presented by:
Carol E. Rose, MD

Mr. Speaker, members of the House of Delegates, Reference Committee B has considered all of the items in the index.

REPORT B, BOARD OF TRUSTEES: POSITIVE IDENTIFICATION OF APPLICANTS FOR MEDICAL LICENSURE AND SUBSEQUENT MEDICAL SOCIETY MEMBERSHIP (RESOLUTION 88-7)

Mr. Speaker, your reference committee recommends that the following substitute recommendation be adopted in lieu of the three recommendations contained in Report B.

Recommendaion: PMS should continue to look at other mechanisms for positively identifying an applicant for medical licensure.

There is a concern for the public that unlicensed and unqualified individuals not be allowed to practice medicine.

The House approved the substitute recommendation.

REPORT C, BOARD OF TRUSTEES: INCONSISTENCY BETWEEN MEDICAL PRACTICE ACT AND OSTEOPATHIC ACT (RESOLUTION 88-8)

Mr. Speaker, your reference committee recommends that Report C be adopted.

The House rejected Report C.

RESOLUTION 89-5: MEDICAL LICENSING ACT

RESOLVED, That the Pennsylvania Medical Society oppose the discrepancies between the Medical Practice Act and the Osteopathic Practice Act; and be it further RESOLVED, That the Pennsylvania Medical Society actively lobby for a uniform licensing law.

Mr. Speaker, your reference committee
recommends that Resolution 89-5 be referred to the Board.

There was much discussion by the reference committee, and there was a lack of consensus about which position the PMS should take regarding elimination of the discrepancies that currently exist. The House rejected the recommendation to refer Resolution 89-5 to the Board. It was moved to call the floor of the House to adopt Resolution 89-5. The House adopted Resolution 89-5.

REPORT D, BOARD OF TRUSTEES: MANDATORY USE OF SEAT BELTS IN SCHOOL BUSES (RESOLUTION 88-13)

Mr. Speaker, your reference committee recommends the adoption of the following substitute resolution in lieu of Report D.

RESOLVED, That the Pennsylvania Medical Society prepare an in-depth report with supporting scientific evidence regarding the issue of passive restraints in school buses. It was moved and seconded from the floor of the House to amend the substitute resolution by deleting the words, "... passive restraints in school buses..." and inserting the words, "... school transportation safety, including equipment and operators." The House approved this amendment. The House adopted the substitute resolution as amended.

RESOLUTION 89-25: CONTROL OF ILLEGAL TRAFFICKING OF PRESCRIPTION DRUGS

RESOLVED, That the Pennsylvania Medical Society study the issue of control of illegal trafficking of prescription drugs in order to determine whether specific legislative initiatives should be promulgated; and be it further

RESOLVED, That the Pennsylvania Medical Society consult with the Pennsylvania Pharmaceutical Association and the compliance section of the Pennsylvania Office of the Attorney General in formulating its recommendations.

Mr. Speaker, your reference committee recommends that Resolution 89-25 be adopted. The House adopted Resolution 89-25.

RESOLUTION 89-56: LICENSE SUSPENSION OF IMPAIRED PHYSICIANS

RESOLVED, That the PMS House of Delegates endorse the concept that a ten-year license suspension of impaired physicians who have, in successful recovery represents excessively severe punishment; and be it further

RESOLVED, That the PMS House of Delegates instruct the PMS Board of Trustees to work with the State Board of Medicine, utilizing all appropriate means to resolve this unfair situation.

The House adopted substitute Resolution 89-56.

RESOLUTION 89-4: LIMITING RESIDENT WORKING HOURS

RESOLVED, That the Pennsylvania Medical Society House of Delegates oppose Senate Bill 455 and any legislative attempts to limit resident or medical student hours; and be it further

RESOLVED, That the Pennsylvania Medical Society form guidelines for all medical students in the Commonwealth of Pennsylvania to receive adequately supervised medical training which does not interfere with the well-being of the trainees or the patients.

Mr. Speaker, your reference committee recommends that Resolution 89-4 be rejected.

Your reference committee was reminded that Resolution 87-49 of the PMS House of Delegates determined that the AMA and the ACGME are the appropriate bodies to determine policy on resident physician working hours. It was moved and seconded from the floor of the House to amend Resolution 89-4 by deleting the final resolved; the House rejected this amendment. The House rejected Resolution 89-4.

RESOLUTION 89-6: RESTRICTING SMOKING IN HOSPITALS

RESOLVED, That the Pennsylvania Medical Society call on its members to act at their local hospital to develop, implement, and enforce the following restrictions on tobacco use in hospitals:

1. In-patients should not be permitted to smoke while in the hospital;
2. Smoking of tobacco products should be banned in all hospitals, including all reception and waiting room areas within the physical confines of the hospital and affiliated outpatient clinics;
3. Smoking should be banned at all nursing stations, labor rooms, physical and occupational therapy, hemodialysis, and emergency room treatment areas, as well as all medical labs and pharmacies;
4. Smoking should be banned in both physician and nonphysician lounges;
5. All tobacco dispensing machines and sales of tobacco should be banned from hospitals, affiliated outpatient clinics, and pharmacies; and be it further

RESOLVED, That the Pennsylvania Medical Society submit a similar resolution restricting smoking in hospitals to the American Medical Association House of Delegates, requesting ratification; and be it further

RESOLVED, That the Pennsylvania Medical Society send a letter to The Hospital Association of Pennsylvania and the American Hospital Association, expressing interest in this resolution and requests contained in this resolution regarding restricting smoking in hospitals.

RESOLUTION 89-41: TOBACCO IN HOSPITALS

RESOLVED, That the Pennsylvania Medical Society House of Delegates reaffirm as policy that tobacco use be excluded from all hospitals in the state of Pennsylvania; and be it further

RESOLVED, That the Pennsylvania Delegation to the AMA introduce a similar resolution to the AMA House of Delegates, asking that it reaffirm as policy that tobacco use be excluded from all hospitals.

Mr. Speaker, your reference committee recommends that the following substitute Resolution 89-6 be adopted in lieu of Resolutions 89-6 and 89-41.

RESOLVED, That the Pennsylvania Medical Society send a letter to The Hospital Association of Pennsylvania and the American Hospital Association, reaffirming Resolution 86-24 calling for a complete ban on smoking in hospitals.

It was moved and seconded from the floor of the House to amend substitute Resolution 89-6 by deleting the words, "... and the American Hospital Association..." and inserting the words, "... reaffirm..." the words, "... AMA substitute Resolution 29 (A-89)..."; the House approved this amendment.

It was moved and seconded from the floor of the House to further amend substitute Resolution 89-6 by adding the first resolved of original Resolution 89-6 which stated,

RESOLVED, That the Pennsylvania Medical Society call on its members to act at their local hospital to develop, implement, and enforce the following restrictions on tobacco use in hospitals:

1. In-patients should not be permitted to smoke while in the hospital;
2. Smoking of tobacco products should be banned in all hospitals, including all reception and waiting room areas within the physical confines of the hospital and affiliated outpatient clinics;
3. Smoking should be banned at all nursing stations, labor rooms, physical and occupational therapy, hemodialysis, and emergency room treatment areas, as well as all medical labs and pharmacies;
4. Smoking should be banned in both physician and nonphysician lounges;
5. All tobacco dispensing machines and sales of tobacco should be banned from hospitals, affiliated outpatient clinics, and pharmacies.

The House rejected this amendment. The House adopted as amended substitute Resolution 89-6.
RESOLUTION 89-63: TOBACCO-RELATED LEGISLATION

RESOLVED, That the Pennsylvania Medical Society pursue the following legislative initiatives: (1) include on each death certificate a specific question regarding tobacco use; (2) mandate reimbursement for medically-monitored smoking cessation efforts; (3) create a commission on smoking and health with the Department of Health; (4) ban tobacco use on school property; (5) prohibit sale of tobacco products to individuals under 18 years of age; (6) increase the tobacco excise tax by 20 cents per pack; (7) ban free distribution of tobacco; and (8) ban tobacco vending machine sales.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-63 be adopted as follows:

RESOLVED, That the Pennsylvania Medical Society pursue the following legislative initiatives: (1) mandate reimbursement for medically-monitored smoking cessation efforts; (2) ban tobacco use on school property; (3) prohibit sale of tobacco products to individuals under 18 years of age; (4) increase the tobacco excise tax by 20 cents per pack; (5) ban free distribution of tobacco; and (6) ban tobacco vending machine sales.

The House adopted substitute Resolution 89-63.

RESOLUTION 89-7: MEDICAL PRESCRIPTION WRITING

RESOLVED, That the Pennsylvania Medical Society work to have appropriate legislation introduced which would allow a preprinted check-off block on the bottom of prescription blanks, indicating "Brand Medically Necessary."

Mr. Speaker, your reference committee recommends that Resolution 89-7 be rejected.

Testimony before the committee showed a lack of consensus in favor of any one form of prescription blank. There is a great deal of confusion on the issue. Your reference committee also feels that the format proposed in Resolution 89-7 could easily be subject to falsification by unauthorized use of the check-off block.

It was moved and seconded from the floor of the House to amend Resolution 89-7 by the addition of the following resolution, "RESOLVED, That after the current prescription blank is repealed, the Pennsylvania Medical Society work to institute a pre- printed check-off block at the bottom, "Brand Name or Substitute Permitted," with room for signature above each of these phrases." The House approved this amendment.

It was moved and seconded from the floor of the House to refer amended Resolution 89-7 to the Board of Trustees. The House approved referring amended Resolution 89-7.

RESOLUTION 89-57: PRESCRIBING GENERIC DRUGS—ACT 154 OF 1988, COMMONWEALTH OF PENNSYLVANIA

RESOLVED, That the Pennsylvania Medical Society do whatever is necessary to have current Commonwealth of Pennsylvania Act 154 of 1988, that encourages the prescribing of generic drugs by the use of the current prescription blank, repealed.

Mr. Speaker, your reference committee recommends that Resolution 89-57 be rejected.

Testimony before the committee showed a lack of consensus in favor of any one form of prescription blank. There is a great deal of confusion on the issue.

It was moved and seconded from the floor of the House to refer Resolution 89-57 to the Board. The House approved referring Resolution 89-57.

ADDRESS OF PRESIDENT ELECT, J. JOSEPH DANYO, MD, RECOMMENDATION 2, GENERIC DRUGS

Mr. Speaker, your reference committee recommends that the following substitute resolution be adopted in lieu of Recommendation 2:

RESOLVED, That the Pennsylvania Medical Society study the appropriateness of the current methodology utilized in testing generic medications; and be it further RESOLVED, That the PMS Delegation to the AMA formulate a resolution that addresses this issue; and be it further RESOLVED, That in the meantime, PMS should further study its support of generic drugs; and be it further RESOLVED, That the Board of Trustees study the original recommendation as presented by Dr. Danyo.

It was moved and seconded from the floor of the House that the following substitute resolution be adopted, "RESOLVED, That the Pennsylvania Medical Society Delegation to the AMA explain our opposition to the manner in which poorly manufactured medications are available to the public; and be it further RESOLVED, That the PMS support testing methods that will provide quality medications to our patients; and be it further RESOLVED, That the House of Delegates support Recommendation 2, Generic Drugs, of President J. Joseph Danyo, MD, until we are assured that the two above resolutions have been met."

Dr. Danyo spoke, informing the House that he planned to bring up the issue of generic drugs at the Board's reorganization meeting for action.

It was moved and seconded from the floor of the House to refer to the Board Recommendation 2, blank at the printer's. The House approved referring Recommendation 2.

RESOLUTION 89-14: SIMPLIFICATION OF PROCESS TO OBTAIN MEDICAL LICENSES FROM THE STATE BOARD OF MEDICINE

RESOLVED, That PMS study the current level of efficiency of granting medical licenses by the State Board of Medicine and, if necessary, encourage the State Board of Medicine to streamline the process.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-14 be adopted as follows:

RESOLVED, That PMS continue to study the current level of efficiency of granting medical licenses by the State Board of Medicine and, if necessary, encourage the State Board of Medicine to streamline the process.

The House adopted substitute Resolution 89-14.

RESOLUTION 89-17: ALLEVIATING THE NURSING CRISIS BY RESTRUCTURING NURSING EDUCATION

RESOLVED, That the Society assert that the nursing crisis could be alleviated, in part, were nursing education programs to be structured in such a fashion as to allow the entry-level individual an opportunity for work-study advancement (should he/she desire such an approach) from the level of the nursing aide to the level of the doctoral-preparing nurse; and be it further RESOLVED, That the Society ask the Pennsylvania Nurses Association to consider supporting this policy; and be it further RESOLVED, That the Society ask the AMA to consider adopting this policy.

Mr. Speaker, your reference committee recommends that substitute Resolution 89-17 be adopted as follows:

RESOLVED, That the PMS assert that the nursing crisis could be alleviated, in part, were nursing education programs to be structured in such a fashion as to allow the entry-level individual an opportunity for work-study advancement from the level of the nursing aide to the level of the doctorally-prepared nurse; and be it further RESOLVED, That the PMS ask the Pennsylvania Nurses Association and other nursing groups to consider supporting this policy; and be it further RESOLVED, That the PMS ask the AMA to consider adopting this policy.

It was moved and seconded from the floor of the House to refer substitute Resolution 89-17 to the Board of Trustees; the House rejected this motion. The House adopted substitute Resolution 89-17.

RESOLUTION 89-35: NURSING CRISIS

RESOLVED, That the Pennsylvania Medical Society study all aspects of the nursing shortage and seek cooperation with the offices of nursing organizations and nursing educational institutions in an attempt to find methods for PMS and its members to help alleviate the nursing shortage crisis.

RESOLUTION 89-40: ESTABLISHING A NURSE/PHYSICIAN LIAISON TASK FORCE

RESOLVED, That the House of Delegates direct the Pennsylvania Medical Society to establish a formal liaison with the State nursing leadership for the express
purpose of recognizing the value of the nurse, and to develop a comprehensive medical/nursing program that would address the nursing shortage and focus on quality patient care.

Mr. Speaker, your reference committee recommends that the following substitute Resolution 89-35 be adopted in lieu of Resolutions 89-35 and 89-40.

RESOLVED, That the Pennsylvania Medical Society in liaison with the State nursing leadership study all aspects of the nursing shortage for the express purpose of recognizing the value of the nurse, and assist in developing a comprehensive medical/nursing program that would address the nursing shortage and focus on quality patient care.

The House adopted substitute Resolution 89-35 in lieu of Resolution 89-40.

RESOLUTION 89-18: OPPOSITION TO ABORTION AND DEATH PENALTY

RESOLVED, That the Pennsylvania Medical Society go publicly on record in opposition to abortion and the death penalty.

Mr. Speaker, your reference committee recommends that Resolution 89-18 be rejected.

The policy of PMS on the abortion issue is that we have no position and there was insufficient consensus to change this policy. No testimony was heard regarding the death penalty.

It was moved and seconded from the floor of the House to table Resolution 89-18. The House approved tabling Resolution 89-18.

RESOLUTION 89-61: ABORTION

RESOLVED, That the Pennsylvania Medical Society become involved in any legislative debate on the issue of abortion in order to ensure both that all relevant medical issues are accurately addressed and that patients retain the right to make important personal medical decisions in consultation with their physicians.

Mr. Speaker, your reference committee recommends that Resolution 89-61 be rejected.

It was moved and seconded from the floor of the House to table Resolution 89-61. The House approved tabling Resolution 89-61.

RESOLUTION 89-33: SUPPORT ARMS CONTROL TO REDUCE HUMAN RISK AND CONSERVE RESOURCES FOR HUMAN NEED AND HEALTH CARE

RESOLVED, That the Pennsylvania Medical Society support an early and careful initiative to develop comprehensive conventional nuclear arms treaties with the Soviet Union and to resume negotiations toward a Comprehensive Nuclear Test Ban Treaty with a letter to this effect being sent to President George Bush, Secretary of State James A. Baker III, Secretary of Defense Richard Cheney, the Majority and Minority Leaders of the House of Representatives and the Senate of the United States, and to Senator H. John Heinz III and Senator Arlen Specter.

Mr. Speaker, your reference committee recommends that Resolution 89-33 be adopted.

The House adopted Resolution 89-33.

RESOLUTION 89-37: CRITERIA FOR APPROPRIATE MANAGEMENT OF END-STAGE PATIENTS

RESOLVED, That the Pennsylvania Medical Society bring together the medical, ethical, and legal expertise to develop criteria for appropriate management of these unfortunate end-stage patients.

Mr. Speaker, your reference committee recommends that the resolution be referred to the Board of Trustees.

There was confusion and misinformation presented by your committee chairman regarding the document published by the PMS in PENNSYLVANIA MEDICINE titled: "Legal Significance of Living Wills." This document is a legal document and not a statement of policy. Therefore, supportive legislation on this topic calls for further study.

The House approved referring Resolution 89-37 to the Board.

RESOLUTION 89-47: MD LICENSE PLATES

RESOLVED, That the Pennsylvania Medical Society recommend that "MD" license plates be available to any physician who chooses to have them; such license plates would, of course, be optional but would facilitate the identification of physicians' vehicles, which would improve parking near medical facilities as well as hopefully assisting them in the occasional rapid trip which are necessary to hospitals for critical medical situations.

Mr. Speaker, your reference committee recommends that Resolution 89-47 be rejected.

No testimony was offered in support of this resolution.

The House rejected Resolution 89-47.

RESOLUTION 89-48: MEDICAL SCHOOL CRISIS

RESOLVED, That the Pennsylvania Medical Society, in conjunction with the Pennsylvania Academy of Family Physicians, support any proposed legislative initiatives that will establish model departments of family practice and model four-year curricula in all medical schools in Pennsylvania.

RESOLUTION 89-49: FAMILY PRACTICE PROGRAMS

RESOLVED, That the Pennsylvania Medical Society support legislative initiatives that will establish model departments of family practice and model four-year curricula in all medical schools in Pennsylvania.

RESOLUTION 89-50: ESTABLISHMENT OF MODEL DEPARTMENTS OF FAMILY PRACTICE IN ALL PENNSYLVANIA MEDICAL SCHOOLS

RESOLVED, That the Pennsylvania Medical Society support legislative initiatives that will establish model departments of family practice in all of Pennsylvania's medical schools.

Mr. Speaker, your reference committee recommends that the following substitute Resolution 89-48 be adopted in lieu of Resolutions 89-48, 89-49, and 89-50.

RESOLVED, That the PMS Board of Trustees create a task force to address the need for family practice residency programs in Pennsylvania medical schools.

It was moved and seconded from the floor of the House to amend substitute Resolution 89-48 by deleting the word "programs," and inserting the word, "departments," in its place; the House approved this amendment. The House adopted as amended substitute Resolution 89-48.

Waiver of Debate List

The following items have been grouped together in a waiver of debate list; no testimony was heard and the committee feels the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends that the following be filed:

REPORT M, BOARD OF TRUSTEES: THE EMS TASK FORCE ON AGING


REPORT Y, BOARD OF TRUSTEES: THE EMS TASK FORCE ON DRUG ABUSE

REPORT A, COUNCIL ON EDUCATION AND SCIENCE

REPORT B, COUNCIL ON EDUCATION AND SCIENCE

The House approved filing the waiver of debate items.

Mr. Speaker, your reference committee recommends that the following be adopted:

REPORT H, BOARD OF TRUSTEES: CREATION OF A HEALTH RISK AWARENESS TASK FORCE (RESOLUTION 88-29)

REPORT 1, BOARD OF TRUSTEES: ENCOURAGING ELIGIBLE PHYSICIAN MEMBERSHIP IN AMERICAN ASSOCIATION OF RETIRED PERSONS (RESOLUTION 88-33)

REPORT V, BOARD OF TRUSTEES: RECOMMENDATION 8 OF THE ADDRESS OF THE PRESIDENT, PUBLIC HEALTH COALITION

REPORT Z, BOARD OF TRUSTEES: THE EMS TASK FORCE ON AIDS

RESOLUTION 89-13: A PROCLAMATION IN HONOR OF BENJAMIN FRANKLIN ON THE OCCASION OF THE 200TH ANNIVERSARY OF HIS LEGACY OF GENIUS

RESOLVED, That the Pennsylvania Medical Society:

1. Acknowledge that 1990 marks the 200th Anniversary Celebration of Benjamin Franklin's Life and Legacy.

2. Recognize the significant contributions that Benjamin Franklin made to medicine, as well as to science, industry, public service and the arts; and

3. Call upon all of its members to foster recognition of the importance of Benjamin Franklin's ideals and achievements through appropriate educational and cultural programs and encourage
RESOLUTION 89-15: ANIMAL RESEARCH
RESOLVED, That the members of the Pennsylvania Medical Society encourage active search for non-animal research alternatives to be used in the development of new drugs and medicines to treat human and animal illness and disease; and be it further
RESOLVED, That the Pennsylvania Medical Society request the American Medical Association to adopt this same resolution.

RESOLUTION 89-66: INCREASE ORGAN DONORS IN PENNSYLVANIA
RESOLVED, That the PMS pursue the feasibility of working with PennDOT, Kidney 1, and other appropriate agencies toward the establishment of organ donor displays at Pennsylvania photo license centers, and be it further
RESOLVED, That employees of the photo license centers provide individuals with organ donor information, actively ask individuals if they would like to become organ donors, and affix the proper organ donor stamp to the license if desired at the time when the photo license is provided; and be it further
RESOLVED, That this information be reported back to the 1990 PMS House of Delegates.

The House adopted the waiver of debate items.

Mr. Speaker, your reference committee recommends that the following items be referred:

ADDRESS OF THE VICE PRESIDENT, GORDON K. MACLEOD, MD, RECOMMENDATION 3, ESTABLISHING A PENNSYLVANIA ACADEMY OF MEDICINE AND HEALTH
ADDRESS OF THE VICE PRESIDENT, GORDON K. MACLEOD, MD, RECOMMENDATION 4, RURAL HEALTH TASK FORCE

The House approved referring the waiver of debate items.

Comments by executive vice president

Roder F. Mecum briefly addressed the House on initial plans regarding unification.

New Business

A recommendation was offered from the floor of the House to reconsider the bullet ballot. It was moved and seconded from the floor of the House to put aside the standing rules; the House rejected this motion.

It was moved and seconded from the floor of the House that an exception to the PMS bylaws be made and James A. Raub, MD, be voted an associate member of the Pennsylvania Medical Society; the House approved this motion.

Remarks by retiring speaker

James A. Raub, MD, retiring speaker of the House of Delegates, briefly addressed the House, commenting on his 25 years as a delegate. Dr. Raub stated that his last seven years as speaker and vice speaker had been a unique pleasure and honor and thanked the House. The House responded with a standing ovation.

Annual assessment

Martin A. Murcek, MD, chairman of the Finance Committee of the Board of Trustees, presented the following report containing the recommendation of the Finance Committee that the annual assessment for full dues-paying members remain at $410.

Mr. Speaker and members of the House of Delegates, at the second session of this House, I presented a report on the 1990 budget which included no dues increase. In that report, I stated that the action of this House could have an effect on the 1990 budget. These actions have not resulted in a significant change in the budget from that presented yesterday.

Consequently, the Board of Trustees recommends that the regular dues for 1990 be $410 for each full dues-paying member and a proportionate share thereof in other dues-paying categories.

Further, the House approved a recommendation from the Board of Trustees, setting the student dues at $5 and a report from the Board recommending that $10 from the 1990 annual assessment be allocated to The Educational and Scientific Trust.

It was moved and seconded from the floor of the House to approve the recommendation of the Finance Committee that the 1990 annual assessment be $410 per active member. The House approved this motion.

Dr. Rhoads recognized Kay A. Barrett, aide to the speaker, who reported that there was no new business before the House.

The House of Delegates adjourned at 11:53 a.m.

Respectfully submitted,

James a. Raub, MD, speaker
Jonathan E. Rhoads Jr., MD, vice speaker Kay A. Barrett, aide to the speaker
David L. Miller, MD, secretary

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Emergency physicians — Full/part-time positions available. Please send resume to: Dr. Elsie Chu, Medical Director, St. Joseph’s Hospital, 16th St. & Girard Ave., Philadelphia, PA 19130.


Staff emergency physician — 177-bed hospital, south central Pennsylvania. $100,000 salary, malpractice, plus other benefits. Wanda Parker, E.G. Todd Associates, Inc., 535 Fifth Ave., Suite 1100, New York, NY 10017, (800) 221-4762 or (212) 599-6200.

Pennsylvania-Pediatrician — A well-rounded pediatrician is offering a salaried position with a possible partnership opportu- nity in a desirable location in northeastern Pennsylvania. The practice is located in a modern medical building adjacent to a com- munity hospital. For consideration, please send CV to: Dr. L.N. Gajula, 12th & Cypress Sts., Lennington, PA 18235.

Cleveland, south — Excellent compensa- tion offered to full-time and part-time physicians at low volume emergency depart- ment. Full malpractice insurance coverage. Benefit package available to full-time staff. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 27, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.


Pennsylvania — Excellent opportunity offer- ing both patient care and administrative as well as academic responsibilities in a 600 plus bed university hospital with active 30,000 visit emergency department. Position provides a competitive salary with attract- ing benefits. Candidate must be able to obtain Pennsylvania medical school faculty appointment and opportunity for clinical research in a highly professional atmosphere on the leading edge of emer- gency medicine. Hahnenmann University Hospital is a Level I trauma center with an active helicopter service. To qualify, you must be a licensed physician, board-certified in emergency medicine. Please forward your curriculum vitae to: Frank Ehrlich, MD, FACEP, Director, Divi- sion of Emergency Services, Hahnenmann University Hospital, Broad & Vine Sts., Mail- Stop 300, Philadelphia, PA 19102-1192 or call (215) 448-4422.

Immediate opening — Excellent opportu- nity to join six-member radiology group, covering two hospitals, approximately 100,000 procedures/year in Johnstown, PA, located approximately 75 miles from Pitts- burgh in the Allegheny mountains. John- stown recently selected as Pennsylvania “Community of the Year,” is noted for its low crime rate, scenic beauty, and high quality of life. Applicant should be compe- tent in all phases of diagnostic radiology in- cluding: MR, CT, ultrasound, nuclear medi- cine and angio. Well established group with good clinical staff interaction. Excellent starting salary and benefits, with equal part- nership to follow. If interested, please call and/or forward your CV to: Jon Abrahams, MD, Conemaugh Valley Memorial Hospital, Dept. of Radiology, 1086 Franklin St., John- stown, PA 15905, (814) 533-9166.

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Medical officer — The Harrisburg Post Office is accepting applications. In order to qualify for the position you must be licensed to practice medicine in one of the states or territories of the United States. You must have the ability to practice medicine, including the performance of medical examinations, the treatment of injuries, and the arrangement of ongoing medical care. Ability to develop and conduct medical and health programs to analyze, interpret and apply medical data pertaining to injury cases and health programs. The United States Postal Service is an equal employment opportunity employer and all employees are entitled to fringe benefits that include annual leave (vacation), sick leave, life insurance, health insurance and the Federal Employees Retirement Fund. Please submit your resume and salary requirements to: Melvin L. Moody, Manager, Personnel Services, 813 King Blvd., Harrisburg, PA 17105-9422; (717) 257-2258.

Florida, Orlando — Faculty/staff position for Orlando Regional Medical Center. Combined clinical and teaching position offers extremely attractive compensation package including occurrence type professional liability coverage, annual guarantee, and fee-for-service compensation. ORMC is a 1,000-bed, non-profit, full-service tertiary care facility and a Level I trauma center with helicopter transport system. Annual ED visits of approximately 70,000. Emergency medicine residency program is in third year with a total of 18 residency positions. Please contact Judy O'Neill, EmCare, Inc., 1717 Main St., Suite 5200, Dallas, TX 75201; (800) 527-2145 or (214) 761-9200.

New York, upstate — Directorship and full-time staff positions available in picturesque, progressive communities. BC/BE emergency medicine, or BC in primary care specialty. Substantial hourly guarantee and fee-for-service incentive provides physicians $165,000–$185,000 annually. Directorship affords extremely attractive stipend. Professional liability insurance provided. Full-time/part-time positions available. Also, positions are available for physician assistants. Compensation is $20,000 per hour and professional liability is provided. Send CV to Judy O'Neill, EmCare, Inc. 1717 Main St., Suite 5200, Dallas, TX 75201; (800) 527-2145 or (214) 761-9200.

Munroe Regional Medical Center ExpressCare Unit in Ocala is a newly constructed free-standing facility and is similar to a family practice. The physicians are seeing an average of 50–60 patients per day, of a very low acuity level. The ExpressCare Unit is staffed from 8:00 AM to 8:00 PM. Physician criteria is BE/BC in a primary care specialty and ACLS certification. Physician compensation is $57.00 per hour versus fee-for-service, whichever is greater. Professional liability insurance coverage is available through EmCare. Send CV to Judy O'Neill, EmCare, Inc., 1717 Main St., Suite 5200, Dallas, TX 75201; (800) 527-2145 or (214) 761-9200.

BC/BE internist to join rapidly growing solo practice in southwestern Pennsylvania in July 1990. Practice includes full range of internal medicine and hematology-oncology. Salary with benefits leading to early full partnership. Send CV and references to: Paul A. Hartley, MD, 650 Cherry Tree Ln., Uniontown, PA 15401.

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Professional office suite in northeast Philadelphia. Private entrance, located in apartment bldg. One block from shopping and transportation. Will renovate to suit tenant. Call (201) 944-8700 or (215) 744-8271.

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Very lucrative Cherry Hill practice (internal and family medicine) available. Send confidential CV to Box 318, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Professional office suite in Norristown. 1,082 net square feet in high visibility location across from Sacred Heart Hospital. For sale or lease. Call Tornetta Realty Corp. (215) 279-4000.

For sale — Doppler PVR-4-C cart model.

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For sale by owner — Used Toshiba Ultrasound unit and Lo-Rad Mammography unit. Excellent condition. Available immediately. Please reply to Box 320, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

For sub-lease — Medical office suite with x-ray facilities. Modern. Prestigious location in the Poconos. Available immediately. Please reply to Box 321, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.


Position available — Administrator for radiology billing service. Located in western Pennsylvania. Ideal candidate will be motivated individual with Bachelor’s Degree and at least five years experience in similar capacity. Basic accounting skills required. Familiarity with Fiscal Information system, a plus. Functions include internal accounting, payroll and related taxes, staff management and third party and client relations. Competitive compensation package and opportunity for advancement. Respond by resume to: D.A.B., P.O. Box 1433, Pittsburgh, PA 15230.

Medical office equipment (used) wanted for expanding family practice. Contact Rothsville Medical Center, 1810 Rothsville Rd., Litzit, PA 17543. Tel. (717) 627-1214.

Practice wanted — Experienced family physician 15 years in practice, wants to buy general/family medicine practice in Chester, Montgomery, Philadelphia, Delaware, or Lancaster counties. Please call (215) 495-5414.

230 Medical Centre — Custom designed medical office for sale, lease or lease with option. Centrally located for easy access to all three Lancaster hospitals. Plenty of parking. Call Bob for more information at (717) 394-9500.

1007 Nissley Road — Free-standing commercial building on 1 acre of land in East Hempfield. 3,000 sq. ft. (expandable) open floor plan adaptable for medical uses. Approvals in place for medical use. Call Jan for details at (717) 394-9500.

New Holland — Main Street, New Holland. Great location for medical professionals or related uses. 3,400 sq. ft. or 1,000 sq. ft. available. Fully carpeted. No tax or CAM charges. Call Jan for more information on this ideal location at (717) 394-9500.

Hempfield Center — Prime west end location. Buy, lease, lease with option. Custom designed to fit your needs. Located just off Rt. 30. Plenty of parking. Call Rich for more details on this excellent west end location at (717) 394-9500.

Florida, Orlando — Opportunities available for academic positions in a 1,000-bed tertiary care teaching facility, specializing in trauma and participating in seven residency programs including an emergency medicine residency program. Volume approximately 70,000 patients annually. Additionally, full-time staff positions available in a new 200-bed community hospital located in southwest Orlando close to the attractions. Extremely strong growth potential; compensation to exceed $170,000 annually. Very attractive opportunity in free-standing ambulatory care clinic near Disney World. Occurrence form malpractice insurance provided. Send CV to Judy O’Neill, EmCare, Inc., 1717 Main St., Suite 5200, Dallas, TX 75201; (800) 527-2145 or (214) 761-9200.

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Word Count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Alexander E. Pearce, M.D.
Merion Station
Hahnemann University School of Medicine, 1937; age 75, died November 1, 1989. Dr. Pearce was a general surgeon.

David E. Pittman, M.D.
State University of New York at Buffalo School of Medicine, 1964; age 54, died October 26, 1989. Dr. Pittman specialized in cardiovascular diseases.

The Educational and Scientific Trust of the Pennsylvania Medical Society provides you with a way to make a significant statement honoring the memory of and paying tribute to your colleagues who are deceased. Send your tax-deductible memorial gift to the PMS Educational and Scientific Trust, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

• Denotes PMS membership at time of death.

John J. Bonessi, M.D.
University of Pittsburgh School of Medicine, 1958; age 63, died November 1, 1989. Dr. Bonessi was a family practitioner.

Anthony G. Ciavarelli, M.D.
Hahnemann University School of Medicine, 1936; age 79, died October 19, 1989. Dr. Ciavarelli was an internist.

John J. Conroy, M.D.
Temple University School of Medicine, 1931; age 84, died November, 1989. Dr. Conroy was an internist.

Sidney J. Diamond, M.D.
University of Vienna, 1937; age 80, died September 27, 1989. Dr. Diamond was a family practitioner.

Walter D. Hawkins, M.D.
University of Toronto School of Medicine, 1924; age 90, died November 24, 1989. Dr. Hawkins was an internist.

Bernard E. Lachman, M.D.
Allentown University of Vienna, 1937; age 79, died October 23, 1989. Dr. Lachman was an ophthalmologist.

William C. Langston, M.D.
Jefferson Medical College, 1926; age 91, died September 11, 1989. Dr. Langston was an obstetrician and gynecologist.

Harold F. Lanshe, M.D.
University of Pennsylvania School of Medicine, 1917; age 94, died November 25, 1989. Dr. Lanshe was an otolaryngologist.
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Any change of insulin should be made cautiously and only under medical supervision.
David B. Soll, MD, FACS, Philadelphia, recently gave a course on “Complications in Ophthalmic Plastic Surgery” at the American Academy of Ophthalmology in New Orleans. He is professor of surgery (ophthalmology) at the University of Medicine and Dentistry of New Jersey/Robert Wood Johnson Medical School at Camden.

John Bell-Thomson, MD, chief of cardiothoracic surgery at Albert Einstein Medical Center, recently addressed the 60th Annual Conference of the Argentine Surgery Association in Buenos Aires. Dr. Bell-Thomson lectured on advances in coronary artery bypass surgery and the surgical management of esophageal cancer.

A special report on cancer by WCAU-TV in Philadelphia in November interviewed Leonard Gomella, MD, urologist, and Carl Mansfield, MD, radiation oncologist, both from Thomas Jefferson University Hospital.

Charles C. Wolfert Jr., MD, has been appointed chairman of the Department of Surgery at the Graduate Hospital in Philadelphia.

Mary B. Daly, MD, Philadelphia, a medical oncologist specializing in breast and lung cancers, has been named associate director of the cancer control science program in Fox Chase Cancer Center's population science division.

Steven Mandel, MD, Philadelphia neurologist, spoke recently to the referees of the Department of Labor and Industry’s Bureau of Workers’ Compensation.

James D. Sink, MD, from Emory University Hospital in Atlanta, Georgia, has been named chief of cardiothoracic surgery at Presbyterian Medical Center, Philadelphia.

Michael A. Tomeo, MD, clinical instructor of dermatology at Hahnemann University, Philadelphia, has announced the opening of his practice in dermatology at Holy Redeemer Hospital Medical Office Building, Meadowbrook.

Leopold S. Loewenberg, MD, Bryn Mawr, has been elected chairman of the Pennsylvania, New Jersey, and Delaware District of the American College of Obstetricians and Gynecologists (ACOG).

V. Paul Addonizio, MD, associate professor of surgery at the Hospital and School of Medicine, University of Pennsylvania, has been appointed professor of surgery and chief of cardiothoracic surgery at Temple University School of Medicine and Hospital.

Eric L. Michelson, MD, has been named director of the division of cardiology in the Department of Medicine at Hahnemann University, and co-director of Hahnemann's Likoff Cardiovascular Institute (CVI). He will continue as professor of medicine at Hahnemann.
At Medical Protective, fighting for our doctors is our number one priority. We know we’re not just insuring your finances. We’re protecting your professional reputation, an asset no amount of insurance can replace. And when we go to battle, our winning record is unsurpassed. The reasons are simple.

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FIFTY HOURS FOR THE POOR!

Russell E. Youngberg, MD

Speaking of the Books of Heaven, Sir William Osler told his medical students “Fully a third of your work will be written on other books than yours.” The Great Physician assures us, “In as much as ye have done it unto the least of these, ye have done it unto me.” From the depths of his desolation, Job was heartened to recall “Because I delivered the poor that cried, and the fatherless, and him that had none to help him. The blessing of him that was ready to perish came upon me: I caused the widow’s heart to sing for joy. I put on righteousness, and it clothed me ... I was eyes to the blind and feet was I to the lame. I was a father to the poor: and the cause which I knew not I searched out.”

At our graduation from medical school we were solemnly charged from Isaiah 58: “To deal thy bread to the hungry, bring the poor that are cast out to thy house, when thou seest the naked, that thou cover him; that thou hide not thine own flesh.” There are marvelous promises attached to these obligations. During six recent years as a medical educator in an underdeveloped country I saw many physicians who are thrilled with satisfactions of meeting the needs of the poor. Some fly regularly to help in remote clinics in Mexico, others spend weeks in India, Haiti, Africa or the South Pacific.

Some types of service call for major adjustments, but each of us can determine to merit the words on a plaque in Reading Hospital and Medical Center regarding one of its physicians, “He stood at the right hand of the poor.”

How to do this most effectively calls for applied research and, like other therapeutic plans, should be carefully thought out, monitored and modified, utilizing concerted efforts, team work, and necessary financing.

As for our giving habits, the divine assurance to those who are faithful in their tithes is, “I will open you the windows of heaven and pour you out a blessing that there will not be room enough to receive it. And I will rebuke the devourer for your sakes ...” this is a carte blanche promise that has been proven true by many. We should not only be giving intelligently but sacrificially.

A man from Texas who had donated to my brother’s orphanage and nutrition hospital in Honduras visited a medical school in Mexico and was impressed by the accomplishments and attitude of one of the orphans, by then a medical student. This man told me “It made me glad that I had given, but I wish that I had given much more.”

“Who gives but what he can afford Won’t hear the praises of the Lord, Who gives but what he’ll never miss Will never know what giving is. The widow’s mite to heaven went Because true sacrifice it meant.”

Dr. Youngberg practices physical medicine and rehabilitation in Reading. His essay was inspired by the article, “Fifty Hours for the Poor?” by Leif C. Beck, in the September 1989 issue. Mr. Beck asked a question. This is Dr. Youngberg’s answer.

MORE ON PSYMETADINE

John L. Coulehan, MD


In the article, psymetadine is included in a list (Table 1) of approximately 100 drugs reported to be associated with depressive symptoms. The list itself was adapted from one presented in Cameron OG (ed.) Presentation of depression: Depressive symptoms in medical and other psychiatric disorders, New York, John Wiley & Sons, 1987. In the text, I use quotation marks around the word “cause” to indicate that an association does not necessarily imply cause. Unfortunately, I neglected to include quotation marks around “cause” in the caption to Table 1.

In any case, I agree with Antell, Murabito, and Karlstad that depression is a quite frequent problem seen in medical patients, in that it is very difficult to establish a causal relationship with the use of a drug under such circumstances.

With regard to drugs, my main points were: first, chronically ill patients tend to be on complex drug regimens; and second, if depressive symptoms develop, one should review the medication list and evaluate the possibility that a new medication may have precipitated the syndrome.

Dr. Coulehan is associate professor in the Department of Clinical Epidemiology and Preventive Medicine at the University of Pittsburgh School of Medicine.
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows.

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

- **Possibly** effective as an adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bt.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude anxiety, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** No side effects or manifestations not seen with other compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage range. Syncope reported in a few instances. Also encountered: isolated instances of skin symptoms, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary incontinence, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide, more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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In IBS,* when it’s brain versus bowel,

In irritable bowel syndrome,* intestinal discomfort will often erupt in tandem with anxiety—launching a cycle of brain/bowel conflict. Make peace with Librax. Because of possible CNS effects, caution patients about activities requiring complete mental alertness.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

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Please see summary of prescribing information on adjacent page.
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Waiting for spring in Lancaster County
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The Fifth Headache Symposium

Advances in the Pathogenesis and Treatment of Headache

Presented by a nationally known panel of headache experts.

Saturday, April 21, 1990
8:30 A.M. - 3:15 P.M.
at The Germantown Hospital and Medical Center
One Penn Boulevard, Philadelphia, PA
(adjacent to LaSalle University at the intersection of Wister, Chew and Olney Avenues)

Featured Speakers and Topics:

Moderator: Gregory J. Tramuta, M.D.*
Chief, Psychiatry Section,
The Germantown Hospital and Medical Center;
Associate Clinical Professor of Psychiatry,
Temple University Hospital

Receptor Mechanisms and Headache
Stephen J. Peroutka, M.D., Ph.D.
Associate Professor of Neurology,
Stanford University Medical Center

Cluster Headache
J. Keith Campbell, M.D.
Associate Professor, Department of Neurology,
Mayo Clinic Medical School,
Rochester, Minnesota

Neurobiology of Head Pain
Michael A. Moskowitz, M.D.
Associate Professor, Department of Neurology,
Massachusetts General Hospital and
Harvard Medical School

Sex Hormones and Headache
Stephen D. Silberstein, M.D.*
Chief, Neurology Section,
The Germantown Hospital and Medical Center;
Associate Professor of Neurology,
Temple University Hospital

Additional participants will include:

Elliott A. Schulman, M.D.*, Attending Neurologist,
The Germantown Hospital and Medical Center;
Associate Professor of Neurology, Temple University;
Fellow of the American Academy of Neurology

Ronald S. Kaiser, Ph.D.*, Licensed Psychologist;
Affiliate, Psychiatry Section,
The Germantown Hospital and Medical Center;
Assistant Professor, Department of Psychiatry,
Temple University Hospital; Adjunct Associate Professor of Psychology, Temple University

Joseph P. Primavera, III, M.A.*, Licensed Psychologist; Affiliate, Psychiatry Section,
The Germantown Hospital and Medical Center;
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*Co-Director, Comprehensive Headache Center

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Great victories are rarely achieved by individuals acting alone. It is unity of effort which is bringing down the regimes of Eastern Europe. And unity will arm physicians for the struggles of the '90s.

Physicians working together: that was the premise behind the formation of PMSLIC 11 years ago. Abandoned by commercial carriers, physicians forged ahead to create their own solution to the professional liability crisis. The company they established honored the role of medical judgment in the insurance process . . . and stood staunchly with physicians in defending against frivolous claims.

Now, the field of conflict is widening—from county courtrooms to the halls of Congress. As unification with the AMA moves forward, PMSLIC-insured physicians face a historic opportunity, to join forces with their peers across the country, to fight the threatening inroads of government, and to preserve the integrity and independence of medical practice.

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Pennsylvania's
auto insurance compromise. It is expected to include Governor Casey's proposal
to limit lawsuits and a legislative plan to roll back premiums by at least 10 percent.
Also retained is a cap on accident-related medical expenses. PMS continues
activity to seek a compromise on the cap provision.

A federal judge ruled January 24 that Pennsylvania's $2 billion Medicaid plan does
not comply with federal law and fails to pay hospitals enough to meet their costs.
U.S. District Judge John P. Fullam, saying that rates paid may be "characterized as arbitrary," ordered state officials to report back within 10 days with a plan
for fixing the program. Temple University Hospital, which filed the suit in 1988, claims
a shortfall of $40 million since 1985.

Through AMA efforts, physicians will now be informed first, prior to beneficiaries,
if a PRO denies payment due to failure to meet quality standards. The concept
to alter the 1989 HCFA rule originated last June in a resolution to the AMA Hospital
Medical Staff Section by Lee H. McCormick, MD, of Pennsylvania. It was among
a group of resolutions on substandard care from which the AMA drew its stand.
Under the new procedure, beneficiaries will not be informed of denial until the
PRO has notified the practitioner of the determination, and formal reconsidera-
tion has been completed.

Jack Wolford, MD, Pittsburgh, became psychiatric director for the Department
of Public Welfare's mental health program on January 3. He is professor of
psychiatry at the University of Pittsburgh School of Medicine and consultant to
the university's Western Psychiatric Institute and Clinic. He will set treatment prac-
tice standards in state hospitals, provide consultation for initiatives in mental health,
and serve as liaison between the department and the psychiatric community. Dr.
Wolford is a past president of Psychiatric Physicians of Pennsylvania.

In a relatively smooth transition of power within the Democratic caucus follow-
ing the death of House Speaker James J. Manderino (D-Westmoreland), Robert
W. O'Donnell (D-Philadelphia) was elevated from the post of majority leader to
the speaker's rostrum. H. William DeWeese (Greene) moved from majority whip
to the leader's office. The new whip, Ivan Itkin (Allegheny) was formerly the
Democratic caucus chairman. Mark Cohen (Philadelphia) was elected to that position
in the only other caucus leadership change. Other Democratic leaders in-
clude Caucus Secretary Thomas Fee (Lawrence); Caucus Administrator Bernard
Dombrowski (Erie); Policy Chairman Allen Kukovich (Westmoreland); and
Appropriations Chairman Max Pievsny (Philadelphia).

PMS President J. Joseph Danyo, MD, and James R. Regan, MD, Bethlehem intern-
ist, testified on HB 700, the Medicare overcharge bill, at a hearing in Harrisburg.
The state Senate Public Health and Welfare Committee, headed by Senator John
E. Peterson of the 25th District in northwest Pennsylvania, held hearings on the
bill February 7 and 8. The bill, passed in the House of Representatives in 1989,
would permit suspension of a physician's license for non-acceptance of Medicare
payment as payment in full.
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Heart RX
IS PATIENT EDUCATION

Because patient education is essential to quality medical care, patients today should be well informed about their health so they may take an active role in their care. The American Heart Association has developed a program called Heart RX designed to meet patients’ needs for education to reduce their risk of cardiovascular disease.

The four major goals of patient education to reduce the risk of cardiovascular disease are to make the patient aware of the health risks of smoking, uncontrolled hypertension, and diet related factors for coronary heart disease, and to inform them of the early warning signs of heart attack and stroke.

Patients who smoke should make a decision to stop smoking and make a commitment to continue to be a non-smoker. It is well-documented that smokers are more likely to suffer heart attacks than non-smokers and that a smoker that has a heart attack is more likely to die suddenly than a non-smoker. Patients also need to be made aware that people who quit smoking will rapidly reduce their risk of coronary heart disease regardless of how long or how much they smoked.

Programs that offer counseling and self-help have proven effective to help people stop smoking and to remain non-smokers.

Physicians should set up a system for individual follow-up of patients who decide to stop smoking. Patients should be checked in one month, six months, and one year, with the follow-up program as either a separate file or incorporated into the existing patient file. The success of this type of follow-up depends on the patient’s understanding its importance to health maintenance.

A patient’s participation in the therapy of lowering the risk of high blood pressure can be accomplished with medication, weight loss, exercise or a combination of these. Equally important is the patient’s understanding of how the circulatory system works. Awareness of the risk factors relating to poor diet helps patients play a more active role in diet modification to reduce those risks. They must be educated in ways to lower cholesterol, reduce consumption of food high in fat

1990 Meeting Dates

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<th>Board of Trustees</th>
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<td>PMS Headquarters</td>
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<td>May 1</td>
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<td>PMS House of Delegates</td>
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<td>October 18–21</td>
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<td>Hershey Lodge and Convention Center</td>
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and sodium and to maintain proper weight control.

Patients who know the value of following a nutritionally balanced, low-fat, low-cholesterol, high-fiber diet with a restricted amount of sodium, will be able to maintain weight control and general good health.

Handout materials are essential tools, along with open communication between the patient and the doctor and his staff. Patient education programs at various levels in the medical practice are available, including posters, brochures, specific instruction, and new techniques along with follow-up.

Learning the early warning signs of heart attack, being informed of the EMS system in the community, and participating in CPR programs are vital educational steps. If a patient and his family are educated in the early warning signs of heart attack and stroke, their emergency actions can increase survival rates. They must also understand that their physicians keep constantly informed about medical advances to lower risk of heart attack and stroke.

The main emphasis when introducing the Heart RX program into the community should be a primary interest in the physician's office. Informing patients of the correlation between high cholesterol and essential hypertension has been successful on a limited basis in our office with handouts, patient education and instruction.

The physician in a new practice who institutes Heart RX at the beginning will have a most powerful practice builder. Patients appreciate the individual attention they are given with Heart RX. They feel it is made especially for them, and it seems to give them that extra incentive to work a little harder at lowering their risks of heart disease.

For more information on obtaining a Heart RX kit for your practice, contact the American Heart Association, Pennsylvania Affiliate, at (717) 657-3383 or your local American Heart Association Office.
UNIFICATION VS. OVER-REGULATION

J. Joseph Danyo, MD

When I consider the multiplicity of federal regulations that will be imposed on medicine this year and later, I'm more grateful than ever that our PMS House of Delegates saw the wisdom of unification with the American Medical Association.

As budgetary pressures bear down on the government, it seems to react instinctively by tightening the screws on physicians. It treats us like a cross between contractors, subject to arbitrary and unilateral terms, and criminals who are not to be trusted.

In short, the bureaucrats want blood—ours.

To practicing physicians struggling just to decipher the regulations, let alone comply with them, it often seems the rules are concocted just to make their work more difficult.

Some examples newly in effect or coming soon:
- The government's new scope of work for peer review organizations requires pre-approval for 10 procedures except when done in the doctor's office (in effect since January 1, 1990).
- Physicians will have to submit Medicare claims for all beneficiaries (starting September 1, 1990).
- Balance billing will be limited (starting 1991).
- Referrals to clinical labs where the physician has an ownership interest will be banned (starting 1992).
- I believe the regulatory climate will get worse before it gets better. But as disagreeable as some of the new regulations are, our situation would be much worse if it hadn't been for the AMA, which won significant victories in the 1989 Medicare provisions. For example:
  - Physicians are guaranteed the right to a reconsideration before beneficiaries are notified of a PRO's determination of "substandard" care.
  - There are no "expenditure targets" (ETs), which would have required automatic recoupment of funds spent for physician services beyond the target.
  - Instead of ETs there will be Medicare volume performance standards (an advisory benchmark for volume of physician services) and mandated research for practice guidelines to reduce unnecessary procedures.
  - Mandatory assignment and physician DRGs have so far been deleted.

Intense discussion of many health issues will continue in Washington, from controlling the volume of physician services to helping the uninsured. Decisions about all of these issues can be influenced by organized medicine.

PMS and the AMA make a powerful partnership. To demonstrate that and to continue earning your support for PMS, I am encouraging the Society to expand its advocacy for physicians in response to government activities. For example, the Board of Trustees has directed the Society to communicate regularly with the AMA's Washington office and to coordinate with it our responses to proposed federal regulations.

Our aim is to turn the tide and provide doctors with the tools to take on their adversaries. Make no bones about it: we are at war with the system. It is the job of PMS and the AMA to develop a battle plan to engage these folks. This shall be done.

All of us in practice are up to the eyeballs with the harassment and ludicrous rules of non-doctors who try to tell us how to practice medicine. I'm convinced that what we did in Pittsburgh in October is the only way to go, and that unfolding events in Washington will prove me right.

I know that many of you have concerns about unified membership. To respond to these, PMS has provided extensive information to the leaders of your county medical society, specialty society, and hospital medical staff.

I hope you will feel free to ask questions and learn more about how unification will benefit you.
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Mr. Ami Elis
President
Elcomp Systems, Inc.

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AMA DELEGATES ADDRESS WIDE RANGING CONCERNS

The AMA House of Delegates considered a full slate of far-reaching issues at the Interim Meeting in December in Hawaii. Several recommendations from the Pennsylvania delegations were adopted and considered.

Issues of nationwide concern debated by the 435 delegates included abortion rights, prevention of drunk driving and drug abuse, access to insurance coverage, and AIDS. The delegates also addressed recent AMA internal financial concerns.

Pennsylvania resolutions

Among the issues addressed by the AMA House were resolutions submitted by the Pennsylvania delegates concerning nursing education, physician reviews, AMA specialty coding and AMA computer protocols.

Pennsylvania’s recommendation to restructure nursing education to help alleviate the nursing shortage was adopted by the AMA House. It expressed the Society’s concerns that nursing education programs should allow entry-level individuals an opportunity for work-study advancement from nursing aide to doctorally prepared nurse. The AMA agreed to ask nursing organizations to consider easier transfer of educational credits from one school to another and from one level of nursing to another.

The AMA delegates agreed with the intent of another PMS resolution, saying they would continue to examine and evaluate the impact of quality analysis of medical care on physicians’ treatment methods.

Concerns about Peer Review Organizations (PROs) and fair hearings for physicians were acknowledged by the AMA House. Delegates agreed to make every effort necessary to establish promptly a fair and impartial appeals process for all actions brought against physicians by PROs.

The suggestion that AMA specialty coding be revised to include new clinically accepted specialties and subspecialties was referred to the AMA Board for consideration. Among specialties which could be added are administrative medicine, genetic counseling, infertility, oculoplasticsurgery, pain control and sports medicine.

Also referred to the Board was a Pennsylvania resolution recommending that the AMA develop computer protocols for continuing medical education software, and require that these protocols be used to be accredited by the AMA.

Fiscal Oversight

Closer communication within the executive branch of the AMA and tighter fiscal control by the Board of Trustees will result from examination of recent internal financial incidents. The measures are the AMA’s response to incidents reported in a Chicago newspaper last fall involving financial decisions made in 1985 and 1987 by Executive Vice President James H. Sammons, MD, and not disclosed to the Board. The Board approved a report of an investigation by independent legal counsel which recommended several Board actions to assure the continued exercise of fiduciary responsibilities.

The first incident involved a $268,000 loan to an AMA executive who needed to relocate, and the second was a $353,000 reimbursement to the president at that time of a subsidiary for stock market losses from his personal pension fund that he claimed were incurred through AMA error.

In a speech before the House, Dr.
Sammons admitted his error and accepted responsibility for the decisions. The independent counsel will continue its broad investigation, and the AMA general counsel will take action to recover all funds. To strengthen board oversight and define limitations of authority, board committees will be restructured. New outside auditors will be retained for 1990, and all expenditures in excess of $100,000, unless otherwise budgeted, must be approved by the chairman of the board.

**AIDS policy update**

The House approved a major policy update on the medical, legal and social implications of AIDS and HIV infection. The Board of Trustees report addressed issues related to education, research, national policy, financing, media coverage, and the prevalence and incidence of AIDS.

Among the report's recommendations were contact-tracing and notification of needle partners; study on cost of care and numbers of patients in each state of HIV infection; funding for research, education, patient care, and alternatives to inpatient care; and involvement with other physician groups, public health officials, and universities to advance training for primary care physicians and specialists.

The report also encouraged physicians to provide HIV prevention information to patients and to become more involved in the care of HIV-infected patients.

The AMA also urged enactment of state legislation to establish requirements for reporting and case follow-up for serious contagious disease, including HIV infection. It requested that the Food and Drug Administration (FDA) address the problem of readable instructions for condoms, and recommended that the FDA not allow home test kits for HIV.

**Abortion policy changes**

The AMA voted to support a woman's right to an "early" abortion, declaring that "early termination of pregnancy is a medical matter between the patient and physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities."

Existing AMA policy takes no position on the issue of a woman's right to an abortion. The resolution caused concern among many physicians, who argued it went too far. What constitutes "early termination" was left undefined by the delegates. In adopting the new policy, the AMA did not alter its respect for a physician's right to refuse to

---

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**Drunk driving prevention**
The House adopted a resolution introduced by the Young Physicians Section that encouraged state medical societies to urge their state legislators to adopt a blood alcohol level of 0.05 percent as per se illegal driving. The resolution also called on Congress to make federal highway funds to states contingent upon state adoption of a 0.05 blood alcohol level.

**Federal liability initiatives**
The AMA endorsed federal solutions to some of the most pressing professional liability problems.

A Board of Trustees report was adopted calling for the AMA to support federal legislative initiatives to: place a limit of $250,000 or lower on recovery of non-economic damages; provide for mandatory offset of collateral sources of plaintiff compensation; establish a decreasing sliding scale of attorney contingency fees; and provide for periodic payment for future awards of damages.

The report cautioned that AMA support for federal initiatives addressing professional liability issues would be "expressly conditional."

**Coverage for uninsured**
The AMA approved several actions aimed at improving access to health care for the uninsured.

The delegates recommended an aggressive program to ensure that health care access for the uninsured promptly becomes a high legislative priority. The program should include employer-sponsored coverage; private approaches, such as risk pools; and the AMA's Medicare and Medicaid restructuring proposals.

The AMA will also explore ways to cover uninsured dependents, who make up more than half of the nation's uninsured population. Mechanisms to be considered include expansion of state or federal government programs, establishment of dependent coverage of self-employed individuals, and coverage of employees' dependents by employers.

**Other AMA actions**
Other measures taken by the AMA House include:
- approving a policy to try legislative, regulatory, and administrative means to change inappropriate enforcement of the Social Security Act and/or Medicare regulations (this is an attempt to make it possible for physicians in solo or group practice to bill and receive payment for professional services to their Medicare patients rendered by colleagues who provide traditional short-term coverage);
- adopting a policy opposing the extension of Medicare peer review to physicians' offices;
- adopting a policy on medical licensure endorsing the concept of a single examination (previously, the AMA had supported the use of both the National Board Examination and the Federaton Licensing Examination (FLEX) for medical licensure).

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**AMA STEPS UP
DRUG ABUSE WAR**

At the urging of a physician from Pennsylvania, Roberta L. Schneider, MD, the AMA agreed in December to recognize substance abuse as its No. 1 public health priority. The action came during the interim meeting of the AMA House of Delegates in Hawaii.

Vice chairman of Pennsylvania's physician Task Force on Drug Abuse, and an alternate delegate to the AMA, the Wyncote doctor persuaded the 425 member AMA House to turn a routine resolution on drug abuse into a declaration of national medical priority.

According to Dr. Schneider, "All of our present and future patients are at risk for the myriad of consequences of substance abuse. Physical and mental illness, the spread of AIDS, violent crime and child abuse are all intertwined with this problem. I'm pleased that the AMA made this strong patient advocacy and public health statement."

Earlier this year, PMS also named drug abuse its No. 1 public health priority.

The new AMA definition of substance abuse includes dependency on tobacco. Under its anti-substance abuse mandate, the AMA is committed to:
- work toward more effective warnings regarding the use of alcohol and tobacco products;
- document the strong correlation between alcohol abuse and other substance abuse;
- work to limit the illegal consumption of alcoholic beverages on college campuses;
- educate physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of addiction, including prenatal addiction;
- encourage development of model substance abuse treatment programs, particularly for pregnant women and women with infant children;
- work to expand the quality and availability of substance abuse treatment programs.

In the Commonwealth, the Society's Task Force on Drug Abuse, chaired by Lee H. McCormick, MD, Pittsburgh, held two state-wide conferences in 1989, bringing together health professionals, law enforcement personnel, legislators, and community leaders to coordinate the battle against drug abuse. Task force members also serve on Attorney General Ernie Fricat's Medical-Legal Advisory Board on Drug Abuse.

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**LEADERSHIP CONFERENCE TACKLES TRANSITIONS**

Leaders of Pennsylvania's medical profession will consider the implications "Medicine in Transition," during the PMS Leadership Conference, May 1-2, at the Hershey Lodge and Convention Center.

For perspectives on the emerging transition in American medical practice, experts on medical demographics, the Canadian health care system, and governmental health care policy will offer their views.

The conference opens on Tuesday afternoon, May 1, with an address by Lawrence S. Lewin, president of ICF Incorporated. Following an audio/visual presentation of the conference theme, William K. Kissick, MD, professor of health care systems from the Wharton School will speak on changing demographics of medical practice.

Also on Tuesday two distinguished
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speakers will address a major element of medicine’s transition, the movement for national health care. Hugh Scully, MD, past president of the Ontario Medical Association, will offer insight into the workings of the Canadian health care system, now being scrutinized by U.S. health care planners.

While Canada’s tightly controlled, centralized system is not likely to replace the decentralized U.S. system, planners are analyzing the Canadian system’s cost efficient practices and practical philosophy.

Serving on Canadian national and regional councils to recommend health care system strategies, Dr. Scully has been a planner of the Canadian health care system.

Dr. Scully is associate professor of surgery at the University of Toronto, deputy surgeon-in-chief at Toronto General Hospital, and deputy head of cardiovascular surgery at Toronto Hospital. He also serves as staff surgeon at Toronto Hospital, consultant surgeon at Sunnybrook Medical Centre, Mount Sinai Hospital, and Women’s College.

AMA Board of Trustees member, Lonnie R. Bristow, MD, an internist from San Pablo, California, will describe the implications of the AMAs special project to preserve the American health care system. The AMAs plan, emphasizing Medicaid and Medicare reform, health insurance expansion, and government financial reforms, aims to improve cost-effectiveness of the American system while maintaining its decentralized, pluralistic structure.

In addition to his position on the Board of Trustees, Dr. Bristow is president of the American Medical Association Education and Research Foundation. He has also served as chairman of the Section on Internal Medicine of the California Medical Association, president of the California Society of Internal Medicine and the American Society of Internal Medicine, and as a member of the Institute of Medicine of the National Academy of Sciences.

After the featured speakers, a panel of experts will field questions in a “talk show” format addressing governmental transitions in medical care. Panel members will include Peter Braun, MD, Harvard School of Public Health; Bernie Patashnik, director, Division of Medical Services Payment, Health Care Financing Agency; and Thomas J. Dehn, MD, immediate past president, American Medical Peer Review Association. Philadelphia health law attorney Alice G. Gosfield will host this segment.

The second morning of the conference, Edward R. Annis, MD, will speak on the doctor patient relationship. Workshops on risk management, dealing with KePRO, and stress management will follow.

The conference concludes at noon on May 2, following an address by PMS President J. Joseph Danyo, MD.
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AWARDS PRESENTED IN PHILADELPHIA

The 364 members of the Philadelphia County Medical Society and guests who attended the society's annual award night dinner program on November 12 renewed old friendships as they applauded the awards presentations that highlighted the evening.

The society presented its highest honor, the Strittmatter Award, to Lewis W. Bluemle, Jr., MD, president of Thomas Jefferson University. This award has been granted by the society since 1923. Another major presentation, the Krasnoff Practitioner of the Year Award, was presented by Philadelphia Mayor Wilson B. Goode to John W. Robertson, Jr., MD, chief of surgery at John F. Kennedy Memorial Hospital.

It was reunion time when 35 out of the 58 graduating physicians from the class of 1939 were applauded as they received their 50 years of medical practice awards. Doris G. Bartuska, MD, president of the society, and George Ross Fisher III, MD, first district trustee of the Pennsylvania Medical Society, made the presentations.

Philadelphia Medicine's William Weiss, MD, editor for 13 years, was honored with the society's David S. Cristol Award for his numerous contributions to organized medicine.

This year's C. Nelson Davis Award honored George E. Woody, MD, chief of the substance abuse program at the Veteran's Administration Hospital.

Since 1948, the society has presented the Benjamin Rush Awards to outstanding Philadelphia citizens and organizations making voluntary contributions to the health and welfare of the people of Philadelphia. Recipients this year were Patricia M. Morley of the American Cancer Society, Philadelphia Division, and the Women of Hope Organization directed by Sister Mary Scullion.

The society honored two resident physicians. The Kenneth Appel Award for the best paper submitted on clinical psychiatry was presented to Heidi Rosa, MD, practicing physician at the Institute of Pennsylvania Hospital. The Humaneness in Medicine Award was presented to Henrik Badkerhanian, MD, from the University of Pennsylvania clinical psychiatry program, for his work with children from the 1988 Armenian earthquake disaster. These physicians each received a cash award.

The Honorable Wilson B. Goode, mayor of Philadelphia, at left, presented the Practitioner of the Year award to John W. Robertson, Jr., MD, right, chief of surgery at John F. Kennedy Memorial Hospital.

John Helwig, Jr., MD, left, was honored with two special citations presented by John Hobart, MD, chairman of the PMS Board of Trustees.

Lewis W. Bluemle, Jr., MD, received this year's Strittmatter Medal from the Philadelphia County Medical Society. George Rosemond, MD, right, is chairman of the Strittmatter Award Committee and a past Strittmatter Medalist.
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5:00 p.m.  Cardiac Problems in Renal Failure
           Ronald S. Pennock, MD
5:30 p.m.  Dialysis in Cardiac Patients
           Charles D. Swartz, MD
6:00 p.m.  Refreshments

Thursday, April 19, 1990
Moderator: Eric L. Michelson, MD
Director, Division of Cardiology
Professor of Medicine

4:00 p.m.  Case Presentation
5:00 p.m.  Color Flow Doppler
           Gerald Scharf, DO
5:30 p.m.  Transesophageal Echo
           Krishnaswamy Chandrasekaran, MD
6:00 p.m.  Refreshments

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President-elect Stanley M. Marks, MD, is board certified in hematology and oncology. He graduated in medicine from the University of Pittsburgh in 1973, was admitted to the ACMS in 1978, and has been a member of the ACMS board of directors since 1985. In addition to his duties as an officer, Dr. Marks is medical advisor to the ACMS AIDS Speakers Bureau. He is affiliated with Allegheny General, Divine Providence, North Hills Passavant, Suburban General, and Washington hospitals.

John A. Burkholder, MD, vice president, is board certified in thoracic and cardiovascular surgery. He graduated from Johns Hopkins Medical School in 1966 and was admitted to the ACMS in 1971. Previously, Dr. Burkholder served on the board of directors from 1981 until 1986.

Lee H. McCormick, MD, will serve a second term of office as the society's secretary. A family practitioner, Dr. McCormick graduated in medicine from the University of Pittsburgh in 1958. Prior to being elected secretary in 1989, he was the society's treasurer and has been a member of the ACMS.

**ALLEGHENY SOCIETY ELECTS 1990 OFFICERS**

George F. Buerger, Jr., MD, an ophthalmic plastic surgeon, has been elected the 125th president of the Allegheny County Medical Society (ACMS). Taking office with Dr. Buerger are Stanley M. Marks, MD, president-elect; John A. Burkholder, MD, vice president; Lee H. McCormick, MD, secretary, and John S. Oehrle, MD, treasurer.

Dr. Buerger graduated in medicine from George Washington University in 1962. Since joining the ACMS in 1966, he has served on many ACMS committees and has been an officer since 1986. He is past-president of the Pittsburgh Ophthalmology Society and is affiliated with Eye & Ear, Shadyside, and Montefiore hospitals.

In addition to being an ophthalmology consultant, Dr. Buerger is a loyal supporter of his undergraduate fraternity, Delta Tau Delta, and the University of Pittsburgh and Eye & Ear Hospital alumni groups.

Of his election to office, Dr Buerger said, "I look forward with enthusiasm to my term of office with an energetic and dedicated slate of officers. We have made a major effort to define the society's goals through a dynamic, strategic plan which will position ACMS as a leader of the profession and in the community we serve. Strengthened by our unification with the AMA, this county can make a difference!"

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In order to protect its members, Professional Choice will contract experienced attorneys to represent the interest of its members individually and as a group in connection with any disciplinary proceedings. This benefit is provided as a service to Choice members, and is not a form of insurance. There are no out of pocket costs to members other than the membership fee.

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physicians and their office staffs in March and September.

"How to Improve Coding: A Review of the Basics" focuses on how to submit clean, accurately coded claims. The program is an introductory or refresher course on how to code properly to ensure maximum reimbursement.

"Advanced Management Strategies for Maximizing Reimbursement" is designed to provide course participants with a better understanding of the reimbursement system. It includes an update on legislation and regulations which will impact on reimbursements from third parties, and maps out strategies that will help physicians to legally and ethically maximize reimbursement income.

In addition to timely, professional instruction, both seminars will feature participation by representatives from Pennsylvania Blue Shield, Medicare, Medicaid, and the Pennsylvania Medical Society who will be available to answer questions.

Dates and locations for the seminars are as follows: How to Improve Coding: Pittsburgh, March 13 and September 11; Harrisburg, March 20 and September 18; Philadelphia, March 27 and September 25. Advanced Management Strategies: Pittsburgh, March 14 and September 12; Harrisburg, March 21 and September 19; Philadelphia, March 28 and September 26.

For more information about the seminars and registration, contact the Council on Medical Practice, 1-800-228-7823 or (717) 558-7750.

SEXUAL HARASSMENT

TOCIP OF MEETING

Elissa Benedek, MD, president-elect of the American Psychiatric Association, will give the keynote address at a national conference, "Sexual Harassment in the Workplace," March 10, 1990, in Philadelphia.

Sponsored by the Committee on Women of the Psychiatric Physicians of Pennsylvania, the conference will be held at The Institute of Pennsylvania Hospital, Philadelphia.

Also speaking at the conference will be Marina Angel, JD, professor of law at Temple University, who will address the legal issues pertaining to sexual harassment, and Harriet Wells, MD, staff psychiatrist at the Institute of Pennsylvania Hospital, to speak on evaluating and treating victims.

For more information, call Pennsylvania Hospital at (215) 471-2094.

SCHOOL OF MEDICINE

TOASTS 225th YEAR

The University of Pennsylvania School of Medicine will celebrate its 225th anniversary in 1990 with a year-long series of special events for alumni, faculty, students and the public. Events will coincide with the 250th anniversary celebrations at the University of Pennsylvania.

As the nation's first medical school, Penn's school was the first American institution to combine formal academic lectures with bedside training and medical research. Founder John Morgan, MD, modelled the school after universities in London and Edinburgh where medical schools were part of larger institutions of higher learning.

The critical role the University of Pennsylvania School of Medicine has played in the evolution of American medicine will be the main theme of the anniversary celebration throughout the year. Events will peak in January, May and October with programs focused on three topics: Frontiers in Science, Contemporary Medicine, and The Future of American Medicine.

Distinguished members of the Penn faculty, along with internationally known experts on medicine and health, will lecture and participate in symposia.

Throughout the year, reunions, dinners, picnics, fireworks displays and a zoo party will complement the scholarly activities.

Anniversary events started on January 18 when Penn's $53 million Clinical Research Building was dedicated. U.S. Secretary of Health and Human Services Louis Sullivan, MD, was the keynote speaker for the occasion. Also in January, the 27th Annual Women in Medicine Dinner was held on the 17th, and a symposium on "Molecular Mechanisms of Disease" took place on January 19. The symposium featured three world-renowned medical scientists: Philip Leder, MD, of Harvard University; Sydney Brenner, MD, of Cambridge, England; and Joshua Lederberg, PhD, of Rockefeller University.

In May, CME credit will be given for a series of faculty-alumnus exchanges as part of the festivities. Other events during the "May Festival," May 16–20, will coincide with the University's 250th anniversary celebration's "peak week," including the annual Medical Alumni Weekend.

October's events include a symposium on the future of American medicine. Arnold Relman, MD, editor of the New England Journal of Medicine, Samuel O. Thier, MD, president of the Institute of Medicine, National Academy of Sciences, and Uwe E. Reinhardt, PhD, professor of political economy at Princeton University, will lead the symposium.

To provide alumni with preferred seating and other special opportunities, a 225th Club membership is being offered by the medical school. More information on the schedule of anniversary events is available after from the school of medicine.

DR. BRADY RECEIVES

GOLD MEDAL AWARD

Luther W. Brady, Jr., MD, chairman of the department of radiation oncology and nuclear medicine at Hahnmann University, has received the Gold Medal Award from the Radiological Society of North America (RSNA). The award, presented during RSNA's 75th Scientific Assembly and Annual Meeting in December, is given to those "who have rendered unusual service to the science of radiology."

Dr. Brady was honored for his talents as a clinician, investigator, author and administrator.

He has served the RSNA in various capacities, including president in 1985, for more than 20 years. Among his numerous leadership positions in other professional societies are his terms as president of the American Radium Society, the American Society for Therapeutic Radiology and Oncology, the Society of Chairmen of Academic Radiation Oncology Programs, the Society of Chairmen of Academic Radiology
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In a day and age where the practice of physicians and all health care professionals is subject to increasing scrutiny by third parties, peer review organizations, and state and federal agencies, this legal representation benefit included as part of your membership in Professionals Choice offers the opportunity for protection against adverse disciplinary actions.

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The American Journal of Clinical Oncology and co-author of the textbook, “Principles and Practice of Radiation Oncology.”

Dr. Brady has been a Hylda Cohn/ American Cancer Society professor of clinical oncology since 1975, and has received numerous awards for his work in radiology. He is an honorary fellow of the Royal College of Radiologists, London; the German Roentgen Ray Society and the Italian Radiology Society.

TRUST'S POSTER PROMOTES NURSING PROFESSION

The Educational and Scientific Trust of the Pennsylvania Medical Society is distributing a four-color poster promoting the nursing profession to physicians, auxiliary members, and high school guidance counselors to assist in nurse recruitment programs.

The poster, entitled “White Cap Excitement,” depicts the challenges posed by skiing, surfing, and being a part of the medical team as a nurse. Part of the poster depicting the rewards of a nursing career is shown here.

The poster includes information on the Trust’s Allied Health Student Loan Program. Through this program, students enrolled in professional nursing programs leading to the RN, LPN, or Associate or Bachelor degrees can qualify for low-interest loans.

To get posters or for more information on the Trust’s Allied Health Student Loans, call the Trust at (717) 558-7750.

WELL-BEING CONFERENCE SET FOR APRIL 19–22

The third annual Conference on Professional Well-Being will be held April 19–22, 1990 at the Penn Tower Hotel, Philadelphia. Jointly sponsored by the PMS Educational and Scientific Trust, the Society for Professional Well-Being, and other organizations, the conference will run for two and one-half days.

Plenary sessions and more than 45 small group workshops will concentrate on ways to recapture the satisfaction of medical practice and to prevent burnout, impairment, and litigation stress.

Fees for the conference are $295, professional; $195, spouse; and $105, student. There is a discount of $25 for society members. Write to John-Henry Pfifferling, MD, 5102 Chapel Hill Blvd., Durham, NC, or telephone (919) 489-9167, for more information.

TRAUMA SOCIETY SETS 1990 DATE

The American Trauma Society (ATS) Pennsylvania Division has set Saturday, March 31, 1990 as the date of its fourth annual conference. Entitled, “Trauma in the ’90s: A Look into the Past, A Step Into the Future,” the conference will be held at the Hershey Lodge and Convention Center in Hershey.

The morning session will involve a trauma case study, following the progression of the patient from prehospital, hospital, rehabilitation and reentry into society. Afternoon workshops will offer in-depth training and discussion for health professionals.

For more information and registration brochures, call Suzanne Bartell at (717) 766-1616.

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MEDICAL STAFFS MUST MAINTAIN SELF-GOVERNANCE

Elizabeth B. Metz

In recent years, a number of hospitals have sought and unfortunately in some cases obtained language in the medical staff bylaws requiring the medical staff to have the governing board’s approval to seat a medical staff officer and allowing the governing board to withhold its approval. In essence, the language authorizes the governing board to veto the election of a medical staff officer. A medical staff should oppose the inclusion in its bylaws of language authorizing the governing board to participate in the selection of a medical staff officer in any manner which would allow the governing board to change or influence the result, as is clearly the case with veto authority.

The authority to veto the election of a medical staff officer is a dangerous weapon in the hands of a governing board whose intent is to rein in the medical staff. Veto authority enables a governing board to emasculate the medical staff leadership. For example, veto authority could be used to exclude physicians critical of the administration or considered not susceptible to administration control. Indeed, a governing board armed with veto authority can force the medical staff to elect the governing board’s candidate by sending the message that all others will be disapproved.

Occasions on which a governing board will not approve the election of a medical staff officer will probably be rare. However, before discounting governing board approval as a mere formality, a medical staff should take heed of the recent experience of the medical staff of Eisenhower Memorial Hospital, described on the following page.

Moreover, the very existence of veto authority could inhibit current and potential medical staff leaders from pursuing quality issues and other concerns as strenuously as they otherwise would and should, because they perceive that such activity is not welcomed by the administration. In sum, vesting the governing board with veto authority is inconsistent with the independence the medical staff must maintain to assure that the administration, through ignorance or improper motives, does not sacrifice quality and caring for profit.

Legality of veto authority

Whether a governing board will be permitted to exercise authority to veto the election of a medical staff officer purportedly conferred by the medical staff bylaws is questionable. The standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandate that the medical staff bylaws must create a framework for “self-governance . . . within which medical staff members can act with a reasonable degree of freedom and confidence.” In addition, while not as explicit, regulations promulgated by the Pennsylvania Department of Health can be interpreted as imposing a similar “self-governance” requirement.

For the same reasons a medical staff should oppose medical staff bylaws language giving the governing board authority to veto the election of a medical staff officer. Such authority is inconsistent with the letter and intent of JCAHO standards and Department of Health regulations. Nonetheless, the issue is far from settled in Pennsylvania. Therefore a medical staff should not concede bylaw language conferring the governing board with authority to veto the election.
THE EISENHOWER EXPERIENCE

In November 1987, The Medical Staff of Eisenhower Memorial Hospital in Rancho Mirage, California elected Dr. David Stoltzman, a 13-year veteran of the staff, as president-elect. The medical staff bylaws contained language stating that "officers elected must be approved by the [governing board]." The hospital corporate bylaws contained similar language. Without any explanation, the governing board refused to approve Dr. Stoltzman, and citing the medical staff and hospital corporate bylaws language, took the position Dr. Stoltzman could not take office.

The medical staff held a second election for the position. Dr. Stoltzman was re-elected by an even wider margin. The board again refused to approve Dr. Stoltzman and again provided no explanation. The medical staff subsequently attempted to negotiate a satisfactory solution with the governing board. When those efforts failed, the medical executive committee seated Dr. Stoltzman. The governing board then sued the medical executive committee in California state court and Dr. Stoltzman countersued. The medical staff once again tried but failed to negotiate a satisfactory solution with the governing board.

In February 1989, a California trial court ruled in favor of the governing board, holding: "Dr. Stoltzman is bound by the terms of a written agreement signed by him in which he expressly agrees to be bound by the bylaws of the medical staff and the hospital. The court has found the bylaws provisions involved in this case to be valid." The court reached the latter conclusion despite the obvious inconsistency between the bylaws language and the California Code which states that the medical staff "shall be self-governing in regard to the professional work performed in the hospital."

The medical executive committee and Dr. Stoltzman appealed. In October 1989, before the appellate court rendered its decision, the case was settled. The governing board agreed to seat Dr. Stoltzman and delete the language in the medical staff and hospital corporate bylaws vesting it with veto authority. The governing board has made no public statement as to why it reversed its position. Needless to say, the considerable time and money spent by all parties could have been avoided had the governing board seen the wisdom of its final position two years earlier.

of a medical staff officer based on an expectation the hospital will not be permitted to actually exercise the authority.

Hospital corporate bylaw bootstrapping

Some governing boards have attempted tobootstrap the authority to veto the election of a medical staff officer by including language to that effect in the hospital corporate bylaws. It is unlikely a hospital will be deemed to hold veto authority solely by virtue of language in the hospital corporate bylaws. Both Pennsylvania law and the JCAHO standards prohibit a governing board from unilaterally amending the medical staff bylaws. Yet that is precisely what the hospital is attempting to do.

In sum, the governing board cannot unilaterally vest itself with veto authority when that authority is not already included in the process for selecting medical staff officers specified in the medical staff bylaws. As a precaution, medical staffs should oppose the inclusion in the hospital corporate bylaws of language that gives veto authority to the governing board. Medical staffs also should include in their bylaws language making it clear that in the event of an inconsistency between the medical staff and the hospital corporate bylaws, the medical staff bylaws prevail. The PMS Model Bylaws include appropriate language.

Indemnification authority is not dependent on veto authority

The Pennsylvania Medical Society encourages medical staffs to require the hospital to agree to indemnify medical staff officers and members against liability and defense costs arising out of the performance of their duties pertaining to credentialing, corrective action, and quality assurance. Some physicians have inquired whether the hospital corporation must possess the authority to veto the election of a medical staff officer in order to be legally authorized to provide indemnification. There is no credible legal support for concluding that indemnification authority is dependent on veto authority. Medical staffs which receive advice to the contrary from the hospital attorney should ask for a second opinion from an unbiased source.

References

1. JCAHO, Accreditation Manual for Hospitals, 104 (1989) (see Ms. 2 & Ms. 2.2).
3. 28 Pa. Code § 103.4(b) (1984); JCAHO, Accreditation Manual for Hospitals, 104 (1989) (see Ms. 2.1).
DETERMINING DISABILITY: THE TREATING PHYSICIAN'S ROLE

Howard Thorkelson

Treating physicians are being asked to play a greater role in helping the Pennsylvania Bureau of Disability Determination (BDD) make accurate determinations of eligibility for disability benefits for their patients who file claims under the Social Security Act. These programs provide Disability Insurance and SSI benefits. In compliance with recent Social Security Administration (SSA) directives, BDD will not only call on treating physicians to provide accurate, complete, and timely medical information about their patients' impairments, but will also request the physician to provide more detailed information concerning how the impairment affects the individual's ability to function. Additionally, the treating physician will be regarded as the preferred physician to perform a consultative examination or test when such additional information is needed.

The disability process begins when an individual seeking benefits files a claim with the Social Security District Office. The district office forwards the claim to the appropriate BDD branch office in Harrisburg, Wilkes-Barre, or Greensburg. It is in these offices that medical and vocational eligibility for benefits is determined.

The test for Social Security disability is a formidable one. A person is defined as being disabled if he or she is unable to engage in any substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment (or combination of impairments) which can be expected to last for not less than 12 months or to result in death.

The severity of an impairment is determined by assessing the limitations imposed by the impairment on the individual's physical or mental ability to perform one or more basic work activities needed to do most jobs. Examples of such activities include walking, standing, sitting, lifting, pushing, seeing, hearing, speaking, remembering simple instructions, and dealing with co-workers.

The "Listing of Impairments" is published in the SSA regulations and contains over 100 medical conditions which would ordinarily prevent an individual from engaging in SGA. The listed conditions do not simply correspond to medical diagnoses. Rather, they are expressed in terms of particular clinical findings and test results. For example, from the Musculoskeletal Listings:

1.08 Osteomyelitis or septic arthritis (established by X-ray):

A. Located in the pelvis, vertebra, femur, tibia, or major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to [disability determination], manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

[20 CFR Pt. 404, Subpart P, App. 1]

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The author is director of the Bureau of Disability Determination in the Pennsylvania Department of Labor and Industry.
Controversy: Sudden Death—Is Electrophysiologic Testing Preferred Over Conventional Evaluation?

Moderator: Leonard N. Horowitz, MD

3:00-3:30 Yes—Charles Gottlieb, MD
3:30-4:00 No—Philip J. Podrid, MD
4:00-5:00 Case presentations—The resuscitated patient—Walter R. Hepp, MD
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Thus the determination whether an individual's condition meets the listing is highly dependent on medical evidence, on both clinical information and test results.

If the impairment does not meet or equal any listing, then the claimant's remaining functional capacity is assessed and compared to the demands of his or her previously held employment. If it is determined that a claimant cannot perform past relevant work, then it is determined whether the claimant's physical and mental capabilities, considering his or her age, education, and past work history, permit the performance of other work that is widely available in the national economy. This determination, as well, requires medical information and judgment.

All information received on a claim is evaluated by the disability claims adjudicator assigned to the case for the initial decision. Working with the adjudicator in the review process is a staff of physicians and psychologists. If a claimant is dissatisfied with the initial decision, he or she may request a reconsideration decision, which is made by a different adjudicator/physician team. Any appeals made by a claimant beyond this point leave the state's disability determination system and enter the federal Social Security system.

As you can see, all determinations of disability are highly dependent on closely analyzed medical evidence. Mere statements of diagnosis or "disability" do not contribute much.

Any evidence received from a physician becomes a part of the medical evidence of record (MER). A sound and accurate medical report from the claimant's treating physician is required for BDD to make a fair and equitable decision based on the MER. Such a report should contain the following elements:

1. History—When did present injury or illness occur? When did it first interfere with the applicant's work capacity? Is there a previous history of the impairment?

2. Objective findings—What is the diagnosis? Give dates and results of physical or mental examinations and clinical and laboratory tests (such as EKGs and tracings, blood tests, range of motion tests, etc.) that show the nature and extent of impairment and support the diagnosis. Describe treatment and response to treatment.

3. Limitations and capacities—To what extent does the impairment limit the person's capacity to perform ordinary activities? What activities can the person still perform?

4. Progress and prognosis—What physical and mental changes have occurred during the period under review? What additional deterioration or improvement in the condition can be expected (and by when, if known)?

Because Social Security regulations also require that the treating physician provide detailed information about functional limitations, a medical source statement (MSS) form has been devised for this purpose. The MSS form asks the treating physician to provide information regarding the claimant's abilities in the areas of lifting and carrying, standing and walking, sitting, posture, and other physical functions. The form also asks for information on any environmental restrictions the claimant may be subject to, as well as non-exertional restrictions such as pain, phobias, stress, depression, and alcohol/substance abuse.

On occasion it becomes necessary to acquire a consultative (CE), examination, purchased at government expense, in order to obtain more detailed medical findings about the claimant's impairments or to resolve conflicts in medical findings in the evidence already in the file. In Pennsylvania, BDD maintains a panel of approximately 2,000 CE physicians across the state. When a disability claims adjudicator requires more medical evidence than that already available in the MER, a physician is drawn from the panel to conduct a consultative examination of the claimant.

Under the new policy, the first resort will be to request a consultative examination performed by the treating physician. Only if a treating physician is unwilling or unable to provide the required information will BDD turn to a panel physician to perform the exam. Treating physicians will be surveyed each time medical evidence of record is requested in order to determine their willingness to perform a consultative examination on their patient if one is needed.

We believe that the emphasis on the claimant's treating physician as the primary source of information will satisfy the claimant by not forcing him or her to submit to a new series of examinations by an unfamiliar physician. Thus, the claimant is assured that he or she is being examined by someone who knows his or her case, and SSA is satisfied that it is receiving the best medical evidence available to provide a fair and equitable decision.

---

A HELPING HAND FOR THE TROUBLED PHYSICIAN

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Write Physicians' Health Programs, The Educational and Scientific Trust of the Pennsylvania Medical Society, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.
Description: Yohimbine is a 3a-15a-20β-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth, Yohimbine is an indolylalkaloid alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone. 

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yoon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychotic patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral α-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. Also, dizziness, headache, skin flushing reported when used orally. 

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence. 1,2,3 tablet (5.4 mg) 3 times a day. For adults males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks. 

How Supplied: Oral tablets of Yoon® 1/12 gr. 5.4 mg in bottles of 100s NDC 53159-001-01 and 1000s NDC 53159-001-10.

References:

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RESOLVED, That the Pennsylvania Medical Society support an early and careful initiative to develop comprehensive conventional and nuclear arms treaties with the Soviet Union and to resume negotiations toward a Comprehensive Nuclear Test Ban Treaty with a letter to this effect being sent to President George Bush, Secretary of State James A. Baker Ill, Secretary of Defense Richard Cheney, the Majority and Minority Leaders of the House of Representatives and the Senate of the United States, and to Senator H. John Heinz Ill and Senator Arlen Specter.

Delegates at the 1989 PMS meeting voted unanimously for this resolution proposed by William A. Freeman, MD, of Shippensburg, committing themselves and the Pennsylvania Medical Society to the cause: working for the reduction and, finally, elimination of nuclear arms. The threat of a nuclear attack or accident is one of many serious public health threats facing every nation in the world. Today, much is said about drugs, the environment, AIDS, and poverty, in themselves terrible problems. But the nuclear threat means that in a matter of minutes, blast, fire, heat, and nuclear radiation could engulf the planet, possibly destroying all life.

“There is no way the medical profession could respond to a nuclear interchange,” said James E. Jones, MD, contact person for the Hershey-Harrisburg chapter of Physicians for Social Responsi-
An International Celebration

When they met in Philadelphia last May, leading scientists and physicians from around the world had an agenda beyond celebration of the region’s bicentennial. They used the occasion to not only honor the bicentennial, but also to pay tribute to the Nobel Foundation and lay the groundwork for improved global relations.

The need for increased international cooperation in an era of competition has never been greater, N. Henry Moss, MD, conference co-chairman said. Governments, businesses, scientists, and physicians are “now engaged in a realistic and intense competitive race for markets, materials, products and processes, as well as the minds of billions of people throughout the globe,” he said.

Sponsored by 12 Delaware Valley institutions and scientific centers and attended by delegates from 14 countries, the program consisted of presentations by more than 20 world-renowned scientific and medical leaders and Nobel Laureates. The highlight of the conference was the award presentation to the Nobel Foundation.

Each of the four sessions of the conference explored the frontiers of global scientific interdependence. Howard V. Perlmutter, PhD, professor of social architecture at the Wharton School of the University of Pennsylvania and co-chairman of the conference, said in his keynote address that we are on an unprecedented, uncertain, and irreversible course toward establishing the first global civilization.

“The SNFI (Simultaneously Neighboring Functionally Interdependent) world will require a new way of thinking in most dimensions of life,” he said. Competition and the necessity for international cooperation have become facts of life in the political, economic, scientific, and sociocultural realms, he said. In presenting their own areas of expertise, the speakers all emphasized this necessity.

Edward C. Carter II, librarian at the American Philosophical Society in Philadelphia, gave a historical perspective to the conference.

Nobel Laureate Baruch S. Blumberg, MD, vice president of Fox Chase Cancer Center, Philadelphia, and master elect at Oxford University, spoke about the global interaction of plagues and epidemics. Sir Gordon Wolstenholme, of the Royal College of Physicians and chairman of the board of governors of Action in International Medicine, London, talked about the activities of Action in International Medicine.

George D. Lundberg, MD, editor of the Journal of the American Medical Association, examined the effects global distribution of medical information is having on research, teaching, and practice.

The co-founders of AIDS virus research presented their views of the global challenges to understanding and treating the disease. Robert C. Gallo, MD, chief of the Tumor Cell Biology Laboratory at the National Cancer Institute, talked about the present and future challenges AIDS will thrust upon scientists and society. Dr. Luc Montagnier, of the Pasteur Institute in Paris, examined a global approach to AIDS research.

George Poste, PhD, DVM, DSc, president of research and development at Smith, Kline and French Laboratories, explained how the pharmaceutical industry stays at the cutting edge of global biotechnology.

Three speakers discussed the technology race. Professor C. W. Chu, from the University of Houston, talked about the global race for materials and applications in the superconductivity arena. Dr. Michael Uenoohara, senior executive vice president of NEC Corporation, Kanagawa, Japan, presented the Japanese approach to the internationalization of advanced computer technology and telecommunications. Harold P. Furth, PhD, director of the Plasma Physics Laboratory at Princeton University, explored the international development of fusion power and its potential for the world energy supply in the twenty-first century.

Dr. Jose Jaz, consultant to the director-general of UNESCO and scientific director of the International Biomedical Institute in Bari, Italy, explained the growing role UNESCO is playing in global interdependent science. Nobel Laureate James D. Watson, PhD, director of Cold Springs Harbor Laboratory in New York and associate director of the National Institutes of Health, talked about mapping the genome. Academician Roald Z. Sagdeev, of the USSR, and Dr. Norman F. Ness, president of the Bartol Research Laboratory at the University of Delaware, spoke about East-West cooperation in the aerospace sciences.

Nobel Laureate and Past Chairman of the Nobel Foundation Professor Sune Bergstrom presented the challenge of promoting research globalization for health.

Dr. James Gustave Speth, president of the World Resources Institute in Washington, DC, addressed the environmental sciences. He talked about global implications of atmospheric changes which have placed the planet at high risk.

Lawrence W. Klein, PhD, Nobel Laureate and professor of economics and finance at the University of Pennsylvania, examined the roles of science, medicine, and technology in an interdependent global economy. Dr. Joshua Lederberg, Nobel Laureate and president of Rockefeller University in New York City, presented an agenda for scientific interdependence.

The conference concluded with a session on the question, “Where do we go from here?”

At least one outcome of the conference, the establishment of the Philadelphia Initiative, is in place. It is a program on global interdependence in three areas: health and medicine, environmental science, and computer networking.
health and other general topics than are featured in scientific journals. It will include essays of opinion and articles by international leaders in the medical profession.

What has glasnost done?
Both the Soviet and American physicians applauded the recent moves toward openness by the Soviet government. "Glasnost has made all the information in the world available to us," Dr. Panina said. "We can now speak the common language. The new openness will increase the quality of our medical education and boost the support given to Soviet medical science. Already investment in Soviet science is up two-fold."

"Glasnost has had a tremendous effect on world relations," Dr. Jones said. "Anyone who says that glasnost isn't for real has to be hiding from the obvious. Who would have predicted all the things that have gone on in the Soviet Union, Poland, East Germany, and Czechoslovakia? Glasnost has opened the way for eastern governments to admit their own shortcomings. It's a real opportunity for all of us and we would be fools not to try to take full advantage of this to reduce the arms race."

Soviet medicine
The Soviet Union has more physicians than any other country. In 1980, there were 1 million active physicians in the USSR, as compared to 433,600 in the United States. In 1980, for every 10,000 Soviets there were 38 physicians, almost double the 19.3 U.S. physicians per 10,000 population.

The Soviet visitors were impressed with the medical technology and quality of health care available in the United States, but criticized the cost and accessibility of this care. In the Soviet Union, health care is provided free of charge to all citizens whenever needed. Their major criticisms of Soviet medicine were the lack of diagnostic equipment and shortages of supplies, especially disposable items.

Another difference between Soviet and American medicine is in quality and utilization review. In the USSR, hospital quality review commissions work only when a mistake or misunderstanding has been reported, Dr. Panina said. Frequently, an unsatisfied patient or family will make a report. The usual discipline is for the physician to pay a disabled patient's pension. In more serious cases, where a court determines malpractice, the physician can go to jail.

On the other side, Soviet utilization review committees work continually. Physicians, like most Soviet workers, have quotas. However, physician quotas have both a maximum and a minimum. These ranges vary according to specialty, Dr. Panina said. For instance, in hematology, Dr. Panina must treat no more than 15 hospitalized patients per day. She said the quotas are set reasonably, with physician input, to assure adequate patient care.

One way the Soviets work to assure better health for their citizens is by emphasizing preventive medicine. Free care and ease of access to physicians encourage Soviet citizens to make regular visits to their doctors. The average Soviet will visit his doctor 14 times in one year; in the U.S., the annual visitation rate is six times a year. As an added step in preventive care, workers are rewarded with trips to sanatoriums, or health resorts where they can rest, relax, and be taken care of.

Problem areas
While the Soviet Union is known for having an excellent model of emergency preparedness, the Soviet physicians acknowledged that their system needs some revisions. Dr. Leparsky said that the Chernobyl and Armenia disasters and several recent railroad explosions have taught the Soviets that their system is "still insufficient." He said that revisions to the system are under deliberation and that a new journal, Medicine of Catastrophes, is addressing this need. He thanked the Americans for their help in the Soviet disasters and invited American input in their deliberations.

The Soviet Union also must deal with threats to public health just as the United States does. In Russia, the major threats are abortion and alcoholism. Nearly a quarter of Soviet women will have an abortion sometime in their reproductive lifetime. Those who do will average six abortions, 10 times more than women in the U.S. Dr. Panina agreed that the abortion rate is high. Part of the problem, she said, is a shortage of effective contraceptive drugs.

Alcoholism poses perhaps the greatest threat to the well-being of Soviet citizens. A disproportionate number of Soviet men die in their thirties, forties, and fifties, in large part due to excessive intake of alcohol. The average Soviet will drink eight liters of vodka each year. More than a quarter of a Soviet family's income is spent on alcohol. Alcoholism trails only heart disease and cancer as a leading cause of death.

Training, education
The medical education processes in the USSR and the United States are fairly similar. After college, an aspiring physician in the Soviet Union attends six years of medical school and completes a one-year internship. Following these "obligatory" years, Dr. Panina explained, physicians can choose how and where they will spend their two-year residency and three-year fellowship.

To keep abreast of activities in their specialties, physicians in the Soviet Union join scientific societies, similar to our specialty societies. Members exchange opinions and share findings from investigations and experiments. Dr. Panina said the meetings are very educational.

International relations
While exchanging glimpses of their medical systems, the Soviet and American physicians were also building personal relations and practicing citizen diplomacy. "Citizen diplomacy is one of the most powerful methods to use in building better understanding and an improved climate between different nations," Dr. Jones said.

Dr. Leparsky agreed. "In establishing personal contacts we can overcome superstitions and mutual misunderstandings," he said. He also advocates that governments work together to establish internationally a mutually beneficial economic equilibrium. Public health and medicine provide many areas in which nations can cooperate, he said. He singled out specific areas in which individual efforts could help open relations: environmental pollution, especially nuclear pollution, alcohol and drug abuse, medical technology, medical education, medical and scientific publications, and family planning and child care.

A good example of such an equilibrium is in the relationship between the United States and Japan. Dr. Jones said. Just 50 years ago, relations between Japan and the United States were contentious, at best. The attack on Pearl Harbor is proof of that. But today, the
economies of the U.S. and Japan are closely tied, making an attack unlikely. "The important thing to remember," Dr. Jones said, "is that we're all a part of the global family. While we have differences, we have more things in common. Most important, we have to survive on the common planet."

One outcome of the exchange programs sponsored by IPPNW, PSR, and other groups is that participants get a chance to share their mutual concerns with the public. Dr. Jones said, "In talking with other doctors, the press, and the American people, the Soviets got the chance to come across as human beings. Medicine, in this case, was only the vehicle that brought us together."

**Family effort**

Building and improving international relations is something everyone should be concerned with and involved in, Dr. Jones said. Even children are concerned with the possibility of a nuclear exchange. In a study several years ago, children were asked what worried them the most. The top two concerns were the loss of a parent and nuclear war.

One of the obstacles to motivating the public to action is fear, coupled with a feeling of helplessness. "People don't like to think about it," Dr. Jones said. "Nuclear war is such a scary subject that people, when they feel they can't do anything about it, tend to suppress it. We're trying to teach people that they can do something about it. They can write to their Congressmen and express their concerns. Most people would like the testing of nuclear weapons to stop, but unfortunately our government so far has been nonresponsive. Even the Soviets have mentioned the irony in that."

Dr. Jones encourages physicians in particular to get involved in the situation. "One of the strengths of the physician movement is that people tend to look up to physicians and seek their opinions," Dr. Jones said. "We need to be knowledgeable and then express our opinions."

He outlined several ways physicians can become more active. "First, we physicians should read about the issues and become educated. Second, we should be outspoken about nuclear war as our greatest public health problem because of what it would do if it ever happened and because it takes resources away from other important needs. Third, we can be political. We can write letters and talk to patients and friends."

"It is important to note what national security really is. You can't wrap yourself in a plutonium security blanket. You're not going to be secure with inequities, homelessness, AIDS, and an uneducated population. National security involves far more than weapons. It involves health care, education, and a livable environment. The dollars spent on weapons are dollars that we're not spending on true national security. The United States Government spends twice as much on the research and development of weapons as on all other research put together."

"History teaches us that war and international strife go back to the beginnings of humankind," Dr. Jones said. "We can't expect international relations today suddenly to be perfect. They probably never will be. But it is crucial for our survival that we work toward a greater tolerance of one another."

Dr. Jones said we must be in it for the long run. "You never know when you're going to make great progress. It's important to never give up."

Dr. Leparsky said, "It's just a matter of time."
A VISIT TO THE SOVIET UNION

Arno Vosk, MD

Last May I was privileged to be a member of the first official delegation of American emergency physicians to visit our counterparts in the Soviet Union. Of the 20 in our delegation, about half were physicians, and the balance paramedics, nurses, and administrators in the field of emergency medical services.

Our principal host was the Sklifosovsky Institute of Emergency Medicine, Moscow’s largest receiving center for emergency and critical care. The Dzhenalidze Institute of Emergency Medicine in Leningrad was another important destination. We also made brief visits to Pyatigorsk, a health resort in the Caucasus mountains, and Tbilisi, the capital city of Soviet Georgia in the southern part of the USSR.

A 10-day trip is hardly enough to get even a superficial impression in a country that covers one-sixth of the world’s dry land, stretches across 11 time zones, and encompasses over a hundred different nationalities in its population of 290,000,000 people. We did, however, learn something of the way emergency medical care is delivered in the cities of the Soviet Union. We also gained some very strong impressions concerning the importance of this kind of exchange with a country that most Americans consider a “potential enemy.”

It is easy for Americans to fall into an “us vs. them” attitude in dealing with the USSR. Before I left I received comments along the lines of: “You know, you will find that Russian medicine is pretty primitive—at least 30 years behind ours!” It seemed important for many individuals to believe that everything in the Soviet Union was worse than in the United States. Our group decided to approach our Soviet counterparts in a somewhat different manner.

Knowing that we were speaking to physicians who themselves either had worked in Armenia after the December 1988 earthquake, or had cared for some of the most badly injured victims of that tragedy who were evacuated to Moscow, we expressed both our sympathy for their country’s loss and admiration for the medical effort mounted in response to the catastrophe. Beyond this, we knew that the pathophysiology of trauma and disease is basically the same everywhere. We proceeded on the assumption that the Soviet physicians were taking part in the same struggle, and against the same enemies, that we were; that is, that their true enemies, like ours, were human illness and suffering.

Emergency trauma service

All over the USSR, you dial “03” to summon an ambulance (“01” is fire and “02” police). In Moscow, when you call “03” you immediately speak to a physician, probably a woman (60 percent of Soviet physicians are women), at the central dispatch center, who will send out either a general or a special ambulance, depending on the nature of the problem. Moscow’s dispatchers sit in a big, brightly lit wood-paneled room in front of computer terminals. They can call up on their screens the location of all the ambulances dispatched from 40 stations throughout the city.

What comes in response to your call is a little white van, about the size of a Volkswagon bus, with a red stripe along the side; bearing the legend “Skaraya Meditsinskaya Pomoisch,” which can be translated as either “First Aid” or “Emergency Medical Care.” It carries a doctor—usually the equivalent of an intern—a driver, and a varying amount of equipment. These little vans are ubiquitous throughout the USSR. They have a flashing blue light on top of the cab, and I never heard one use a siren.

A comparatively new development in
Their true enemies, like ours, were human illness and suffering.

fact that for most patients the first steps of physician diagnosis and treatment have already been accomplished by the time they roll up to the hospital door. However, the Soviet doctors expressed considerable interest in our paramedic system, and were curious to learn how we trained nonphysicians to do certain jobs they normally expect to see done by doctors. We explained to them that the concept of paramedics in the U.S. was in part originally based on the Soviet “feldshers,” nonphysicians who were trained to provide basic medical care in remote and underserved areas of the USSR.

Soviet hospitals
How did the facilities we saw in the USSR compare to those we are used to here? Most of the rooms in which patients were cared for appeared Spartan compared to the decor of our newer hospitals. On the other hand, nearly every room had bright natural light, either from large windows or skylights—a welcome sight for one accustomed to working in the windowless environment of a typical U.S. emergency room.

The Soviet institutes appeared to have most of the technology found in the U.S., but compared to them our hospitals seem very wealthy. In other words, where we might have 10 monitor-defibrillators, they have one. They do not use all the disposable items that we do, and several physicians we talked with expressed a strong desire to have them. The recent episodes involving transmission of AIDS among infants in the southern part of Russia illustrated this problem in a tragic fashion. We were told that the few disposable syringes presently used in the Soviet Union must all be imported from a factory in Czechoslovakia, although a new facility for manufacturing them is presently under construction in Russia.

Skills and techniques
Comparing the clinical skills of their physicians to ours is of course very difficult. There is not only the barrier of language, but also some difference in technologies. Because we visited two of the Soviet Union’s premier institutes, it would be hard to generalize from what we saw there to the rest of the country. It appeared to me that, in intelligence and clinical knowledge, the Soviet physicians we met were our equals. Some of their methods differed from what we are accustomed to, but in the brief period of time we had there was no way for us to judge the value of their practices as compared to ours.

During one conference a Leningrad researcher outlined a technique in which the blood of a septic patient, in a set-up analogous to hemodialysis, is purged through a freshly-harvested porcine spleen in order to supplement compromised host defenses. Studies of this technique, he said, have shown that it can reduce mortality from 40 percent to 25 percent in this group of very sick patients.

In Moscow’s Skilisovsky Institute, patients with serious infections are commonly treated via “endolympathic therapy.” A microscope is used to introduce a cannula into a lymphatic vessel, and drugs are delivered directly into the lymphatic system. Why this route should be more effective than the intravenous one did not seem immediately obvious to us, but we had no opportunity to learn about the technique in detail, or see any of the studies supporting its use that have been published in the Soviet medical literature.

The head of the Moscow ambulance services mentioned to us the use of electrotherapy and magneto-therapy for relieving the pain of myocardial infarction. These were only a few of the intriguing glimpses we got of Soviet methods that are relatively unknown in the U.S. Some
of these techniques may seem strange to us; but who is to say how effective they really are? Many of the things we American doctors do every day would have seemed bizarre 50 years ago, and doubtless many of the things we currently esteem will be laughed at in the future. Certainly, a knee-jerk response that just because the Soviets are doing these things they must be wrong does not seem appropriate.

**Personally speaking**

Our treatment by the Soviet physicians was without exception kind and hospitable. They appeared eager to talk to us, and eager to hear what we had to say. Language was a problem. I was the only member of our delegation who spoke any Russian, having made a desperate effort in the months before the trip to revive what I had learned more than two decades ago in college. The Soviets, who study languages much more intensely in school than we do, are fortunately accustomed to this deficiency in American visitors. Those among their physicians who knew English were brought to the fore, and nonphysician interpreters were supplied when physicians were not available.

They were rather frank in comparing their lives and the system in which they practice medicine with what they knew of ours. Their income is much less than American physicians'. The basic salary for a doctor just finishing training is 120 rubles, or about $200, per month. Seniority and other factors can increase this base. Most of the doctors we met were earning 200 rubles ($330) or more. While most households have more than one income, it seems clear that Soviet physicians do not generally enjoy the same material standard of living that most of their American colleagues do.

There is more to the picture, however. Rent in the cities is fixed at one-tenth of whatever one's income is, so that a person earning 200 rubles pays 20 rubles per month for his apartment, electricity and heat included. Medical care is free. The standard fare on public transportation in the cities is five kopeks (eight cents). Malpractice suits are unheard-of. Business costs connected with medical practice are nonexistent. On the other hand, a subcompact car costs 3,000 rubles, and a larger compact 7,000. Anyone who visits the USSR quickly learns that, in addition to what is official, money changes hands in many other ways, but I would not presume to consider myself an expert on this topic.

Does the profession of medicine carry the same prestige in the USSR that it does in the U.S.? Workers in skilled trades, like construction or metal work, earn considerably more than doctors. This is because Soviet government policy offers financial incentives to encourage people to enter those occupations in which there is a particular need or shortage. Soviet doctors expressed discontent to us at their level of income. Yet, in proportion to population, many more young people in the USSR choose to study medicine (and more places in medical academies are available) than in the U.S. The only explanation for this can be that for the Soviets the intangible rewards of being a physician are still generally considered important enough to motivate people to join the profession. I did get a definite impression that many of the physicians we met considered research more prestigious than clinical practice, and that advancement of one's career in the big institutes required at least part-time involvement in research.

**Historical perspective on peace**

It is said that it is impossible even to attempt to understand the Soviet Union without knowing its history. Certainly, as a nation, the Soviet people have suffered in ways that we Americans (at least white Americans) can barely begin to comprehend. In this century alone, their country has been invaded three times. In World War I, two million Russians died (as compared with 126,000 Americans). The actual Soviet Revolution of 1917 did not produce a great number of casualties, but during the Civil War and famines that followed from 1918 to 1920, it is estimated that as many as 20 million people lost their lives. During this period, the fledgling Soviet Union was invaded by armies from 16 different nations, including the United States: several thousand troops sent by Woodrow Wilson occupied the Siberian cities of Archangel and Vladivostock.

In the German invasion of World War II, 20 million Soviet people, including soldiers and civilians, died. In the city of Leningrad, under siege for three years from 1941 through 1943, one million out of the city's population of three million died, 500,000 by starvation. Two-thirds of the Soviet Union's industrial capacity and one-third of its total national wealth were destroyed.

Fresh flowers appear every day on the war memorials in every Soviet city. They aren't put there by the government. Countless "babushkas," solitary old women encountered everywhere in the USSR, are an unceasing reminder of an entire generation of young men lost in World War II. At the same time, the rhetoric of peace is something that springs easily from the lips of Russians greeting American visitors, and I, for one, believe that this is genuine. The Soviets are acutely conscious of the constant threat of nuclear war hanging over their heads. Thus to them, as to us, meetings between Soviets and Americans are fraught with significance.

On discovering that we were receptive, Soviet physicians extended themselves to be friendly to us. A physiological researcher at Skifosovskiy who was studying medical English, upon learning of my interest in Russian, presented me with a big Russian-English medical dictionary after we had talked for only a few minutes. The head of the cardiology department of Leningrad's Dzenalidzkie Institute, after having been up all the previous night with two critical patients, insisted on spending a day showing us around his city. One administrator, on bidding us goodbye, gave us an impromptu talk on the importance of the Soviet and American people getting to know each other to help increase the trust between our two nations and reduce the threat of nuclear war. He had tears in his eyes as he finished.

Approaching the Soviet physicians not as enemies or competitors, but as allies in a common struggle against disease and suffering, was something that for our group produced surprising results. Not that we can take all the credit: obviously our hosts were ready themselves to share openly their ideas with us.

In a country as huge and complex as the USSR, no individual can hope to understand more than a tiny part of the total picture. But our group's perceptions were intriguing and made us want to learn more. Most of us hope to go back some day. For our part, we told the Soviet doctors what we all know to be the truth: that in dealing with the illnesses and accidents that are the daily preoccupation of every physician, no one knows more than partial answers. Sharing information across national borders is one way in which we can all hope to learn.
Hahnemann University
Department of Medicine
GRAND ROUNDS—WEDNESDAYS
8:30 A.M.—9:30 A.M.

FEBRUARY 1990

February 7, 1990
SOMATOSTATIN, CARCINOID SYNDROME
John Oates, MD
Professor & Chairman
Department of Medicine
Vanderbilt University, Nashville, TN

February 14, 1990
LYME DISEASE
Steven Billstein, MD, MPH
Associate Professor of Medicine
Columbia Presbyterian Medical Center

February 21, 1990
NEOPLASTIC DISEASE ADVANCES IN THERAPY
Isadore Brodsky, MD
Professor of Medicine
Department of Neoplastic Diseases
Director, Institute of Cancer & Blood Diseases

February 28, 1990
CLINICAL PATHOLOGIC CONFERENCE
Chief Residents:
Michael DeAngelis, MD
Ana Nunez, MD
Ralph McKibben, MD
Matthew Sandler, MD

MARCH 1990

March 7, 1990
IMMUNE INTERVENTION IN TYPE I DIABETES MELLITUS
Jay S. Skylar, MD
Professor of Medicine
Director, Diabetes Mellitus
University of Miami, Miami, FL

March 14, 1990
LYME DISEASE
Steven Billstein, MD, MPH
Associate Professor of Medicine
Columbia Presbyterian Medical Center

March 21, 1990
NEOPLASTIC DISEASE ADVANCES IN THERAPY
Isadore Brodsky, MD
Professor of Medicine
Department of Neoplastic Diseases
Director, Institute of Cancer & Blood Diseases

March 28, 1990
DERMATOLOGIC TREATMENT WITH RETINOIDS AND CYCLOSPORINE
Richard L. Spielvogel, MD
Professor of Medicine and Dermatology
Director, Division of Dermatology

WEDNESDAYS
MEDICAL SEMINAR SERIES
8:30 A.M.—3:00 P.M.

MARCH 7, 1990

Diabetes Mellitus: Immune Mechanisms & Insulin Therapy Innovations
Hahnemann University Faculty
Jeffrey L. Miller, MD
Leslie L. Rose, MD
Guest Faculty
Jay S. Skylar, MD
University of Miami
Robert Tannenberg, MD
Georgetown University

MARCH 28, 1990

Dermatology: Treatment with Retinoids and Cyclosporine
Hahnemann University Faculty
Richard L. Spielvogel, MD
Eric C. Vonderheide, MD
Gary R. Kantor, MD
Guest Faculty
Cynthia Guzzo, MD
University of Pennsylvania School of Medicine
Henry H. Roenigk, MD
Northwestern University

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Presented by:
William S. Franki, MD
Professor of Medicine
Chairman, Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
Department of Medicine

Location:
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THE HOSPITAL AND THE IMPAIRED PHYSICIAN

In this article we discuss organizational and attitudinal barriers to the recognition and management of impairment in hospital medical staff, and recommend cooperation and sharing of expertise and resources by hospital, county, and state level impaired physician programs. Although physician impairment includes cognitive, emotional, and physical impairment as well as chemical abuse, more than 80 percent of cases seen in most state medical society programs are cases of chemical addiction, and that will be our prime concern in the present article. A follow-up article will outline the components of a hospital-based program for impaired physicians.

There is a prevalent myth that an impaired physician must "hit bottom" and ask for help before he/she can be helped. In fact, constructive coercion is usually necessary, and can be a beneficial impetus both to obtain treatment and to participate in the impaired physician program until the physician can maintain recovery on his/her own initiative. The myth of "MDism" implies that physicians, bright and educated to the point of being superhuman, are not prey to the illness of chemical addiction. Related false beliefs are that overcoming chemical impairment is simply a matter of morality, willpower and intellect, and since physicians are well endowed with all these traits, they should be able to overcome impairment on their own. The impaired physician is often a threat to other doctors' delusions of invincibility. Additionally, there is widespread hopelessness about recovery, despite the generally positive data on physician addicts treated under the auspices of impaired physician programs (Talbott).

There is a widespread belief that an impaired physician is doomed to personal, professional and economic ruin, and therefore should be avoided and ignored.

There is a fear of contamination by the impaired colleague. Colleagues who recognize chemical impairment usually feel too embarrassed, helpless, and afraid to confront the drug user. There is frequently a fear of retaliation in the form of a lawsuit or personal and professional retribution. It is convenient to believe that a colleague's addiction is "none of my business." As use of cocaine has gained acceptance and even prestige among young professionals, there is reluctance on their part to acknowledge recreational drug use as abnormal. Younger physicians frequently underestimate the social and legal implications of dabbling in drugs.

Many aspects of the hospital medical staff environment are inimical to the management of physician impairment on the medical staff level. Hospital medical staffs are conservative and anarchic by tradition, uniting only to lobby against unwanted developments. Individualism is so highly valued that medical staff members are reluctant to restrain or even evaluate a colleague in any way. It is better for a physician's practice financially, in this competitive era, to go with the flow than to stir up trouble with an impaired colleague. The traditional "us vs. them" stance makes it difficult for medical staff and administration to take a unified approach to the impaired physician. Physicians commonly adopt combative win/lose behaviors when stressed or faced with conflict. They tend to prefer quick, short term solutions instead of long term efforts (i.e., the acute illness versus the chronic illness model). These behaviors are not well suited to the delicate task of managing physician impairment.

Physicians may have as many as five or six relationships with their associated health care system (e.g., hospital, HMO, lab, urgicenter), which can make it diffi-
cult for any one organization to influence the doctor's behavior. On the other hand, the number of physicians in salaried staff positions (with decreased autonomy) versus private practice is increasing, making them more subject to colleagues' scrutiny. Physicians' duties are increasingly formally structured, and evaluated by increasingly higher standards. The interdependence of physicians with other professionals in the health care organization, which is necessary for an organizational approach to physician impairment, is felt by some physicians to demean the traditional power and authority of the medical staff.

Physicians identify more with their specialty than with organizations. The trend toward increasing specialization and technological complexity works toward fragmentation of power. The potential then exists for political struggles between specialized departments competing for organizational resources at a time when technical complexity demands increasing collaboration and cooperation. While this situation increases the difficulty of forming a workable impaired physician committee in a hospital medical staff, it also fosters interaction between different departments, making it less likely that an impaired colleague can remain hidden from his/her peers. A medical staff that is concerned about exposure of its members to the danger of practice with impaired physicians will develop an internal mechanism to assure adherence to the group standard of care. Confrontation of the impaired physician must carry the threat of expulsion from the group if help is rejected. Success in this endeavor establishes the validity of medical staff claims to autonomy.

There are also many organizational obstacles to the recognition of impairment in hospital medical staff and to referral for treatment when impairment is recognized. First, a problem with an impaired physician is a relatively infrequent occurrence for any one hospital. Second, the institution's well-being is perceived by the administration as being more important than that of the individual physician. This may manifest itself as an excessive emphasis on controlling physician behavior. Furthermore, impaired physicians can bring adverse publicity on the institution. Also, hospitals frequently try to take care of their own

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despite a lack of relevant expertise and resources. They believe they know best how to handle internal problems, and are overprotective of their medical staff. Excuses may be made, rationalizing unacceptable behavior by citing the stress the physician is under.

Other forms of denial include invoking medical illness or family problems as an explanation for unacceptable behavior. This puts the problem external to the impaired medical staff member, making it unnecessary for him/her to change his/her behavior. The problem may be relegated to the impaired physician's chief of service, who rarely is an expert in the management of addictive disorders. He/she may also dread confrontation because of his/her close working relationship with the impaired physician. The institution can take an exclusively administrative stance which is disciplinary and legalistic rather than advocate. Usually there is a significant underresponse to early signs of impairment. This might include minimization and oversimplification of the problem. Early signs of dysfunction are missed by a rigid focus on minimum practice standards. There is also a tendency in hospitals to use cookbook restricting policies with different physician impairment problems in different stages. The institution may have had an adverse experience with an impaired physician in the past, causing a rigid negative attitude toward impaired physicians.

Nevertheless, there are forces acting on the institution which favor the recognition and treatment of physician impairment. Increasing monitoring and accountability for the process and outcome of patient care is likely to bring to light substandard or irregular patterns of care which may be part of the syndrome of physician impairment. As the hospital environment becomes technologically more intense and the inpatient population sicker, there will be less room for an impaired physician to go undetected. With external competition threatening the organization's market share and revenue base, there is likely to be increasingly less tolerance for mistakes, inefficiency, or bad publicity due to physician impairment. Also, there is a growing demand by educated, assertive consumers for errorless medicine by perfect doctors. The public perception that medicine is failing to serve society and to police itself is leading to increasing pressure on the medical profession to do both. The era of the "conspiracy of silence" is rapidly coming to an end.

Despite these limitations, there is much that can be done at the hospital level to alleviate the problem of physician impairment. A hospital-based committee can be a vehicle for the primary prevention of physician impairment, gathering and disseminating information on topics relevant to the well-being of professionals. Relevant topics would include stress management, burnout prevention, signs and symptoms of impairment, career development, counseling services, and treatment programs for addictive disorders. Such a committee could be utilized to help identify organizational problems that contribute to stress on the medical staff. It may facilitate health promotion activities such as recreation and athletics. The committee may serve an educational function, sponsoring lectures or workshops on physician well-being and impairment. Its activities can foster collegiality among the medical staff, and between the medical staff and the administration.

A hospital committee can be a valuable resource for secondary prevention of physician impairment, too, acting to identify, make appropriate referrals, and give support to physicians experiencing problems. A properly functioning committee can provide an alternative to "voluntary" resignation and/or costly legal proceedings. Because few hospital programs have the funding, resources, or monitoring capabilities necessary for state-of-the-art functioning, it is advisable for them to make use of the resources of state and/or county professional advocacy programs. At the very least, the medical institution with a comprehensive program for impaired physicians can use the state medical society program to interface with legal entities such as the licensure boards. This is particularly advisable in a state such as Pennsylvania, with mandatory reporting of impaired physicians and a diversion program administered by the state medical society.

There are other significant advantages to an alliance with the state medical society-based impaired physician program. Early signs of impairment are often seen first outside the hospital, in the impaired physician's family, office, and community. Signs seen in the hospital setting are usually seen with later stage impairment. Intervention requires special training, and is preferably done before the physician reaches the later stages of impairment. In addition to taking referrals from physicians' families, colleagues, and hospital staff, the state impaired physician program receives referrals from office staff, the state board of medical licensure, impaired physician programs in other states, and other sources which are unlikely to report to a hospital-based program. The Physician Health Program of the Pennsylvania Medical Society offers resources and capabilities for rapid investigation, prompt intervention, triage, monitoring of progress during treatment and re-entry into medicine, establishing liaisons with and approval of the licensing authorities, as well as education to promote earlier recognition of impairment. These capabilities supplement the services of the hospital program as necessary and as desired by the hospital.

Ideally, hospital, county and state medical society programs complement one another. If a hospital linked with the state program is unsuccessful in encouraging an impaired physician to seek treatment, the state medical society may become involved and thereby assure that the physician does not evade the issue even if he/she changes his/her hospital affiliation or practice mode. Smaller hospitals might choose to let all functions be performed by a county or state program due to resource constraints and intimacy among small medical staffs. Hospitals and state and county medical societies can be effective allies in dispelling the dark cloud of physician impairment, to the benefit of the physician, his/her patients, the hospital, and the medical profession.
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Robert L. Brent, MD, PhD, chairman of the Pediatrics Department at Thomas Jefferson University Hospital and professor of anatomy and of radiology at Thomas Jefferson University (JMC), was granted the title of distinguished professor.

Murray R. Glickman, MD, Philadelphia, attending physician in Albert Einstein Medical Center's department of orthopaedic surgery and former president of the Pennsylvania Orthopaedic Society, served as coordinator of the society's fall meeting.

Milton A. Wohl, MD, interim chairman of the Department of Orthopaedics at Albert Einstein Medical Center, has been elected president of the Pfahler Foundation, Philadelphia. He has been a member of the Pennsylvania Medical Society's House of Delegates since 1972, and is a past president of the Philadelphia County Medical Society.

Mona Shangold, MD, Philadelphia, associate professor of obstetrics and gynecology at Hahnemann University, is director of the new Sports Gynecology and Women’s Life Cycle Center at Hahnemann. An expert in sports gynecology, she is co-author of *The Complete Sports Medicine Book for Women*.

Carl M. Mansfield, MD, Philadelphia, chairman of Thomas Jefferson University Hospital’s Department of Radiation Oncology and Nuclear Medicine, was honored recently by Gwynedd-Mercy College for his contributions in support of minority students in the allied health fields.

Mark D. Widome, MD, associate professor for the Department of Pediatrics, Milton S. Hershey Medical Center, Pennsylvania State University, has been elected to the board of directors of the National Safety Council.

William A. Buchheit, MD, professor and chairman, Department of Neurosurgery, Temple University Hospital, has been named one of the “outstanding medical specialists in the U.S.” by “Town and Country Magazine.”

Harold Isard, MD, and Sonia Stupniker, MD, Philadelphia, were presented the Maimonides Award by the Israel Bond organization. Both are on the staff of Albert Einstein Medical Center.

Cyril H. Wecht, MD, Pittsburgh, was appointed as a consultant in forensic pathology and legal medicine for the District of Colombia by Matthias I. Okoye, MD, chief medical examiner. Dr. Wecht is on the faculties of the University of Pittsburgh Schools of Medicine, Dentistry, and Public Health and at Duquesne University Schools of Law and Pharmacy.

Phyllis S. Buckwalter, MD, has been honored by the American Cancer Society’s Philadelphia Division with a “Volunteer Achievement Award,” recognizing her efforts on behalf of the organization. She is on the staffs of Abington Memorial and Holy Redeemer Hospitals.

Randall L. Braddock, MD, vice president for medical affairs of Moss Rehab, Inc., and John Whyte, MD, director of research at Moss Rehabilitation Hospital’s Drucker Brain Injury Center, testified before the National Institutes of Health endorsing the establishment of a Rehabilitation Medicine Center which would foster the development of a group of rehabilitation scientists.

John S. Bomalski, MD, an arthritis specialist from Exton, is the recipient of two research prizes. The Arthritis Foundation has named Dr. Bomalski an Arthritis Investigator for his research work in inflammation and arthritis. He is also a co-recipient of the Martha and Howard Holley Research Prize, given annually by the Southeastern Region of the American College of Rheumatology.

Layton McCurdy, MD, has been named president of the American Board of Psychiatry and Neurology (ABPN) for a one-year term. Dr. McCurdy is psychiatrist-in-chief at Pennsylvania Hospital, Philadelphia.

Dara G. Jamieson, MD, of Havertown, recently joined Temple University Hospital’s Department of Neurology as attending physician and researcher in cerebrovascular disease.

R. Barrett Noone, MD, of Haverford, was installed as president of the Plastic Surgery Educational Foundation, the national organization which directs all educational activities in the specialty. Dr. Noone is clinical associate professor of surgery at the University of Pennsylvania School of Medicine and is chief of plastic surgery at the Bryn Mawr Hospital and Lankenau Hospital.
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<tr>
<td>Dermatology</td>
<td>Florida</td>
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<td>ENT</td>
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<td>Family Practice</td>
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<td>Neurosurgery</td>
<td>Philadelphia</td>
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<td>OB/GYN</td>
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<td>Radiology</td>
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Case Western Reserve University School of Medicine, 1956; age 63, died November 19, 1989. Dr. Williams was a pediatrician.

Leonard R. Woodring, Wyomissing
Temple University School of Medicine, 1952; age 66. Dr. Woodring was a general practitioner.

Allen N. Bracher, York
University of Oregon School of Medicine, 1933; age 83, died November 25, 1989. Dr. Bracher was a general practitioner.

Joseph F. DeMarco, Philadelphia
Facolta di Medicina Chirurgia dell'University di Roma, 1957; age 60, died November 18, 1989. Dr. DeMarco was an obstetrician and gynecologist.

Ursula M. Huber, Broomall
University of Pennsylvania School of Medicine, 1937; age 77, died November 14, 1989. Dr. Huber was a general practitioner.

William D. Loose, Erie
University of Pennsylvania School of Medicine, 1942; age 73, died December 6, 1989. Dr. Loose was a thoracic surgeon.

William M. Tinsman, New Castle
University of Pittsburgh School of Medicine, 1947; age 68, died November 9, 1989. Dr. Tinsman was an internist.

B. Ralph Wayman, Jr., Morrisville
Jefferson Medical College, 1963; age 56, died October 17, 1989. Dr. Wayman was an internist.

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University of Barcelona School of Medicine, 1967; age 45. Dr. Antich was a child psychiatrist.

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University of Pennsylvania School of Medicine, 1941; age 75, died November 23, 1989. Dr. Atlee was a general surgeon.

Daniel Braslow, Newtown
Philadelphia College of Osteopathic Medicine, 1961; died April 4, 1989. Dr. Braslow was a general practitioner.

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Jefferson Medical College, 1912; age 100, died October 24, 1989. Dr. Clerf was a surgeon.

Rollin V. Davis, Jr., Pittsburgh
University of Pittsburgh School of Medicine, 1952; age 67. Dr. Davis was a general practitioner.

August H. Ehrlr, Erie
University of Michigan School of Medicine, 1932; age 89, died November 30, 1989. Dr. Ehrlr was a general practitioner.

Milton W. Golomb, Pittsburgh
University of Pittsburgh School of Medicine, 1930; age 83, died November 18, 1989. Dr. Golomb was an internist.

Gerald A. Goodman, Wyomissing
University of Pennsylvania School of Medicine, 1963; age 51, died November 28, 1989. Dr. Goodman was a radiologist.

Samuel B. Hadden, Wynnewood
University of Pennsylvania School of Medicine, 1924; age 89, died November 28, 1989. Dr. Hadden was a psychiatrist.

Lois M. Merkel, Mercer
Medical College of Pennsylvania, 1929; age 89, died October 31, 1989. Dr. Merkel was a pediatrician.

Edward R. Preininger, Ormond, FL.
University of Pittsburgh School of Medicine, 1934; age 84, died November 11, 1989. Dr. Preininger was a family practitioner.

Maurice M. Rothman, Philadelphia
University of Pennsylvania School of Medicine, 1921; age 93, died December 10, 1989. Dr. Rothman was a gastroenterologist.

John E. Scheid, Lower Burrell
Duke University School of Medicine, 1946; age 66, died November 29, 1989. Dr. Scheid was a general surgeon.

J. Monroe Thorington, Philadelphia
University of Pennsylvania School of Medicine, 1919; age 95, died November 27, 1989. Dr. Thorington was an ophthalmologist.

John T. Valenti, Wilkes-Barre
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OLD OFFICES CLOSED; NEW ONE OPENED

Donald E. Harrop, MD,

Because of the changes required under the new Scope of Work, we have tried to keep you posted on those items which will directly impact on physicians’ and hospitals’ practices and procedures. I believe it is also important for you to be advised of organizational changes which are taking place to accommodate the new requirements.

As reported in the December issue, KePROM has discontinued first level physician advisor review on-site at the hospitals. This was done to improve the review process through the use of a matching specialist at first level quality review; however, this also eliminated any further need to retain our field offices. Therefore, effective November 30, 1989, the Erie, Johnstown, Williamsport, and Avoca field offices were closed.

Another move which was made to comply with new HCFA requirements was the opening of a Rural Review Office. The purpose of this is to assure that urban physicians review urban physicians and rural physicians review rural physicians. An office was recently opened in Bloomsburg to handle first level review for all Pennsylvania hospitals classified by HCFA as rural hospitals.

As of January 1990, physicians may now schedule a time to discuss by telephone a pending quality concern with a KePROM physician advisor in the same manner as has been allowed for pending denials.

A number of changes also have been made in staff responsibilities. In addition to the Review Operations and Administrative Operations Divisions, a new Medical Affairs Division has been formed and will be the responsibility of the central medical director. Reporting to this director will be the director of review interventions as well as the associate medical directors.

Review Analysis and Communications Departments also have been established. The Communications Department will coordinate meetings with providers, medical staffs, county medical societies, etc., in addition to preparing and mailing informational material such as provider bulletins.

All of these changes have been made in an effort to improve the review process and to increase the efficiency and effectiveness of the organization.

\[ \text{Dr. Harrop is president of the Keystone Peer Review Organization and a past president of the Pennsylvania Medical Society. He is a family physician in Phoenixville.} \]

LIFE AFTER SECTION 89

Jeffrey B. Sansweet

If you have never heard of Section 89, then you can stop reading this article right now. For those of you who are aware of Section 89, there is good news: it has been repealed!

Included as part of the 1986 Tax Reform Act, Internal Revenue Code Section 89 set forth stringent and complicated nondiscrimination and documentation requirements for various fringe benefit plans. The intent behind Section 89 was to cut down on tax-free fringe benefits that were provided only to, or in much greater amounts for, the highly paid employees. However, the end result of the new rules in many cases was the elimination of fringe benefit programs by employers, as opposed to increasing the benefits provided to the “rank and file.”

In any event, Section 89 is gone. What does that mean for you, as a professional corporation? Generally, the rules regarding tax-free fringe benefits that were in effect prior to 1986 have been reinstated. As far as health insurance goes, that means there are no nondiscrimination rules or documentation requirements. Thus, for example, you could have family health insurance coverage for the physicians, and just individual coverage for all other employees. This would have been a problem under Section 89.

In addition, the medical expense reimbursement plan (“MERP”) rules of Code Section 105(h) have been reinstated. Under a MERP, employees are reimbursed for any medical, dental, optical, or prescription drug expenses that are not covered by insurance. Employees can be excluded from a MERP until they have worked three years, have attained age 25, and work at least 35 hours per week.

Under Section 89, the rules would have been reduced to a one-year wait, age 21, and 17-1/2 hours per week. However, the same dollar limit on annual reimbursements must apply to all employees. Also, a MERP must be set forth in writing.

Finally, Code Section 79(d) has been reinstated regarding group term-life insurance. You can provide up to $50,000 of tax-free life insurance per employee. The amount of insurance provided may vary according to the relative compensation of the employees.

If you have altered your fringe benefit plans in response to Section 89, you should contact your advisors and discuss reverting back to the previous benefits structure.

One unpleasant note in all of this relates to health plans. For years beginning in 1989, a Form 5500 will be required to be filed with the IRS for health plans, even if they are fully insured plans, such as Blue Cross/Blue Shield. This requirement was not repealed with Section 89. The initial reports are due by July 31, 1990.

\[ \text{Mr. Sansweet is an attorney associated with Kalogridis Law Associates, Ltd. and Professional Practice Consulting, Inc., of Wayne.} \]
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MEDICARE RULE UPDATE

Arlen Specter

Knowing of your interest in the Health Care Financing Administration’s proposed rule to deny Medicare payments for substandard quality care, I wanted to bring you up-to-date on this issue.

As you know, the Health Care Financing Administration (HCFA) has issued proposed regulations providing authority to the Peer Review Organizations (PROs) to deny Medicare payments to physicians or hospitals for services that are found to be of substandard quality. I am advised that this denial of payment would be based on a review conducted by the PROs.

In light of the concerns raised by physicians and health care providers in Pennsylvania, on May 11, 1989, I wrote to Louis B. Hayes, acting administrator of HCFA, informing him of these concerns. I also requested that he consider the potential effects of this proposed rule on the health care providers, as well as the patients.

Currently, these regulations remain in the proposal stage. The Health Care Financing Administration has informed me that, in an effort to ensure that the regulations reflect a sensitivity to all relevant points of view, they continue to analyze the comments which have been received. According to HCFA, these regulations also must be approved by the Department of Health and Human Services, (HHS), the Surgeon General’s Office, and the Office of Management and Budget (OMB). If review of the proposals leads HCFA to make substantial revisions, I have been informed that HCFA would be required to initiate a new review process and provide any revisions as newly proposed regulations.

Be assured that I will keep your views in mind should the Senate consider this important issue. Please continue to keep me apprised of your views on this or any other matter of concern.

KNOCKED-OUT TEETH CAN BE SAVED

Paul R. Krasner, DDS

Tooth avulsion (knocked-out tooth) is a widespread and serious problem. Many tooth avulsions occur at school or during school related activities such as sports. In the United States more than 2 million teeth are knocked out each year. One in every 200 children will suffer from this injury and face a lifetime of dental treatment bills. Most of these avulsed teeth are needlessly lost; dental research has developed methods and technologies for saving almost all of them.

The American Dental Association has recommended a treatment for an avulsed tooth based on extensive dental research. This treatment consists of: (1) replantation of the avulsed tooth into its socket within 30 minutes of the accident; (2) splinting of it to the adjacent teeth; and (3) follow-up root canal treatment.

The cost of replanting a tooth and the follow-up dental treatment is about $350 vs. $1,500 to $10,000 over a lifetime for
the necessary replacement fixed bridge-work. In addition, a replanted tooth looks and feels like a natural tooth. Artificial replacements for a missing front tooth often have compromised esthetics and sensations.

Often replanting an avulsed tooth immediately is not possible. Either the accident victim has other, more serious injuries that require immediate attention, the person at the accident scene does not feel competent to replant it, or the victim is in pain, unconscious, and/or uncooperative.

If the tooth is not replanted immediately, then it must be stored in a nurturing environment until a dentist can be located. After just a few minutes outside of the mouth, the cells of the tooth begin to degenerate and even if the tooth is replanted it will be rejected by the body.

The key to longterm success for replanted avulsed teeth is to prevent damage to the cells of the tooth root. Care must be exercised to avoid crushing these cells or allowing them to dry out. Crushing can be avoided by picking the tooth up by its enamel and avoiding the root. Incidences of crushing also can be reduced by placing the avulsed tooth in a soft container. Holding an avulsed tooth in a glass container should be avoided. The container should have a securely fitting top to prevent the preserving medium from spilling out during transportation.

The second way to prevent damage to the tooth is to store it in one of several types of preserving media. The best storage medium is a pH balanced buffered cell preserving fluid. This fluid contains ingredients such as glucose, calcium, and magnesium, which nurture the tooth cells. It is sterile and does not permit bacteria to grow on the tooth. It has been found to preserve and rejuvenate the tooth for up to 12 hours. The fluid is packaged in a device called the Emergency Tooth Preserving System, which contains a specially engineered basket and netting that protects the tooth cells from being crushed during transportation.

It is not sufficient for the solution to be merely wet; it also must be compatible with the cells of the tooth. Other media that can be used to preserve avulsed teeth are: milk, sterile saline, and saliva. Milk is an acceptable storage medium, but it must be whole milk, not skimmed or powdered, and it must be kept refrigerated. If the milk is sour or becomes sour (for example, on a hot day), it will become damaging to the avulsed tooth. Thus, milk cannot be kept in pre-made containers and carried in team sports bags.

Saliva also can be used to store the tooth, but it has some serious drawbacks. First, it becomes damagifying to the tooth after one hour. Second, the tooth can be swallowed if it is placed in the mouth of the victim for storage and the victim is hysterical or unconscious.

Sterile saline is another storage medium, but it preserves the tooth for only two hours and is not usually available at an accident scene.

The use of water should be avoided if at all possible. Water is incompatible with the tooth and is as damaging as using tissues. The avulsed tooth should never be wrapped in drying media such as tissues or cloth.

The tooth and the victim should be brought to a dentist as quickly as possible to receive proper treatment. If these steps are followed more than 90 percent of all avulsed teeth can be retained for life.
HIV TRANSMISSION! 
POTENTIAL RISKS 
FOR PROVIDERS

George J. Pazin, MD

Transmission of human immunodeficiency virus (HIV) is of such overriding importance that the fourth, fifth, and sixth installments of this series have dealt with spread and acquisition of HIV, first in general terms and then in relation to homosexual and heterosexual settings. With the considerable national attention to spread of HIV in the health care setting in the past few months, it is appropriate that we direct our attention to issues of health care worker risks in this installment.

Do you recall who Lorraine Day is? No, I am not referring to Lorraine Day, the Hollywood star who married Leo Durocher, former manager of the N.Y. Giants baseball team. I'll give you a clue. You might know her if you were an orthopedic surgeon. Answer? She is the former chief of orthopedic surgery at San Francisco General Hospital. Former, because she recently resigned in protest to the ways the threat of HIV to health-care providers is being handled in that institution. Perhaps you heard Dr. Day on 60 Minutes (September 24, 1989) or Nightline or read about her concerns in Newsweek (p. 82–3, Nov. 20, 1989 issue). The publicity that has been generated is troublesome to say the least.

What is the background information? How many health-care workers have developed AIDS? How many have had other identifiable risk behaviors? Is providing health care risky business? How many accidents in the health-care setting have led to infection? What is the risk per accidental exposure? What should be done when an accidental exposure occurs? Does zidovudine (ZDV, Retrovir, formerly called AZT) provide any protection following a needle stick accident? Do aerosols constitute a risk? How do we know? Clearly, there are many specific questions that need to be addressed—openly, truthfully and sensibly. AIDSpeak will not fly here. We need some AIDSense to have credibility, especially with respect to our surgical colleagues.

How many health-care providers have developed AIDS? The often presented answer is 14–18, but that actually refers to health-care providers who have had a documented accidental exposure with blood of an HIV-infected patient and have proceeded to develop antibodies to HIV, indicating acquisition of HIV infection in association with a specific accident. The answer to the introductory question is, “More than 2,500 health-care providers have developed AIDS,” but that answer is misleading because 95 percent of health-care workers with AIDS have other risky behaviors that probably account for their having acquired the infection. Still, after careful investigation, somewhere between 45 (fully investigated) and 140 (incomplete or partially investigated) health-care workers with AIDS have not had other risky behaviors identified.

Thus, health-care workers who have risky behaviors in their private lives are probably more likely to get infected outside of work than on the job. On the other hand, many providers of health-care are not practicing risky behaviors in their private lives and a relatively small, but slowly increasing, number are developing AIDS. Therefore, it is not unreasonable for these health-care providers to be concerned about potential risks in the medical workplace.

Do health-care providers account for a disproportionately large number of persons with AIDS? No. Approximately 6.8 million workers or 5–6 percent of the national work force are health-care providers and approximately 5–6 percent of reported persons with AIDS on whom there are occupational histories are health-care providers. Interestingly, approximately 5 percent of persons with
AIDS have no identifiable risky behaviors and approximately 5 percent of health-care providers with AIDS have no identifiable risky behaviors. Thus, at this time, health care providers with AIDS are not accounting for a disproportionate number or appropriately large percentage of persons with AIDS nor are health-care workers with AIDS and no identifiable risky behaviors. Although some health-care workers with AIDS and no identifiable risky behaviors probably have not admitted risky behaviors in their private lives, it is not appropriate to ignore these cases and give the impression that on-the-job risks in the medical workplace do not exist or are not significant.

In any case, 18-25 health-care workers have been documented to have been infected in association with accidents and 45-140 health-care providers have developed AIDS with no identifiable risky behaviors. If we make the not unreasonable assumption that 10-15 persons have been infected with HIV for every case of AIDS, it follows that 450-1,000 or more health-care workers may have been infected with HIV on-the-job to date. Fortunately, this is a small number when one considers that 6.8 million persons are employed in delivery of health care and health care workers have provided a tremendous amount of health-care for persons with AIDS over the past decade.

What is the risk of infection after a needle stick exposure? . . . after a mucosal exposure? In order to calculate this figure one must have a numerator of persons infected following exposure as well as a denominator for the number of persons exposed. An early compilation of seven studies with prospective follow-up showed three acquisitions among 770 persons with health-care exposures and a more recent update revealed six infections acquired after 1,600+ exposures. Thus, the ratio of infections to exposures seems to be holding steady at about one infection in 250-300 exposures—a reassuring number for those of us who rarely stick ourselves, but a worrisome number for those health-care providers who have occasion to puncture or cut themselves with contaminated needles or sharps. Clearly, there is a need to modify behavior in order to reduce punctures and cuts in relation to health-care delivery.

Permit me to digress for a paragraph in order to comment on an estimate of risk mentioned in Dr. Day's 60 Minutes interview. She said that someone else has calculated the risk of acquiring HIV during performance of surgery at 12 percent per year or nearly 50 percent in four years. I am not aware of how her source arrived at that number, but it seems grossly inflated to me. Perhaps the person multiplied 24 needlesticks on HIV-infected persons per year with a 0.5 percent (one acquisition per 200 exposures) likelihood of transmission to ar-
rived at the 12 percent per annum estimate. It would be truly regretful if any surgeon were so careless as to have 24 accidental needlesticks per year on HIV-infected persons. If this were common, I believe HIV-infections among health-care providers with no other identifiable risky behaviors would be much more apparent already even if one considered the delays for disease to become manifest after infection.

A recent article in the surgical literature surveyed surgeons in a high HIV prevalence area regarding needlestick injuries, and assuming 5 percent prevalence of HIV infection and one acquisition of HIV infection among 250 needlestick exposures, calculated 30-year cumulative infection rates of <1 percent for 50 percent of their surgeons, 1-2 percent for 25 percent, 2-6 percent for 15 percent and greater than 6 percent for 10 percent of the surgeons surveyed. Again, these calculations emphasize the need for some surgeons to modify their behaviors to reduce risks.

What about splashes onto mucosal membranes such as inside the mouth or onto open eyes? Thus far, prospective studies of more than 1,000 splash exposures have not documented transmission in this manner. On the other hand, three instances of transmission in this manner have been documented outside the prospective study setting. Thus it happens, but uncommonly. Interestingly, recognition of these three instances of transmission via splashes seems to have been the impetus to the development of the concept of universal precautions.

Finally, what about transmission by aerosols? The lack of acquisition of HIV by family members living with persons with AIDS in family-exposure studies and the lack of persons with AIDS and no identifiable risks other than only having lived with persons with HIV infection provide powerful circumstantial evidence that HIV does not spread through ordinary aerosols, which are generated during day-to-day living. But family studies do not address the question of transmission of HIV via bloody aerosols generated during high-speed drilling or cutting of bone or perhaps during procedures such as dermabrasion.

Fortunately, if we consider the observation that all body fluids, even blood, contain relatively little AIDS virus and the requirement for entry into the body and attachment of HIV to a cell containing the appropriate (CD4) receptor in order for infection to occur, it would appear that activities in which bloody aerosols are generated do not have a high likelihood of spreading the virus. However, it would seem to be sensible and reasonable to reduce the risk of mucosal exposure to bloody aerosols as much as possible. Physicians who ask for thoughtfully designed facial shields and even "spacesuit" helmets should not be ridiculed or labeled as alarmists for being concerned about low probability, but potentially highly dangerous, special medical situations.

Before concluding this installment, the question of zidovudine (ZDV, Retrovir, formerly AZT) preventive treatment after accidental exposures of health-care workers should be addressed. I am deeply disturbed that the controlled clinical investigation of the efficacy of prophylactic zidovudine has been abandoned because of non-cooperation by physicians. A "window of opportunity" has been closed and will probably never be re-opened. Instead, glib statements are being made that 24-hour hospital hotlines enable health-care workers to obtain prophylactic treatment with an anti-AIDS virus drug if the health-care worker decides to take it. This gives the misleading impression that this preventive "therapy" is likely to be effective and potential short-term and long-term side effects are minimal or almost nonexistent.

Careful review of studies of prophylactic zidovudine in animal models involving other retro-viruses or non-human primate models involving HIV reveals beneficial treatment effects, but does not show truly preventive or prophylactic effects even with early intervention. Offering zidovudine prophylactically despite the absence of supportive efficacy data in the prophylactic setting gives the misleading impression that it provides additional protection, which it may well not provide. Indeed, it may do nothing more than prolong the period of uncertainty following accidental exposures.

Clearly, avoidance of accidental exposures to HIV is strongly preferred to reliance on proven, hypothetical, speculative prophylactic treatment with a drug that involves DNA synthesis and may have as yet unrecognized long-term side effects. In my opinion, it is truly sad that we have not learned from historical precedents such as the unfortunate unproven use of diethylstilbesterol (DES) to reduce spontaneous abortions, which was both non-efficacious and apparently has led to vaginal malignancies in female offspring years later! Unproven expectations are leading to frequent use of a potentially toxic drug, which may also lead to a false sense of security. It is far better to emphasize and dwell on protective behaviors which reduce accidental exposures than to imply that we have safe, potentially efficacious, preventive treatment when in fact, there is no assurance of benefit and a real potential of unrecognized harm.

After careful review of the information regarding development of AIDS among health-care workers with no other identifiable risky behaviors (45-150 persons), the documentation of health-care workers who have become infected with HIV in association with the specific accidental exposures during health-care delivery (18-25 persons) and the apparent risk of one transmission per 250-300 needlestick or sharps exposures, and having an awareness that there are 6.8 million persons involved with delivery of health care, I conclude that health care delivery is relatively low risk behavior. Nevertheless, since acquisition of infection with HIV is an ALL-OR-NONE phenomenon, which occurs on single occasions and is "100 percent" for the health-care worker who is infected in the line of duty, it behooves us to practice universal personal precautions in order to minimize risks of transmission of HIV in the health-care setting. Furthermore, it is not unreasonable for health-care workers who avoid risky behaviors in their personal lives to employ careful precautions to reduce exposure to bloody aerosols in their professional activities.

Let's be honest. In today's world, it would be truly unfortunate to acquire HIV accidentally in the health-care setting. (See "When a house officer gets AIDS," Sept. 7, 1989, New England Journal of Medicine for a personal account.) All reasonable measures to avoid acquisition of HIV should be exercised continuously and carefully. On the other hand, to provide unproven prophylactic treatment with zidovudine after an exposure is of dubious value and may reduce the carefulness with which we avoid accidental inoculation with HIV in the health-care setting.
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Early spring fishing trip

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Great victories are rarely achieved by individuals acting alone. It is unity of effort which is bringing down the regimes of Eastern Europe. And unity will arm physicians for the struggles of the '90s.

Physicians working together: that was the premise behind the formation of PMSLIC 11 years ago. Abandoned by commercial carriers, physicians forged ahead to create their own solution to the professional liability crisis. The company they established honored the role of medical judgment in the insurance process... and stood staunchly with physicians in defending against frivolous claims.

Now, the field of conflict is widening—from county courtrooms to the halls of Congress. As unification with the AMA moves forward, PMSLIC-insured physicians face a historic opportunity, to join forces with their peers across the country, to fight the threatening inroads of government, and to preserve the integrity and independence of medical practice.

The stakes are high. The need for solidarity has never been more urgent. Since 1978, PMSLIC has been there when the physicians of Pennsylvania needed it. Now PMSLIC—and the profession itself—need you.

PMSLIC—Your liability insurance company.
Physicians should have received by March 5 the 1990 "Dear Doctor" letter from Pennsylvania Blue Shield identifying the many Medicare reimbursement and policy changes occurring this year. The letter is part of the annual Medicare carrier package that includes information regarding physicians' decisions whether to be "participating" or "non-participating" under Medicare. Also included is customary and prevailing charge data. Physicians have until March 31 to make their decisions for the period from April 1 through December 31, 1990. No action is required for those wishing to retain current status.

The Institute of Medicine (IOM) recommended March 5 that the federal government abandon the peer review organization program because it is "excessively adversarial and punitive." In its congressionally mandated report, the IOM proposed that PROs be replaced by Medicare quality review organizations which would be research- and education-oriented. The IOM concluded that PROs are unwieldy for providers, rigid, redundant, and heavy handed. The IOM believes the system should be based on analysis of scientific outcomes. In an unrelated action, the PMS Board ordered a cost effectiveness study of federally mandated peer review in Pennsylvania. The Board took the action after hearing that the Keystone Peer Review Organization has issued only four denials to date in the pre-procedural certification process.

New laws effective February 21 set stiffer restrictions on the dispensing of anabolic steroids. Persons who prescribe, dispense, or consume steroids for purposes of increasing muscle mass, strength, or weight gain can be penalized with up to five years' imprisonment and/or a $15,000 fine. Under the new laws, physicians must state the purpose for which anabolic steroids are being prescribed, school districts must establish regulations prohibiting steroid use, and the dangers of the drug's misuse must be part of existing drug and alcohol education programs.

The PMS Board of Trustees at its February meeting reaffirmed 1989 priorities for 1990. They are: opposition to any effort to link licensure to anything other than training and capability; liability tort reform; cost containment with quality assurance; membership; addictive drugs, alcohol, and AIDS education and information; medical care for the indigent; and development and expansion of internal and external communications efforts.

Robert R. Weiser, executive director of Keystone Peer Review Organization (KePRO), submitted his resignation to the KePRO Board of Directors, effective June 30, 1990. Weiser has been executive director since KePRO's inception four and one-half years ago. He has held positions at PMS since 1973, including assistant director of communications, manager of the co-op, and executive director of the Educational and Scientific Trust, and administrative vice president. A search committee has been appointed to fill the vacancy.

In a surprise move, James H. Sammons, MD, the AMA's executive vice president for the last 15 years, resigned February 9, a year before his planned departure. The Board of Trustees immediately named James S. Todd, MD, acting executive vice president. Dr. Todd, 59, has served as senior deputy executive vice president since 1985. Dr. Sammon's resignation is the latest development resulting from the public disclosure last fall that two financial decisions, made by Dr. Sammons in 1985 and 1987 and not reported to the board, had resulted in financial losses to the AMA. Dr. Sammons told the American Medical News that he resigned because "we were spending an absolutely incredible amount of time non-productively with these allegations and innuendos."
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**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and other information, FDA has classified the indications as follows: "Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy; benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy.

Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmyotics and/or low residue diets.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.
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William H. Mahood, MD

Dr. Mahood is chairman of the PMS Council on Medical Economics and a PMS delegate to the AMA House of Delegates. He is a gastroenterologist practicing in Abington.

In January's PENNSYLVANIA MEDICINE, AMA President Alan R. Nelson, MD, told why and how the AMA works. His answer to the question, "What does the AMA do for me?" described the value of some less-well-known, but vital, AMA projects. These projects, he said, are "simply the glue that binds us into an organization, that if it did not exist, we would have to create one." Here, from William H. Mahood, MD, is a sample of more of that "glue" to which Dr. Nelson referred. Dr. Mahood believes these AMA initiatives need to be remembered and weighed when members consider unification and/or their dues payment.

What does the AMA do for me?
Let me count the ways:

1. AMA succeeds in urging Congress to accept education instead of punitive action in PRO statutes:
   During the budget reconciliation process, Congress debated the "unwilling or unable" sanction provisions in the PRO statute. That statute currently contains a requirement that the office of the Inspector General in the Department of Health and Human Services (HHS) determines that the provider or practitioner has demonstrated an "unwillingness or lack of ability substantially to comply" with program obligations before imposing sanctions. The Inspector General had proposed elimination of this requirement. His proposed change was also supported by the Administration, the American Medical Peer Review Association, the American Association of Retired Persons and the Administrative Conference of the United States.
   The AMA opposed this change, favoring, instead, preservation of the language which emphasizes education rather than punitive action.
   The AMA did it and you won... but did you pay your dues?

2. AMA battles civil-monetary penalties:
   During these discussions, Congress also considered a compromise proposal to raise the civil monetary penalty to $7,500 from the current cost-of-service standard. The AMA fought against civil monetary penalties.
   The AMA did it and you won... did you pay your dues?

3. AMA fights to maintain physician control over development of practice parameters:
   Interest in parameters as a guide to assist physicians in clinical decision making continues to mount. Parameters are also receiving attention as a mechanism to improve quality of care, as are appropriate utilization and elimination of inappropriate costs.
   Since the first parameters were developed by a physicians' organization over 50 years ago, more than 25 physicians' organizations have produced several hundred parameters. Many of the parameters explicitly acknowledge their potential use in quality assurance; utilization review, and payment decisions. Currently, more than 35 physicians' organizations are engaged in developing parameters.
   The AMA's primary objective for parameters is to ensure that they are properly developed and implemented, so that patients receive appropriate, effective, and necessary medical care.
   We have established the AMA/Specialty Society Practice Parameters Committee (PPC) and Practice Parameter Forum which involve, at varying levels of participation, all medical specialty societies represented in the AMA House of Delegates and interested in participation.
   With the national medical specialty societies, the AMA has advised Congress that only physicians' organizations should develop parameters. The AMA maintains that these should allow an effective approach to assure appropriate utilization in place of recommended expenditure targets.
   AMA policy provides that in certain circumstances, parameters may specify that variations from the parameters are deemed by the preponderance of medical opinion to be inappropriate in any clinical situation. However, in most circumstances, variations from parameters should constitute only a signal for further peer to peer considerations relative to quality, utilization, or payment issues.
   The AMA is doing it! But did you pay your dues?
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In this space I have criticized the bureaucratic and regulatory “zapping” of doctors. Now I want to add some historical perspective and hope for the future.

Although doctors feel particularly stressed today, we are not the first to have our work made more difficult by regulatory intervention. History shows that other professions and industries have gone through the same experience: unions, the auto and steel industries, teachers, NASA, the airlines, and the defense industry, to name a few.

All have come under public and governmental scrutiny because of perceived excesses. Government routinely responds by more regulations and sanctions. But when the bashing phase has run its course, the chase turns to another quarry and the first one gets a reprieve.

Our troubles arise from the fact that health care consumes 11 to 12 percent of the Gross National Product. Someone, somewhere has decided that this is too high a price to pay, and that doctors and hospitals are to blame.

It’s not clear how that decision was reached, for no one really knows the true cost of care in this country. The data are too wide and varied; the study mechanisms are inadequate, and there are not enough health economists available. We can only assume that the 11-plus percent represents an extrapolation of ancient data. Yet we are stuck with the premise.

It is very simple to say, “You doctors and hospitals charge too much, and we’re going to make you stop.” Regardless of whatever restrictions government and insurance bring to bear on medicine, costs cannot go down. Regulations cost money—they don’t save it.

The best we can hope for is to slow the rate of annual cost increases. For our population is both growing and aging; technology seems able to expand infinitely, and people will always want to live longer and better lives.

We can expect more of the same bashing from bureaucracy, until delivery of patient care may become choked—but only up to a point. Given history, the choking lasts for a few years but does not result in asphyxiation. Before that happens, the choker will let go of one victim and set upon another. Meanwhile, patient care continues and the climate improves after the storm passes.

What can be done in the meantime? It’s imperative to maintain a rigorous response to the regulations and a firm attitude toward the regulators and legislators. The environment is like guerrilla warfare: many groups, agencies, shadow organizations, and single-issue folks are out there sniping at health providers. Occasionally we can collaborate with other groups, but ultimately we are left to look after our own interests.

To survive we need dedication, resolve, and financial commitment. Doctors must become politically knowledgeable; they must be willing to part with dollars to effect change; and they must espouse the good things they are doing, with no apologies. Through the Pennsylvania Medical Society and the American Medical Association, we can cultivate that knowledge, generosity, and pride, and use them to make things better.

In this era, we are no longer responsible for costs. The second opinion programs, HMOs and their cousins, PROs, Health Care Cost Containment Council, fourth parties, Joint Commission on Accreditation of Healthcare Organizations, health department—all have put into place programs to cut costs. It’s only fair that we allow them to deliver.
Now, KTI puts them all together in a special FREE report! Eight physicians and four medical office managers gathered recently to discuss the benefits and cautions of practice automation. KTI captured their observations, and is making them available to you in an eye-opening report.

Learn what automation can and cannot do. What to look for in a system. How it can affect office staff. What to expect from the company that sells you a system, and much more.

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You'll get a lot of answers from just a few minutes of reading.
It's what happens when people working together achieve results greater than the sum of their individual efforts. It's the reason the Pennsylvania Medical Society has now unified with the AMA.

In working together with the AMA and county societies, Pennsylvania physicians gain strength in the battle against threats to:
- physician autonomy,
- quality patient care, and
- the right of patients to select their own physicians.

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Health care consultant Lawrence S. Lewin will open the 1990 Leadership Conference of the Pennsylvania Medical Society with his perspective on the theme of the meeting, "Medicine in Transition."

Physician leaders from across Pennsylvania will gather at the Hershey Lodge and Convention Center May 1 and 2 to consider the implications of the transition facing the medical profession.

Lewin will speak at 1 p.m., Tuesday, May 1, at the opening session. He founded Lewin and Associates in 1970 and now serves as chairman of the Lewin/ICF Health and Income Group and as senior vice president and director of American Capital and Research Corporation, the parent company.

Lewin is an elected member of the National Academy of Sciences of the Institute of Medicine and chairs its study of the financing of drug abuse treatment.

Lewin is no stranger to Pennsylvania. His firm conducted the basic indigent care study commissioned by the state's Health Care Cost Containment Council, and was used as a consultant by the Pennsylvania Medical Society in its further study of that subject prior to preparation of its recommendations to the Council. Lewin earned an AB degree at Princeton's Woodrow Wilson School of Public and International Affairs and an MBA at the Harvard Business School.

William L. Kissick, MD, DrPH, also will speak Tuesday afternoon on the changing demographics of medical practice. Dr. Kissick is the George Seckel Pepper professor of public health and preventive medicine at the University of Pennsylvania School of Medicine, and chairman of the Governing Board of the Leonard Davis Institute of Health Economics at Penn, where he also holds professorships at the School of Nursing and the Wharton School. His appointment at Penn two decades ago to joint professorships in medicine and management established a national precedent. A diplomate of
A New Clinical Study For Drug Resistant Cancers.

Fox Chase Cancer Center is actively seeking patients for a one-year clinical trial to test the effectiveness of a compound that makes drug-resistant cancers more vulnerable to chemotherapy. All patients will receive chemotherapy with melphalan in addition to the chemotherapy sensitizing agent.

Pre-clinical data indicate that the treatment may be most effective in cancers commonly treated with alkylating agents or platinum-type compounds, e.g. ovarian, lung, breast, head and neck, as well as lymphomas and myelomas.

For more information on whether your patient can benefit from this trial, call 728-2983.
the American Board of Preventive Medicine, Dr. Kissick studied abroad extensively and is widely published in the fields of both medicine and management.

Hugh Scully, MD, past president of the Ontario Medical Association also will speak on Tuesday. He is expected to offer insights on the Canadian health care system. He is associate professor of surgery at the University of Toronto School of Medicine, deputy surgeon in chief at Toronto General Hospital, and deputy head of cardiovascular surgery.

In contrast, the AMA's special project to preserve the American health care system is the subject of an address by Lonnie R. Bristow, MD, an internist from San Pablo, CA, and member of the AMA Board of Trustees. The plan emphasizes Medicare and Medicaid reform, health insurance expansion, and government financial reforms. Its aim is to improve the cost effectiveness of the American system while maintaining its decentralized, pluralistic structure.

Audience participation in a talk show format will follow the major addresses and a panel of experts will field questions. Panel members will include Peter Braun, MD, Harvard School of Public Health; Bernie Patashnik, director, Division of Medical Services Payment, Health Care Financing Agency; and Thomas J. Dehn, MD, immediate past president, American Medical Peer Review Association. Philadelphia health law attorney Alice G. Gosfield will host this segment.

The second morning of the conference, Edward R. Annis, MD, will speak on the doctor/patient relationship. Workshops on risk management, dealing with KePRO, and stress management will follow.

PMS President J. Joseph Danyo, MD, will report to the Society's leaders as the finale of the conference on Wednesday, May 2, at noon.

Further information on the conference, which is open to all members, is available by calling 1-800-558-7823, and asking for Leadership Conference. The registration fee is $25.

**DR. DANYO TESTIFIES AGAINST 'MOM' RULES**

PMS President J. Joseph Danyo, MD, told the Senate Public Health and Welfare Committee that the proposed bill on doctors' Medicare fees would "place a chill over the entire Medicare program in Pennsylvania." In his February 7 testimony, Dr. Danyo likened HB 700, which would mandate that all Pennsylvania physicians double discount their fees to Medicare patients, to "using a chain saw to remove a thorn."

He warned that the bill would especially affect access to health care in rural areas. It would also further reduce the fees of primary care providers, exacerbating the problem of a shortage of new physicians in the areas of family practice and internal medicine.

"Ironically," Dr. Danyo said, "the vast majority of the bills this proposed legislation will affect are approved charges from family practitioners and internists, the very first line of defense for older Pennsylvanians and the specialties which are already in shortest supply."

Dr. Danyo asked the committee to allow doctors and other voluntary groups to work together, possibly establishing a voluntary patient telephone hotline to help with problem bills. He said HB 700 will benefit only a fraction of one percent of Medicare beneficiaries in Pennsylvania, could lessen physicians' office time with elderly patients, and will shift more health care costs to employers and workers.

He told the committee, "As of now, we are on a collision course for we disagree that there is a crisis. Enactment of this bill will be the crisis."

**STATE SOCIETY PROTESTS AUTO INSURANCE PLAN**

PMS was among strong voices of opposition heard from the medical community when Governor Casey's auto insurance rate cuts were approved February 7. J. Joseph Danyo, MD, PMS president, said, "Disregarding warnings from hospitals and doctors, the governor and the legislators have latched on to a slogan of '110 percent of Medicare' as an easy way to cut the cost of saving the lives of thousands of injured Pennsylvanians."

The measure caps medical costs that can be paid through auto insurance and reduces the amount of coverage drivers must maintain. Medical costs are capped at 110 percent of the Medicare reimbursement rates for all injuries except those requiring treatment at burn or trauma centers. Required medical coverage is reduced from $10,000 to $5,000 and insurance for lost wages, funeral benefits and uninsured motorists is optional.

The measure freezes current auto insurance premium rates and requires insurance companies to slice premiums by 10 percent for every policyholder and 22 percent for motorists who forgo their right to sue in all but the most serious cases. The new rates take effect July 1 and remain in effect for the next year.

Because they will lose money under the plan on policies in Pennsylvania, some insurance companies quickly prepared suits to stop the law from taking effect. The state's health care organizations are also considering means of opposition.

In criticizing the legislation Dr. Danyo said that PMS and other health care providers "have urged that a more reasonable and fair payment schedule be adopted which would still provide an incentive to hospitals and physicians to accept accident victims. Unfortunately, both the governor and legislative leaders have turned a deaf ear.

"The result is that the most critical and expensive kind of medical care...will now be reimbursed by a flawed payment schedule designed primarily to handle the chronic health problems of older Pennsylvanians."

**THOMAS JEFFERSON U. NAMES PRESIDENT ELECT**

Paul C. Brucker, MD, a pioneer and nationally recognized leader in family medicine, was elected president of Thomas Jefferson University on February 5.

Dr. Brucker, alumni professor and chairman of Jefferson's Department of Family Medicine since 1973, will succeed Lewis W. Blumle Jr., MD, president since 1977, who retires June 30. Dr. Brucker was chosen following a
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year-long search that evaluated nearly 100 aspirants. The search committee’s highest priority was a demonstrated ability to sustain and build upon the benchmark impact of what is called “the Blue Nile Era” at Jefferson.

Dr. Brucker said, “It is an honor to be elected president to follow Dr. Blue Nile and to inherit the spirit he brought and the success he inspired. I will certainly do all that I can to see that Jefferson continues to soar.”

Seventeen years ago, Joseph S. Gonnella, MD, senior vice president and dean of the college, persuaded Dr. Brucker to leave a successful private practice and join Jefferson to establish a new department of family medicine. Through Dr. Brucker’s leadership, the department has become first in the northeast and fifth in the nation in average percentage of graduates entering family practice residency programs.

James W. Stratton, vice chairman of the Jefferson board and chairman of the search committee, said, “First and foremost, the trustees see Paul Brucker as an eminently qualified leader. His deep familiarity with Jefferson and our people is an obvious asset, but he was elected because of his nationally recognized record of innovation in his field, the extraordinary depth and versatility of his clinical, teaching and administrative experience, and his thoughtful vision of the challenges and issues in health care which lie ahead.”

Dr. Brucker has chaired or served on every major college and hospital committee for education and patient care, as well as numerous special committees. He is active in numerous professional organizations: the American Academy of Family Physicians, the American Board of Family Practice, the American Board of Medical Specialties, Pennsylvania Academy of Family Physicians, Pennsylvania Medical Society, Philadelphia County Medical Society and the National Board of Medical Examiners. He served as president of the American Board of Family Practice in 1987-88.

Born in Philadelphia in 1931, Dr. Brucker earned a BS degree summa cum laude from Muhlenberg College and a medical degree from the University of Pennsylvania School of Medicine. He served his internship at Lankenau Hospital in Philadelphia, completed his residency in family medicine at Hunterdon Medical Center in Flemington, NJ, and took additional residency training in internal medicine at Lankenau.

Dr. Brucker and his wife of 32 years, Joan, reside in Ambler. Their two daughters and son are employed in healthcare professions in Philadelphia and Boston.

LEWIS TAKES CHARGE OF LICENSING BOARDS

Christopher A. Lewis, Pennsylvania’s new Secretary of the Commonwealth, says he will continue Governor Casey’s initiative to streamline and strengthen the professional licensing and disciplinary action process.

As secretary, Lewis heads the Department of State’s Bureau of Professional and Occupational Affairs, which serves as the administrative arm to the state’s 26 professional and occupational licensing boards.

Lewis, 34, succeeds James J. Hagerty who vacated the post to become general counsel to the Governor. Casey nominated Lewis to the seat last July. Prior to coming to state government, Lewis was a partner in the litigation department of the Philadelphia law firm of Dilworth, Paxson, Kalish and Kauffman.

AIDS CONFERENCE AIMED AT LEGISLATORS

The Pennsylvania Medical Society has joined with the Pennsylvania Bar Association in sponsoring a Conference on AIDS, April 17, aimed at updating legislators and community leaders. Scheduled prior to legislative session and located conveniently inside the
"CAN YOU AFFORD NOT TO HAVE EXPERIENCED REPRESENTATION"

In a day and age where physicians and health care professionals are subject to increasing scrutiny by third parties, state and federal agencies, and peer review organizations, Professionals Choice legal representation benefit provides its members protection against adverse disciplinary actions including:

Medical Staff Privilege Disputes
Medical Professional Review Organization (KEYPRO)
Medicare/Medicaid Reimbursement Disputes
Pennsylvania Licensure Disputes

The cost to a physician or other health care professional to offer a defense in many of these proceedings can easily run over $50,000. More importantly, the threat of loss of medical staff privileges or the threat of sanction by a professional review organization may irreparably harm a physician's ability to practice medicine and to earn a living.

In order to protect its members, Professional Choice will contract experienced attorneys to represent the interest of its members individually and as a group in connection with any disciplinary proceedings. This benefit is provided as a service to Choice members, and is not a form of insurance. There are no out of pocket costs to members other than the membership fee.

Further, your membership in Professionals Choice will entitle you to participate in many other cost saving programs such as:

The Choice Insurance Program
The Choice Financial Services Program
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capitol complex, the conference is designed to provide legislators, township commissioners and other invited community leaders with current medical, scientific, epidemiological and legal information on the status of AIDS in Pennsylvania.

James Curran, MD, head of the Center of Disease Control in Atlanta, will address the epidemiology of AIDS in the Commonwealth. Following Dr. Curran, a panel of physicians will discuss the medical impact of the disease on sectors of the state's population.

John Dennehy, MD, Geisinger Medical Center, chairman of the PMS Task Force on AIDS, will discuss implications in rural areas. Robert Sharrar, MD, Philadelphia, will deal with the disease's affect on urban and minority populations.

Training for effective communication with legislators was provided at PMS headquarters on January 31 to a group of 55 physicians and PMS Auxiliary members. The American Medical Association/Pennsylvania Medical Political Action Committees training seminar focused on grassroots political involvement between physicians and legislators. Instructed by Karen Bauer, vice president of Michael Dunn & Associates, a Washington, D.C. public affairs consulting firm, physicians appointed as PMS’s “key federal contacts” learned methods to enhance their liaison role with legislators. The group, including members of the PMS Council on Governmental Relations and PAMPAC board, was also briefed on the AMA 1990 legislative agenda and political action issues.

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**ACCREDITATION:**
The University of Medicine and Dentistry of New Jersey-Center for Continuing Education certifies that this continuing medical education activity meets the criteria for 90 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association, provided the program is completed as designed.

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CANCER INCIDENCE REPORT ISSUED

The state health department has issued the Pennsylvania Cancer Registry's second cancer incidence report, which describes cases of cancer for 1984. The initial registry report listed new cancer cases in 14 counties in 1983. Cancer cases diagnosed in 1985 in all 67 counties will be contained in next year's report.

The second report finds lung cancer the most frequently diagnosed form among men, and breast cancer the leading cancer among women. The report provides information on 45 of the state's 67 counties, representing 83 percent of the state's population, and covers all regions of Pennsylvania except the northeast and north central areas.

The 186-page report is based on new cases of cancer reported by hospitals. It lists new cases of cancer by age, sex, race and county, as well as the type of cancer and its stage of development at the time of diagnosis.

PMSLC REPORTS CLAIMS STATISTICS

The Pennsylvania Medical Society House of Delegates Resolution 86-17 requires that the Pennsylvania Medical Society Liability Insurance Company (PMSLC) report certain claim statistics to the House of Delegates on a semi-annual basis. In response to this resolution, PMSLC published the first semi-annual report in the September 1987 issue of Pennsylvania Medicine. The data included in the following tables is an update of the most recent five years' experience of the data requested by Resolution 86-17, as follows:

Table 1. Joinders—Includes PMSLC physicians joined by other parties and other parties joined by PMSLC.

Table 2. Number of claims and suits filed by specialty, January 1, 1985–December 31, 1989


Readers who have questions regarding the information contained in these exhibits should contact Lawrence E. Smarr, senior vice president, statistics and research, Pennsylvania Medical Society Liability Insurance Company, 777 East Park Drive, P.O. Box 8375, Harrisburg, PA 17105-8375.

Table 3: Number of Claims and Suits (C & S) Filed By Specialty—January 1, 1985–December 31, 1989

<table>
<thead>
<tr>
<th>Specialty</th>
<th>C &amp; S</th>
<th>Closed Claims (Except Verdicts)</th>
<th>Closed Verdicts</th>
<th>Closed Settlements w/ Loss Pmt.</th>
<th>Closed Verdicts** w/ Loss Pmt.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</td>
<td>0 $-0-</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>46</td>
<td>35 2,981</td>
<td>1</td>
<td>3,316</td>
<td>42</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>4</td>
<td>7 1,552</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Neurology</td>
<td>55</td>
<td>43 4,436</td>
<td>5</td>
<td>26,750</td>
<td>21</td>
</tr>
<tr>
<td>General Surgery</td>
<td>133</td>
<td>52 3,354</td>
<td>3</td>
<td>34,275</td>
<td>47</td>
</tr>
<tr>
<td>General medicine</td>
<td>42</td>
<td>41 2,890</td>
<td>1</td>
<td>28,255</td>
<td>4</td>
</tr>
<tr>
<td>Gynecology</td>
<td>13</td>
<td>12 6,244</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>28</td>
<td>22 2,518</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>General Surgery</td>
<td>261</td>
<td>143 3,880</td>
<td>11</td>
<td>24,878</td>
<td>104</td>
</tr>
<tr>
<td>Oncology</td>
<td>1</td>
<td>1 45</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

# Claims and suits filed during this period resulted from policy years 1978-1989. PMSLC's limit of liability is $100,000 per incident for policy years 1978-1982, $150,000 for 1983 and $200,000 for 1984-1989.

** Cases tried to verdict which are still open pending final resolution due to post trial motions, appeals, etc. are counted as open files.
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Wednesday, April 11, 1990

 Advances in Dermatology
Wednesday, April 18, 1990

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Wednesday, April 25, 1990

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Friday, May 11, 1990
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Table 1: Number of Cases in which a Physician Is Joined as an Additional Defendant by a Hospital or Physician

| Since beginning tracking joinder data on April 1, 1987, 48 PMSLIC insureds were joined by other parties through December 31, 1989, as follows: |
| PMSLIC Insured | Number of Joined by: Times |
| Hospital | 22 |
| Other Physician | 6 |
| Nursing Home | 2 |
| Drug Company | 1 |
| Commercial Business | 5 |
| Plaintiff | 5 |
| Pharmacy/Pharmacist | 3 |
| Other | 4 |
| Total | 48 |

During the same period, PMSLIC joined seven other parties, as follows:

| Party Joined by PMSLIC | Number of Times |
| Physician | 4 |
| Drug Company | 1 |
| Manufacturer | 1 |
| Other | 1 |
| Total | 7 |

Table 2: Number of Claims Filed by Specialty
January 1, 1985–December 31, 1989

| Specialty | Number of Claims |
| Orthopedic Surgery | 585 |
| Otolaryngology | 89 |
| Pathology | 12 |
| Pediatrics | 142 |
| Plastic Surgery | 96 |
| Preventive Medicine | 1 |
| Proctology | 7 |
| Psychiatry | 23 |
| Pulmonary Diseases | 1 |
| Radiology | 198 |
| Rehab/Physiatry | 32 |
| Rheumatology | 3 |
| Thoracic Surgery | 24 |
| Urology | 81 |
| Vascular Surgery | 14 |
| Vascular and Thoracic Surgery | 1 |
| Not otherwise classified | 35 |
| Corporate Liability | 81 |
| Partnership Liability | 4 |
| Nurse Anesthetist | 2 |
| Nurse Midwives | 2 |
| Physiotherapist | 1 |
| Physician’s Assistant | 1 |
| Registered Nurse | 1 |
| Total | 4,456 |
The practice of medicine came naturally to Robert Lasher, MD, a surgeon from Erie who is the newly-elected trustee to the Pennsylvania Medical Society’s Eighth District. His father was a surgeon in Erie. “I remember at the age of 12 making rounds with him; watching him in the operating room; and even being taken to the Cleveland Clinic to see my father and other surgeons of the day operate,” he recalls. His mother’s brother was a physician who was killed in World War I; her sister was a laboratory technician. Both families lived next door to the hospital. His brother, Donald, is in practice with him.

Growing up in a family rooted in the medical community instilled in him not only an early passion for the profession, but also a life-long willingness to take part in organized medicine. “One reason I’ve always taken an active part is that I believe that even what little I can do as one individual is worthwhile,” he says. “There are so many problems in medicine today, you don’t know where to start. But I can see people in the state Society and other organized groups beginning to work on different facets.”

Group problem solving, however, is not enough, Dr. Lasher says. He sees an urgent need for individual physicians to become more politically active. “One of the major problems facing organized medicine is a failure of the majority of physicians to understand that they have to be united, forceful, and politically motivated to pull the profession together and fight the external forces.”

He says, “We have a strong organization in PMS. We need to fight the elements that are trying to divide and conquer organized medicine. I define those problems as No. 1, legal entanglements, and No. 2, government over-regulation.”

Legal entanglements in the medical profession stem from a myriad of worsening conditions, Dr. Lasher says. Primary among them are the profession’s inability to police itself and the practice of overly-defensive medicine. As a result, he says, physicians suffer from a poor public image. “There is a small group of physicians that is ruining medicine. These are the ones you can’t do anything with because of legal restraints; the physicians that are overcharging; the ones that won’t talk to their patients, the physicians that are in it only for the money. The legislature is over-reacting to this segment of physicians by passing more and more regulatory measures. And when we question these measures, they say we are not doing enough to police ourselves.”

There are no shortcut solutions to reverse this trend, Dr. Lasher says, but changes in individual physicians’ attitudes could help. “It’s got to come one-on-one,” he says. “PMS must help the individual physician change his behavior pattern. Advertising (by the state Society) to change physicians’ public image is not cost-effective; the physicians themselves have to change.”

The challenge of technology
While enmeshed in internal pressures of their profession, physicians must also keep up with this decade’s unrelenting influx of new information and technology, Dr. Lasher says. Dealing with the dawning ethical as well as professional challenges posed by these ever-advancing technologies will occupy organized medicine into the 1990s. “We’re dealing with a changing relationship with patients. Whereas a few years ago patients were content to accept the opinion of the family practitioner, now they demand ever-more use of modern advances,” he says.

Along with over-reliance on specialization and technology, patients increasingly fail to take responsibility for the impact of their own actions, Dr. Lasher says. “Whether it’s medicine or business, or whatever, it’s the attitude of the people,” he says. He sees a profession in which physicians are left to balance the resulting trends from this changing relationship with patients; narrowing spe-
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cialization, over-use of technology as defensive medicine, and the accompanying soaring health care costs.

Organized medicine must grapple with the most basic issues presented by these problems, Dr. Lasher says. "I think attitudes will slowly change. Our (PMS and AMA) participation in judicial councils and in professional ethics is a beginning. By defining when a patient should be given the right to die or when you don't use prolonging or heroic methods, we can help the government to eventually set payment limits on some treatments in these circumstances." We may be moving toward a system similar to the British health care system, which already sets such limits on over-use of technology, he adds.

All of these pressures — technological change, government over-regulation and legal entanglements — are rapidly affecting the nature of the profession and of physicians, Dr. Lasher says.

"Over the last 30–40 years, I've seen physicians retiring earlier. When I started practicing we had many physicians still practicing at the age of 75 or 80; in the last five to ten years, that age has dropped to about age 65, and we're even seeing people between 55 and 60 retiring because of the strain of the profession."

At the same time, he says, younger physicians are gravitating toward salaried, less-stressful specialties, and away from the long hours of independent practice. Because the attitudes of physicians, young and old, are changing, Dr. Lasher says, "Medical school should stress compassion, understanding, and communication with patients."

Serving organized medicine

While Dr. Lasher left Erie to seek his education in universities at opposite corners of the state, he always intended to return to Erie to practice. He received his undergraduate degree at the University of Pittsburgh, then attended Temple University School of Medicine, earning his medical degree in 1947.

As a PMS trustee, Dr. Lasher represents physicians in Crawford, Erie, Forest, McKean, Mercer and Warren counties. Previously, he was active in organized medicine in many capacities both in Erie County and at the state level. He has served as president of the Erie County Medical Society and as a board member, delegate to the PMS House of Delegates, and treasurer. He has served on the county society's committees on physicians medical services and on emergency disaster services.

At the state level, has been a member of the PMS Council on Governmental Relations, the Bylaws Committee, and the Board of Directors of the Pennsylvania Medical Political Action Committee. Other committees and councils on which he has served include the Commission on Professional Liability Insurance, and the councils on legislation, medical economics and medical service. He is a delegate to the AMA and was a member of the PMS Building Committee.

Despite his strong commitment to involvement in legislative affairs, he says, "I was active with PMSLIC (a member of the Board of Directors of the Pennsylvania Medical Society Liability Insurance Company) for 10 years. I still do some claims work and feel more comfortable in that area than in some of the politically acclimated situations."

Dr. Lasher says he has always enjoyed the administrative side of things, contributing his abilities to many arenas in his home community. He was a founder of the Erie Transit Authority, and is chairman of the board of Northwest Savings Bank, having served on the board for some 28 years. He has also been on the board of trustees of Thiel and Villa Maria colleges.

Dr. Lasher is active in the American College of Surgeons, serving on many committees on state as well as local levels.

The next generations

Involvement in the medical profession has not continued into a third generation of the family. He says he allowed his children freedom, encouraging them "to do their best at whatever they choose to do."

He and his wife, Dee, a past president of the PMS Auxiliary, have four grown sons. Robert, 39, is director of commercial program development for Computer Sciences Corporation, Washington, D.C. William, 35, a PhD candidate this year, is teaching engineering at the Behrend campus of the Pennsylvania State University. Scott, 31, is a regional representative for Fieldstone Kitchens. Youngest son, Brian, 29, is a Navy helicopter pilot attending Navy post-graduate school in Monterey, California, for a master's degree in international relations.

The Lashers have three grandchildren, ages six, four and one. Returning the younger generation to a closeness with the medical community, Brian is engaged to Susan Moore, MD, a pediatrics resident at Hershey Medical Center.

Another of Dr. Lasher's long-time passions, in addition to his profession, family and community, is sailing on Lake Erie.
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Professor of Medicine

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5:00 p.m. Cardiac Problems in Renal Failure
          Ronald S. Pennock, MD
5:30 p.m. Dialysis in Cardiac Patients
          Charles D. Swartz, MD
6:00 p.m. Refreshments

Thursday, April 19, 1990
Moderator: Eric L. Michelson, MD
Director, Division of Cardiology
Professor of Medicine

4:00 p.m. Case Presentation
5:00 p.m. Color Flow Doppler
          Gerald Scharf, DO
5:30 p.m. Transesophageal Echo
          Krishnaswamy Chandrasekaran, MD
6:00 p.m. Refreshments

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Effects of Air Pollutants and Acid Rain on Human Health

Acid rain conjures surreal images in the fanciful mind and incites anger and frustration among sportsmen and naturalists. But a walk in the rain, however acidic, will not result in dissolving umbrellas or chemically burned flesh. Neither will an acidified lake produce a strike on the line of the most experienced angler.

Acid rain spearheads the larger issue of environmental contamination by manmade sources. Atmospheric pollutants, some of which are responsible for acid precipitation, are now ubiquitous in our environment. Pennsylvania tolerates the reputation of being both a major contributor to and receiver of atmospheric pollution. It is the purpose of this paper to review the evidence and conclusions about the human health effects of major atmospheric pollutants and to suggest the role that physicians must assume with this regard.

It is a popular misconception that pH is equal to acidity. Technically, pH is the negative logarithmic value of the ambient H⁺ ion concentration and is determined by the tendency of H⁺ ion to dissociate from its anionic partner. Rainwater is a complex solution of various chemical species partially comprised of both strong and weaker acids. Since the strong acid moiety, principally composed of sulfuric and nitric acids, contributes 95 percent or more of the total acidity, it is useful and fairly accurate to consider that the pH of rainwater is a good indicator of its acidity. Rainwater which is at equilibrium with atmospheric concentrations of CO₂ has a pH of roughly 5.6 and therefore rainwater with a pH less than this is considered acid rain.

The average pH of Pennsylvania rainwater is 4.1. We live in a region which receives the most acidic precipitation in the United States. Rainwater samples from individual storms in Pennsylvania have measured as low as pH 3.4. Although there are seasonal variations, the overall rainwater pH has remained relatively stable over the past decade.

Acid rain has drawn attention to the wet deposition of atmospheric pollution. However, there is an important process of dry deposition that occurs in between the periodic washout of pollutants by pluvial events. The deposition of particles is a process that is principally governed by size, reactivity, emission characteristics and meteorologic patterns. Size determines whether a particle settles gravitationally or remains airborne until absorbed, dissolved, or impacted. Obviously, highly reactive compounds will undergo rapid chemical changes. Many chemicals are not intrinsically very reactive when emitted into the atmosphere, but become increasingly more likely to undergo chemical reactions as their atmospheric residence time is prolonged. The most common example of this is the photo-oxidation of sulfur and nitrogen species.

Atmospheric conditions influence both the wet and dry deposition of atmospheric pollutants. Emissions from enormously tall smokestacks designed to alleviate local pollution create regional problems due to long-range pollutant transport. Perhaps as much as any other variable, weather patterns determine pollutant deposition. Important factors include both regional parameters such as prevailing winds and annual volume of rainfall and local considerations such as lake and mountain effects. Some of the most dramatic health hazards of air pollution have occurred during so-called
"thermal inversions"—a condition in which an unusually stable warm air mass sits aloft and resists the tendency to degenerate. This situation creates a stagnant air mass into which industrial and motor vehicle effluents are pumped and concentrated over time.

The number of atmospheric pollutants is legion, but the Environmental Protection Agency, which monitors national ambient air quality standards (NAAQS), has identified six "criteria pollutants": O$_3$, SO$_2$, NO$_x$, CO, particulates, Pb. Some of these contribute to acid rain; all have effects on human health. All of these pollutants, except for NO$_x$, have defined threshold levels for occupational exposure and for ambient air. All of these are reliably detected and measured by generally accepted methods.

The health effects of air pollutants can be considered as primary and secondary. Primary effects in humans are essentially pulmonary and result from inhalational exposure. The secondary effects are chiefly attributable to mobilization of toxic metals contributing to ground water pollution. Ingestion of polluted food sources, particularly fish which can bioaccumulate toxic metals to high levels, is another secondary source. Tertiary effects which might be genetic are only speculative.

The knowledge of human health effects derives from two bodies of data, controlled human exposure studies and epidemiologic studies. Both methods have relative strengths and shortcomings. In the following review, the results and conclusions of many studies are presented, interpreted and integrated to portray the emerging picture of the adverse human health effects of atmospheric pollutants.

**Ozone**

Ozone, O$_3$, is not a component of acid rain per se, but is a major constituent of smog implicated as the primary human health hazard in photochemical pollution. This pollutant is the same chemical which forms the ozone layer in the stratosphere where it performs a protective function by absorbing large amounts of harmful ultraviolet wavelength radiation. Pollutant ozone gas is formed at ground level from photo-oxidation processes in the presence of hydrocarbons and nitrogen oxides produced by motor vehicle and manufacturing emissions. This powerful oxidant is a noxious pulmonary irritant which has a distinctive, pungent, "electrical" odor detectable at levels well below the current ambient air quality standard of 0.12 ppm average concentration per hour.

As with each of the individual air pollutants, there is debate about the level at which meaningful human health effects occur. Controlled environmental chamber studies have clearly demonstrated that resting healthy adults become symptomatic with subternal chest pain and tracheal irritation and develop significant declines in pulmonary function following ozone inhalation at levels ranging from the 0.12 ppm standard to several times greater; the threshold for symptoms is lowered by exercise and heat. Measurable reduction in pulmonary function occurs at levels below the air quality standard. Some results suggest that unspecified ambient cofactors are so significant that ozone chamber studies may substantially underestimate the O$_3$-associated responses that occur in populations engaging in normal outdoor recreation.

Experimental evidence suggests that children and adolescents are more susceptible than adults to the effects of low ozone concentrations. Diminished pulmonary function in children engaged in normal activities and exercising was detected at levels of 0.10 ppm to 0.12 ppm. Children and adolescents, however, do not become symptomatic at these levels. Data analysis of children camping in northwestern New Jersey implicates daily ozone exposure as an important factor contributing to pulmonary function abnormality.

The data are more significant in light of the fact that children are more apt to play and exercise outdoors during the summer when ozone levels are highest and environmental factors are most contributory. Also, many monitored urban areas have failed to achieve ozone levels below the standard. Though children may have altered pulmonary function at ozone levels lower than 0.12 ppm, the significance of the lack of symptoms is debatable. On one hand, it may suggest that the standard is satisfactory in protecting populations from becoming symptomatic; on the other hand, the lack of symptoms may place children at greater risk to the effects of prolonged low level ozone exposure.

The pathologic effects of ozone are incompletely known. Ozone is a very strong oxidant and is capable of altering cell membrane lipids. This may be a mechanism for increased respiratory epithelial permeability caused by ozone inhalation. Human mucociliary function is acutely stimulated by ozone with peripheral mucous flow into central bronchi increasing after a brief exposure to very low levels. Ozone induces bronchial hyperreactivity to bronchoconstrictors by a cholinergic-mediated pathway and pulmonary inflammation is associated with this response.

**Sulfur dioxide**

The combustion of fossil fuels (coal, oil and refined petroleum products) is the principal contributor of anthropogenic sulfur to the atmosphere. In the U.S., the major source is coal-fired power plants and Pennsylvania coal is particularly notorious for its high sulfur content. The air quality standard for sulfur dioxide (SO$_2$) gas is a daily average concentration of 0.14 ppm not to be exceeded more than one day per year. The ambient concentration of atmospheric SO$_2$ must be interpreted with an understanding of the physical properties and dynamics of the reactive sulfur species, for SO$_2$ gas undergoes a complex series of photo-
oxidation reactions in the atmosphere which results in the formation of sulfate \((\text{SO}_4^{2-})\) particles. The two dominant forms of this are sulfuric acid, \(\text{H}_2\text{SO}_4\), and ammonium sulfate \((\text{NH}_4\text{SO}_4)\). No air quality standards currently exist for ambient sulfur acid or sulfate aerosols. Another important facet of atmospheric sulfur dynamics is its relatively long residence time and its long-range transport which together permit deposition of particles long removed in time and space from the initial source.

Early clinical investigation of human subjects breathing sulfur dioxide gas at rest established reasonably consistent respiratory and cardiopulmonary responses with bronchoconstriction developing in healthy adults mouth breathing 1.0 to 2.5 ppm sulfur dioxide.\(^1\)\(^2\)\(^3\)\(^4\)\(^5\)

The detrimental effects of sulfur dioxide inhalation in subjects with reactive airway disease is particularly well studied. Asthmatics develop bronchoconstriction at lower exposure levels than healthy subjects\(^6\)\(^7\)\(^8\) and often become symptomatic at concentrations of 0.5 ppm.\(^9\)\(^10\) Some asthmatics develop significant bronchoconstriction at levels as low as 0.10 ppm if they are engaged in moderate exercise.\(^11\)

The asthmatic response to \(\text{SO}_2\) exposure is similar to those elicited by a variety of bronchoconstrictive agents. The response magnitude varies as a function of concentration but actual inhaled concentration depends on the mode of administration. In chamber experiments, mouthpiece breathing produces effects at lower concentrations than natural breathing, particularly for water soluble pollutants such as \(\text{SO}_2\).\(^12\) Bronchoconstriction in asthmatics is also potentiated by increasing exercise intensity.\(^13\)

Sulfate and particulates

\(\text{SO}_2\) gas is quite water soluble and in the atmosphere it is oxidized to sulfuric acid and particulate sulfate \((\text{SO}_4^{2-})\) species which commonly are transported great distances in upper level air masses. It is likely, therefore, that there is greater exposure to these daughter chemicals than to \(\text{SO}_2\) gas itself. Sulfuric acid contributes to the strong acid moity in acid rain but as such is very unlikely to cause primary injury to humans. The most acidic of rainfalls has never reportedly caused skin irritation. However, fog can achieve substantial concentrations of strong acids (as low as pH 1.7). Indeed, several historical air pollution disasters were associated with foggy weather. Yet controlled studies of health effects of sulfuric acid in humans have generated conflicting results\(^14\)\(^\text{—}^\text{18}\) and no air quality standards for sulfate and particulates currently exist.

There is more evidence for increased asthmatic response to \(\text{H}_2\text{SO}_4\) aerosol than against it. Some asthmatic individuals develop transient airway dysfunction following sulfuric acid aerosol inhalation at lower levels than normal adults often do.\(^19\) Mildly exercising adolescent asthmatics may become symptomatic at even lower levels.\(^20\) The bronchoconstrictive effects in asthmatics appear to be mediated by the acidity and by particle size in aerosols.\(^21\)\(^\text{—}^\text{23}\)

**Nitrogen oxides**

Various nitrogen-oxygen species are formed by manufacturing combustion processes and motor vehicle emissions. Probably the only significant pollutant of these is nitrogen dioxide, \(\text{NO}_2\), which is a yellow-brown gas. An important ancillary role of the oxides of nitrogen, however, is ozone production via photooxidation processes. While \(\text{NO}_2\) is regulated by the Environmental Protection Agency as an outdoor criteria pollutant, its human health effects at outdoor ambient concentrations are controversial. There are strong data suggesting that \(\text{NO}_2\) is an important indoor pollutant, however.

Silo-filler's disease is caused by acute exposure of \(\text{NO}_2\) in concentrations greater than 200 ppm such as develop in corn silage containers. Such exposure causes an acute chemical pneumonitis ultimately leading to pulmonary edema. Permanent pulmonary parenchymal damage may ensue. Ambient \(\text{NO}_2\) exposure probably seldom exceeds values one thousand times lower than those causing silo-filler's disease.

The conclusions regarding lung function effects from exposure to ambient levels of \(\text{NO}_2\) are mixed, but probably there are more data suggesting that there is no significant health risk, even among "susceptible" populations. Spanish investigators correlated excessive numbers of asthmatic attacks requiring hospital visits immediately following the peak ambient \(\text{NO}_2\) level of 0.50 ppm when other pollutants (\(\text{SO}_2\) and \(\text{O}_3\)) were not significantly changed.\(^22\) Some data suggest that asthmatics are more susceptible to adverse effects of \(\text{NO}_2\) than are other people.\(^23\)\(^\text{—}^\text{25}\) In contrast to these reports, other investigators have found no significant differences between the pulmonary function of normal and asthmatic subjects.\(^26\)\(^\text{—}^\text{28}\)

An experimental model has shown that oxidant injury by \(\text{NO}_2\) results in altered cell membrane function,\(^29\) a postulated mechanism for \(\text{NO}_2\)-induced pulmonary injury. Other models suggest that \(\text{NO}_2\) reduces the efficacy of lung defense mechanisms by effects on mucociliary clearance, the alveolar macrophage and the immune mechanism.\(^30\) The findings of a recent study suggest, but do not prove, that \(\text{NO}_2\) alone may increase adult susceptibility to respiratory virus infection.\(^31\) While the results of this study are inconclusive, the morbidity implications of such a correlation, should it be proved, are stunning. The experimental concentrations of 1–3 ppm \(\text{NO}_2\) are excessive for outdoor exposure, but typical for indoor exposure in poorly ventilated settings of gas stoves and cigarette smoke. Increased respiratory disease rates and diminished pulmonary function associated with \(\text{NO}_2\) exposure are documented in children.\(^32\)\(^\text{—}^\text{34}\)

**Carbon monoxide**

Carbon monoxide, \(\text{CO}\), is a common product of incomplete combustion. This colorless, odorless gas is chiefly produced from motor vehicle exhaust. The mechanism of carbon monoxide toxicity is well known to the medical community. Hemoglobin has an affinity for \(\text{CO}\) which is greater than 200 times its affinity for oxygen. The formation of carboxyhemoglobin lowers the effective oxygen carrying capacity of blood. Furthermore, it shifts the hemoglobin dissociation curve to the left and alters its

---
shape thus making available hemoglobin far less likely to give up oxygen to tissue. Injury results from tissue hypoxia.

The symptoms of carbon monoxide toxicity depend on the blood concentration of carboxyhemoglobin. Levels below 10 percent are generally asymptomatic. Heavy cigarette smokers may have a baseline carboxyhemoglobin level that approaches the 10 percent threshold. Levels in the 10 to 30 percent range may produce headache and nausea and occasionally mild central nervous system dysfunction including diminished visual acuity and impaired cognitive function. Symptoms become increasingly severe in the 30 to 40 percent range and CNS manifestations may include ataxia. Cardiopulmonary failure, coma, and convulsions ensue at levels greater than 50 percent.

**Epidemiologic studies**

Observational epidemiologic data promote understanding of how ambient levels of pollutants affect human health. However, the quantitative interpretation of any given pollutant actually inducing a symptom or effect is diluted by the many vagaries inherent in the collection and analysis of environmental data. These uncertainties include: the methods of measuring pollutant concentration; the extrapolation of ambient concentrations to inhalation exposure; the various activity levels (or minute ventilations) of population subsets and there time of exposure; the intrinsic susceptibility of certain populations; the web of interactive biological, chemical and physical parameters, some of which may act synergistically, arithmetically or protectively. So it is that stacked against this wall of limitations, meaningful epidemiologic data loom higher and do provide useful insight into the effects of air pollutants on human populations.

A comprehensive and ambitious prospective epidemiologic project, the Harvard Six City Study, is designed to obtain comparable data from a variety of communities with differing levels of pollution and to determine the human health effects of the measured air pollutants, particularly SO₂, sulfates, and respirable particulate matter. Air pollution data are collected from outdoor and indoor monitors. Pollutant levels are correlated with indicators of pulmonary function and disease in randomly selected adults and children. Among the many results and conclusions reported by this investigation are the following:

1. Ambient exposures to ozone at levels below the NAAQS standard are associated with transient decreases in lung functions, the long-term significance of which is uncertain.
2. Exposure to moderately elevated concentrations of pollutants (total suspended particulates and SO₂ gas) increases the risk of bronchitis.
3. Rates of respiratory illnesses and symptoms are elevated among children living in cities with high particulate pollution and children with hyperactive airways may be particularly susceptible.

The increased rates of illness, however, are not associated with permanent loss of pulmonary function.

Other epidemiologic studies also confirm the deleterious effects of atmospheric pollutants on human health. The UCLA Population Study of Chronic obstructive Respiratory Disease reports poor lung function tests in populations exposed to high concentrations of SO₂, particulates and hydrocarbons compared to a population with low concentration exposure. The studies also
yielded results suggesting that long-term exposure to high concentrations of oxidants, NO₂, and sulfates in ambient air may result in measurable impairment in smokers and nonsmokers. 

The Harvard University Energy and Environmental Policy Center initiated a multidisciplinary study which incorporated various data sets standardized for comparative purposes and applied statistical risk analysis techniques to determine morbidity and mortality effects of air pollution. This cross-sectional mortality analysis using 1980 U.S. vital statistics and available ambient air pollution data bases indicated that "typically 5 percent of the total mortality was associated either with ambient sulfate or fine particle pollution." A time series analysis of 14 years of New York City data indicated 2 to 4 percent of total excess mortality is estimated to be due to air pollution. A time series analysis of 10 years of Los Angeles data indicated that temperature, NO₂ pollution and in some years O₃ pollution had significant association with daily mortality. Morbidity effects of ambient pollutants determined by a two week survey of 100,000 people in 12 metropolitan areas found that fine particle pollution was a significant predictor of minor restricted-activity days although other pollutants (SO₂, O₃, and total suspended particulates) were not statistically significant. Additional important conclusions emerging from the studies are that the fine particle fraction and sulfate mass are the most significant predictors of residual mortality, and that the fine particulate fraction may be a particularly significant health hazard since it often includes carcinogens, toxic trace metals and acidic organic components.

Canadian epidemiologic studies have also implicated air pollutants as a public health menace. One study reported a positive association between ambient levels of SO₂, O₃, temperature, and hospital admissions for respiratory illness. This correlation was still significant when asthma-related hospital admissions were omitted from the analysis. Studies of acute exposure of asthmatic and nonasthmatic children to LRTAP (long-range transport air pollutants, principally SO₂ and NOₓ) indicate that both groups exhibit transient decreases in measured pulmonary function associated with elevated pollutant levels. A cross-sectional study investigating chronic health effects of LRTAP exposure attributed both decreased lung function and increased symptoms (colds, allergies, cough) to elevated pollutant levels.

Acid rain secondary effects

The secondary effects on human health of acid rain pollutants primarily relate to the potential toxicity of metals including lead, mercury, aluminum, and cadmium. The metals are present in soils bound to clay particles and organic contents. Acid water influx may mobilize bound metals by ion exchange and dissolution of soluble carriers. The intrinsic buffering capacity of systems is determined by geo-logic factors such as the nature of bedrock, depth, and texture and chemistry of overlying soil. Areas with shallow soil banks overlying granitic or gneissic bedrock, such as the Northeastern U.S., are most vulnerable to the leaching effects of acid rain and thus to the modification of surface and groundwater. Thus, polluted water may be consumed by humans directly or indirectly through the food chain, particularly fish.

Lead

Lead is ubiquitous in our environment and its widespread distribution is essentially entirely anthropogenic. The highest concentrations both in air and soil are near smelters and busy roads. The health hazards of lead are medically well recognized and include depressed heme biosynthesis and erythropoiesis, deranged vitamin D metabolism, renal damage and peripheral and central nervous system toxicity. Chronic exposure in young children causes chronic central nervous system dysfunction which may manifest as intelligence and behavioral deficits. Lead can cross the placental barrier and appears in umbilical cord blood at nearly the same concentration as in maternal blood. As with many of the environmental pollutants, children are both particularly vulnerable to and at risk for the detrimental effects of lead.

While it is probably not meaningfully quantitated as yet, it seems reasonable to assert that acid rain contributes at least indirectly to human lead exposure. Lead solubility increases with acidity or in inverse relation to pH). Therefore, acid precipitation increases mobilization of lead from soils, especially in poorly buffered systems, and solubilizes lead from pipes and lead soldered joints in cisterns. A study of roof catchment cistern water quality in Clarion and Indiana counties in Pennsylvania revealed that over half of the 40 systems studied exhibited cistern bottom sediment/water Pb concentrations in excess of the 50 mg/L drinking water standard. Although none of the cistern water samples exceeded the limit, unusually heavy usage might deplete the supply to levels where toxicity from particulate lead in the sediment layer becomes hazardous. Atmospheric acid deposition may also contribute to increasing environmental lead levels through accelerated weathering of painted surfaces.

Mercury

The devastating effects of methylmercury on health were made manifest by the unfortunate experiences of contaminated fish consumption from Minimata Bay in Japan during the 1950s and contaminated seed in Iraq in the early 1970s. Fish and fish products remain the primary source of mercury exposure to humans. The nervous system is the target organ; cerebellar, auditory, visual and sensory function are all affected. The toxin crosses the placenta and may induce congenital birth defects. The clinical presentation is apparently dose-dependent.

Evidence suggests a strong relationship between pH levels of freshwater lakes and mercury levels in inhabiting fish. Metallic mercury is increasingly mobilized at low pH levels, thus being made available for methylation to the biologically toxic state. Mercury methylation, however, may decrease with increasing acidity and consequently it is postulated by the EPA that increased mercury mobilization by acidic deposition should not pose a human health threat. Nonetheless, methylmercury accumulates in fish
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3:30-4:00  The treatment of hypertrophic cardiomyopathy—Steven J. Nierenberg, MD
4:00-5:00  Case presentations—Unusual forms of hypertrophic cardiomyopathy—T. John Mercuro, MD
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and increases in concentration at progressive levels up the food chain with the highest levels present in predatory gamefish such as pike, trout, and bass.

Cadmium

Among the common heavy metal pollutants, cadmium mobility is the most responsive to increased acidity. Cadmium toxicity generally develops from chronic accumulation resulting in renal disease. Ingestion is the commonest route and, due to a protracted biological half-life, virtually all absorbed cadmium is retained. Therefore, cadmium absorption by crop plants, which is enhanced at low pH levels, could constitute a public health hazard that may warrant prospective control.

Aluminum

Aluminum is the most abundant metal, but it is not utilized in any natural biochemical process. It has generally been considered relatively nontoxic to humans as it is ingested in large amounts as aluminum hydroxide in antacids. However, it is suspect for causing "dialysis dementia" in patients with chronic renal failure. Brain and musculoskeletal tissues in affected patients demonstrate elevated aluminum levels which is thought to derive from dialysis fluid or oral intake. Aluminum is also implicated in the osteodystrophy of chronic renal failure. It has also been proposed that aluminum may be important in the development of Alzheimer's disease since it has been detected in the pathologic lesions. Studies have confirmed a higher incidence of Alzheimer's disease in regions with elevated aluminum levels in drinking water and suggest that aluminum in drinking water may have higher bioavailability.

It requires a large leap of faith to implicate acid rain as significantly increasing aluminum toxicity by its action of mobilizing aluminum in soils and bedrock. Nonetheless, the mechanism is established and the relationship is recognized, thus providing the impetus for further investigation.

Conclusions

It is clearly evident from the abundance of experimental and observational data that atmospheric pollutants responsible for acid precipitation produce adverse human health effects. Transient primary pulmonary effects due to pollutant inhalation are unequivocal. These effects most commonly result in impairment of pulmonary function parameters measured by spirometry and occasionally produce symptoms of cough, dyspnea, and increased secretions. Children and particularly asthmatics are at greater risk than healthy adults. The current national ambient air quality standards may not adequately protect the sensitive subpopulation from significant morbidity. Various individual pollutants may induce adverse effects at concentrations commonly experienced in ambient air particularly in urban areas. The combined effects of these pollutants, however, is poorly characterized.

The secondary effects of acidic precipitation on human health remain a subject of conjecture. The mechanism of metal ion leaching by acidic water passing through poorly buffered systems is well established. The adverse health effects of leachable metals such as lead and mercury are medical certainties. The link between these is plausible, but is not proven beyond reasonable doubt. It seems judicious, however, to recognize the potential public health hazard of secondary effects.

What then is our responsibility as physicians to this public health hazard? Do we as scientists insist on more factual demonstrations of pollutant-induced ill health before embracing the issue as a serious concern? Do we as caregivers confess that air pollutants probably do, at least on occasion, exacerbate existing health problems and possibly predispose to ill health?

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Leadership Conference Registration
This is the second of two articles on physician impairment in the hospital or other medical institution. The first article, published in the February issue of Pennsylvania Medicine, dealt with background issues. These include knowledge and attitudes about impairment, organizational and medical staff characteristics relevant to physician impairment, obstacles to and advantages of hospital-based impaired physician programs, and advantages of collaboration between hospital, county, and state medical society impaired physician programs.

The present article summarizes possible components and structures of institutional impaired physician programs and committees.

Program goals
The impaired physician committee should be able to address all presenting problems, including drugs/alcohol, psychiatric illness, neurologic disabilities, and stress-related disorders. The primary focus is on impairment, not on incompetence or illegal activities, although there are some cases which involve both. When a case of impairment is accepted by the committee, it should be taken to a definitive conclusion rather than dropped. A positive conclusion is the rehabilitation and return of the recovering physician to the practice of high quality medicine. An alliance with the state medical society program can help assure the successful completion of what is started.

The impaired physician committee should be willing to work with ambiguous, often ill-defined situations with maximal flexibility, clinical orientation, and rapid response. The committee should promote rehabilitation and provide advocacy, with the goal of high standards of personal and professional well-being. In contrast, state agencies have legal disciplinary mandates to protect the public by enforcing minimal professional standards.

The committee should realize that physician well-being is an integral part of institutional and public well-being. The committee works in the best interests of patients and the institution, as well as for the benefit of the medical staff. It also fulfills the staff’s responsibility for self-regulation. The committee should be involved in peer review, with such a mandate incorporated in the bylaws. A physician health committee would help formulate formal policy for inclusion in bylaws, with provisions for immediate suspension of privileges if a physician poses a threat to self or patients. The bylaws would provide for due process as well as other legal elements (e.g., confidentiality, informed consent, immunity, etc.) The committee should, however, have no formal disciplinary power.

The committee should attempt to minimize the disruption of the impaired physician’s practice and preserve the right of the competent physician to return to practice when adequately treated and on the road to recovery.

The program should meet the needs of the individual hospital. It should promote a philosophy and policy of rehabilitation rather than a punitive approach to impairment. The time-honored dictum, above all do no harm, applies here.

Program structure and components
There are many possible variations of committee structure. The committee can be formal (incorporated in the medical staff bylaws) or informal (off the record); ad hoc or standing. Membership may be restricted to physicians or may include administrators, other hospital staff, house staff, medical students, and family members. Inclusion of a legal advisor is
also recommended. A psychiatrist, an addictionologist, or a recovering physician can bring valuable expertise regarding physician impairment to the committee. At least one member of the committee should be visible in the hospital and the community as a contact person and liaison with the county and state medical society programs.

There is debate in the physician impairment field over the advisability of including in the impaired physician committee anyone who has disciplinary authority over the medical staff. Those who favor it argue that the committee has a responsibility to assure the quality of patient care; those against it argue that the committee cannot be both the impaired physician's ombudsman and disciplinarian. Likewise, potential conflicts of interest should be avoided, such as a member serving both on the impaired physician committee and on the credentialing committee.

Multiple specialties should be represented. No one specialty or philosophy (e.g., psychiatry or 12-step programs) should dominate the work of the committee. Those on the committee should be trained in the area of physician impairment. Members' terms of office should overlap and be of sufficient length—at least three years—so that expertise can be developed and continuity preserved. Meetings should occur at least every three months, or as often as needed. Records of committee meetings may be kept, but details of any particular case might be better maintained at the state medical society program.

Program Functions

Case finding: The committee should be the designated recipient of information about potential impairment in a physician. It should use existing hospital mechanisms for early case finding to assure quality medical care as well as the health of physicians.

Some cases of impairment come to light through the work of credentialing and other peer review committees. A special contact person, mechanism, and/or hotline for use by colleagues, nurses, other hospital personnel, family members and patients, would serve as a supplement to routine methods of contact with the committees, such as direct phone calls, letters, and conversation with committee members. Policies discouraging anonymous reports and requiring written reports influence a source's willingness to report and decrease the likelihood that the committee will find out about cases of impairment. These policies must be adopted and made known by the committee. The information available on a potential case of impairment may be limited at first, with a more comprehensive picture developing over time. This necessitates patience, persistence, and long-term recordkeeping.

Verification of a report of impairment starts when the committee considers the initial report or information. The committee then plans means of obtaining corroboration and additional information within the scope of the committee's advocative structure. It must be understood that the committee is not an investigatory agency. Such a role would endanger the goals of the committee by inducing fear and discouraging referrals, to say nothing of the legal hazards.

The referral source may require assistance in administrative and/or personal areas. In seeking verification, the committee should request documentation of observable behaviors rather than words. It is necessary to have a policy concerning whom information is shared; reputations can be damaged by ill-advised communications.

Intervention: Intervention is the process of confronting an impaired physician with the problem and need for treatment. It is a skill which requires training.

Ideally, the intervention process is positive, with the intervenor(s) enlist the cooperation of the impaired physician. However, impaired physicians rarely accept intervention unless they are already in severe distress from their impairment or some sort of pressure to cooperate is brought to bear on them. Sources and methods of therapeutic coercion must be available to the impaired physician committee. If policies, loyalties, or other circumstances hinder the hospital impaired physician committee from developing and using these resources, they should use the state and county medical society programs.

An initial treatment and monitoring plan needs to be made prior to undertaking an intervention. Intervention can be accomplished with more than one contact if the first approach is not successful in getting the impaired physician into treatment. Firmness and use of coercion can be gradually escalated. The committee should stay engaged with the impaired physician even if disciplinary and legal actions come into play.

The impaired physician who acquires to treatment will often try to design that treatment; this is no more appropriate than a trauma patient in the emergency department overseeing his/her own treatment. The committee must make continuing efforts to publicize the fact that theirs is not a treatment program, but rather a program of advocacy. Because an intervention needs to be brought to a conclusion and not dropped in mid-stream, the committee must plan for the "worst case" scenario, and anticipate possible roadblocks.

The medical director of the state medical society program, or a particularly experienced member of the committee, can perform triage, but the committee should refer impaired physicians to appropriate practitioners and programs for formal assessment.

Monitoring: After successful treatment for impairment, the recovering physician should be monitored for three to five years, with the frequency and intensity of monitoring diminishing as the physician's time in recovery increases. Monitoring might include proctoring of procedures, chart reviews, supervision of patient care, and urine screening for drugs.

It is necessary to have a written rehabilitation plan, such as that used by the Pennsylvania Medical Society Physicians Health Program (see appendix). This includes plans for appropriate initial, continuing, and long-term treatment until the impairment is adequately resolved. It includes a complete assessment of all major areas of function, from physical, mental, and family, to financial. The plan provides for documentation of the physician's progress in recovery at designated intervals by all who are involved. Provision is made for treatment of other medical problems the recovering physician may have and for prescriptions written for him/her by other physicians. The plan requires abstinence from all psychoactive drugs, including alcohol and prescribed medications (except under certain explicit defined circumstances such as post-operative pain control).
Participation in self-help programs is stipulated. Provisions are made for information exchanges between the hospital impaired physician committees, the state program, the hospital, licensure board, and other involved with the recovering physician. The hospital medical staff impaired physician committee must designate how and when they wish to receive status reports from these agencies.

In testing for psychoactive substances, urine samples should be collected under direct observation. Although the impaired physician may object to this, it increases the credibility of the results and is especially advisable considering today's litigious climate. The cost of the testing and who is going to pay for it must be specified at the outset. The lab must test for all drugs abused, including, for example, l entail. Samples may be tested on a random or routine basis, for advocacy (to document abstinence) and/or to refute allegations of relapse.

Impaired Physician Agreement

I, ______, agree to the terms of this AGREEMENT between me and the PHYSICIANS' HEALTH PROGRAM OF THE EDUCATIONAL AND SCIENTIFIC TRUST OF THE PENNSYLVANIA MEDICAL SOCIETY, (PHP), for a period of ______year(s) beginning on ______, and concluding on ______.

I understand that, if I should not abide by this AGREEMENT, I will release the PHP from any further advocacy role on my behalf, unless a new AGREEMENT can be reached. I further understand the PHP will take action as is necessary and/or legally mandated to report my failure to comply with the provisions of this AGREEMENT to persons(s), group(s), and organization(s) that need to be informed for the sake of investigation, patient protection, and my own well-being and protection. I understand that this AGREEMENT has been designed to allow my colleagues to assist me in meeting my personal and professional needs as a recovering impaired physician, and is entered into for the purpose of assuring complete understanding of the terms and times specified for my participation in the PHP.

This document may be subject to revision from time to time with the expressed consent of all parties involved. If it is deemed appropriate, an AMENDMENT will be prepared to reflect any such revision(s).

I Agree to Abide by the Following Provisions of this Agreement:

1. I agree to enter an inpatient hospital and/or treatment center for evaluation, detoxification, and/or rehabilitation/therapy on ______, and will remain until discharged by my therapist(s):

   FACILITY: ______
   THERAPIST(S): ______
   WRITTEN REPORT/CLINICAL RECORDS REQUIRED: 
   NEUROPSYCHOLOGICALS/OTHER TESTING PERFORMED: ______

2. I agree to participate in an outpatient rehabilitation/treatment program instead of or following hospitalization for a period of ______.

   FACILITY: ______
   FREQUENCY OF THERAPY: ______
   THERAPIST(S): ______
   WRITTEN REPORT/CLINICAL RECORDS REQUIRED: 

3. I agree to professional practice retraining and/or assessment.

4. I agree to enter into therapy for a period of ______, or until such time as the attending therapist(s) discharge me from such treatment in collaboration with PHP.

   (Individual: ______
   Group: ______)

FACILITY: ______
FREQUENCY OF THERAPY: ______
THERAPIST(S): ______
WRITTEN REPORT/CLINICAL RECORDS REQUIRED: ______

SCHEDULE FOR RE-ASSESSMENTS: How often ______

By whom ______

(4a) I agree to attend ______

12-Step Program meetings per week.

MONITOR: ______

He/she has ______ agreed to serve as a PHP contact.

(4b) I further agree to attend, when available, Caduceus Club meetings, medical 12-Step Program meetings, and/or other professional recovery group meetings. I will document my attendance and forward a copy monthly to the PHP.

MONITOR: ______

(4c) The address of IDAA, International Doctors in AA, will be forwarded to me for my use in establishing contacts in the recovering physician community.

(5) I agree to participate in a specified urine and/or blood analysis program approved by the PHP.

FREQUENCY OF TESTING:

METHOD: ______
LOCATION: ______
MONITOR: ______

EMPLOYER TO MONITOR URINES: ______
LAB: ______
WRITTEN/VERBAL REPORTS TO: ______

(6) I agree to seek consultation and evaluation about the usefulness and indications for the prescription of Antabuse ______, Naltrexone ______, Psychotropics ______ or other Medications ______.

PHYSICIAN - CONSULTANT: ______
WRITTEN/VERBAL REPORT TO: ______

(7) I agree to maintain contact with my PHP monitor.

MONITOR: ______

FREQUENCY OF CONTACT: ______

(8) I agree to maintain abstinence from the use of any mood altering chemicals (drugs and/or alcohol) unless prescribed by another physician in an appropriate manner for the treatment of illness with full knowledge and agreement of the PHP.

(9) I agree that my personal physician(s) may inform PHP of conditions for which I am under treatment including any and all drugs or medications, prescription and over-the-counter, included in the treatment plan. I will also request that drugs of addiction/controlled substances not be prescribed to treat illness unless there is no alternative treatment available. I will engage in a complete physical/medical examination if indicated.

WHEN: ______
BY WHOM: ______
WRITTEN REPORT TO: ______
PERSONAL PHYSICIAN'S NAME AND ADDRESS:

(10) I agree to communicate with and/or meet with the Medical Director of the PHP periodically to discuss my progress. I further agree to communicate with and/or meet with the ADVISORY COMMITTEE ON THE PHYSICIANS' HEALTH PROGRAMS AS DEEMED APPROPRIATE.

FREQUENCY OF CONTACT: ____________________

(11) I agree to enter into a Contract/Agreement of recovery and relapse consequences with my employer/institution, and give permission for my therapist(s) and the PHP to communicate with my employer/institution.

EMPLOYER(S): ____________________

ADMINISTRATIVE/MEDICAL STAFF/OTHER MONITOR:

__________________________ MEDICAL PRACTICE MONITOR/PROCTOR: ____________________

PRESCRIBING PRACTICES REVIEWER: ____________________

QUALITY OF PRACTICE REVIEW: ____________________

When: ____________________

By Whom: ____________________

Reports To: ____________________

(12) I agree to inform other appropriate persons and/or institutions of my impairment and participation in the PHP. I further agree to allow the PHP to communicate with and offer assistance to these individuals/institutions and to my family, and to encourage their participation in the PHP and/or self-help/support groups.

OTHERS INVOLVED:

( ) Institutional/Hospital IPP ____________________

( ) County Medical Society IPP ____________________

( ) Family Member(s) ____________________

( ) Other IPP ____________________

( ) Other Institutional Committee ____________________

(13) I agree to the PHP working with and communicating with as necessary the State Board of Medicine Impaired Professional Program and consultant and/or other administrative/legal entities as my advocate. I further agree to notify the PHP of any and all licensure and other legal changes.

STATUS WITH THE STATE BOARD OF MEDICINE: (Participation in Board IPP is necessary for anonymity to be maintained)

BOARD PROSECUTING ATTORNEY: ____________________

BOARD PCI: ____________________

OTHER CONTACTS/LEGAL ENTITIES: ____________________

REPORTS TO BE SENT TO: ____________________

(14) I agree to open communication between the PHP and those involved in helping me with my recovery as delineated in this AGREEMENT.

(15) I agree to advise all parties to this AGREEMENT immediately if I should suffer a relapse and to comply with the recommended treatment. This includes all legal entities with whom I am engaged.

(16) I agree to notify the PHP of any change of address, employment, telephone numbers, legal status, and marital/family conditions that might have relevance to recovery from impairment.

ATTORNEY: ____________________

TELEPHONE: ____________________

ADDRESS: ____________________

(17) I agree to take responsibility for all my expenses incurred as a result of my impairment and recovery. I further agree to pay for all costs incurred in necessary urine monitoring for my protection and to document my recovery.

(18) I agree to participate in any follow-up interviews and data collection concerning my recovery.
Contemporary medical training relies heavily on abbreviations. Before leaving residency, we are well versed in hundreds of them: CHF, DKA, BKA, CVA, ABG, and CBC. Residency training programs, however, are not addressing another group of abbreviations essential to the practice of medicine. Just eavesdrop in the doctors’ dining room and you will hear attending physicians refer to PPOs, IPAs, HMOs, HCFA, and KePRO. We need to take these topics out of the lunch room. Physicians in training need a working knowledge of them.

Because today’s medical environment requires a physician to do more than just manage disease, the Resident Physicians Section (RPS) is addressing the issues these abbreviations represent. Residents need to understand the socioeconomic, regulatory, and bureaucratic aspects of medicine before entering practice. The focus of this article is the resident’s perspective on the Keystone Peer Review Organization (KePRO).

KePRO is a wholly owned subsidiary of PMS. The Health Care Financing Administration (HCFA) was mandated by Congress to establish peer review organizations to monitor utilization and quality of care of patients on Medicare. Resident physicians perceive the PROs as having little impact upon them. Although KePRO has never issued a quality citation directly against a resident or fellow, this may be changing.

HCFA released a directive stating that the PROs should begin communicating directly with resident physicians.

Residents have key role

Because they are accountable for quality of care, residents play a key role in the peer review process. The house officer’s history and physical, progress notes, and discharge summaries are used in chart reviews to identify potential quality problems. Attendings rely heavily on the resident to document essential information in order to avoid quality concerns with KePRO. Yet few house officers know what is expected of them by the PROs.

With its new contract in hand, KePRO has begun to implement the new scope of work. KePRO will continue its chart review process with nurse reviewers using generic quality screens provided by HCFA. When potential problems are located, a physician reviewer will examine the chart. If confirmed, these problems will be assigned one of four quality levels. When a set number of quality problems (weights) are triggered, the responsible physician will be subjected to either more intensive reviews, educational programs, or even sanctions. This process has been described in detail in Pennsylvania Medicine.

Focus on documentation

Residents who want to avoid problems with KePRO should focus primarily on proper documentation. A thorough discussion of your plan of care is the best way to escape quality allegations. Daily review of laboratory x-ray, and EKG reports is important to preventing delays in discussing results that have returned to the chart. Even minor findings, such as previously known cardiomegaly or atelectasis on a CXR, should be mentioned in your notes. Nurses notes and those of other health professionals should be read; they are reviewed by the KePRO nurses. Discharge summaries must include follow-up care and plans for future testing or further evaluation.

The generic screens used by the nurse reviewers are quite specific. For example, a patient’s chart will be pulled if a temperature was greater than 101 F, a pulse less than 50, or a systolic blood pressure greater than 180 mm Hg within 24 hours of discharge. No IV fluids or medications can be given after midnight on the day of discharge. Patient falls or other nosocomial complications are of particular concern to the PROs. Additional specifics of these screens should be obtained from your hospital’s KePRO coordinator.

Residents and fellows need to learn more about the PROs, and should encourage attending physicians to share their experiences with housestaff. Not only will this allow us to become more effective practitioners but also it will serve to improve the quality of care. Other measures that could be taken include: comprehensive medical training including more focus on quality and cost-effectiveness; representation of house staff on the QA/UR committees within hospitals; chart review sessions with seasoned clinicians for interns; lectures and conferences on these issues incorporated into the curriculum of teaching hospitals.

Let us hear from you on this subject.
**CLINICAL INFORMATION:** This is a 69-year-old male who is unable to abduct his right arm and who has difficulty extending his arm. This is associated with right shoulder pain.

**FINDINGS:** Figure 1 is a proton density image in the coronal plane of the right shoulder. There is degenerative hypertrophy of the right acromioclavicular joint with a prominent inferior projecting osteophyte (A). A roughly linear area of low signal intensity inferior to the right distal clavicle represents the medial aspect of the rotator cuff (labeled B). A thin linear structure of low signal intensity superior to the right humeral head (labeled C) represents the lateral portion of the rotator cuff. Figure 2 is a T2-weighted image again demonstrating the inferior projecting osteophyte from the acromioclavicular joint (A) and the components of the torn rotator cuff (labeled B and C) as previously described. Increased signal intensity material between the torn portions of the rotator cuff represents joint fluid lying both within the joint space and in the subacromial bursa. Image #3 is a partial flip angle image which is sensitive for T2-weighting. This exhibits increased signal intensity in the immediate region of the rotator cuff tear as well as extending lateral over the right humeral head. The level of this slice is slightly anterior to figures 1 and 2 and the increased signal intensity material represents joint fluid extending over the right humeral head into the subdeltoid bursa.

**COMMENT:** MR imaging is the only modality capable of directly visualizing and differentiating the various soft tissue components of the musculoskeletal system. Only CT arthrography approaches this degree of accuracy in the detection of rotator cuff tears, however CT arthrography like its cousin, routine shoulder arthrography, is invasive and requires injection of contrast into the shoulder joint. MR is the imaging modality of choice in the initial evaluation of soft tissue injuries of the shoulder joint with routine or CT arthrography reserved for those patients on whom the MR study was indeterminate.
CONSIDERING MERGER? LOOK AT THESE ISSUES

The Health Care Group

Over the past decade, medical practices have been learning many lessons from the business world. Doctors have begun thinking of their practices as businesses, and are employing business-oriented strategies for growth and success.

In this period of decreasing reimbursements and increasing competition, many practices are considering one long-standing business strategy to enhance success: the merger. On the surface, a merger often seems a direct and attractive way to accomplish a medical practice's business goals. But there are major challenges involved in the process, and quite a few pitfalls if the merger is not planned and implemented carefully.

Why merge?
Practices merge for many reasons, some better than others. The primary reasons for merger are to increase the size and reach of the practice.

Some practices are aiming for diversification. As medicine becomes more technically complex, a practice may need to provide a broader range of services to "lock in" its patient base. Through merger, practices may gain the resources required to offer either broader or more in-depth subspecialty services. This is one reason a general internal medicine practice may merge with a cardiology or gastroenterology practice. Or, a non-invasive cardiology practice may merge with a group of cardiovascular surgeons.

Other practices merge to build multispecialty practices which can offer all services through a single group—"one-stop shopping." Why refer outside your practice when you can profitably provide those services in-house?

Geographic expansion also fosters mergers. As practices seek increased market share, they often find that increased size affords access to new geographic areas—beyond greater effectiveness in protecting or penetrating their existing geographic markets. Of course, practices also merge to protect their market share against potential competitors. A merger can protect referral networks; it may also help alleviate problems with state laws on referrals, the Medicare Fraud and Abuse Laws, and other joint venture restrictions. Of course, mergers can raise their own set of legal snags, such as anti-trust concerns.

Finances and economics are often catalysts for mergers. A larger practice offers economies of scale, a great ability to raise capital, and increased financial leverage. Adding new offices, purchasing new and possibly expensive technologies, subspecializing, adding a higher level manager, or bringing on new associates become possible. A solo or small group practice may see a practice merger as the way to a more secure future. For example, it removes the solo practitioner's need to sell the practice at retirement, and it can mitigate income loss if a physician suffers a personal disability.

A personal hardship may induce one physician to seek a partner to bear the burden of his practice, though he wishes to continue to practice and does not want to sell out completely. A merger may help the doctor meet both goals. Physicians who choose to alter their practice styles—through reduced call, or shortened office hours—may find that merging with a group practice facilitates that change.

Not a panacea
Mergers are not easy, however, and they will not serve every practice's goals. There are many good reasons not to merge your practice with another. If you are considering a merger, look carefully at the business, legal and personal implications. Only then may
you fairly evaluate the risks.

First, understand the variety of ways that practices can combine. The word "merger" is used to cover a range of legally distinct combinations; however, "merger" has an exact legal definition that is different from either "acquisition" or "consolidation." Merger means that when two practices combine, one is subsumed into the other. A consolidation occurs when practices join and form a wholly new, distinct corporation. In an acquisition, practice A buys practice B outright and subsumes it into its practice. The differences, although technical, have very different implications for the new entity and the way it's run. The choice of legal method for combining the practices will affect which Provider I.D. numbers and practice reimbursement profiles the new entity assumes, how legal arrangements are continued, and which checking accounts and vendor accounts will be used.

Second, be aware of the important emotional implications for the combination choice. In a merger, the surviving corporations' Provider I.D. Numbers, practice name, telephone numbers and the like have probably been maintained, with the other corporation transferring all its assets into that surviving corporation. Therefore, years after a merger, one doctor may still feel that "it's my practice, you joined me." By contrast, in a consolidation, both sets of practice accoutrements—and, with luck, the accompanying emotional value—are usually either retained or relinquished.

There are also looser types of practice affiliations such as partnerships of professional corporations, joint ventures, and various types of expense sharing or referral networking that are available as a lesser step than a merger. Each alternative has its pros and cons, and these alternatives also should be reviewed.

Third, merger is like a marriage: anything short of it is more akin to dating or living together. The relationship that you should have depends on your ultimate goals and how easily you want to be able to "call it off" if it doesn’t work out. If you’re planning for long range goals, commitment is important. It shouldn’t be easy to pull out of the merger in the short run, so a true merger (or consolidation) is usually best.

Fourth, it is also essential to understand the regulatory, tax and personnel implications of a merger. For example, Medicare law may be violated if you purchase another practice, but this is a substantive change in the organization of the practice, except to lock in referrals. Likewise, you may create an anti-trust problem if your merger creates a monopoly or has an anti-competitive effect on specific medical services in your area.

Though some mergers may be tax-free, there are important and complex tax decisions to be made. You may want to incorporate, alter existing retirement and/or profit sharing plans, change the way your benefit packages treat highly-compensated physicians, and so on, to plan for and to take advantage of various tax laws.

There also may be new personnel, legal and tax requirements—both state and federal—that apply if the practice is larger. For example, if your merged practice will have over 20 employees (counting physicians as employees), you will be subject to the Consolidated Omnibus Reconciliation Act of 1987 (COBRA). COBRA requires that you offer continued health insurance coverage for most employees leaving your practice—although you may not be required to bear the cost for the coverage. There are also federal anti-discrimination rules that could apply to your new group—rules pertaining not only to discrimination in hiring and firing, but also to benefits, pension plans, and so on. Finally, dependent on your actual size, special notices may be required for closing an office or laying off a number of staff. The merged practice should be ready to meet all newly-applicable state and federal laws.

Given the complexity and frequent changes in these laws, it is important to have good advice through each step in this planning and implementation process.

Finding a merger candidate

A merger is not a goal in itself. It is a means toward specific personal, professional or business goals. All potential players should benefit from the merger. That benefit may be unequal, but a merger that benefits only one party probably will not succeed. You should assess what each person brings to the merger.

Take a hard look at each player as a potential partner to decide if they should be a member of the new practice. Also, evaluate the personal compromises you are asked to make in your planning and decisions about the players. No one can force you to merge with a player you don’t want to have as a partner.

Think of your potential merger partner as your spouse. Don’t underestimate the amount of time you will spend with your new partner in the office, the operating room, the clinic, or other medical and business environments. You and your partners should be personally and professionally compatible. Practice styles and personalities should work to your mutual advantage. Take the time to discuss practice philosophies and styles thoroughly, including each player’s philosophy on participating with the Medicare program. Do any players do pro bono or clinic work? Would you describe your practice styles as similar?

Be realistic. Don’t expect anyone to change personality or practice style. How much do you trust your merger partners’ business and medical judgments? Any reservations should be thoroughly discussed and each player should be comfortable with potential partners.

Compatibility goes beyond the physicians. Staffs must also work together, so their personalities and styles should mesh, with a focus on the new merged entity. Staffs that cannot (or will not) work together will doom your merger.
Even when you get down to the nuts and bolts issues with a specific merger candidate, take a fresh hard look at the merger and ask if it remains financially worthwhile to you to merge. Having already determined each player’s professional and personal contributions, next determine what financial value each player offers and how the pieces fit together. Develop a detailed financial picture of the merged practice. Evaluate what the merged entity will gain and where it will be lacking.

What hard assets will each player add? Are all of each merger partner’s hard assets to be contributed? How will those assets be valued? Are all of the available hard assets needed by the new entity? Should they be assumed anyway?

Be certain that all the assets currently in use in the practice are included in this review process. Some practices take advantage of the tax laws to expense up to $10,000 per year in equipment, instead of recording and depreciating the assets on the practice’s balance sheet. (These are known as “Section 179” assets.) If your practice does this, those items’ value should be included with the contributed assets. Conversely, some items might be excluded. Assets such as artwork, or possibly automobiles, might properly be considered personal to the doctor, and therefore be excluded from mutual ownership.

The practices’ assets should be valued in a similar, objective manner. Generally a modified net book value (assets minus liabilities) approach to valuing the practice assets is recommended. For the hard assets, the depreciation is restated on a straight line basis for a number of years that more fairly represents the true economic life of the majority of the assets. Assets might be depreciated over as long as 15 years, depending upon their realistic useful life, with a minimum value assigned for all assets. Avoid valuing technology-related or customized assets, such as computer programs, under this method. These may be best valued by an independent appraiser appointed by both groups.

Note and include any significant prepaid assets (particularly malpractice insurance, leases, and deposits) or accrued but unpaid liabilities (particularly pension liabilities) as of the merger date.

The topic of accounts receivable deserves serious consideration among the potential partners. If accounts receivable are excluded, the entity will have no immediate source of cash with which to pay its bills, make its payroll, and so on. If contributed, these receivables should also be critically valued by a single, objective standard that accounts for adjustments and write-offs, with any differences equalized.

Whether to include goodwill in the overall financial valuation is a thorny question. Goodwill might be a significant practice asset and an important aspect of current inter-doctor arrangements. However, including goodwill makes the merger much more complex and sometimes unachievable. For this reason, detailed goodwill value analyses are often excluded from the financial analysis of a potential merger.

Usually, each shareholder-player to the merger is required to contribute the same amount to the merger—if the intention is to be equal partners. To equalize relative contributions among the partners, determine the maximum amount of assets to be contributed and have all players not contributing an equal share of asset value make up the difference. Other ongoing financial differences can then be accounted for over time.

Income division

One of the most important and complex tasks you will face in merging a practice is developing an income division formula. The division might be equal, based on productivity, or some combination of the two; the decision is guided largely by practice style, philosophy of practice, and your specialty. Primary care physicians often divide income equally, while surgical specialties—whose income can vary greatly—are often allocate income based on productivity.

There are other inter-doctor matters that require resolution. For example, how much sick pay will be allowed for disabled or ill physicians? How much time will be available for vacations or for leaves of absence? How will partial retirement be handled? How will future expansion be financed? What arrangements will be contemplated for bringing on new physicians?

Many physicians merge for the security of being a member of a larger group. Those physicians usually expected to be bought out of their own group and will likely in turn intend to be bought out of the new group. Therefore, structuring new buy-out arrangements becomes increasingly important and complex.

With new buy-out arrangements, you should consider imposing significant limitations on a physician’s right to be bought out—for example, allow no buy-out if somebody decides to leave during the first year. This is a time when the merger is new and uncertain. It is important to give the entity a chance to succeed before members voluntarily bail-out—particularly since you may be committed to a substantial liability on the buy-out that may be payable over a number of years.

Additional limitations on a physician’s right to be bought out may be predicated upon reducing the separation pay for any disability or sick pay the departing physician received prior to separating. Restrictions on subsequent competition with the merged practice, and a minimum payment cap, are also important restrictions to consider placing in the buy-out provision of a merger agreement.

Likewise, "bail-out" issues should be addressed in case the merger does not work. The terms and the timing of the bail-out should be defined, including what happens to each of the contributed assets. Everything should be spelled out up front, so that if push comes to shove, you don’t have to fight things out.

Getting ready

Mergers can be high risk/high return ventures. The challenges you face are numerous and complex; yet the rewards can be significant, both for the constituent practices and for the individual doctors. Careful consideration of the multifaceted issues, followed by complete preparation, are the keys to a successful merger. There must be comprehensive research and discussion before the deal is struck and thorough planning to implement the merger, anticipating and responding quickly to the array of problems and issues you will face in the early weeks and months of the new practice.

Having chosen a merger partner, agreed on goals, and determined the merger’s value and feasibility, now it is time to commit your plans and objectives to paper, to determine the actual financial, legal, and management structure of the new practice, and to put your plans into effect. Part two of this article will discuss some of the practical considerations of implementing those plans.
Department of Family Medicine
Jefferson Medical College
of Thomas Jefferson University, (TJU), Philadelphia, Pennsylvania
presents
The Edna G. Kynett Memorial Foundation
First Annual Symposium - Update in Cardiology for Primary Care Physicians
"Evolving Concepts in Ischemic Heart Disease: Practical Application to Primary Care"
April 5, 1990
1:00 p.m - 5:30 p.m.

1:00 - 1:30 p.m. Registration

Moderator..........................Sheldon Goldberg, M.D.
Professor of Medicine, Associate Director of Cardiology
Director, Cardiac Catheterization Laboratory
Jefferson Medical College, TJU

1:30 - 1:35 p.m. Welcome
Paul C. Brucker, M.D.
Alumni Professor and Chairman, Department of Family Medicine,
Jefferson Medical College, TJU

1:35 - 1:45 p.m. Introduction, Sheldon Goldberg, M.D.

1:45 - 2:25 p.m. "The Unstable Plaque: Pathophysiology and Therapeutic Implications"
Richard K. Myler, M.D.
Clinical Professor of Medicine, University of California,
San Francisco and Medical Director, San Francisco Heart Institute

2:25 - 3:00 p.m. "Issues in Selection of Patients for Medical Versus Interventional Therapy: Role of Both Non-invasive and Arteriographic Findings"
Richard H. Helfant, M.D.
Professor of Medicine,
School of Medicine, University of California, Los Angeles

3:00 - 3:20 p.m. Refreshments with faculty

Moderator..........................Albert N. Brest, M.D.
and Discussion Leader
James C. Wilson Professor of Medicine and Director, Division of Cardiology, Jefferson Medical College, TJU

3:20 - 3:30 p.m. Introduction, Albert N. Brest, M.D.

3:30 - 4:05 p.m. "What is the Clinical Significance of Silent Myocardial Ischemia?"
Carl J. Pepine, M.D.
Professor of Medicine and Acting Director, Division of Cardiology,
University of Florida, Gainesville

4:05 - 4:35 p.m. "Coronary Angioplasty: Indications, Contraindications and Limitations: Have New Devices Helped?", Richard K. Myler, M.D.

4:35 - 5:10 p.m. "Current Approach to Patients with Myocardial Infarction"
Sheldon Goldberg, M.D.

5:10 - 5:30 p.m. Panel Discussion

For further information and registration, contact Linda Buzard at:
(215) 928-2352
1015 Walnut Street, Room 401
Philadelphia, PA 19107

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PREPROCEDURE REVIEW GRIDLOCK

Donald E. Harrop, MD

Perhaps the most challenging task KePRO has encountered during the four and one-half years of our existence has been the implementation of preprocedure review of 10 surgical procedures required as of January 4, 1990. By now, most physicians are aware of the problems which we experienced with this new review requirement especially during the first few weeks.

The major complaint initially was that the Preoccurrence Department’s telephone lines were constantly tied up. Also, written or FAXed early requests for surgery scheduled more than a few days after the January 4 effective date were not immediately reviewed because cases were being triaged by date of surgery. These unanswered requests were followed up by telephone from the physicians’ offices or the hospitals, further contributing to the tie-ups.

Duplicate requests became a serious problem and usually occurred because an approval number was not immediately assigned since surgery was not imminent. Other duplicates resulted from a lack of coordination between some hospitals and their medical staffs as to who would seek approval.

Another major and continuing problem results from submission of inadequate information on the written and FAXed requests. Many times results of certain tests or studies are necessary to the request for approval of the planned surgery. These results, however, are not always included with the approval request. Seeking this information by telephone is time-consuming and labor-intensive.

Based on HCFA’s projections, we can expect 7,367 requests for reviews each month. Instead, we received 9,371 requests in three weeks. There is nothing we can do about the volume of cases. We did take a number of steps to ease the congested telephone lines and to speed up the process. These included the installation of additional telephone lines, adding more staff to the Preoccurrence Department, and revising some internal procedures. Some improvements should also occur as a result of computer equipment which has been installed. We could not order this equipment until we received the renewal contract and, as has been reported, this was not known until November 30, 1989.

There are several things physicians should keep in mind about this review. There is no penalty for not obtaining preapproval on an individual case; however, a pattern of cases without preapproval could result in some action taken against the physician or provider and may even lead to a sanction. Also, without preapproval, payment for the service could be delayed as much as 60 to 90 days because the case would require retrospective review and approval before payment is made. Further, for emergency situations, with insufficient time to obtain preapproval, a post-discharge, prebilling system has been developed. The system should provide a much faster turnaround time for completion of review and payment of the case.

Although many of the earlier problems have been solved or alleviated, the unexpectedly high volume of requests continues to cause some difficulty. We are monitoring the process on a daily basis and will continue to take all necessary steps to smooth out any rough spots in the system.

Dr. Harrop is president of the Keystone Peer Review Organization and a past president of the Pennsylvania Medical Society. He is a family physician in Phoenixville.

The telephone number listed in the January issue for Donald E. Harrop, MD, President of the Keystone Peer Review Organization, has been changed. The new number is 215-933-7453.
Description: Yohimbine is a 3a-15a-20β-17α-hydroxy Yohimbine-16α-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L.) Benth. Yohimbine is an indolealkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine’s peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yoon° is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient’s sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardiac-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral effects. These include, anticholinergic, and anti-cholinergic, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. Also dizziness, headache, skin flushing reported when used orally. 1, 2, 3, 4

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence, 1, 2, 3, 4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 days. 3

How Supplied: Oral tablets of Yoon° 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

Rev. 1/85
Obituaries

Pauline Coonel, Wyomissing
Syracuse University Medical School, 1932; died December 27, 1989. Dr. Coonel was an otorhinolaryngologist.
•

Francis S. Ericson, Warren
McGill University Faculty of Medicine, 1939; age 78, died December 13, 1989. Dr. Ericsson was an obstetrician and gynecologist.
•

Carl C. Fischer, Deeray Beach, FL
Hahnemann University School of Medicine, 1928; age 87, died December 23, 1989. Dr. Fischer was a pediatrician.
•

Charles F. Fox, Jr., Vanderbilt
Hahnemann University School of Medicine, 1935; age 83, died January 20, 1990. Dr. Fox was a general practitioner.
•

Joseph T. Freeman, Philadelphia
Jefferson Medical College, 1934; age 81, died December 5, 1989. Dr. Freeman was an internist.
•

Isadore W. Ginsburg, Overbrook Hills
Temple University School of Medicine, 1934; age 84, died December 11, 1989. Dr. Ginsburg was an internist.
•

Samuel Levine, Wynnewood
Age 89, died December 2, 1989. Dr. Levine was a radiologist.
•

Francis J. McAndrew, Bethlehem
Georgetown University School of Medicine, 1931; age 90, died January 5, 1990. Dr. McAndrew was a general practitioner.
•

Silvio Miceli, Villanova
Age 84, died January 17, 1990. Dr. Miceli was a urologist.
•

Edward J. Schultz, Claysburg
University of Pittsburgh School of Medicine, 1935; age 79, died January 7, 1990. Dr. Schultz was a general practitioner.
•

William B. Templin, Johnstown
Temple University School of Medicine, 1958; age 57, died December 21, 1989. Dr. Templin was a general surgeon.
•

Eugene L. Thomas, Philadelphia
Age 83, died December 27, 1989. Dr. Thomas practiced occupational medicine.
•

Louis Tuft, Philadelphia
University of Pennsylvania School of Medicine, 1920; age 91, died December 19, 1989. Dr. Tuft was an allergist.
•

Warren E. White, Johnstown
Temple University School of Medicine, 1937; age 76, died November 16, 1989. Dr. White was a dermatologist.
•

Maurice H. Alexander, Wynnewood
Jefferson Medical College, 1935; age 79, died January 3, 1990. Dr. Alexander was an otorhinolaryngologist.
•

Bernard N. Bathon, Hanover
University of Maryland School of Medicine, 1957; age 58, died December 1, 1989. Dr. Bathon was a cardiologist.
•

Katharine Butler, Kennett Square
Cornell University Medical College, 1935; age 91, died November 18, 1989. Dr. Butler was an internist.
•

Harold L. Casey, Carbondale
Georgetown University School of Medicine, 1925; age 89, died December 31, 1989. Dr. Casey was a general practitioner.
•

Mary R. Curcio, Philadelphia
Medical College of Pennsylvania, 1933; age 83, died December 27, 1989. Dr. Curcio was an internist.
•

Jeffrey S. Farkas, Pittsburgh
Wayne State University School of Medicine, 1969; age 26, died December 4, 1989. Dr. Farkas was a pediatrician.
•

Gene F. Haring, Slavetown
Women's Medical College of Pennsylvania, 1965; age 49, died November 27, 1989. Dr. Haring was a psychiatrist.
•

Ralph A. Luongo, Linwood
Philadelphia College of Osteopathic Medicine, 1956; age 65, died December 19, 1989. Dr. Luongo was a general practitioner.
•

Helen E. Richmond, Allentown
Medical College of Pennsylvania, 1935; age 80, died December 7, 1989. Dr. Richmond was a dermatologist.
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Richard Kunkle, MD, director of Latrobe Area Hospital Department of Emergency Medicine, visited Romania on December 26, 1989, as the only physician on a four-man disaster assessment team sent by the U.S. office of Foreign Disaster Relief. Dr. Kunkle, a nationally recognized authority on disaster medicine, arrived in Romania the day after the execution of Nicolai Ceausescu.

David Cornfeld, MD, was honored with a portrait dedicated by Children’s Hospital of Philadelphia for his 33 years of service to sick children. Dr. Cornfeld is deputy physician-in-chief at the hospital.

Arnold T. Berman, MD, professor and chairman, Department of Orthopedic Surgery and Rehabilitation, Hahnemann University, and medical director, Hahnemann University Hospital, has been named chairman of the Admissions Committee of the American College of Surgeons for Pennsylvania.

Herbert Needelman, MD, professor of psychiatry and associate professor of pediatrics at the University of Pittsburgh School of Medicine, and colleagues, published findings in the New England Journal of Medicine. January 1990, of the first conclusive evidence that the damaging effects of low-level lead exposure in children are long-lasting.

John C. Lyons, MD, orthopedic surgeon and biomedical engineer from Erie, was honored for his contributions to water safety programs at Presque Isle State Park. For four years, Dr. Lyons, a former Presque Isle lifeguard, has taught lifeguards how to respond to drownings, diving accidents and other injuries.

James B. Snow, Jr., MD, professor and chairman, University of Pennsylvania Medical Center, on March 1 became director of the National Institute on Deafness and Other Communication Disorders, National Institutes of Health. Dr. Snow has been professor of otorhinolaryngology and human communication at Penn and chairman of the clinical department at the university hospital for 17 years. He is also medical director of the Smell and Taste Center and of the Speech and Hearing Center.

Herbert L. Hyman, MD, an Allentown internist and gastroenterologist, has been named to the Council of Trustees of Kutztown University. Dr. Hyman is a senior consultant in gastroenterology at Allentown Hospital and Lehigh Valley Hospital Center, as well as a consultant for other area hospitals.

Ralph C. Eagle, Jr., MD, director of the pathology service at Wills Eye Hospital, Philadelphia, received the American Academy of Ophthalmology (AAO) Honor Award for excellence in teaching and service to the Academy.

Lewis Kuller, MD, DrPH, was named associate director, the epidemiology and preventive oncology division of Pittsburgh Cancer Institute (PCI). He succeeds Seymour Grufferman, MD, DrPH, who became professor and chairman of clinical epidemiology and preventive medicine at the University of Pittsburgh School of Medicine.

Richard P. Wilson, MD, director of the Glaucoma Service Diagnostic Laboratory at Wills Eye Hospital, received an American Academy of Ophthalmology (AAO) Honor Award at the organization’s 94th annual meeting in New Orleans. The awards are presented for excellence in teaching and service to the academy.
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8:30 A.M.—9:30 A.M.

MARCH 1990
March 21, 1990
CLINICAL PHARMACOLOGY
Vincent J. Zarro, MD, PhD
Associate Professor of Pharmacology & Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

March 28, 1990
DERMATOLOGIC TREATMENT WITH RETINOIDs AND CYCLOSPORINE
Richard L. Spielvogel, MD
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

APRIL 1990
April 4, 1990
CARDIAC ELECTROPHYSIOLOGY: EVOLVING DIAGNOSTIC AND THERAPEUTIC MODALITIES
John D. Fisher, MD
Professor of Medicine
Director, Cardiac Arrhythmia Service
Acting Director, Division of Cardiology
Montefiore Medical Center
New York, NY

April 11, 1990
MEDICAL MANAGEMENT OF GALLSTONE DISEASE
Hans Fromm, MD
Professor of Medicine
Director, Division of Gastroenterology
The George Washington University
Washington, DC

April 18, 1990
ENDOCRINOLOGY AND METABOLISM: RECENT ADVANCES
Leslie J. Rose, MD
Professor of Medicine
Director, Division of Endocrinology and Metabolism
Hahnemann University

Jeffrey L. Miller, MD
Associate Professor of Medicine
Division of Endocrinology and Metabolism
Hahnemann University

April 25, 1990
PROSTHETIC VALVE ENDOCARDITIS
William E. Dismukes, MD
Professor & Vice-Chairman for Educational Programs
Department of Medicine
University of Alabama
Birmingham, AL

MAY 1990
May 2, 1990
VENOUS THROMBOEMBOLIC DISORDERS: UPDATE 1990
John C. Hoak, MD
Director, Division of Blood Diseases and Resources
National Heart, Lung and Blood Institute
National Institutes of Health
Bethesda, MD

May 9, 1990
IMMUNE MECHANISMS: BREAKTHROUGHS IN IMMUNOSUPPRESSION
George H. Hitchings, Jr, PhD, DSc
Nobel Prize Winner, 1988

WEDNESDAY MEDICAL SEMINAR SERIES
8:30 A.M.—3:00 P.M.

March 28, 1990
Cyclosporine and Systemic Retinoids: Therapeutic Options
Guest Faculty
Cynthia A. Guzzo, MD
Assistant Professor of Dermatology
University of Pennsylvania, Dept. of Pathology
Philadelphia, PA

Henry H. Roenigk, Jr, MD
Professor of Dermatology
Chairman, Dept. of Dermatology
Northwestern University, Chicago, IL

April 25, 1990
Infectious Diseases: Treatment of Difficult and Opportunistic Fungal Infections
William E. Dismukes, MD
Professor and Vice-Chairman
Department of Medicine
University of Alabama School of Medicine

David J. Drutz, MD
Adjunct Professor of Medicine
University of Pennsylvania School of Medicine
Adjunct Professor of Microbiology & Immunology
Temple University Medical School

Thomas J. Walsh, MD
National Cancer Institute
National Institutes of Health

May 9, 1990
The Age of Immunosuppressive Therapy and Organ Transplantation
Guest Faculty
George H. Hitchings, Jr, PhD, DSc
Nobel Laureate, 1988, Medicine and Physiology
Adjunct Professor of Pharmacology & Experimental Medicine
Duke University

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Presented by:
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Professor of Medicine
Chairman, Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
Department of Medicine

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Location:
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2nd Floor New College Bldg.
Hahnemann University
15th Street Entrance
15th and Vine Streets
Philadelphia, PA
The Educational and Scientific Trust of the Pennsylvania Medical Society is a nonprofit, tax-exempt public organization established in 1954 to serve medicine through charitable, educational, and scientific activities.

The Trust benefits medicine and the public by:
- Providing loans to medical and allied health students;
- Developing professional educational materials to meet identified needs;
- Administering the Physicians' Health Programs (formerly Impaired Physician Program) which provides support for impaired physicians, families dealing with impairment, physicians experiencing litigation stress, and disabled, handicapped, and senior physicians;
- Conducting marketing research on professional and public health issues;
- Providing consulting and administrative services to other health care professionals and organizations; and
- Conducting charitable projects and activities.

Simply, the mission of the Trust is:
Research to build the future;
Education to protect it.
Reaching Out...

Reach out and touch someone...the
Trust slightly modified the slogan of
this popular advertising campaign and
adopted it as our theme for 1989.

Reaching out to make someone's life a
little better is what The Educational
and Scientific Trust strives to do.

The Trust extends its reach to Pen-
sylvania's physicians and the public
through its programs and projects. Each
year, trustees and staff meet for a com-
prehensive planning meeting to system-
atically determine what programs will
best serve public and professional
needs. This planning session also estab-
lishes a base for making sound deci-
sions concerning the direction and
growth of the Trust.

June 1989 was the latest such ses-
son. The participants determined that
the Trust should maintain its existing
programs of fund-raising, student loans,
educational projects, contracted proj-
ects, the Physicians' Health Programs,
and elective administrative services.

The Trust will also continue to enhance
its relationship with the Pennsylvania
Medical Society.

Identified as future challenges for the
Trust were:

- Recognizing and addressing emerg-
ing public health needs;
- Equipping physicians to adopt a
leadership role in responding to current
and potential health care concerns;
- Promoting the concept that "medi-
cine is a good profession" and, despite
criticisms, physicians are doing good
things for people;
- Encouraging physicians to volun-
tee some time to care for the poor;
- Making better use of the knowl-
edge and experience of senior (retired
or semiretired) physicians; and
- Providing effective help to troubled
physicians and their families.

The Trust is determined to build on
its proven record of accomplishments.
In reaching out to the future, the trust-
ees continue to affirm their commit-
tment to Pennsylvania's physicians and,
above all, to the public they serve.

Student Loans

During the 1989-90 school year, the
Trust loaned more than $577,285 to
medical and allied health students.

Because of our student loan program,
182 medical students and 53 allied
health students received financial assis-
tance to continue their education.

Grants and Studies

Elder Abuse
The Trust is working under contract
with the Pennsylvania Department of
Aging to develop training materials and
conduct a series of educational seminars
on elder abuse and protective services.
Law enforcement personnel, bank
employees, emergency department
personnel and home health nurses were
targeted to receive the training. These
programs will help professionals work-
ing with the elderly recognize signs of
abuse and educate them about protocols
to follow to get help for abused elderly
persons.

Agent Orange Update
Through a contract with the Pennsylva-
nia Department of Health, the Trust
researched and produced, "The Viet-
am Experience: An Overview of the
Health Problems Associated with Viet-
am Service." This guide seeks to
inform health professionals about poten-
tial health problems in Vietnam
veterans resulting from service in
Southeast Asia. Chapters include:
information on Agent Orange; tropical
diseases prevalent in Southeast Asia;
Post Traumatic Stress Disorder and
other psychological problems experi-
cenced by Vietnam veterans; and re-
sources health professionals can use to
help these servicemen get proper treat-
ment. The booklet is a follow-up to
"Toxic Herbicide Exposure (Agent
Health data analysis.

Leadership
For the past two years, the Trust has been working toward establishing a physician leadership program. This long-term project focuses on providing physicians with leadership skills to give the profession a continuing voice in the changing health care arena. The Trust conducted a research study and sponsored a physician conference on the issue. We have identified areas which must be developed to effectively produce leaders who can serve the medical profession. An institute for physician leadership will soon be created to provide a workable umbrella for these efforts.

Emergency Physicians
The Trust conducted two marketing studies for the Pennsylvania Chapter of the American College of Emergency Physicians (PaACEP). During the past year, the Trust helped PaACEP: (1) identify the needs and priorities of its membership and gather demographic data through a membership needs assessment; and (2) determine how its board review course fared in the marketplace by conducting a competition analysis.

Psychiatry
The Pennsylvania Psychiatric Society (PPS) recently maintained its 501(c)(3) charitable status and created a new organization for the psychiatric specialty, the Psychiatric Physicians of Pennsylvania (PPP). The Trust is now working under contract with PPS to develop fund-raising strategies to support the group’s educational and research projects.

PMS
The Trust is conducting a statewide marketing study for the Pennsylvania Medical Society (PMS) to: identify members’ satisfaction with PMS services and activities; determine trends for developing new services; and identify how the practice of medicine is changing for members. Through focus group discussions, the Trust seeks to discover members’ opinions on such areas as government representation, communications, hospital/physician relations, and professional standards.

Nursing
The Trust produced a four-color poster promoting the nursing profession to encourage individuals to consider a career in nursing. The poster, entitled “White Cap Excitement,” depicts the challenges posed by skiing, surfing, and nursing, and includes information on the Trust’s Allied Health Student Loan Program. It was distributed to physicians, auxiliary members, and high school guidance counselors across the state. As part of the Trust’s efforts to help deal with today’s nursing shortage, 38 nursing students received financial support through our Allied Health Student Loan Program.

Financial Aid Officers’ Workshop
For the sixteenth consecutive year, the Trust held a workshop for financial aid officers of Pennsylvania medical schools. This program continues to be a stimulating interchange of ideas on issues related to student financial support. At this workshop, the Pennsylvania Medical Society Auxiliary officially presented more than $87,000 to Pennsylvania medical schools on behalf of the American Medical Association Education and Research Foundation (AMA-ERF).

Charitable Projects Overseas
The Trust continues its special project to support continuing medical education for foreign physicians. We have been raising funds to purchase an ophthalmologic laser for a Trust student loan borrower who has been giving a few years of free medical care to the people of St. Lucia, an island in the Caribbean.

Physicians’ Health Programs

On January 1, 1989, the Trust assumed responsibility for the Pennsylvania Medical Society’s Impaired Physician Program (IPP). This move was requested by the PMS Board of Trustees so IPP would be eligible for grant monies and other financial support available under the Trust’s nonprofit, tax-exempt status.

Since then, several changes have been made to enhance the Impaired Physician Program. Because the program’s services were expanded and because the term, “impaired” has negative connotations, the program’s name was changed to Physicians’ Health Programs.

PHP offers an array of services for physicians and their families. It encompasses the following activities:
- Impaired Physician Program—locates, contacts, and offers advocacy services to physicians who suffer impairment due to alcohol and drug abuse, and mental, physical, and aging problems.
- Litigation Stress Program—provides information and support to physicians and their families going through legal proceedings. The program encourages the development of local support networks and the linking of defendant physicians with supportive colleagues. Educational programs are also offered to county medical societies, hospital medical staffs, and other groups.
- Family Support Services—helps impaired physicians’ spouses and children cope and assist in the recovery regimen of the physician. The program also encourages the development of local support networks.
- Disabled and Handicapped Physician Program—offers advocacy to the disabled and handicapped physician.
- Senior Physician Assistance Program—provides a contact point for the sharing of information among retiring and aging physicians.
- Treatment Loan Fund—offers financial assistance for physicians entering a rehabilitation program.
- Reentry of Practice Loan Fund—provides resources to physicians wishing to resume practice after recovery.
- Laboratory Monitoring Fund—helps physicians pay for periodic blood and urine monitoring during rehabilitation. This is often required for physicians entered in PHP’s Impaired Physician Program.
Management Services

The Trust provides administrative and management support to the following health care organizations:

- The Pennsylvania Diabetes Academy—accounting services, and marketing and management support;
- The Pennsylvania Oncologic Society—accounting, meeting management, and administrative management services;
- The Pennsylvania Chapter, the American College of Emergency Physicians—accounting and marketing services;
- The Psychiatric Physicians of Pennsylvania—accounting and marketing services;
- The Pennsylvania Psychiatric Society—accounting and marketing services;
- The Keystone Safety Belt Network—accounting services;
- The Pennsylvania Orthopaedic Society—accounting services;
- The Robert H. Ivy Society of Plastic and Reconstructive Surgeons—accounting services; and
- The Pennsylvania Medical Society—marketing services.

Pfahler Foundation

The Trust again thanks the Pfahler Foundation for its 1982 gift of student loans receivable. This Foundation is administered by the Philadelphia County Medical Society.

The Trust has now collected more than $129,653 in principal and interest. Only five loans remain outstanding representing $8,936 in principal. Over the years, these funds have been added to the Medical Student Educational Fund to help support new student loans.

Contributions

The Trust is pleased to recognize those individuals and groups whose support has been vital in making this past year a success. Their contributions demonstrate their deep commitment to The Educational and Scientific Trust.

Every effort has been made to recognize all individuals and organizations supporting the Trust in 1989. If, however, we made an error, we apologize. Please contact the Trust so we can correct our records.

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Members of the Trust's most distinguished group of benefactors contribute $1,000 or more each year. Members of the College have the privilege of designating their contributions for a specific project, or allowing the Trust to use the funds where the need is greatest.

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Special Thanks

The following county medical societies have donated advertising space for the Trust in their publications:
Beaver County Medical Society
Berks County Medical Society
Chester County Medical Society
Delaware County Medical Society
Lehigh County Medical Society
Luzerne County Medical Society
Montgomery County Medical Society
Westmoreland County Medical Society

The following organizations have been generous and sustaining benefactors of the Physicians’ Health Programs.

Pennsylvania Hospital Insurance Company
Pennsylvania Medical Society
Pennsylvania Medical Society
Liability Insurance Company
Pennsylvania Osteopathic Medical Association
PHP Key Supporters

The Trust is grateful to the many hospitals which have become Key Supporters of the Physicians’ Health Programs (PHP). Under this program, hospitals contribute $10 for every medical staff member to the PHP. Hospitals can become Key Supporters until July 30, 1990. This is a united effort between hospital administrations and physicians that will result in a more effective program to help troubled physicians. In the coming years, Key Supporters who continue to contribute will receive special recognition in future Trust Annual Reports.

<table>
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<th>Hospital/Medical Center</th>
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<tr>
<td>Abington Memorial Hospital</td>
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<td>Allentown-Lehigh Valley Hospital Center</td>
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<tr>
<td>Altoona Hospital</td>
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<tr>
<td>Braddock General Hospital</td>
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<td>Brookville Hospital</td>
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<tr>
<td>Bryn Mawr Rehab. Hospital</td>
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<td>Chestnut Hill Rehab. Center</td>
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<td>Charles Cole Memorial Hospital</td>
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<td>Chestnut Hill Hospital</td>
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<td>Citizens General Hospital</td>
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<td>Jameson Memorial Hospital</td>
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<td>Rehab. Institute of Pittsburgh</td>
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<td>York Hospital Medical Center</td>
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</table>

PHP Contributors

The Trust is grateful to the individuals, organizations, and the hospital medical staffs and administrations who supported the Physicians’ Health Programs through their contributions in 1989.

<table>
<thead>
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<th>Name</th>
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<td>Holy Spirit Hospital Medical Staff</td>
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<td>J. Preston Hoyle, MD</td>
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<td>Morgan M. McCoy</td>
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<td>York Hospital Medical Center</td>
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</tbody>
</table>
Memorial and Honorary Gifts

Individuals making a memorial or honorary contribution to the Trust have gained the satisfaction of making a gift that creates a lasting remembrance while serving others. Giving a gift in memory or in honor of a special individual is a rewarding way to acknowledge a friend's accomplishments or successes.

The following individuals have been memorialized through contributions to the Trust:

Mithlesh G. Asnani, MD  
Harry Ballis  
Myron Ball, MD  
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John V. Blady, MD  
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Lewis T. Buckman, MD  
Dorothy Coffey, MD  
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Henry Milford, MD  
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Frank P. Perrone, MD  
J. Douglas Phillips, MD  
Mr. Earl F. Rader  
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Isadore Robins, MD  
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F. Budd Schooley, MD  
Joseph M. Shelton, MD  
Anna Sickie  
Mrs. Virginia Spannuth  
Margaret Sutton  
John Testa, MD  
Philip R. Weist, MD  
William F. Wolfe, MD  
Reba Harvey Zeikus

The following individuals have been honored through contributions to the Trust:

Edgar Cordero, MD  
J. Joseph Danyo, MD  
Jonathan Holt, MD  
Juan E. Kraljevic, MD  
Mrs. Sue Krasnoff  
Mrs. Stanley P. Meyers, Jr.  
Philip A. Pomerantz, MD  
Leon H. Venier, MD  
James Wong, MD
## Summary of Financial Data

### Balance Sheet

December 31, 1989  
(Unaudited)

<table>
<thead>
<tr>
<th>Assets</th>
<th>Operating</th>
<th>Endowment</th>
<th>Total</th>
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<tbody>
<tr>
<td>Cash and Investments, at Cost (Market Value, $899,793.52)</td>
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<td>$51,020</td>
<td>$851,394</td>
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<tr>
<td>Accounts Receivable</td>
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<tr>
<td>Loans Receivable</td>
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<tr>
<td>Office Equipment (Less accumulated depreciation of $16,276)</td>
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<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$5,487,095</strong></td>
<td><strong>$51,020</strong></td>
<td><strong>$5,538,115</strong></td>
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<table>
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<th>Liabilities</th>
<th>Operating</th>
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<td>Accrued Taxes</td>
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<td>Unearned Interest Income</td>
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<td><strong>Total Liabilities</strong></td>
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<th>Fund Balances</th>
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<td>Available for Designated Purposes</td>
<td>760,509</td>
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<td>811,529</td>
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<td><strong>Total Fund Balances</strong></td>
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<table>
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<td>Fund Balances, January 1, 1989</td>
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<td>Excess of Revenues over Expenses</td>
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<td>Other Charges in Fund Balance: Transfer Endowment Fund net investment income to Operating Fund</td>
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<td>(5,454)</td>
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<td><strong>Fund Balances, December 31, 1989</strong></td>
<td><strong>5,480,627</strong></td>
<td><strong>51,020</strong></td>
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<thead>
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<th>Statement of Fund Balances</th>
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<td>Physicians’ Health Programs</td>
<td>311,370</td>
<td>311,370</td>
<td></td>
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<tr>
<td>Medical Student</td>
<td>4,324,167</td>
<td>4,324,167</td>
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<tr>
<td>Allied Health Student</td>
<td>277,086</td>
<td>277,086</td>
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<tr>
<td>Start-Up of Practice</td>
<td>230,723</td>
<td>230,723</td>
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<tr>
<td>Loan Stabilization</td>
<td>58,397</td>
<td>58,397</td>
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</tr>
<tr>
<td>Endowment</td>
<td>51,020</td>
<td>51,020</td>
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<tr>
<td>Board Designated Reserves</td>
<td>136,243</td>
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<tr>
<td>Continuing Education</td>
<td>12,865</td>
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<tr>
<td>Foreign Philanthropy</td>
<td>204</td>
<td>204</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>4,661,721</strong></td>
<td><strong>58,397</strong></td>
<td><strong>5,531,647</strong></td>
</tr>
</tbody>
</table>
## Statement of Revenues and Expenses

December 31, 1989  
(Unaudited)

<table>
<thead>
<tr>
<th>Revenues:</th>
<th>Operating</th>
<th>Endowment</th>
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<tbody>
<tr>
<td>Contributions</td>
<td>516,696</td>
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<td>Memorial Contributions</td>
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<td>Honorary Contributions</td>
<td>3,250</td>
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<tr>
<td>Fund-Raising Projects</td>
<td>180,846</td>
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<tr>
<td>Investment and Savings</td>
<td>77,328</td>
<td>3,364</td>
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<tr>
<td>Net Gain on Sale of Investments</td>
<td>33,491</td>
<td>2,346</td>
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<tr>
<td>Loans Interest</td>
<td>211,781</td>
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<tr>
<td>Loans Delinquency Charges</td>
<td>576</td>
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<tr>
<td>Administrative Services</td>
<td>34,445</td>
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<tr>
<td>Projects and Programs</td>
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<tr>
<td>Miscellaneous</td>
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<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>1,133,307</strong></td>
<td><strong>5,760</strong></td>
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<table>
<thead>
<tr>
<th>Expenses:</th>
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<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>447,507</td>
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<tr>
<td>Temporary Help</td>
<td>4,810</td>
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<tr>
<td>Travel and Meetings</td>
<td>25,449</td>
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<tr>
<td>Consultants</td>
<td>14,847</td>
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<td>Legal Fees</td>
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<td>Computer Support</td>
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<tr>
<td>Accounting and Auditing</td>
<td>6,087</td>
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<tr>
<td>Project Development</td>
<td>100,740</td>
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<tr>
<td>Advertising and Fund-Raising</td>
<td>25,384</td>
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<tr>
<td>General and Administrative</td>
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<tr>
<td>Investment Management Fees</td>
<td>4,764</td>
<td>256</td>
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<tr>
<td>Collection Fees</td>
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<tr>
<td>Uncollectible Loans</td>
<td>12,489</td>
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<tr>
<td>Miscellaneous</td>
<td>3,838</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>722,264</strong></td>
<td><strong>256</strong></td>
</tr>
<tr>
<td><strong>Excess of Revenues over Expenses</strong></td>
<td><strong>$411,043</strong></td>
<td><strong>85,504</strong></td>
</tr>
</tbody>
</table>

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- R. William Alexander, MD
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Family practice, BC/BE, 3 person primary care office, active hospital practice, suburban Philadelphia—excellent opportunity with early buy in. Send CV to Box 292, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.


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Primary care opportunities — Family practice, internal medicine, and pediatric private practice opportunities for BE/BC physicians available in several attractive communities in central Pennsylvania. The state’s fastest growing, economically sound area offers wonderful housing market; stable rural, semi-rural, and suburban locations. These medical groups combine fee-for-service and pre-paid practice and offer competitive salary and benefit packages. For confidential consideration contact. Robert Shannon, MD, 214 Senate Ave., Suite 202, Camp Hill, PA 17011, (717) 763-9313.

Pittsburgh, Pennsylvania — Penn Group Medical Association (PGMA), a multi-specialty group practice affiliated with the largest HMO in Pittsburgh, is seeking BE/BC physicians in: family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. We are formally affiliated with major teaching hospitals and leading community hospitals in Pittsburgh. PGMA serves seven ambulatory care centers, all conveniently located near cultural, educational, recreational, and corporate activities. Excellent salary, fringe benefits, and incentives. For confidential consideration contact: Angela Lascola, HealthAmerica, 5 Gateway Center, Pittsburgh, PA 15222 or call collect (412) 553-7502.


Pocono Mountains (Northeastern) Penna. — Family practitioner needed for a young, fast growing two-physician practice. Must be BC/BE in family practice. Please send CV to Bruce Davis, MD, 1803 W Main St., Stroudsburg, PA 18360.


Staff emergency physician — 177-bed hospital, south central Pennsylvania. $100,000 salary, malpractice, plus other benefits. Wanda Parker, E.G. Todd Associates, Inc., 535 Fifth Ave., Suite 1100, New York, NY 10017, (800) 221-4762 or (212) 599-6200.

Immediate opening — Excellent opportunity to join six-member radiology group, covering two hospitals, approximately 100,000 procedures/year in Johnstown, PA, located approximately 75 miles from Pittsburgh in the Allegheny mountains. Johnstown recently selected as Pennsylvania “Community of the Year;” is noted for its low crime rate, scenic beauty, and high quality of life. Radiologists should be comfortable in all phases of diagnostic radiology including: MR, CT, ultrasound, nuclear medicine and angiography. Well established group with good clinical staff interaction. Excellent starting salary and benefits, with equal partnership to follow. If interested, please call and/or forward your CV to: Jon Abrahams, MD, Conemaugh Valley Memorial Hospital, Dept. of Radiology, 1086 Franklin St., Johnstown, PA 15905, (814) 533-9166.

Excellent opportunity for BC/BE Ob/Gyn person. Solo or partnership. Ideal location to raise family. Excellent schools. Reasonable drive to cities—Philadelphia, New York, Washington, DC. Variety of hospitals and hospital facilities. Send to Box 310, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

BC/BE Internist to join rapidly growing solo practice in southwestern Pennsylvania in July 1990. Practice includes full range of internal medicine and hematology-oncology. Salary with benefits leading to early partnership. Send CV and refer- ences to: Paul A. Hartley, MD, 650 Cherry Tree Ln., Uniontown, PA 15401.

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Canonsburg, PA 15317
(412) 745-0488 (home)
(412) 745-6100, ext. 5030 (office)

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Physician Recruitment
Suite 202
1020 Franklin Street
Johnstown, PA 15905

Medical Practice
Sales and Appraisals

Listed below are several of the practices which are currently for sale:

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>LOCATION</th>
<th>REVENUE</th>
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<tbody>
<tr>
<td>Dermatology</td>
<td>Florida</td>
<td>$225,000</td>
</tr>
<tr>
<td>ENT</td>
<td>New Jersey</td>
<td>$500,000</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Central PA</td>
<td>$190,000</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Philadelphia</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>New Jersey</td>
<td>$300,000</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>New Jersey</td>
<td>$900,000</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Indiana</td>
<td>$350,000</td>
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<tr>
<td>Ophthalmology</td>
<td>New York City</td>
<td>$450,000</td>
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<tr>
<td>Ophthalmology</td>
<td>Philadelphia</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Florida</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Radiology</td>
<td>Philadelphia</td>
<td>$800,000</td>
</tr>
</tbody>
</table>

For additional information, please contact: Ed Strogen, FULTON, LONGSHORE & ASSOCIATES, INC., 527 Plymouth Rd., Suite 410, Plymouth Meeting, PA 19462 (215) 834-6780, (800) 346-8397.

Ed Strogen
Fulton, Longshore & Associates
527 Plymouth Road, Suite 410
Plymouth Meeting, PA 19462
(215) 834-6780
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Internist — BC/BE to join dynamic group practice established for the past six years, southeastern Pennsylvania area. Seeking hard-working and dedicated physician motivated by exposure to outpatient acute care medicine as well as inpatient responsibilities. Contact: Medical Director, Bensalem Family Health Center, (215) 638-0666.

New York — Full-time position available for an emergency physician to join a stable team at a full-service, 170-bed hospital. Competitive compensation, outstanding outdoor recreational activities and a low cost of living plus a solid benefit package including seven weeks off. Live in the beautiful Adirondack region and enjoy a low cost of living. For more information, contact: Scott Powell, Weatherby Health Care, 25 Van Zant St., Norwalk, CT 06855 or call 1-800-365-8900 or (203) 866-1144.

Student health physician, Carnegie Mellon University — Carnegie Mellon is seeking a board eligible/board certified family practitioner or internist for a part-time position. Twenty hours per week academic year, limited summer hours. Position available immediately. Interested physicians should contact: Anita Barkin, Director, 1060 Morewood Ave., Pittsburgh, PA 15213, (412) 268-2157.

General/Vascular surgeon — BE/BC, immediate opening in prestigious private practice, rapid growth opportunity in north central Pennsylvania. Send CV to Box 323, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Board Certified FP seeking BC/BE FP or IM to join busy practice in a growing university town in central Pennsylvania. Excellent opportunity-competitive salary-no OB. Inquiries to Lewisburg Family Practice, 55 N. 5th St., Lewisburg, PA 17837.


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1-800-423-USAF Toll Free
Radiologist — Full or P/T for out-patient imaging center, suburbs of Phila. CT experience necessary. MRI experience desirable. Call Judy Weiss (215) 752-8080.

Seeking general and peripheral vascular surgeon — Fellowship-trained in vascular surgery, to join a group of general and peripheral vascular surgeons practicing in northeast Philadelphia, and the suburbs. Please send CV and a letter detailing expectations. Box 326, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.


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profile of a poet-physician

34  Capital commentary  
Developing legislative ties that bind

8  What is the price of personal freedom?  
helmet law defended

12  AMA begins health care access effort  
16-point plan announced

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"To get the right answers, right away, all we need is the right ID Number and Provider Number. Give me those two numbers, and I can do almost anything. It's that simple."

—Ashley Frye

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—Brenda Hollingsworth

Gino Francavilla
Vice President
Customer Service
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Don’t wait. We’re here to solve problems—to make it right."

—Judy Morrow

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Western: 412.471.7916

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717.763.5700

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SOCIETY'S SUIT CHALLENGES CAPS IN AUTO REFORM LAW

The Pennsylvania Medical Society filed suit March 27 challenging the constitutionality of the compensation and patient billing limitations of the state's new auto insurance law. The law restricts physicians' fees for treating auto accident victims to 110 percent of the Medicare fee schedule. The Society's suit was filed in Commonwealth Court and seeks a permanent injunction against implementation of those provisions and a preliminary injunction barring implementation until the Court reaches a decision. The limitations are in effect April 15 unless the Court enjoins them. PMS President J. Joseph Danyo, MD, called the act a "vague, discriminatory nightmare," and said it would increase paperwork and provide increasingly insufficient reimbursement as Medicare continues to slash fees.

SENATOR TILGHMAN SAYS END HEALTH CARE COST COUNCIL

Senator Richard A. Tilghman, chairman of the state Senate Appropriations Committee, has introduced a bill to abolish Pennsylvania's Health Care Cost Containment Council immediately. The council is scheduled to go out of existence at the end of 1992 unless extended by legislative action. Tilghman alleged the council has been "grossly mishandling state funds," and said that the council is supported only by big business. The PMS Task Force on Health Care Cost Containment is scheduled to meet on the matter April 11.

PMS INSURANCE COMPANY FILES FOR RATE DECREASE

On March 13, the Pennsylvania Medical Society Liability Insurance Company filed with the Insurance Department for a 15 percent rate decrease for all classes and specialties. The decrease was attributed not only to fewer paid claims, but also to a trend toward lower award amounts. If approved by Insurance Commissioner Constance Foster, this will be the largest overall rate reduction in PMSLIC's 13-year history. Assuming the July 1 effective date is approved, the third and fourth quarter bills of all PMSLIC insureds will reflect this downward adjustment.

PENNSYLVANIA MEDICINE NAMED FOR SPECIAL AWARD

PENNSYLVANIA MEDICINE again was chosen for a special award in the 15th annual medical journalism competition conducted by Sandoz Pharmaceuticals. The 1990 award carries a money prize and certificate for outstanding design and editorial qualities.

LINKING EDUCATION FUNDS TO MEDICAID PROPOSED

PMS has voiced concern about recent proposals to link payment of medical education funds for some teaching hospitals to the percent of physician Medicaid participation at these hospitals. The proposals surfaced during negotiations between the Hospital Association of Pennsylvania (HAP) and the Pennsylvania Department of Public Welfare (DPW) to settle litigation involving Medicaid payments to hospitals. PMS President J. Joseph Danyo, MD, Board Chairman John H. Hobart, MD, and Executive Vice President Roger F. Mecum scheduled a meeting with DPW Secretary John White on April 2 to discuss this and other critical Medical Assistance funding issues. Approximately 44 out of 66 teaching hospitals in the state would be affected; those not affected already serve a disproportionate number of Medicaid recipients.

SOCIETY ALERTS MEMBERS ABOUT MEDICARE CHANGES

Key changes in Medicare procedures were the subject of a PMS all-member letter in March. The PMS letter followed Blue Shield's "Dear Doctor" letter, explained the changes, and reminded physicians that March 31 was the deadline for notification to Blue Shield of Medicare participation status. Starting April 1 all physicians' charges must be assigned for beneficiaries who are Medicaid eligible. All physicians must submit all Medicare claims, both assigned and unassigned, beginning September 1, 1990.
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BR #1993
WHAT IS THE PRICE FOR PERSONAL FREEDOM?

J. Stanley Smith Jr., MD

Each spring, motorcyclists invade Capitol Hill in Harrisburg to seek repeal of the helmet law in the name of personal freedom. They say they have the right to get hurt and that helmets are associated with their own types of injuries. But recent medical literature refutes these assumptions, showing that "injured motorcycle riders constitute a significant portion of a trauma center’s patient population" and that "the instances of severe brain injury were 600 percent higher for patients riding without a helmet."1 Further evidence shows that those who survive brain injury following a motorcycle accident "sustained residual longterm disability."2 Further, "riding a motorcycle is dangerous and riding without a helmet is foolhardy."3

These are rather brash statements. What statistics support them? First, motorcycles are dangerous. When riding a motorcycle, the body is fully exposed, safety restraints are not possible, and protective clothing including helmets, gloves, and boots only minimize injury slightly. In states with no helmet laws, such as Oregon, only 36–38 percent of the motorcyclists wear helmets.1 Motorcycles constitute 0.4 percent of all vehicles, but account for 20 percent of our trauma patients.1

Motorcyclists are 50 times as likely to be injured as occupants of automobiles, and the risk of death is 14 times greater.1 In fact, 1 of 17 motorcyclists is involved in an accident, and there is a motorcycle fatality in 1 of every 43 motorcycle accidents.2 Regarding cars, approximately 1 in 14 are involved in accidents, but only 1 in 572 accidents are fatal.2 In fact, Heilman has shown that the accident rate is higher when helmets are not worn.3

What good are helmets? Bachulis states that "helmet laws reduce the incidence of brain injury."4 Other authors, including Cookro, Heilman, McSwain, and Ward, state that helmets decrease the incidence of head injury, death, and disability in motorcycle accidents.4,5,6 Further studies from the Department of Transportation and the National Highway Traffic Safety Administration show that helmets decrease the death and disability related to motorcycle accidents.7,8

In another study, Bried found that motorcyclists not wearing a helmet had an increased risk of head injury that was statistically significant.2 In fact, motorcyclists with a head injury had an increased need for intensive care and ventilator following their accidents.2 The costs associated with head injury were nearly double those associated with injuries where the head was not involved.2 Further, patients with head injury were less likely to return to baseline function.2

In further analyzing this study from Tucson, Arizona, Bried noted that expenses following an accident for the non-helmeted motorcyclists were 30 percent higher than for the helmeted motorcyclists and were 84 percent higher if a head injury occurred.2 This study also showed that no patients were permanently brain damaged if wearing a helmet, and the only time that spinal fractures occurred were in the non-helmet group.2

Because of the foregoing statistics, I think we can presume that motorcycles are not only dangerous, but that helmets do help to decrease the incidence and severity of injury, especially to the head and face.

Now let’s look at who pays for the care of motorcycle accident victims. How much of the cost is paid for by public funds and is a societal cost rather than a cost related to individual payments? In a study by Rivara done in Seattle, Washington, 63 percent of all costs were paid from public funds, and Medicaid accounted for 89 percent of those public

Dr. Smith is assistant professor of surgery and chief of Trauma Services at University Hospital, The Milton S. Hershey Medical Center, Hershey. For reprints write J. Stanley Smith Jr., MD, Chief, Trauma Services, Hershey Medical Center, P.O. Box 850, Hershey, PA 17033; or call (717) 531-7161.
funds. Sixty percent of those costs were for initial hospital care and 23 percent were for rehabilitation or readmission. In another study by Bach in Massachusetts, 46 percent of the motorcycle injury costs were paid from public funds, and in California by Bray, 82 percent of the motorcycle accident costs were paid from public funds. In fact, they showed that the follow-up care and rehabilitation, which is usually not covered by insurance and therefore comes out of public funds, amounted to 40 percent of total charges. These facts led Rivara to conclude, "Society may not only be deprived of the individual's contribution, but have to support him and his family as well." It appears that most of these motorcyclists are from jobs with below-average wages and they cannot afford full coverage of medical payment insurance.

Again this past spring, the motorcyclists descended on the state Capitol demanding repeal of the state's helmet law. We must ask ourselves, "Are we, the citizens of the Commonwealth of Pennsylvania, willing to pay for the costs of the increased injuries caused by granting a personal freedom to a few?"

References
WHY JOIN YOUR PAC?

J. Joseph Danyo, MD

If doctors think we can disavow politics and stay above the battle, the barrage of shots leveled across medicine's bow early this year should dissuade us of those thoughts.

The unworkable Medicare overcharge measure, against which I testified; the caps on medical fees for treating auto trauma; and the administration's attempt to cut the medical education budget—all show the havoc state government can wreak.

But we have the power to speak up and fight back. In fact, next month's primary elections in Pennsylvania offer us an important opportunity to make a difference in the General Assembly, where many of the government's disagreeable actions begin.

In this election, there are many races with no incumbents running; in my area alone, there are three such open races, for one seat in the Senate and two in the House of Representatives. An open race means true competition for the seat and a greater possibility of electing a legislator with a fresh outlook.

How can we physicians make the most of this opportunity? In addition to our individual votes, we can combine our voices with those of our colleagues across the Commonwealth by joining PaMPAC—the Pennsylvania Medical Political Action Committee.

Belonging to PaMPAC allows you, just one individual, to speak with a powerful, amplified voice. PaMPAC enables organized medicine to speak as one and to expand its influence in the political arena.

PaMPAC offers direct financial contributions to candidates friendly to medicine. That financial support, in conjunction with your personal campaign participation, can make for a potent political force.

By joining PaMPAC you also become a member of AMPAC, the American Medical Political Action Committee. In this way you also become involved nationally with the selection of candidates who support medicine.

Why isn't paying your PMS membership dues enough to help support medicine's political goals? Because, by law, the Society is not permitted to support candidates financially. PMS can do many things for physicians politically—lobbying, drafting legislation, testifying about bills, educating legislators about medicine—but only PaMPAC can give money to candidates.

PMS research shows time and again that, more than anything else, physicians want their State Society to represent them before the government. Yet, only 16 percent of Pennsylvania physicians belong to PaMPAC.

That is a small showing indeed, compared with several hundred attorneys of the plaintiffs' bar who contribute more dollars annually to their PAC than our 20,000 physicians give to theirs.

Physicians who think they are above politics are really saying that democracy is beneath them. We cannot expect to turn the tide without involvement of both the body and the wallet. Your leaders and staff cannot do it alone.

Many individuals and groups are in the frame of mind to legislate the practice of medicine. We are the only voice advocating the views of the profession, and every physician benefits from PaMPAC's successes.

You can strengthen that advocacy with your membership. Call the PaMPAC office today, toll free, at 1-800-228-7823. Joining is one of the best ways to make sure your voice continues to be heard.
Dyspnea...chronic productive cough...or wheezing in patients too young for smoker's emphysema or chronic bronchitis could be due to an inherited deficiency of alpha₁-antitrypsin (AAT).¹ Associated with panacinar emphysema, AAT deficiency may be fatal.

An estimated 40,000 Americans have AAT deficiency.² Smoking hastens the progress of the disease.

AAT deficiency is easy to diagnose. A simple blood test can show serum concentrations of AAT <35% of expected values.

Do you have patients with AAT deficiency in your practice? For more information about specific therapy for emphysema caused by AAT deficiency, please call 1-800-CUTTER-1.

AMA BEGINS HEALTH CARE ACCESS EFFORT

In response to growing concerns about the nation's 31 million uninsured, the AMA in March launched "Health Access America," a campaign to promote the association's proposal to improve access to affordable, quality health care. The program's goal is to "restore, reform and reinforce the American health care system."

With media tours tentatively scheduled in 24 major cities, the campaign stresses the AMA's 16-point proposal to expand access to health care coverage to all Americans, while controlling inappropriate cost increases and reducing paperwork and bureaucracy. The AMA proposal emphasizes the association's belief that improving our system to health care must be based upon the strengths and successes of the present system. Cornerstones of the proposal are the individual's freedom of choice and a free and independent medical profession.

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. Its 16-points are:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level;
2. Require employer provision of health insurance for all full-time employees and their families;
3. Create risk pools in all states to make coverage available for the medically uninsurable;
4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program, financed by individual and employer tax contributions during working years;
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level;
6. Enact professional liability reform essential to reducing inordinate

Preliminary Call to the 1990 Annual Meeting
PMS House of Delegates

The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Hershey Lodge and Convention Center, Hershey, Pennsylvania, on Friday, October 19, 1990. The second session will convene Saturday, October 20, 1990, and the third session Sunday, October 21, 1990. Details regarding the starting times of all three sessions will appear in the Official Call in the August 1990 issue of Pennsylvania Medicine.

All proposed amendments to the Bylaws must be submitted to the Office of the Secretary of this Society on or before June 19, 1990. Such amendments may be proposed upon the written petition of fifteen active or associate members of the Society, or by the Committee on Bylaws. Resolutions to be considered by the House may be submitted in writing to the Secretary by a delegate acting in his own behalf or for the component medical society or specialty society he represents. If received prior to September 19, 1990, resolutions will be published in the Official Reports Book.
A New Clinical Study For Gastric Cancer.

Fox Chase Cancer Center is actively seeking patients with primary adenocarcinoma of the stomach to participate in a multidisciplinary clinical study.

This trial, utilizing a combination of drugs, surgery and intraoperative radiotherapy is unique to Fox Chase Cancer Center.

Patients with suspected or documented gastric cancer with no obvious evidence of disseminated disease are being sought. Other qualifying factors apply.

Referring physicians will be informed during the time the patient is under treatment at Fox Chase and will be encouraged to participate in follow-up care. For more information on whether your patient could benefit from this trial, call the multidisciplinary gastrointestinal cancer center at 728-3096.

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costs attributable to liability insurance and defensive medicine;
7. Develop professional practice parameters under the direction of physician organizations;
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices;
9. Develop proposals which encourage cost-conscious decisions by patients;
10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance;
11. Urge expanded federal support for medical education, research, and the National Institutes of Health;
12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention;
13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition;
14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs;
15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike;
16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

Also in early March, the AMA commended the Pepper Commission for its report offering broad-based recommendations on how to resolve the problems of the uninsured. Past AMA President James E. Davis, MD, one of the 15 members of the commission, said, “The American people were the real winners in the Pepper Commission deliberations and final report... The Commission proposal builds upon the strengths of the long-standing history of sharing responsibility for care between the public and private sectors, while addressing the legitimate concerns of small business enterprises.”

CONFERENCE TO EXAMINE CHANGES IN MEDICINE

Does everything in medicine today seem to be accelerating around you—changes in medical demographics, career tracks, delivery systems, financing? The PMS Leadership Conference offers the opportunity to slow the blur of rapid change by providing a sharp focus on the facts behind these trends. Pennsylvania’s physicians will gather May 1-2 at the Hershey Lodge and Convention Center to examine “Medicine in Transition.”

The meeting will open with remarks
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Ten years of successfully fighting for our patients’ independence has given us the experience and insight to see a future that promises exciting advancements in brain injury rehabilitation.

Complete information on the Bryn Mawr Brain Injury System is now available.

Contact the Public Relations Office at (215)251-5401.

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by Lawrence S. Lewin, a nationally-known health care consultant familiar not only with national health care trends but also with aspects germane to Pennsylvania. His firm, Lewin/ICF Health and Income Group, conducted the basic indigent care study commissioned by the state's Health Care Cost Containment Council and was used as a consultant by PMS in its further study of the subject. Lewin is an elected member of the National Academy of Sciences of the Institute of Medicine.

The changing demographics of medical practice will be addressed by William L. Kissick, MD, DrPH of the Wharton School, a widely published authority in both medicine and management. Dr. Kissick is the George Seckel Pepper professor of public health and preventive medicine at the University of Pennsylvania School of Medicine and chairman of the Governing Board of the Leonard Davis Institute of Health Economics at Penn, where he holds professorships in both medicine and in management.

To offer insights on the Canadian health care system, Hugh Scully, MD, past president of the Ontario Medical Association, will speak on Tuesday. Contrasting the Canadian perspective, the AMA's special project to preserve the American health care system will be described by Lonnie R. Bristow, MD, an internist from San Pablo, CA, and member of the AMA Board of Trustees.

Governmental transitions in medical care will be the topic for a panel discussion in "talk show" format. On the second morning of the conference, Edward R. Annis, MD, will speak on the doctor-patient relationship. Discussions will continue on other topics, including risk management, dealing with KePRO, and stress management, during workshops on Wednesday morning.

Further information on the conference, which is open to all members, is available by calling 1-800-228-7823, and asking for Leadership Conference. The registration fee is $25.

**ACADEMY MAY FORM TWO ORGANIZATIONS**

During the annual meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology to be held June 22 and 23, Academy members will vote on separating to form two independent specialty societies.

The agenda includes national authori-

ties to speak on special interests of the two specialties. Jerome C. Goldstein, MD, of Washington, D.C., executive vice president of the American Academy of Otolaryngology, will be guest of honor.

Speakers include Stephanie Mensh, Washington, D.C., assistant director for federal reimbursement policy for the American Academy of Ophthalmology, and Richard L. Mabry, MD, otolaryngologist from Dallas, Texas. Both specialties will offer symposia and papers on major topics.

**PMS ISSUES THIRD REPORT ON PHYSICIAN MANPOWER**


For the first time the report contains special sections on family and general practice, internal medicine, pediatrics, and on the general category of primary care. The remainder of the report is as it has been in previous years, providing basic statistics for physicians and health planners attempting to project physician supply and demand. Charts and graphs are delineated by county, specialty, sex, age, major professional activity, type of practice, and school of graduation.

Part one of the report reveals that the number of active physicians (MDs) in Pennsylvania per 100,000 residents increased from 251.2 in 1987 to 258.45 in 1988. Physician "drift" to urban areas continues, with the least populated counties losing physicians in 1988, even though the state as a whole gained physicians.

Among other aspects reported about the state's physician population: Female physicians now represent 35 percent of the physician workforce under age 35; 12 percent of the state's physicians are DOs, compared with a national average of 4 percent; 39 percent of MDs and nearly half of DOs practice in primary care specialties; the majority of our physicians (63 percent) are under age 45.

The second section of the report, concerned with primary care specialties, shows that 13 percent of active physicians specialize in family/general practice, 12 percent are internists, and 3 percent are pediatricians. Of family/general practitioners, 24 percent of those under age 35 are female, compared to 6 percent of those over 65.

Copies of "Physician Manpower in Pennsylvania: 1988" are available to Society members at $25 each, to non-members for $30 each. To receive a copy of the study, write to Management Information Systems, Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA, 17105-8820.

**DR. HOSTETTER RE-ELECTED CHAIRMAN OF TRUST**

Abram M. Hostetter, MD, a Hershey psychiatrist, has been re-elected chairman of the Board of Trustees of The Educational and Scientific Trust, the tax-exempt charitable organization of the Pennsylvania Medical Society.

Doris G. Bartuska, MD, on the the faculty of the Medical College of Pennsylvania in Philadelphia, was re-elected
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3:00-3:30  What is the optimal timing for aortic or mitral valve replacement?—W. Clark Hargrove, III, MD

3:30-4:00  When is coronary artery obstruction significant?—William P. Santamore, PhD

4:00-5:00  Case Presentation—Patients who need valve replacement and coronary artery bypass surgery—Stafford Smith, MD

Panel discussion—Terry Langer, MD, Thach N. Nguyen, MD, William J. Untereker, MD, Gary J. Vigilante, MD

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DISCIPLINARY PROCEEDINGS

"CAN YOU AFFORD NOT TO HAVE EXPERIENCED REPRESENTATION"

In a day and age where physicians and health care professionals are subject to increasing scrutiny by third parties, state and federal agencies, and peer review organizations, Professionals Choice legal representation benefit provides its members protection against adverse disciplinary actions including:

- Medical Staff Privilege Disputes
- Medical Professional Review Organization (KePRO)
- Medicare/Medicaid Reimbursement Disputes
- Pennsylvania Licensure Disputes

The cost to a physician or other health care professional to offer a defense in many of these proceedings can easily run over $50,000. More importantly, the threat of loss of medical staff privileges or the threat of sanction by a professional review organization may irreparably harm a physicians ability to practice medicine and to earn a living.

In order to protect its members, Professional Choice will contract experienced attorneys to represent the interest of its members individually and as a group in connection with any disciplinary proceedings. This benefit is provided as a service to Choice members, and is not a form of insurance. There are no out of pocket costs to members other than the membership fee.

Further, your membership in Professionals Choice will entitle you to participate in many other cost saving programs such as:

- The Choice Insurance Program
- The Choice Financial Services Program
- The Choice Buying Group
- The Choice Leasing Program

Therefore, we urge you to consider joining Professionals Choice without delay. For membership information or to receive a brochure highlighting these programs, simply call our toll free number.

1-800-638-4545
vice chair, and David L. Miller, MD, an internist in New Bethlehem, was re-elected treasurer.

LeRoy Erickson, Mechanicsburg, was reappointed secretary and executive director of the Trust. J. Michael Barlow, Mechanicsburg, was reappointed assistant treasurer. William E. Miller Jr., Esq., Harrisburg, was reappointed legal counsel.

Appointments to the board of the Trust are made each year by the PMS Board of Trustees.

**EMERGENCY COUNCIL MEETS IN JUNE**

The Pennsylvania Emergency Health Services Council (PEHSC) will hold its 13th annual conference June 22-24, at the Harrisburg Marriott Inn.

Co-sponsored by PEHSC and the Pennsylvania Department of Health, this year's conference theme is: "Responding into the 1990s." The largest such meeting in the state, the conference attracts emergency medical technicians, paramedics, emergency nurses, emergency physicians, EMS and ambulance service managers, and hospital administrative personnel.

Special session topics will include drug abuse, extrication methods, hands-on skill labs, and vehicle maintenance.

For additional information, contact the Pennsylvania Emergency Health Services Council, 3425 Simpson Ferry Road, Camp Hill, PA 17011, or call (717) 763-4678.

**NEW RESTRICTIONS ON DISPENSING STEROIDS**

Two state laws effective only recently set fines and penalties for individuals who prescribe, dispense or consume steroids for purposes of increasing muscle mass, strength, or weight.

Illicit distribution or possession with intent to distribute steroid products by a health care practitioner is a felony under the new law. Violations carry penalties of up to five years' imprisonment and/or a $15,000 fine.

Physicians must state the purpose for which anabolic steroids are being prescribed, and pharmacists may fill only those prescriptions indicating a valid medical purpose. Under the new requirements, school districts must establish and enforce rules and regulations to prohibit the use of anabolic steroids—except for a valid medical purpose—by any student involved in school-related athletics. Education about the dangers of steroid use is also required as part of existing drug and alcohol education programs.

**LIVING WILL ACT CHANGES ENDORSED**

The Revision of the Uniform Rights of the Terminally Ill Act (URTIA 1989) adds the appointment of a proxy or
TO ALL PHYSICIANS:

We are pleased to announce our endorsement of Professionals Choice, a purchasing group that provides numerous benefits to physicians and other health care professionals at discounted prices through group buying power.

Simply by joining Professionals Choice you will be eligible to receive at no cost legal representation by qualified attorneys in professional disciplinary proceedings. These proceedings include:

- Medical Staff Privilege Disputes
- Medical Professional Review Organization (KePRO)
- Medicare/Medicaid Reimbursement Disputes
- Pennsylvania Licensure Disputes

This benefit is provided as a service to Choice members, and is not a form of insurance. There are no out of pocket costs to members other than the membership fee.

The cost to a physician or other health care professional to offer a defense in many of these proceedings can easily run over $50,000. Even a hospital staff disciplinary action can involve major expenses. More importantly, the threat of loss of medical staff privileges or the threat of sanction by a professional review organization such as KePRO may irreparably harm a physician’s ability to practice medicine and to earn a living.

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Timothy I. McCarthy
Chairman

Carmen J. Cocca, Jr.
President
surrogate as an alternative to the living will provisions of this act. The revision also authorizes a patient’s close relatives to consent to the withdrawal of life-sustaining treatment for persons in a terminal condition who are no longer able to make such decisions.

The revised act was approved by the Uniform Law Commission (ULC) at its 1989 Annual Meeting in Hawaii. The ULC drafts uniform and model state laws and works toward their enactment in the state legislatures.

The original act, completed in 1985 and adopted in seven states, allows a competent adult to execute a declaration specifying the withholding of life-sustaining medical treatment. This declaration, known as a living will, would only become operative when a patient reaches the last stages of a terminal condition and is no longer capable of making decisions about his or her medical care.

The American Bar Association endorsed the revised measure at its February 1990 meeting.

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**PITT BEGINS TRIALS ON NEW AIDS THERAPY**

Researchers at the University of Pittsburgh AIDS Clinical Trials Unit (ACTU) and the Pittsburgh Cancer Institute (PCI) have begun clinical trials on a new AIDS therapy designed to boost the immune system of patients infected with the AIDS virus, HIV.

The new treatment involves the removal, activation and return to the patient of virus-killing T-cells or CD8 cells. AIDS disarms the immune system by crippling helper T-cells, which normally direct killer T-cells to multiply to disease-fighting levels. The new therapy addresses this problem by selectively removing and amplifying killer T-cells through the use of interleukin-2 (IL-2).

The six-month study began in December 1989 and is co-sponsored by Applied Immune Sciences Inc. and the AIDS Clinical Trials Group of the National Institute of Allergy and Infectious Diseases (NIAID). It is under the direction of Monto Ho, MD, professor and chairman of infectious diseases and microbiology at Pitt’s Graduate School.

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**QUARTERLY REPORT FROM KEPRO OVERSEERS**

The PMS House, through Resolution 86–44 (Amended) has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings. This report from the Ad Hoc Committee on KePRO Oversight covers the period April 1, 1989 through September 30, 1989. It shows the number of Medicare discharges, cases reviewed by KePRO physician reviewers, number of pending denials issued, and final denials issued. The report also indicates the number of DRG changes made by KePRO.

### KePRO Data for All Pennsylvania Hospitals (Second Quarter 1989)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicare discharges</td>
<td>136,251</td>
</tr>
<tr>
<td>Cases reviewed (retrospective)</td>
<td>46,161</td>
</tr>
<tr>
<td>Cases referred to KePRO physician reviewers</td>
<td>6,586</td>
</tr>
<tr>
<td>(Cases did not meet KePRO admission review criteria)</td>
<td></td>
</tr>
<tr>
<td>Pending denials issued</td>
<td>1,166</td>
</tr>
<tr>
<td>(Issued by KePRO physician reviewers for necessity of admission)</td>
<td></td>
</tr>
<tr>
<td>Final denials—necessity of admission</td>
<td>358</td>
</tr>
<tr>
<td>(Issued for necessity of admission after second level of physician review)</td>
<td></td>
</tr>
<tr>
<td>Final denials—information deficiency</td>
<td>262</td>
</tr>
<tr>
<td>(Issued for lack of timely or additional information on necessity of admission)</td>
<td></td>
</tr>
<tr>
<td>Administrative denials—incorrect provider number, no record/charge information submitted</td>
<td>178</td>
</tr>
<tr>
<td>Total final denials—necessity of admission</td>
<td>798</td>
</tr>
<tr>
<td>(Issued by KePRO physician reviewers)</td>
<td></td>
</tr>
</tbody>
</table>

### Prospective Payment System (PPS) Hospitals Only

- DRG changes (retrospective and prepay) 1,996
  - (Made by KePRO as a result of mandated 5 percent DRG validation sample process)
  - (DRG validations are performed on all reviews of PPS hospital cases)
- PPS hospitals under intensified review (Resulted from reviews performed during 4/1/89–6/30/89) *
of Public Health and chief of the ACTU, and Ronald Herberman, MD, director of PCI.

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**DR. STEMMLER NAMED LEADER OF AAMC**

Edward J. Stemmler, MD, will succeed John F. Sherman, PhD as executive vice president of the Association of American Medical Colleges (AAMC) on July 1. Dr. Stemmler is Robert G. Dunlop Professor of Medicine and dean emeritus at the University of Pennsylvania Medical Center.

Dr. Sherman will retire from the AAMC executive vice presidency in June but continue as a consultant to the association.

Dr. Stemmler is past chairman of the Association of American Medical Colleges, its highest elective office. He is treasurer and a past vice chairman of the National Board of Medical Examiners, master of the American College of Physicians, and a member of the Institute of Medicine of the National Academy of Sciences.

Sheldon Hackney, PhD, president of the University of Pennsylvania, said of Dr. Stemmler, "(He) is a national figure in medical affairs, and he can only enhance the ability of the AAMC to deal with the changes in medicine and their impact on medical education. As dean at Penn, Ed constantly emphasized medicine as a scholarly and humanistic profession rather than a vocation."

---

**INFANT SURGERY SHOWN LIVE ON PUBLIC TV**

On February 20, public television broadcast a live, 90-minute operation performed at the Children's Hospital of Philadelphia to correct a 15 month-old girl's facial deformity due to plagiocephaly.

Produced by WHYY/Philadelphia, the broadcast was carried live on at least 12 public television stations and was taped for later broadcast by an additional 10 stations.

Children's Hospital surgeons Linton A. Whitaker, MD, and Luis Schut, MD, performed the operation, which involved reshaping the infant's skull and reconstructing the area around her left eye. Dr. Whitaker, director of plastic and reconstructive surgery at Children's Hospital and Dr. Schut, director of neurosurgery, standardized the techniques for this form of craniofacial surgery during the mid-1970s. They now perform about 100 craniofacial surgeries a year at Children's Hospital.

"Infant Skull Surgery" also included an explanation of brain functions, pre-recorded interviews with the patient's parents, a look at how surgeons have overcome problems of operating on infants and close-ups of the medical specialists who work together to treat craniofacial problems, including ophthalmologists and psychologists.

Paul and Lynn Miller of central New Jersey, parents of the patient, Michele Miller, agreed to permit televising so that other parents could see that surgery is an option in conditions like their daughter's.

The broadcast is WHYY's second live broadcast of an operation, "The Back Operation", which aired June 19, 1989, received strong public interest.

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**KePRO Data for All Pennsylvania Hospitals (Third Quarter 1989)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicare discharges</td>
<td>151,901</td>
</tr>
<tr>
<td>Cases revised (retrospective)</td>
<td>27,625</td>
</tr>
<tr>
<td>Cases referred to KePRO physician reviewers</td>
<td>5,284</td>
</tr>
<tr>
<td>(Cases did not meet KePRO admission review criteria)</td>
<td></td>
</tr>
<tr>
<td>Pending denials issued</td>
<td>620</td>
</tr>
<tr>
<td>(Issued by KePRO physician reviewers for necessity of admission)</td>
<td></td>
</tr>
<tr>
<td>Final denials—necessity of admission</td>
<td>187</td>
</tr>
<tr>
<td>(Issued for necessity of admission after second level of physician review)</td>
<td></td>
</tr>
<tr>
<td>Final denials—information deficiency</td>
<td>162</td>
</tr>
<tr>
<td>(Issued for lack of timely or additional information on necessity of admission)</td>
<td></td>
</tr>
<tr>
<td>Administrative denials—incorrect provider number, no record/charge information submitted</td>
<td>207</td>
</tr>
<tr>
<td>Total final denials—necessity of admission</td>
<td>556</td>
</tr>
<tr>
<td>(Issued by KePRO physician reviewers)</td>
<td></td>
</tr>
</tbody>
</table>

**Prospective Payment System (PPS) Hospitals Only**

- **DRG changes (retrospective and prepay)**: 1,368
  - (Made by KePRO as a result of mandated 5 percent DRG validation sample process)
  - (DRG validations are performed on all reviews of PPS hospital cases)

- **PPS hospitals under intensified review**
  - (Resulted from reviews performed during 7/1/89—9/30/89) 1 on DRG Intensified Review

**NOTE:** If a hospital has a minimum of six admission denials and a denial rate of 5 percent or greater, the hospital is placed on intensive review by KePRO for the following calendar quarter.

*Intensification may be under one of two methods, either 100 percent of identified subsets or 50 percent of all Medicare admissions when no subsets can be identified.

*The period of intensified review does not exactly coincide with the quarter in which review was performed because it takes approximately one month to obtain the statistics and make the necessary calculations.
TAKING A
POSITIVE
APPROACH
TO CHANGE

Elaine S. Herrmann

Though he practices medicine and teaches in Philadelphia, George R. Fisher III, MD, has spent long hours visiting and contemplating that other city of medical eminence, Chicago. He has represented Pennsylvania in the Chicago-based AMA House of Delegates for more than 13 years. His 1980 book analyzing the American health care financing system is entitled, “The Hospital That Ate Chicago.”

While continuing to serve as an AMA delegate during 1990, Dr. Fisher has added Harrisburg to his itinerary, representing Philadelphia County physicians as a Pennsylvania Medical Society district trustee. He maintains a practice in internal medicine and endocrinology in Philadelphia, and is an assistant professor of clinical medicine at Jefferson Medical College and at the University of Pennsylvania School of Medicine.

Prior to his election as a PMS trustee, Dr. Fisher served as a leader in county and state medical organizations for many years. Among his positions were chairman of the PMS Council on Medical Economics, member of the Society’s Council on Medical Services and of its Committee on Health Planning and Facilities, and member of the Pennsylvania Medical Care Foundation Board of Directors.

Combining his broad understanding of the complexities of medical economics with long experience maneuvering the inner machinery of organized medicine, Dr. Fisher has developed a pragmatic methodology for effecting change: “For the last 13 years I have been advancing a resolution each (AMA House of Delegates) meeting—sometimes two resolutions each year—on some small change in the American (health care) system. . . I’m not the only one making proposals, and if you aggregate 50—100 small proposals of change, you develop an incremental positive approach, such that if any one of those ideas turns out to be a bad idea, the whole system doesn’t topple on its ear. I believe that’s the general approach we need.” Among the many successful AMA resolutions Dr. Fisher has authored are IRAs for health, risk pooling for uninsured, and last-year-of-life insurance.

While persevering on this exacting course, he has sparked change in arenas beyond the AMA House. He has offered his perspective on medical economic issues before Congress, been invited to meet with White House policy staff, has served as consultant to the federal Health Care Financing Administration.

Now is the time to approach the federal government with carefully laid proposals, he says, because the next six months will be a time for constructive bargaining. His overall perspective on the shape of things includes a warning about heeding the identity of organized medicine’s opposition—interest groups in particular: “People who are seeking to advance their own cause can make big problems for you even though they don’t hate you. Sometimes those problems are worse than the ones from your enemies; these other things come from behind and hit you over the head.”

The Canadian question
Safeguarding the American medical system through an “incremental approach” to change will be more effective in the long run—and has already proved itself more efficient—than the sweeping reforms in American health care advocated by some legislators, academics, and labor leaders, Dr. Fisher says. He points to the narrowly averted threat from proponents of the Canadian and British health care systems. "I do believe
Catastrophic Illness is Rare and the Treatment is Critical.

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I was sort of a Paul Revere," he says. Dr. Fisher was the Pennsylvania Medical Society representative on the AMA visitation to study the British and Canadian medical systems. He helped instigate the AMA's 1989 study of the Canadian system, which credited some assumptions of that system's superiority. "I became alarmed, because some people were touting it (the Canadian health care system) as a replacement for our own. Although it isn't as bad as the British system, it's a worse threat because it's more achievable," Dr. Fisher says.

Changing people's minds

Effecting change within the medical community, or even within the political community, is not so difficult as organized medicine's most vexing challenge, Dr. Fisher says: Swaying public opinion.

"Organized medicine has to organize the package, put it together, polish it, implement it, give it assistance, give it guidance, work on the publicity angles, and all the rest of it; but fundamentally the way to change the opinion of the American public is to have the doctor talk to his patients."

Of the other tack frequently used in the past, depending on charismatic leaders to defeat the proposals of powerful legislators, Dr. Fisher says, "it's entirely too dangerous to depend on that approach. That's too easy: to pay your dues to the AMA and just go out to the golf course; or worse yet, to not pay your dues to the AMA and just go out to the golf course and complain about it. We have educated our members, I'm afraid, to expect that."

In addition to motivating the general PMS membership, Dr. Fisher says he would like the Society to try to court the involvement in organized medicine of two important groups: young physicians and scientifically eminent Pennsylvanians. "I feel we must get the younger physicians active, because it is their future that is being talked about."

On a project level, Dr. Fisher says PMS should exert national leadership in computerizing the administration of insurance claims. Such a paperless system, he says, could reduce medical costs in the state by 20 percent.

Several factors unique to Pennsylvania make a paperless system feasible here, Dr. Fisher says: dominance of Blue Shield as one carrier; very high market penetration of the "blues"; a heavy proportion of large group carriers. "And I can't think of any organization in a better position to do the job than the Pennsylvania Medical Society," Dr. Fisher adds, because of PMS' close ties to Blue Shield. PMS is also the most likely candidate to tackle this job, he says, "Since the major obstacles (to achieving such a paperless system) are political, it will take a political organization to achieve it."

Physician, teacher, pioneer

"The one thing I don't enjoy about teaching these days is having someone with grey hair come up to me and say, 'do you remember me? I used to be your student.'" Dr. Fisher says. In the next breath, however, he states emphatically, "I have no plans to retire... ever!"

In addition to medical practice and teaching, since early in his career Dr. Fisher has enjoyed keeping up with the evolution of computerization. "In 1958, I did a research project and it had more data than I could handle, so I apprenticed myself to the hospital data processing person to learn what was then a highly secret trade, a guild. They thought it was harmless to teach a doctor." He became acquainted with several computer pioneers in Philadelphia, learned programming, and combined his growing programming knowledge with his background in medical economics. He continues to provide advice about system selection and planning when called upon. "The problems with computers are technical to some degree, but most of them are sociological... Quite often, those who've advised me thought my advice was worthwhile in helping them get around the political obstacles that they didn't really expect when implementing a change."

While continuing to guide students, physicians, and medical institutions around life's obstacles, Dr. Fisher enjoys observing the progress of his four children and six grandchildren. Three of his children are in careers outside the health professions and a son, Stuart, is an intern at Bethesda Naval Center. His wife, Mary Stuart Fisher, MD, professor of radiology at Temple University Hospital, was a classmate at Columbia University College of Physicians and Surgeons, where he graduated in 1948. He was born in Erie in 1925 and raised in Pittsburgh.

Among the list of posts in organized medicine which Dr. Fisher has held are: co-chairman of the Health Policy Center of the College of Physicians of Philadelphia; president of the Pennsylvania Society of Internal Medicine; a member of the Board of Incorporators of Pennsylvania Blue Shield; trustee of the Institute for Experimental Psychiatry; chairman of the Standing Committee of Medical Economics of the Philadelphia County Medical Society.

Other PMS committees which he has served include the Committee on Planning and Evaluation; Task Force to Study Professional Liability Insurance; Ad Hoc Committee on Long Range Strategy; Task Force on Public Policy Aspects of Competition; and the Ad Hoc Committee on Medical Assistance.
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POETRY AND MEDICINE: STRIKING PARALLELS

William Carlos Williams, Lewis Thomas, Walker Percy, Richard Selzer—their names come forth in any discussion of the impact of medicine on the arts. These physicians are literary giants. There are many parallels in the practices of the medical arts and the literary arts.

John L. Coulehan, MD, MPH, associate professor of clinical epidemiology and preventive medicine at the University of Pittsburgh School of Medicine, is in that tradition. A poet since his teens, he took his early literary efforts lightly, but he is now a recognized poet. In 1988 he was selected a fellow of the Institute for Humanities and Medicine and in 1989 was awarded a grant by the Pennsylvania Council for the Arts. Approximately 75 of his poems have been published and he has a book of poetry awaiting publication.

"Poetry holds a negative position in our society," Dr. Coulehan believes. "When people think of poetry, immediately their thoughts turn to 'rhymes.' But poetry has to do with expressing insight. Poetry communicates many experiences in a very direct manner."

Parallels of poetry and medicine

But how do poetry and medicine relate? Dr. Coulehan contends that poetry is therapeutic. "Reading and, to a greater degree, writing poetry releases pent-up ills," he says. "It helps in relieving tension and facilitating the healing of troubled interpersonal relationships."

"Beyond that, poetry and medicine are similar in that they both deal with concrete, specific issues, and they both synthesize parts into a whole. For instance, you take a patient's symptoms, history, experience, beliefs, behaviors, and test results and compile them into a comprehensive diagnosis and understanding of the patient. You do the same kinds of things with poetry. You blend specific thoughts, experiences, beliefs, behaviors, insights, and feelings, blending them into poetry."

Most of Dr. Coulehan's poetry follows the theme of healing. The basis for many of his poems, in fact, comes directly from his experiences with patients. One patient, a professor of English at Indiana University of Pennsylvania, was the catalyst as Dr. Coulehan started to take his poetry more seriously. She learned through a mutual friend that Dr. Coulehan wrote poetry and encouraged him to write regularly and to study with her. That was just four years ago.

The art of medicine

Much of the art of medicine lies in fostering good doctor-patient relationships. A "good" doctor listens to his patients, Dr. Coulehan says. He or she has the ability to understand how the patient feels and validates these feelings by communicating that understanding back to the patient. The good physician also holds patients in positive regard, meaning that he or she is able to suspend judgment.

To some doctors these traits may come naturally, but if they don't, fear not. Dr. Coulehan says that although doctors have different personalities, communication skills can be learned. The question is, when? Is medical...
school the time? The problem, according to Dr. Coulehan, is that students often have these skills when they enter medical school but not when they come out. “In medical school students focus on a narrow segment of patients—typically, the acutely ill, hospitalized patients. The organ-oriented discussions and narrow perspectives so common in medical school can stifle communication skills. That is one reason why today we are seeing a return of medical ethics and interviewing courses in medical schools.”

Benefits to communications skills

Physicians who nurture communication skills have an added benefit in that the risk of a malpractice suit is decreased, Dr. Coulehan says. “In general the doctor-patient relationship is more contentious today. The best defensive medicine is a good doctor-patient relationship. A large proportion of suits occur because of poor communications with patients.”

To improve patient relations, Dr. Coulehan holds, resident physicians are now taught to involve the patient more in health care decisions. The problem with that is that physicians sometimes give the appearance of being tentative and indecisive.

“Physicians must realize that how they act can influence how a patient responds,” Dr. Coulehan says. “I call this phenomenon symbolic healing. Doctors affect their patients three ways: through the treatment prescribed, through their efforts to change the patient’s behavior, and through a more mysterious means that we call symbolism. Symbolic healing deals with both the patient’s and the doctor’s beliefs and faith. A doctor’s confidence in his diagnosis and treatment will go a long way toward healing the sick patient. A patient’s sense of that confidence bolsters his beliefs and faith that he is going to get better.”

Dr. Coulehan explained this theory in his article, “The faith that heals,” in the April 1987 issue.

Other skills to learn

Defensive medicine and overtesting receive a lot of media attention currently. Dr. Coulehan suggests that improved pa-

---

**The Knitted Glove**

You come into my office wearing a blue knitted glove with a ribbon at the wrist. You remove the glove slowly, painfully, and dump out the contents, a worthless hand. What a specimen! It looks much like a regular hand, warm, pliable, soft, you can move the fingers.

If it’s not one thing, it’s another. Last month the fire in your hips had you down or up mincing across the room with a cane. When I ask about the hips today, you pass it off so I can’t tell if only the pain or the memory is gone. The knitted hand is the long and short of it, pain doesn’t exist in the past any more than this morning does.

This thing, the name for your solitary days, for the hips, the hand, for the walk of your eyes away from mine, this thing is coyote, a trickster. I want to call, “Come out, you son of a dog!” and wrestle that name to the ground for you, I want to take its neck between my hands. But in this world I don’t know how to find the bastard, so we sit. We talk about the pain.

Published in *Manhattan Poetry Review*.

---

**Old Man With Stars Inside Him**

I look at the X-ray,
a shadow of pneumonia
deep in this old man’s chest,
and watch Antonio shake
with a cough that traveled here
from the beginning of life,
As he pulls my hand to his lips
and kisses my hand,
Antonio tells me, for a man
whose death is gnawing at his spine,
the world advances
so delicately
the great white image of his heart.
The shadow advances
every time Antonio moves—
when a nurse positions his body,
when he takes a sip of ice,
when he shakes with a cough,
I see in that delicate shadow
a cloud of gas
at the galaxy’s center,
a cloud of cold stunned nuclei
beginning to spin,
spinning and shooting
a hundred thousand embryos of stars.
I listen to Antonio’s chest
where stars crackle from the past
and hear the boom
of blue giants newly caught.
I hear the snap
of white dwarves coughing, shooting.
The second time Antonio kisses my hand
I feel his dusky lips
reach out from everywhere in space.
I look at the place
his body was
and see inside Antonio, the stars.

Published in *Midwest Poetry Review*. 
tient relations may be one solution to the problem. Another approach he recommends is to use medical tests in a more rational manner.

"Many physicians confuse medical technology and science," he says. "Physicians must learn to use tests more rationally by basing their use on scientific probability. In observing a patient, the physician gets a good idea of what is wrong. Unfortunately, physicians don't pay enough attention to what they observe. They rely too heavily on medical tests. Physicians need to get a firm understanding of what test results mean."

**Student of the arts**

Dr. Coulehan has established a track record as a student of the arts—the arts of both poetry and medicine. Besides his extensive clinical medical writing, he is a frequent contributor of articles to Pennsylvania Medicine, is associate director for education at Pitt's Center for Medical Ethics, and is co-founder of Pitt's Ethics for Lunch program.

The center, established three years ago to serve as a focus for resident education and consultation, is partially supported by a grant from the Vera J. Heinz Foundation. It has developed a clinical ethics training program and provides weekend retreats for Pitt faculty and attending physicians. The center currently is working on a grant to develop an ongoing relationship with hospitals in western Pennsylvania.

The Ethics for Lunch program brings in speakers on the humanities and medical ethics 10 to 12 times a year. Most discussions focus on clinical topics and legal cases.

Dr. Coulehan teaches courses in clinical epidemiology, medical problem solving, and clinical medical ethics, and leads medical rounds for third- and fourth-year students.

He is the co-author of a textbook on medical interviewing in use in many of the nation's medical schools. He is board certified in internal medicine, preventive medicine, and public health. His special interests besides medical ethics and poetry include Navajo medicine (see his article "Lessons from the Navajo" in the March 1989 issue) and the incidence of psychiatric illness in medical patients. He is a graduate of Pitt's School of Medicine and Graduate School of Public Health, and received his undergraduate degree from St. Vincent College, Latrobe, PA.

**How about the future**

Dr. Coulehan says he has faith in the future of medicine. He says the influx of people into the medical profession in the 1970s has now reversed itself, as evidenced by the declining number of applicants to medical school. "Before, medicine was a land of opportunity and income. Today, that is not so. Added to that is the exorbitant cost of attending medical school. Nevertheless, I still have faith that the role of the true physician will assert itself despite the present constraints on the medical profession and the lack of financial incentive. I would, however, caution young people to be quite clear what they are getting into. I also would advise medical students to learn how to use technology and not to let it use them."
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however inadequate studies are at hand to quantify this effect in terms of Yohimbine dosage.

Indications: Yoon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.1,2 Also dizziness, headache, skin flushing reported when used orally.1,3

Dosage and Administration: Yohimbine dosage reported in treatment of erectile impotence.1,3,4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness... In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

How Supplied: Oral tablets of Yoon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10. 

References:
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CLEANING UP MISCONCEPTIONS

Donald E. Harrop, MD

Based on some questions directed to us, apparently a number of misconceptions are still prevalent concerning KePRO's release of physician-specific quality information to hospitals. You may recall the announcement over a year ago that for admissions occurring on and after January 1, 1989, KePRO would advise hospitals of certain quality problems of physicians which were identified through retrospective review. After a series of meetings on this subject and with input from the Pennsylvania Osteopathic Medical Association (POMA), the Hospital Association of Pennsylvania (HAP), the PMS Hospital Medical Staff Section and the PMS Oversight Committee, the policy regarding disclosure had been formulated.

The policy allowed that the information would be released to the hospital's medical staff president and to another "designated" physician in the event the medical staff president was the physician identified as having the quality problem. Also, the hospital's chief executive officer (CEO) would be advised when such a notice was sent to the medical staff president but the notice to the CEO would contain no identifiers (neither physician nor patient). This was merely to alert the CEO that a quality problem had been identified.

The original policy required that only information on severity indicators 3, 4 or 5 be released to the medical staff president. The only part of the policy which has now been changed, this was done because of changes in the new PRO Scope of Work. Since there is no real correlation between the previous five (5) severity indicators and the new Scope of Work's three (3) severity "levels", the KePRO Board has decided that only cases assigned severity level 2 or 3 will be disclosed. These are the more serious problems. Only the physician is advised when a severity level 1 problem is confirmed.

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DEVELOPING LEGISLATIVE TIES THAT BIND

Jerry L. Rothenberger
Larry L. Light

How well do you and other physicians in the local medical community get along with your legislators? Several county medical societies do very well; others do not. Here is a look at how individual physicians and county societies can have a better working relationship with state legislators and even with members of Congress.

If your county medical society, the PMS, the AMA, or any association sets out to establish a good relationship with your legislators, there are a few basic rules to help both you and the legislator(s). Throughout the state there are a few county medical societies that go beyond the basics of a good working relationship and have, in fact, established an extraordinary rapport with their local legislators. We want to comment on how you might attain that level.

Communications
Establishing a good communications network with your legislators is basic to building a relationship. Always include them on your county society mailing list for newsletters and media releases. You might also contact your legislators and ask that they include you on their mailing lists so that you have timely information about local meetings, not only relating to medical issues, but also to those that are important to the community in general. Every legislator in the state or federal government has local offices whose job is to provide services to their constituents. Your newsletters and announcements should be sent there.

Personal contacts
Since most legislators stay in office for several years, it is important that they learn to rely on small groups of local physicians who can serve as personal contacts for them on medical and even political issues. Physicians should have a broad interest in all health issues that have an impact on the general public. One of the contacts certainly should be your county medical society president. However, since these officers change annually, it is important to identify two or three physicians who are long-term leaders in your society to serve as contacts. Ideally, they should know the legislator personally either from time together in school, from membership in the same organizations, or perhaps from participation in the same church.

Yes, invite them
It probably would be helpful to physicians and legislators if you have an opportunity to invite them to a county society meeting to discuss issues of mutual interest. The meeting does not, however, have to be formal. You can invite them to meet with your Executive Board or simply to sit down with the county society president and staff. You can contact the PMS Governmental Relations Department to determine what health care issues might be of interest, or focus your discussion on local issues. These talks should be low key, if possible, and friendly to put both the legislators and the physicians at ease, and to aid in the development of a good working relationship. Meetings should be conducted in such a fashion as to encourage follow-up contacts on a regular basis. They need not be scheduled every month, and even if they are held only once or twice a year they should prove to be beneficial. If you have several legislators in your county, they all deserve the respect of being invited.

When you invite legislators to attend a more formal county medical society meeting, make sure they have a chance to say a few words and to comment on issues, but make every effort to avoid putting the legislators on trial to defend issues with which they may not be familiar. Those kind of contacts should be made on a personal basis, not before a group. By all means, if a dinner meeting is scheduled, include the legislator's spouse on the invitation if your spouses have been invited.

Timing is everything
As with all aspects of our lives, timing is everything. If your county medical society meets on a Monday night in June,
Hahnemann University
Department of Medicine
GRAND ROUNDS—WEDNESDAYS
8:30 A.M.—9:30 A.M.

APRIL 1990
April 11, 1990
MEDICAL MANAGEMENT OF GALLSTONE DISEASE
Hans Fromm, MD
Professor of Medicine
Director, Division of Gastroenterology
The George Washington University
Washington, DC

April 18, 1990
ENDOCRINOLOGY AND METABOLISM: RECENT ADVANCES
Leslie I. Rose, MD
Professor of Medicine
Director, Division of Endocrinology and Metabolism
Hahnemann University
Jeffrey L. Miller, MD
Associate Professor of Medicine
Division of Endocrinology and Metabolism
Hahnemann University

April 25, 1990
PROSTHETIC VALVE ENDOCARDITIS
William E. Dismukes, MD
Professor & Vice-Chairman for Educational Programs
Department of Medicine
University of Alabama
Birmingham, AL

MAY 1990
May 2, 1990
VENOUS THROMBOEMBOLIC DISORDERS: UPDATE 1990
John C. Hoak, MD
Director, Division of Blood Diseases and Resources
National Heart, Lung and Blood Institute
National Institutes of Health
Bethesda, MD

May 9, 1990
IMMUNE MECHANISMS: BREAKTHROUGHS IN IMMUNOSUPPRESSION
George H. Hitchings, Jr, PhD, DSc
Nobel Prize Winner, 1988 in Medicine & Physiology
Duke University
Durham, NC

Adjoint Professor of Pharmacology
University of North Carolina
Chapel Hill, NC
Scientist Emeritus
Burroughs Wellcome Co.

Terry Strom, MD
Professor of Medicine
Harvard Medical School
Director of Clinical Immunology
Beth Israel Hospital
Boston, MA

May 16, 1990
INFECTIOUS DISEASES: NEWEST ADVANCES
Abdolghader Molavi, MD
Associate Professor of Medicine & Surgery
Director, Division of Infectious Diseases
Hahnemann University

May 23, 1990
"NEW FASHION" CLINICAL PATHOLOGIC CONFERENCE
Kenneth Cohen, MD
Assistant Professor of Medicine
Director, Internal Medicine Residency Program
Hahnemann University

May 30 1990
"OLD FASHION" CLINICAL PATHOLOGIC CONFERENCE
Eugene Coodley, MD
Professor of Medicine
University of California, Irvine
Director of Geriatric Medicine
Longbeach VA Hospital

WEDNESDAY MEDICAL SEMINAR SERIES
8:30 A.M.—3:00 P.M.

April 25, 1990
Infectious Diseases: Treatment of Difficult and Opportunistic Fungal Infections
William E. Dismukes, MD
Professor and Vice-Chairman
Department of Medicine
University of Alabama School of Medicine

David J. Drutz, MD
Adjunct Professor of Medicine
University of Pennsylvania School of Medicine

Adjunct Professor of Microbiology & Immunology
Temple University Medical School

Thomas J. Walsh, MD
National Cancer Institute

and Hahnemann University Faculty

May 9, 1990
The Age of Immunosuppressive Therapy and Organ Transplantation
Guest Faculty

George H. Hitchings, Jr, PhD, DSc
Nobel Laureate, 1988, Medicine and Physiology

Adjunct Professor of Pharmacology & Experimental Medicine
Duke University

Adjunct Professor of Pharmacology
University of North Carolina

Scientist Emeritus, Burroughs Wellcome Co.

Terry Strom, MD
Professor of Medicine
Harvard Medical School
Director of Clinical Immunology
Beth Israel Hospital

President, American Society of Immunology

and Hahnemann University Faculty

Presented by:
William S. Frankl, MD
Professor of Medicine
Chairman, Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
Department of Medicine

Location:
Classroom C (Alumni Hall)
2nd Floor New College Bldg.
Hahnemann University
15th Street Entrance
15th and Vine Streets
Philadelphia, PA

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you will soon discover that legislators will always be unable to attend. Without fail, the legislature is in session every week in June debating the budget. As a result, legislators seldom return to their districts for meetings of any type. So try to be flexible and ask the legislator when it would be convenient for him or her to attend. Wednesday and Thursday nights are often better for legislators because they are generally not scheduled to be in Harrisburg. If their schedules are busy, and they cannot accept your invitation, it may be nothing more than a schedule conflict. Do not take “no” for an answer. Try to schedule another date.

Next level—rapport with legislators

If physicians and legislators work well at the local level, it is likely that the basic principles of communication and participation in meetings on a regular basis have been followed over a period of years. If you want to reach the next level and develop an extraordinary relationship, more effort will be required. This

of the Southeast Pennsylvania Arthritis Foundation’s Professional Education Committee.

Louis A. Karp, MD, has been named chief of the section on ophthalmology at Pennsylvania Hospital. Dr. Karp, who joined the hospital in 1973, also serves as clinical associate professor of ophthalmology at the University of Pennsylvania School of Medicine.

Temple University’s Fels Institute for Cancer Research and Molecular Biology recently received a $2.5 million grant from the Lucille P. Markey Charitable Trust to help support the institute’s work in molecular biology. Carlo M. Croce, MD, who is known for his work on the molecular basis of human leukemias and lymphomas, is director of the Fels Institute and chairman of the Department of Molecular Biology at Temple.

Paul Stolley, MD, MPH, Philadelphia, has been named to the national board of the New England Journal of Medicine. The new 24-member board, selected from doctors throughout the U.S., will replace the current board which consists of physicians from the Boston area. Dr. Stolley is professor of medical sciences in the Department of Medicine of the University of Pennsylvania Medical Center. He is also codirector of the clinical epidemiology unit.

Fredric Jarrett, MD, a Pittsburgh surgeon, recently was elected recorder of the Eastern Vascular Society and to the board of advisors of the Three Rivers Shakespeare Festival.

John S. Macdonald, MD, medical director of the Temple University Comprehensive Cancer Center, was principal investigator in a national study on colon cancer published in the New England Journal of Medicine in February. Results from the study, conducted from 1984 to 1987, confirmed the therapeutic value of the levamisole plus 5-fluorouracil (5-FU) treatment after surgery to prevent relapse in approximately 40 percent of patients with aggressive large bowel colon cancer.

Sponsoring a local fundraiser

Law makers face election every two, four, or six years, depending on their office. It is no secret that one of the main ingredients to a successful campaign is its financing. Although you cannot use county medical society funds to sponsor a fundraising event, physicians should consider, as a demonstration of their personal commitment, holding fundraisers in their homes and inviting their colleagues and other friends to attend. The resources of the Pennsylvania Medical Political Action Committee (PaMPAC) are available in the proper circumstances to provide the seed money for such an event. However, do not consider PaMPAC’s involvement as a replacement for the work that you can do on the local level. Even though a PaMPAC check is personally handed to a legislative candidate by a PaMPAC member, funds raised locally for a candidate can be a more significant part of any campaign. The personal participation of local constituents far exceeds the good will that comes from a PaMPAC check because it demonstrates that local physicians and auxiliaries have become personally involved in the campaign. If local physicians and PaMPAC work together, the results can be rewarding.

Final points

These are just a few ideas about what you can do to establish a good working relationship with your state legislator. If you never contact a legislator, if you never make a political contribution, if you do not invite the legislator to meet with your physicians and discuss health care issues, then in all likelihood, daily contact between physicians and lobbyists in Harrisburg coupled with the commitment of PaMPAC will have little impact. Like all relationships in your personal and professional lives, a good relationship with your legislator requires all parties to make a concerted effort. We know that there are legislators who count on their contacts with the physician community, and there are county medical societies who want to do the same.

David B. Nash, MD, MBA, has been appointed to the new position of director of health policy and clinical outcomes at Thomas Jefferson University Hospital. He formerly was medical director of the Health Evaluation Center at the Hospital of the University of Pennsylvania.

John S. Bomalski, MD, a Philadelphia area rheumatologist, recently was named co-recipient of the Martha and Howard Holley Research Prize, given annually by the American College of Rheumatology. He also was elected vice president and president-elect of the Veterans Administration Rheumatologists, during a recent meeting of the American College of Rheumatology, and chairman of the Southeast Pennsylvania Arthritis Foundation’s Professional Education Committee.

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When you refer a patient to The Sleep Center, he will undergo an extensive screening and evaluation process, and will be asked to complete a detailed questionnaire and sleep log. Overnight sleep studies to monitor and record your patient’s physiological systems are also performed as indicated. We then promptly inform you of all results. With the data, we can help you make an accurate diagnosis, enabling you to recommend the best method of therapy … so your patient can benefit from a good night’s sleep.

If you’d like to receive further information or to refer one of your patients, contact The Sleep Center at West Penn Hospital at (412) 578-6836.
PLANNING FOR A SUCCESSFUL MERGER

The Health Care Group

Last month we discussed some of the financial, legal, and personal implications of merging your practice with another. Careful consideration of those implications is necessary for an intelligent business decision on whether to merge, and with whom.

Once you have decided your business goals are best served through merger, and have identified a potential partner, comprehensive planning becomes the imperative. In the planning phase, the issues raised are practical ones, and the questions can be endless: How will the merged practice be managed on a day-to-day basis? How will staffs be integrated? Do you need an administrator? How will your insurance reimbursement profiles be affected? The best way to handle myriad issues is through teamwork.

The first practical step is to set a target date for the merger. Then, establish a realistic agenda and a schedule to cover the issues leading up to that date. Identify each major individual step on the merger path and assign specific dates for their completion. Be sure to set reasonable goals. An unrealistic, unachievable schedule will only lead to frustration, and will set the merger off on the wrong foot.

Once you have a sense of timing involved, select a planning team and a coordinator. When larger group practices are involved, there is no need to have every doctor on the planning team—each practice should be represented by a limited number of doctors. These representatives should keep all of their colleagues informed of major issues and proposed resolutions. Those doctors not on the planning team can play an active role in the process by serving on committees handling specific issues. Membership on the planning team becomes a moot issue for solo or small-group mergers, which will usually require active planning by all of their physician-members.

The coordinator or team leader should oversee merger activities, manage the schedule, and facilitate decision making. Generally, it is the coordinator who should communicate with the team’s legal, financial, and management advisors. Nothing will drive up advisors’ fees like several physicians calling with similar questions—or with conflicting requests.

Distribute minutes of the planning meetings to each doctor and advisor. This will keep everyone focused on the many detailed issues covered, and gives advisors the opportunity to provide timely advice and direction.

Early on, the planning team should select a new advisory team—an attorney, accountant, and consultant for the merged entity. New advisors do not harbor loyalties to the pre-existing entities, so they are better able to offer objective advice. During planning and negotiation stages—until the merger is a fait accompli—the current advisors should continue to represent their client’s best interest.

Operational planning

The planning team will need to make decisions in two distinct areas: (1) financial and leadership relationships and agreements among the physicians/owners (which we reviewed in Part 1 of this article); and (2) operational and management aspects of the merger itself. Operational decisions should begin with the basics: staff assignments, records management, scheduling, and inter-office communications. For example, how will you rotate physicians through each office?—necessary for promoting your “group” presence. How will you assure charts are at the same office as the
patients? Are the computer systems compatible? Which office(s) will do the billing? How will the staff be integrated? Who will manage the new entity day-to-day? Which office will be the main office?

Moving beyond the basics, it will be essential to anticipate the actual financial results of the merger. Therefore, the planning team must deal with several key reimbursement issues. With which third-party payors will the new entity participate? How will current contracts or joint venture arrangements be affected by the merger? Are those contracts assignable to the new entity? What effect will the new merger have on the overall reimbursement profile?

Developing synergies is an important goal of a merger and the planning team should strive to identify areas ripe for operational synergies. Does one practice have a facility large enough to become the merged practice’s main office? Are there types of medical services currently being referred out, that a merger-partner might now perform? Will the merged practice have the time, talent, and technology necessary to provide a new line of ancillary services?

In your planning, do not be misled by the myth that a merger will automatically reduce your overhead. In fact, mergers tend to lead to higher overheads for the short term. In the long term, these increases will often moderate; or, the synergies developed may create revenue increases that more than compensate for the overhead.

The new manager

Early in your merger planning, one staff-level person should be assigned to handle the details. Here we normally recommend that merged groups hire a single practice manager. Start by determining the level of experience this person will need to be effective. If you are a two-physician group and you intend to practice out of one office, you are looking for a basic office manager. On the other hand, if you are a group of three or four physicians merging with a like-size group—and anticipating two or three offices—then you are looking for a mid-level manager with specific comparable experience. With a resulting group size much over five to eight, look for a non-physician administrator who will take active responsibility for molding individual physicians into a coordinated and effective group. This person should have an MBA or similar practice credentials, and should become the physicians’ alter ego.

Although the temptation is strong, be wary of promoting one of your existing practice managers to head the entire group. This not only subordinates one manager to the other, but it also sends a message to your staffs about which practice may get preferential treatment. If you do choose an existing manager to run your practice, be aware of the potential fallout; communicate your rationale clearly to all your employees; and make every effort to answer their questions and address their concerns as soon as they are raised.

It’s important that the practice manager’s involvement be synchronized with your planning. Early involvement minimizes the need for physician handling of the minute details of the merger. It allows more time for planning the budget, identifying synergies, and exploring other strategic activities. On the other hand, don’t hire a practice manager until you are relatively certain the merger is on.

Anticipate the rough spots

Recognize that, like any major change, a merger is somewhat destabilizing for all involved. Problems are both inevitable and usually solvable. Anticipating problems and responding effectively to them is critical to the success of your merger. Handling personnel issues is often a problem. While some turnover is normal, office staffs are particularly susceptible to merger anxiety, and this can lead to unnecessary turnover even before the merger is completed. Individual staff members may believe they will become expendable—a feeling that often originates with the office managers, who recognize that the practice may only need one manager. Questions about job security can spread quickly through an office, whether or not they are justified. Look for hints of staff anxiety and respond to it as frankly and directly as possible.

The way you notify the staff of your merger discussions, and of the potential redesignation or relocation of their jobs, is critical. People react differently to such significant changes, particularly where they feel that their jobs may be at risk. Discuss the merger in a casual meeting with all the staff, and stress the benefits of the merger. Announce a time when staff members from both practices will get to meet each other. This should usually take place in a neutral environment, perhaps at a staff picnic, where everyone has the chance to meet new co-workers.

Each staff comes to the merger with loyalty to their physicians or group. Those loyalties often have been nurtured for a number of years and you should try to build on them, not erase them. Throughout your merger discussions, let your staff know they have your loyalty, and that they can communicate directly with you, while they are building loyalties to the new entity. Help them understand that this change is something that you want to succeed. Finally, whenever possible, help them feel they can be part of the new group, though possibly in a different position.

The merging practices will likely have different personnel policies, such as vacation allowances, time off, disability and fringe benefits. A member of the planning team should organize these into a single overall personnel policy. Inevitably, there may be “winners” and “losers” from this synthesis, and compromises from the doctors and their staffs will be necessary.

Realigning to meet new staffing requirements could be a difficult process. Some positions may be eliminated or redesigned. Approach this task with equal measures of sensitivity for your employees’ feelings and objectivity about the long-term welfare of the merged practice. Overstaffing is a significant problem you want to avoid; therefore, make the tough choices. “Spreading the work around” can be more detrimental to
practice and personnel than biting the bullet and eliminating unnecessary personnel. New job descriptions should be drawn up, and positions should be redesigned to match the work that needs to be done. It is also important that you put in place a good system for employee evaluations and merit increases.

Remember that multiple offices create complexity, and multi-office practices have problems never experienced by single-office practices. One common problem is the "wrong place at the right time" syndrome. Do not under-estimate the difficulty your staff will have in coordinating the new flow of patient and billing information, meshing and rotating the doctors' schedules, and adapting their own work schedules to the practice's new staff needs. This problem is exacerbated when separate staffs are thrown together without adequate preparation—and can lead to ill-will among new co-workers. Educate your staff about the new procedures that will be instituted with your merger. Tell your staff to anticipate, and not be frustrated by, day-to-day management problems; they will be resolved best with everyone's patient cooperation. Above all, be sure to address any inter-staff rivalries or antagonisms as they develop.

Physicians must adapt too
Uneasiness about the merger is also common at the doctor level. Until mutual trust develops, there is the anxiety that comes from newly-shared decision making, new lines of authority, and new rules to work within. The new group may decide to do things differently from the way you have always done them. Your schedule may shift, your coverage may change, and you may no longer have full control over the practice. It is difficult to give up old patterns and systems. However, with time and commitment, developing new and improved ways of doing things benefits everyone. The emphasis should be on developing the benefits of your merger, while giving each other time and reasons to trust each other.

Your merger could spur mixed reactions in the broader medical community as well. Your traditional referring physicians may hesitate to continue referring to you if they are unsure whether they can refer patients to you directly. Also, as you grow larger—and particularly as you sub-specialize or lean toward multi-specialty groups—you will compete with a greater number of people. Colleagues may take a much more competitive stance, both personally and professionally. Address this up-front with your referrals by promoting the benefits of your merger: increased coverage, broader talent and expertise, etc.

Establishing each doctor's role in decision making and in running the merged practice are the most difficult and critical tasks the planning team will face. Of course, each of the owners of the original practices probably should be shareholders in the merged entity; likewise, each should be named to the board of directors, to have a say in running the practice. But if you have to call a meeting with everyone in attendance to vote on every decision, nothing will ever be decided.

In a small group (two to five doctors), we recommend appointing a managing doctor to handle routine business matters. The managing partner runs the practice on a day-to-day basis, and reports back to the group for input on the larger decisions. The managing doctor may have time allocated out of his or her practice schedule to handle the affairs of the merged entity.

Groups of six or more physicians should consider creating an executive committee, a team of two to three physicians selected to manage the practice and make day-to-day decisions. This group must work to build a consensus for their actions, foster effective decision making, and promote valuable ideas. The executive committee concept does not obviate the shareholders' vote on important issues regarding overall goals and broad direction of your merged entity.

Marketing is essential
No matter how successful the original practices were, the merged group cannot coast along without promoting itself. Why? First, you need to overcome any fallout or hesitant reaction in both the medical and lay communities. Second, you should build on the new opportunities your merger creates to become even better than you were individually. Effective promotion of the merged practice requires a well-thought-out game plan, with concrete objectives and manageable time frames. For example, on your merger date you should send a written notice to all of your referring doctors and friends. You should send a different notice to all of your patients for the past four years. To accomplish these objectives, someone must be assigned or hired to write the announcements and have them printed, develop a mailing list, etc.

Your marketing goals are two-fold: 1) develop name recognition for the new group and its physicians; and 2) get the word out about the benefits of your merger to those people who most need to know about it: your referral base and your patients.

Focus on the unique benefits your merger offers each group you notify: your patients, referral sources, friends, hospital administration, paraprofessionals, etc. When notifying your patients, for example, highlight factors such as the added convenience of additional talented doctors; the longer office hours and additional locations; the decreased waiting time for an office visit; and the greater range of talent within your new group. Also, take this opportunity to develop a new patient information brochure to highlight these strengths. When addressing the medical community, take advantage of your new size to offer a broader range of talent and more comprehensive services; highlight your increased flexibility in scheduling, in hospital coverage, in sharing on-call time, and so on.

Finally, if the issue was not resolved early on, remember to formalize and promote the new name for the merged practice. That name should be used on all promotional material, and the individual practice names should slowly be phased out. Also, don't forget to publicize any new phone numbers, and to update your listings in the white and yellow pages, community directories, etc.

Summary
Merging your practice with another will be one of the most complex business challenges you take on. It requires that you analyze nearly every aspect of your practice's operations—and review your own personal and professional objectives. The benefits can be significant, but pitfalls loom for those who enter the merger process unprepared. We recommend that doctors give very careful consideration to their reasons for seeking a merger, and that they plan thoroughly in order to make their merger a success.
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Thursday, April 19, 1990
Moderator: Eric L. Michelson, MD
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4:00 p.m. Case Presentation
5:00 p.m. Color Flow Doppler
Gerald Scharf, DO
5:30 p.m. Transesophageal Echo
Krishnaswamy Chandrasekaran, MD
6:00 p.m. Refreshments

Thursday, May 17, 1990
Moderator: Eric L. Michelson, MD
Director, Division of Cardiology
Professor of Medicine

4:00 p.m. Case Presentation
5:00 p.m. Cardiogenic Pulmonary Edema
Daniel Mason, MD
5:30 p.m. Non-Cardiogenic Pulmonary Edema
Harold L. Paz, MD
6:00 p.m. Refreshments

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William A. Barclay, Indiana 
George Washington University School of Medicine and Health Sciences, 1963; age 53, died January 6, 1990. Dr. Barclay was an orthopedic surgeon. •

William H. Chamberlain, Bristol 
McGill University Faculty of Medicine, 1944; age 75, died January 11, 1990. Dr. Chamberlain was a thoracic surgeon. •

William J. Cushing, Cincinnati, OH 
Saint Louis University School of Medicine, 1955; age 60, died January 7, 1990. Dr. Cushing was a cardiovascular surgeon. •

Duane C. Goldman, Lancaster 
Hahnemann University School of Medicine, 1959; age 57, died February 13, 1990. Dr. Goldman was a radiologist. •

Francis S. Mainzer, Huntingdon 
Jefferson Medical College, 1926; age 91, died January 5, 1990. Dr. Mainzer was a general surgeon. •

Melvin L. Mallit, Pittsburgh 
University of Pittsburgh School of Medicine, 1956; age 58, died February 1, 1990. Dr. Mallit was a family practitioner. •

Domenic J. Pontarelli, Rosemont 
Hahnemann University School of Medicine, 1940; age 77, died February 11, 1990. Dr. Pontarelli was an obstetrician and gynecologist. •

Max W. Safley, Indiana 
University of Iowa College of Medicine, 1952; age 62, died January 23, 1990. Dr. Safley was a diagnostic radiologist. •

John R. Spannuth, Lebanon 
University of Pennsylvania School of Medicine, 1926; age 93, died February 21, 1990. Dr. Spannuth was an internist. •

Robert W. Staley, Pittsburgh 
University of Pittsburgh School of Medicine, 1935; age 79, died January 25, 1990. Dr. Staley was a neurologist. •

Lawrence C. Fisher, York 
University of Pennsylvania School of Medicine, 1935; age 79, died January 2, 1990. Dr. Fisher was an ophthalmologist.

Edwin Stein, Williamsport 
Philadelphia College of Osteopathic Medicine, 1957; age 59, died January 8, 1990. Dr. Stein was a psychiatrist.

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**Contraindications:** Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H₂-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Drug Interactions:** No interactions have been observed with theophylline, omeprazole, lofepramine, phelbamid, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,000 mg of aspirin daily), increased plasma levels of metabolites were seen when nizatidine, 150 mg b.i.d., was administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the incidence of dermatolymphoide-like (DCL) cells in the gastric exocrine mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo.

Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinomas and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinomas in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 365 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genotoxic toxicity, including bacterial mutation tests, washed rat bone marrow DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosomal aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch belted rabbits at doses up to 56 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had spotty, decreased number of live fetuses, and depressed fetal weights. On intra-venous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, calcification of the aortic arch, and edematous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and emphysema in one fetus. There is, however, no adequate and well-controlled studies in pregnant women. It is also not clear whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups raised by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use—Safety and effectiveness in children have not been established.**

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,200 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.1%), and somnolence (2% vs 1%) were significantly more common with nizatidine, it was not possible to determine whether a variety of less common events was due to the drug.

**Hepatic—**Hepatic injury (elevated liver enzyme tests or alkaline phosphatase) probably or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 U/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 U/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo-treated patients. No deaths have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachydysrhythmia occurred in two individuals administered Axid and in three untreated controls.

**References:**
1. USP/D Update, September/October 1988, p. 120.

**Multiple potential for drug interactions**

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**References:**
1. USP/D Update, September/October 1988, p. 120.

**Additional information available to the profession on request.**

**Endocarditis—**Clinical pharmacology studies and controlled clinical trials showed no evidence of antiarrhythmogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported with both drugs.

**Hematologic—**Fat thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombophotic purpura have been reported.

**Gastrointestinal—**Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and erosive dermatitis were also reported.

**Hypersensitivity—**As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hyper-sensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other—**Hypersensitivity unassociated with gout or nephrolithiasis was reported on nizatidine, fever, and nausea related to nizatidine have been reported.

**Overdosage—**Overdoses of Axid have been reported rarely. If overdose occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for toxic accumulation may be required at a plasma concentration of 462.85 mg/L.

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1. USP/D Update, September/October 1988, p. 120.

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As the operation and management of medical practices becomes more complex, the value of a good computerized practice management system becomes more important. With this growing complexity, the criteria for determining which systems are good and truly state-of-the-art also become more complex. That means physicians who are selecting their first system or are replacing an existing system face a more difficult challenge in finding the right system for their practice.

In part, the difficulty in selecting a truly state-of-the-art system is simply due to the fact that these systems are much more sophisticated than they used to be. The primary challenge in selecting a system used to be to determine if a particular feature needed by the practice was actually available. Now, the issue is not ensuring that the feature is present, but that this particular vendor's design for that feature fits into the practice's current operations. A feature that is not tailored to the practice's needs becomes worthless.

For example, Medicare non-participating physicians require the capability for multiple fee schedules, one for their MAACs and at least one other for their standard fees. Many vendors can accommodate multiple fee schedules, but not all vendors tie the fee schedule to the insurance plan and automatically bring up the proper fee associated with the insurance plan covering the patient. Fee schedules that are not directly linked to specific insurance plans are virtually useless and may cause billing problems, not eliminate them.

In selecting a computerized practice management system, attention must focus on the criteria and categories of features that are important in today's practice environment. Those features fall into the following categories:

1. Screen flow and on-line features
2. Compliance with billing regulations
3. A/R follow-up features
4. Ancillary modules

On-line features

On-line features are related to the look, feel and flow of the system. They govern how the screens look, how data is entered and the paths you can follow in performing tasks. There have been many significant enhancements in this area, resulting in vast improvements in productivity and efficiency in system use.

In this category, the most important consideration is screen flow and the use of menus. At one time, a menu driven screen flow was considered state-of-the-art because it provided a simple way for the user to select and perform particular tasks such as registering a patient or printing insurance claim forms. Menu driven systems often require the user to pass through multiple menus, making a selection at each step; they can slow down a user, particularly one who is familiar enough with the system to know exactly which screen they would like to go to.

In true state-of-the-art systems, menus are seen as an obstacle to easy and efficient movement from one area of the system to another. The most advanced systems minimize the use of multi-layered menus and allow the user to move directly from one function or task to another through the use of simple commands. These systems also accommodate new users by providing a list of all possible commands at the bottom of each screen.

Another aspect of screen flow is the order in which screens are chained together within a function. In each system,
screens are arranged in a particular sequence to accomplish the function being performed. Each screen is formatted with fields and information to accomplish the task being performed. For example, in patient registration there may be three screens which need to be completed: one to capture information about the patient, a second screen for the guarantor, and a third screen for insurance information.

Because screen flow and formats usually cannot be changed, it is critical that they fit precisely within the practice’s operations. If they don’t, they can negatively affect productivity and also increase the possibility of errors which are difficult to detect down the road.

Compliance with third parties
Third party billing regulations are expanding at a pace which is difficult to match. Most practices, particularly in the surgical specialties, are seeing more of their claims denied and pended due to missing information.

Much of the difficulty lies in capturing and reporting complete information about the patient, subscriber and the services provided. Depending upon the policies and specialty of the practice, the capabilities that may be important include:

1. Flexibility in designating acceptance of assignment by charge, patient, doctor or insurance plan,
2. Capturing and reporting pre-authorization, Medicaid PSR and Medicare PRO numbers, and
3. Fields to enter information such as claims processing addresses, provider numbers for each insurance, and subscriber name and patient relationship to the subscriber.

Obviously it is imperative for the software to be updated to accommodate new regulations. Vendors must be diligent in staying current with all of the changes. That means they must have a dedicated programming staff to respond to the changes and new fields required on claim forms.

Second, the programs must be designed to accommodate changes, especially the addition of new fields that may be required to properly register the patient or to enter charges. The newer programming languages known as “fourth generation” or “database” languages greatly simplify this process. They allow new fields to be added to programs and records very easily, and they cut the time necessary to test and debug changes to programs.

Accounts receivable follow-up
The key to achieving a high collection ratio and reasonable cash flow is accounts receivable follow-up. Following-up on delinquent insurance claims and self-pay accounts has always been difficult and time consuming but in current systems there are a variety of features to assist in this process.

The standard A/R follow-up features offered by most vendors are reports listing, by patient or guarantor, the age and outstanding account balance. For insurance balances, these aging reports are usually broken down by insurance carrier. Thus, all accounts out to a particular carrier can be followed-up at the same time.

One drawback in these reports is that often they do not contain all of the information necessary to follow-up on a claim. Certain vendors do not provide complete insurance information such as group identification numbers; others are lacking important information about the specific services on the outstanding claim. State-of-the-art systems have all of the necessary information available.

There are many other features important to proper follow-up on accounts. For insurance follow-up, one of the most important features is the ability to track expected payment amounts from each carrier. When the actual payment for a service is less than expected, the transaction is flagged and the user has the option to generate the forms necessary to request a review of that claim.

Other features in the latest versions of billing systems that facilitate the collection of past due insurance and patient accounts include:

1. Ability to enter a future follow-up date and then produce reports showing which accounts are scheduled for follow-up,
2. Sophisticated algorithms for billing guarantors based upon criteria such as new charges or payments received, and
3. Automatic rebilling of delinquent insurance claims.

Ancillary modules
One of the most exciting developments in practice management systems is the availability of software to streamline other activities in the practice, beyond billing. Appointment scheduling and word processing are the most common ancillary modules. In the better systems both of these programs are fully integrated to the patient database. Both word processing and appointment scheduling can pull patient names, addresses and account balances from the billing program. In word processing this simplifies patient correspondence. In appointment scheduling, it means that delinquent accounts can be easily identified when the patient calls to schedule an appointment.

The cutting edge of new modules is in medical records and clinical tracking. Most vendors will say they have medical records features. However, usually these features are very simple, limited to entering certain text in free form fashion and reporting on it.

These best clinical modules will automatically extract key information on procedures, diagnoses and medications, and will alert you to missing test results for pre-designated diagnostic procedures. They can play a very valuable role in quality assurance and patient management.

Conclusion
The quality of a software package has always been the primary component to focus on when selecting a computer system. As the functional needs of medical practices change, software continues to be the critical component of the system. Next in importance, a very close second to software, comes the credentials of the vendor. Years in business, number of installations, reputation for service and reputation for continuous software enhancements are some of the factors to consider in selecting vendors. Finally, next in order of importance, is the adequacy of the hardware.
TRANSMISSION
OF HIV: A WRAP-UP

George J. Pazin, MD

Since the previous four installments in this series dealt with transmission and acquisition of human immunodeficiency virus (HIV) and addressed general aspects of spread of HIV as well as specific aspects in relation to intimate homosexual and heterosexual settings and the health care delivery setting, I was tempted to leave this aspect of the HIV/AIDS problem. However, there are a few aspects of transmission that have not been addressed so I have decided to do a summary “wrap-up” installment.

“AIDS is not spread by casual contact” is an often-heard statement, but a critical person might point out that AIDS is not spread, the AIDS virus, human immunodeficiency virus (HIV), is spread. He or she might ask, “How do you know the AIDS virus is not spread by casual contact?”

I agree wholeheartedly that AIDS is not spread, the virus is spread, and I would indicate that family exposure studies show that the AIDS virus is NOT spread by casual or close personal household type contact. By family exposure studies, I mean studies in which persons who have lived in the same household with persons with AIDS are tested afterwards for infection with HIV when they could be expected to have developed antibodies to HIV which would indicate infection with the virus.

At least seven “family-exposure” studies involving nearly 500 persons living with more than 200 persons with AIDS have NOT shown family members, who were not the sexual partner or did not have their own risky behavior, becoming infected. Note that it is not necessary to wait 10 years to find out whether the other family members have become infected. The failure of household members to develop antibodies to HIV after a year is good evidence that family members do not become infected by close household contact.

It is important to emphasize what we learn from family exposure studies, but it is also important to appreciate the limitations of these studies. First, we learn that the AIDS virus is not transmitted in households by everyday direct contact, by indirect contact with shared articles such as toilets, tubs, sinks, telephones, etc. nor by ordinary aerosols generated by talking, coughing or sneezing.

On the other hand, family exposure studies do not tell us anything about which intimate factors are involved in transmission of the virus. For example, family studies do not address the question of whether the virus can be transmitted via passionate kissing. Also, although the lack of spread within family households provides important circumstantial evidence against aerosol transmission of the virus, it does not address the possible risks associated with aerosols of blood produced in special medical situations.

In the spirit of truthfulness and openness, another limitation should be disclosed. In a well-intended effort to reassure the public, former Surgeon General Koop indicated that HIV was not spread in household settings even though family members shared shaving razors and toothbrushes. Review of one of the more publicized family studies reveals that only 9 percent and 7 percent of family members acknowledged sharing the razors or toothbrushes with other family members. Furthermore, I suspect that sharing of razors and toothbrushes might have been infrequent and sporadic. In any case, the data are not sufficient to indicate that sharing razors or toothbrushes are not potentially risky. Therefore, we should not exaggerate and mention that HIV was not spread in family settings even though razors and toothbrushes were shared.

These family exposure data are supported by the observation that HIV has not been spread to family members with whom HIV-infected persons live outside of the setting of family studies. I am only aware of two exceptions to this generalization. One is a young boy in West Germany who presumably became infected from a younger brother and the second is a mother who seemingly became infected from her child, for whom the mother provided healthcare without taking any healthcare precautions. The rarity of these exceptions tends to indicate that HIV is not being spread inadvert-
Transmission via insects

One should not leave the topic of transmission of HIV without briefly addressing the question of transmission of viruses by insects. It is clear that some viruses are spread by insects, but when they are, the virus is replicated in the insect and is found in the insect's salivary glands. Mosquitoes have been allowed to feed on HIV infected tissue in carefully controlled situations and the virus was found in the mosquitoes, but not in the salivary glands, which seems to be a prerequisite for efficient spread of a virus by mosquitoes.

Could the insect act as a purely mechanical vector analogous to a contaminated needle? Is there any epidemiological data which addresses this question?

The issue of possible transmission of HIV by mosquitoes was raised by a couple physicians practicing in the Belle Glade, Florida, area. In response to these concerns, the Centers for Disease Control in Atlanta, Georgia sent an investigative team to study the situation. They found that HIV-infected persons in Belle Glade tended to have the same risky behaviors which were associated with acquisition of HIV infection elsewhere except that the percentage of heterosexual acquisition was higher than usual. This was explained by an increased number of Haitian persons in the sample who were presumably infected heterosexually in Haiti.

Interestingly, the HIV-infected persons in the study did not include anyone less than 10 years of age nor more than 60. Mosquitoes are not expected to discriminate whom they bite on the basis of age, but perhaps, the very young and older persons are not outdoors as much during evening feeding period. The issue was addressed further by performing blood (serological) tests for antibodies to known mosquito-borne viruses on HIV-infected and non-HIV infected persons who lived in the Belle Glade area. No increased positivity for four of five known mosquito-transmitted viruses was found in HIV-infected persons as compared to non-HIV-infected persons. One mosquito-borne virus (dengue) was found more frequently in the HIV-infected group, but again it seemed to be accounted for by Haitian borne HIV-infected persons.

Overall, the virologic and epidemiologic studies do not support insects as vectors for spread of HIV.

Recently, new quantitative studies of the amount of HIV in blood have been reported. These studies have shown HIV both in peripheral blood mononuclear cells (PBMC) and free in plasma. They have also shown that the amount of virus in blood and the frequency of culture positivity in blood increase as the infection progresses and becomes symptomatic.

On the other hand, there seems to be less virus in blood of persons on zidovudine (Retrovir, formerly AZT). Some public health oriented persons may speculate that persons in the early asymptomatic stage of infection or on zidovudine therapy may be less contagious. I would caution the public not to count on less contagiousness when we do not know how much virus is needed for infection.

Intravenous drug users

Before concluding this "wrap-up" segment, a few comments on transmission of HIV in the setting of intravenous drug usage should be included. The proportion of new cases of AIDS attributable to IV drug use via needle-sharing is increasing as the epidemic is expanding. HIV-infected drug users are also serving as a "bridge" to the general public through heterosexual infection of sexual partners and also indirectly to babies via their mothers' transmission of HIV to the fetuses in utero.

Finally, it is important to realize that drug addicted persons are often willing to exercise precautions to avoid acquiring or transmitting HIV if they are educated about the required precautions.

In summation, during the past several installments in this series, I have tried to emphasize that playing an "odds game" with HIV infection is not advisable. Infection with HIV is an ALL-OR-NONE phenomenon that always occurs for the first time on a single occasion. Risk elimination, avoidance of exposure and inoculation, is the preferred goal and is achievable if one confines one's sexual intimacy to an uninfected partner or uninfected partners and does not share needles. The test for antibodies to HIV can be very useful in determining whether prior potentially risky experiences or behaviors have led to infection. Risk reduction or reducing the likelihood of infection via barrier prophylactics (condoms with or without spermicide) is recommended for persons who engage in intimate behavior with potentially infected partners. But we should not ignore the troubling reality that condoms do NOT prevent or block the direct exchange of all potentially infected bodily fluids.

Finally, the gradual "leveling off" of the incidence of cases of AIDS must not lead to an attitude of complacency. The gradually expanding scope of HIV infection requires that our efforts at risk reduction and risk elimination be ongoing and continuous.
A CAUTIONARY TALE

John L. Coulehan, MD

Once upon a time...Let's call it January, 1989. A young woman, recently engaged to be married, wakes up feeling lousy. Her nose is congested, she aches all over, and her throat feels like it is lined with hot asphalt. Two days later, still sick, she decides to visit her family doctor. "Strep throat," he says, although he notes to himself that there is no exudate or other suggestive physical findings. Penicillin, 10 days.

Two days later, Ms. D still has a bad sore throat and calls her physician again and he prescribes an expensive broad-spectrum antibiotic. She gets this filled, confident that she will soon feel better. In another two days, however, she begins to experience a sense of dizziness. "Hard to describe," she says. The room doesn't actually move or spin. She doesn't feel like passing out. She hasn't actually fallen, but feels like perhaps she might fall. The doctor didn't qualify. Besides, I wanted something more articulate. Painting—fine, but messy, cumbersome. Sculpture? I once looked at a stone and preferred it the way it was. I couldn't see myself cutting stone, too much spring in my legs to stand still that long. To dance? Nothing doing, legs too crooked. Words offered themselves and I jumped at them. To write, like Shakespeare! And besides I wanted to tell people, to tell 'em off, plenty. There would be a bitter pleasure in that, bitter because I instinctively knew no one much would listen...*

Whether anyone listens much is certainly important but even more important is to have an acceptable way to "tell 'em off" ("em" = them = society's squeeze appliers = frustrated ideals = cynicism). The humanities, the arts, provide all varieties of colorful ways to "tell 'em off" and in the telling an art form can be produced and the idealistic practitioner can be recreated. Poetry, music, and all the arts shape us and pull us together. Art is art because it brings together body, soul, and intellect.

A TURN FOR THE WORSE

Judy Hopkins Schaefer, RNC

Doctors and nurses scarred from the trenches often lose touch with why they are there in the first place. We run far afield of the crystalline reasons that first drew us to these professions. All the idealism of the early days vanishes, but where does it go? Why do we take this turn for the worse? We seem to provide health care and do all the intermediary paperwork for all the wrong reasons. Keeping one step ahead of a malpractice attorney or keeping up with the Joneses are wrong reasons, aren't they? Yet, society's complexities apply the squeeze and our defensive plays are instinctive.

William Carlos Williams in his autobiography said,

The big fight came at the beginning when I was making up my mind what to do with my incipient life. The preliminary skirmish concerned itself with which art I was to practice. Music was out: I had tried it and

The author is chairman of the Creative Writing Committee of the Center for Humanistic Studies at the Pennsylvania State University School of Medicine, where she is coordinator for the Hemophilia Center of Central Pennsylvania.

prescribes Antivert, and sends her to an otolaryngologist who says that he can’t find anything wrong with her ears, but that she should continue taking the expensive antibiotic another two weeks. “Sometimes these things take a while to heal.”

Soon Ms. D’s throat is better, but the dizziness continues and becomes more frightening. Although she tries to work most days at her secretarial job in a local construction firm, she feels like her concentration and the quality of her work is suffering. Certainly her social life is not up to snuff. The dizziness makes Ms. D anxious and irritable. She stays home rather than going out with her fiancé. He alternates between anger and concern. “There’s something wrong with your head,” he says. Her doctor agrees and sends Ms. D to a neurologist. “No hard findings on your examination,” the neurologist reports, “but let’s admit you to the hospital for a work-up.” So she spends five days in the community hospital and has a head CT, an MRI, an EEG, and a lumbar puncture which—lo and behold!—reveals no evidence of multiple sclerosis. An infectious disease consultant orders a variety of cultures and serological tests, finally informing the patient and her panic-stricken mother that she definitely does not have tularemia. Nor Rocky Mountain spotted fever, for that matter.

However, this fishing trip does come up with at least one catch—not exactly a big one, but at least a fish that has a name. An echocardiogram reveals a “slightly” thickened and “mildly” redundant anterior mitral leaflet. Even though Ms. D has neither a systolic murmur nor a click, one diagnosis is patently obvious. Mitral valve prolapse. Her doctor prescribes propranolol, warns her about palpitations, and sends her to a cardiologist.

Out of the hospital, the patient finds that she is still dizzy. In fact, propranolol makes her far dizzier and also “blah.” She has no energy. Ms. D is so desperate now that she decides to stop her oral contraceptives in the middle of a cycle, suddenly recalling all she has read about bad side effects of the Pill. The cardiologist tells her to stop

Perhaps if we can find and recognize the regenerating part of ourselves we can return to some of the more gruesome tasks of health care with renewed energy.

Dr. Eric Bonsall is a child psychiatry resident at The Milton S. Hershey Medical Center of the Pennsylvania State University School of Medicine and editor of a literary journal, Wild Onions.** Dr. Bonsall’s poem “The Life and Times of Timothy P.,” was a winner last year of one of the prizes in the Doctors Kienle Competition in Literature.*** In his winning poem he says:

“... A what? A tube from the brain to the gut? Why? Slow down Doctor; This is my son Not a course in fluid dynamics.

**Wild Onions** is a literary magazine edited and managed by medical students and supported by The Center for Humanistic Medicine of The Pennsylvania State University, School of Medicine, Hershey, PA. The Pennsylvania State University School of Medicine has had a Department of Humanities since the school’s creation in 1967.

***The Doctors Kienle Competition in Literature was founded in 1986 by members of the Center for Humanistic Medicine of the Pennsylvania State University School of Medicine.

You expect me calm as bath water While you talk of cutting into the brain. And it’s not The Brain anyway; It’s His Brain. It’s tiny and soft and He knows my face now. He can Smile... Will a doctor who writes sonnets, plays the violin, reads Shakespeare, or paints with the style of Demuth or Cassatt be a better doctor? Will a doctor who sings to the lyre be sued less often for malpractice? Will such a doctor have more friends? Will such a doctor be better skilled at reading a bone marrow slide or slipping out a foul appendix? Will such a doctor be kinder to nurses? Who knows? Yet, it seems that the individual who has a reflective art can better bear the pain of idealism’s passing.

The humanities hold up a mirror, a mirror of the world. It reflects back and we can see our own motion, Brownian and otherwise. Our reflective nature supposedly separates us from the beasts of the forest. We can see that we matter, that we do good things and bad things. The reflection can remind us of the ideal and the reality. Dr. Ronald David, a neonatologist and deputy secretary for public health programs in the Pennsylvania Department of Health, has listened to the muses. His reflections are in a poem entitled “Progeria”:

Refusing succor and solace
He had the countenance and
Disposition you might expect of
Any chronically ill elder
Purse-lipped pink puffer
Sparse of hair
Furrowed brow anxious stare
Cantankerous
Regrettably irascible
But understandably so
Breathing being the
Overwhelming all consuming
Task that it was
(He’d already been through
Hill only to get this far)
A seasoned skeptic
Not yet six months old
Aging as he had been born—
Prematurely

The view from Parnassus can put us back in touch with the core of ourselves and make us dance again as an athlete and poet, when all the spirit, flesh, and intellect is in sync. The skills of medicine and nursing are then practiced and performed as a science and an art. We then can take a refreshing turn for the better.
the propranolol, but doesn’t make it clear just what he thinks the problem is. “You don’t need drugs,” he tells her. “If you still feel dizzy in a couple of weeks, call me and we’ll schedule a 24-hour Holter monitor.” Meanwhile, the patient experiences two menstrual periods within a couple of weeks, and sees her gynecologist who prescribes treatment for monilial vaginitis, an infection which developed while she was taking those four weeks of broad spectrum antibiotic.

By this time Ms. D believes she may well die. Or at least she envisions a future full of suffering and progressive, mysterious disability. This must be a particularly serious and rare condition, she figures, one that not even the best doctors know how to identify. Something like a ghost or an alien spirit. Her family physician is also desperate. A referral to a second otolaryngologist yields a promising lead. “No hard findings,” she says. “Your throat and ears look fine. No nystagmus. Romberg negative. But why don’t we try steroids for a week? Maybe it’s allergic.” The first day’s dose of prednisone gives her a splitting headache. But the doctor says, “Once you start that seven day pack, you have to finish. It’s dangerous to stop.” Meanwhile, she schedules an ENG to further evaluate the dizziness.

The family doctor is not quite satisfied with this turn of events; three months and the patient—who looks so much like an attractive, healthy 20 year old woman—is still dizzy. She sits at home, afraid to go out. The spectre of disease must lurk somewhere where all the king’s roentgens can’t reach it. Perhaps, he thinks, it is one of those sinister latent viruses. So he orders a panel of Ebstein-Barr titres, though already three separate mono spot tests have been resoundingly negative. Lo and behold! The panel shows a pattern “consistent with past infection.” Of course, he knows that a high percentage of the population have patterns consistent with past infection. But, no matter, he decides to refer Ms. D to a university health center where specialists are studying chronic fatigue syn-
drome. By this time Ms. D is virtually unable to work because of anxiety. Even though fatigue has not been a prominent symptom (since she stopped the propranolol), and she has neither feverishness nor swollen lymph nodes, it seems appropriate for her to see a chronic fatigue specialist. But, covering all bets, her doctor also prescribes an antidepressant to use before bedtime. A week later, while taking 50 mg. of amitriptyline, Ms. D feels truly fatigued as well as increasingly dizzy.

“Doctor,” the patient’s mother tells the new specialist, “You have to do something. My Debbie’s condition is getting worse day by day.”

What a quandary! The high-powered specialist pages through a stack of records. Ms. D has brought to him, a seemingly endless series of negative procedures and lab tests. He could, of course, do a test to determine the adequacy of the patient’s natural killer cells, or perhaps a C4/C8 ratio. Moreover, one of her complaints, a problem that developed since she started the amitriptyline, is “muscle twitching.” He could order an EMG at this point, as well as nerve conduction velocities, although—he flips back through the records—CPKs on four different biochemical profiles have been normal.

Finally, it comes to him. There is one last test, one final straw to grasp. He decides to sit down and talk with Ms. D and take a thorough medical history. “Let’s not talk about dizziness,” he says, “Let’s talk about you.”

The scene slips back to December, even back to November. Ms. D’s parents are separating. The holidays are rough. The patient and her mother prepare to move out of the family home, and do so in early January. First, they move in with a friend of the mother’s, but this doesn’t work out. Ms. D’s fiancé tries to be supportive; in fact, he’d like her to move in with him. A perfectly natural thing. She wants to, but . . . she doesn’t want to. Not until after the wedding in June, she tells him. Mother and daughter find their own apartment at the end of February, but by this time both are in a state of frenzy over the dizziness. Ms. D’s employer tells her if she keeps missing work—hospital, doctors, tests—he’ll have to let her go. What is her diet like? “We eat a lot of frozen dinners, and I’m living on Diet Coke.”

“Here’s what I think,” the specialist says. And he decides to talk like a doctor rather than like a medical tech-
nician. “You’ve had a real rough time for three months, and I don’t know that I can give you a simple answer, or give you a name for your dizziness. But I do think that all the tests and all the medicines you’ve had have not helped. In fact, they’ve made it worse, and kept it going for a long time after it otherwise might have gone away . . . because you’re a lot more frightened now than you were before all this stuff . . . ” He holds up the pile of records. “All this stuff has helped to convince you there is something dreadfully wrong, if not in your body, then in your mind. But I want to ask you to trust me, and to believe me when I tell you that you are not going crazy, there is not something dreadfully wrong, and, Debbie, you will get better.”

Then he spends a long time talking about her life situation, and how well she is coping with a series of major changes, both good and bad. “You’re a strong person,” he tells her. “You’ve been through enough to make anyone dizzy.” But he avoids focusing on labels and causes and medicines. He talks about what she can do. “First, stop all the medicine.” (She is still taking amitriptyline, a decongestant, and an occasional Antivert.) “Second, no more tests.” (The 24 hr. Holter monitor is still pending.) “Third, I want you to eat a regular diet, and let’s talk about what that means. Fourth, an exercise program, but you have to start slow, and let’s talk about what that means . . . ”

The first visit takes over an hour, but the next is shorter. A week later Ms. D still has her “baseline dizziness” but the sharp episodes have almost disappeared. In another week, she complains that her mother is too pushy (for the first time the patient comes in alone), but that the living arrangement is tolerable and the wedding plans are progressing. After missing a visit two weeks later, Ms. D calls her doctor (for by now she thinks of the chronic fatigues specialist as her doctor) to say that she can’t leave work to keep her appointment, she’s missed too much work already, but that she feels okay. Not great. Sometimes dizzy. But basically okay.

Okay? Just okay? That’s a good enough way to end the story. It is, after all, a lot more honest and human than “happily ever after” would be. So that’s the happy ending of this cautionary tale: Ms. D, after all they tried to do to her, is basically okay.
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PMS profile
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profile of leadership in medicine

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exposing indirect costs

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LEADERSHIP CONFERENCE ATTRACTS 400 PHYSICIANS

The Society’s Leadership Conference at the Hershey Lodge and Convention Center, May 1-2, drew 448 physicians and health care leaders, a marked increase in attendance over previous years. This year’s figures also included a higher percentage of new attendees, reflecting renewed support for the annual PMS program. A strong roster of speakers included William L. Kissick, MD, Dr PH, from the Wharton School; Lonnie R. Bristow, MD, AMA Board of Trustees; and a panel on governmental transitions in medical care.

PHYSICIANS NOT LIABLE FOR CAT FUND PAYOUTS

The Pennsylvania Medical Society won an important victory for physicians in Pennsylvania with a Superior Court ruling that physicians are not responsible for the CAT Fund’s share of a malpractice award even if the CAT Fund fails to pay. The case, Tominello vs. Janeway, was appealed after a trial court ruled that a physician was required to advance the CAT Fund’s share of the award when the CAT Fund exercises its statutory prerogative to delay payment until December 31 of the year following the CAT Fund claims year.

PMS BOARD SUPPORTS COST COUNCIL REPEAL

The PMS Board at its April 4 meeting voted to support a Senate bill to repeal the Health Care Cost Containment Act and abolish the Cost Containment Council. The action reversed the Society’s former support of the law. The bill was introduced by Senate Appropriations Committee Chairman Senator Richard Tilden. Excessive costs to hospitals and taxpayers, the Mediqua System’s inadequacy to assess quality of care, and the council’s failure to send an indigent care proposal to the legislature with a financing plan were cited as reasons. The Board suggested that health care data be collected and published in an alternative private sector initiative. Letters written over the names of individual trustees have been sent to newspaper editors to explain the Board’s decision. The letters state, “Simply put, Act 89 over-promises and is too costly.”

PMS BOARD CREATES REVIEW TASK FORCE

A new Task Force on the Cost Effectiveness of Peer Review is in place as a result of action by the PMS Board of Trustees on April 4. Members of the task force are: Irving Williams III, MD, chairman; John A. Burkholder, MD; George R. Fisher III, MD; Victor F. Greco, MD; David J. Shulkin, MD; and Joseph J. Trautlein, MD.

BLUE SHIELD ISSUES COMMITTEE FORMED

The Society’s Board of Trustees has established a Blue Shield Issues Committee, to address such Blue-Shield related issues as the establishment of an indemnity system involving a value orientation. Committee members are: J. Joseph Danyo, MD, chairman; Richard D. Baltz, MD; George R. Fisher III, MD; John W. Lehman, MD; William H. Mahood, MD; Michael J. Prendergast, MD; and Jonathan E. Rhoads Jr., MD.

FAMILY PRACTICE FOCUS OF SUPPORT

Several actions to encourage more training in family medicine were approved by the Society’s Board on April 4. The initiative would establish model family medicine departments in Pennsylvania medical schools, working with the Pennsylvania Academy of Family Physicians to develop curriculum and program organization. The Board also asked the PMS Educational and Scientific Trust to survey its loan recipients about problems they encounter pursuing family practice as a specialty. In its suggestions, the Task Force on Family Practice also noted that only three of the seven state medical schools have family medicine departments, and funding for those departments is continually threatened.

NEW MEDICAL DIRECTOR APPROVED FOR KEPRO

Herbert E. Segal, MD, has been named medical director of the Keystone Peer Review Organization (KEPRO), effective July 1, 1990. He was formerly a career armed services physician.
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Contact the Public Relations Office at (215)251-5401.

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ZERO
OPTION TIME

J. Joseph Danyo, MD

Health care costs continue to dominate our psyches. New terms emerge, but the message is the same: doctors are the bad guys. They have no conscience. Everyone else is doing their best to hold costs down—except physicians.

The Bush Administration has no health policy. Some say there is a plan of discontinuity. During this period of convulsion the emphasis is on slashing reimbursement, perverting the practice of medicine, and hounding providers of care. Simply put, the government’s “solutions” are extremely costly: do not measure quality and cheat the elderly.

The sorry PRO program has changed physicians’ attitudes toward government when government needs our understanding more than ever before. Government credibility is zero. The U.S. is running out of ideas to control costs. The day of the Zero Option is near.

As it approaches, medicine’s potential leadership will be more apparent to those who have tried government’s solutions and found them lacking. Physicians must target the fallacies of those initiatives. How? Flood your legislators with reports of how their missiles are out of control. Include your patients and family in your letter campaign. The heat must be turned up on the regulators who, by now, are pressed to show something for their efforts. Pour it on! We’re in the habit of raling at KePRO, but the real villain is in Washington.

On the state level, Governor Casey has chosen to pick fights with health care providers when he should be stroking them to bail the state out of years of patterned transgressions. Federal court decisions have halted the past under-funding of hospitals for Medicaid services. Now the Commonwealth is scrambling for dollars to ante up. Residency programs, medical school subsidies, and doctors’ reimbursements are endangered.

Next comes an attempt (well-meaning, I might add) by some legislators to cut medical school subsidies by using the students as pawns. House Bill 2282, at this writing in the House Health and Welfare Committee, ties medical school funding to the percentage of students signing a declaration that they will practice in Pennsylvania for three years and treat patients for free during that period. Imagine the scene if this bill becomes law.

PMS argued forcefully against HB 2282. I believe reason will prevail.

As unthinkable as the bill seems to us, it is motivated by a desire for us to become partners in social change. The legislature, Governor Casey, the media, and others want to know what we’re doing about the crack epidemic, the homeless, the environment, the down and out—why we are not answering the bell.

Frankly, I believe that clamor for our input is appropriate. We can no longer languish in the sanctity of our offices.

In particular, medical schools with their vast potential must be enlisted to join organized medicine in shaping the future. Many of the best minds reside in academia. The tumult in the system has fueled a growing antagonism between town and gown. This must be redirected into a partnership that recognizes the new callings and continued needs.

As we meet with various groups in and out of government in a greater effort to serve as a resource for problem-solving, the traditional role of medicine will change and, with it, the role of every individual physician. We are more than private practitioners now. We are called upon not just to criticize misguided actions but to fill the existing void with service and leadership.
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FEE CAP IN EFFECT IN AUTO ACCIDENT CASES

On April 15, Pennsylvania's new Auto Insurance Law (House Bill 121) became effective, restricting physician's fees for treating auto accident victims to 110 percent of the Medicare fee schedule. The new law exempts the state's 25 designated trauma centers and its handful of burn centers.

The Pennsylvania Medical Society filed suit March 27 challenging the constitutionality of the compensation and patient billing limitations of the new law. The suit, filed in Commonwealth Court, seeks a permanent injunction against implementation of those provisions. The Society had fought to establish a fee schedule for medical services to accident victims at 80 percent of individual physician charges. PMS President J. Joseph Dan- yo, MD, criticized the measure, saying it will lead to increased costs as more patients are transferred to trauma centers, and increased paperwork for physicians and insurers.

Meanwhile, PMS is working with the state Insurance Department to obtain clarification and favorable interpretation of unclear provisions. In addition to capping physician fees, the law also places limitations on patient billing and mandates peer review of necessity of care.

The fee cap, which applies in certain circumstances, is either 110 percent of the prevailing charge at the 75th percentile or the physician's usual and customary charge. An amendment to the PMS suit challenges what the prevailing charge at the 75th percentile is; the state's interpretation results in a lower charge than does the Society's interpretation.

The law is unclear as to whether the trauma/burn center exemption applies to physicians services in those centers. So far, it appears the Insurance Department interprets the exemptions as including physician services.

In certain circumstances, a patient billing limitation applies under which the physician must bill the insurer, not the patient. PMS interprets the limits on compensation and billing as applying only when reimbursement is available under an auto insurance policy, NOT under sources such as health insurance, worker's compensation, or a patient's funds. So far, the Insurance Department seems to agree with this interpretation, but PMS continues to seek clarification.

The third provision affecting physicians states that insurers must contract with a private entity (peer review organization) to review the medical necessity of care billed to the insurer.

The act leaves unanswered a number of fundamental questions, such as when the limits on compensation and patient billing apply. PMS is working to clarify the many unresolved issues and to keep members informed as the situation evolves. Contact the PMS Council on Medical Economics toll free at 1-800-228-7823 for further information or assistance concerning the new law.

PMS MEDICAL INSURANCE OPEN ENROLLMENT NOW

The Society's semi-annual open enrollment campaign for Capital Blue Cross and Pennsylvania Blue Shield has begun. Members, their families, and their employees have until June 1, 1990 to enroll.

The basic plan offers coverage for
If you are considering automating your practice within the next 12 months, I will send you a free video tape, which will enable you to learn the major factors contributing to the success or failure of a computer system in a medical practice. This tape gives you the opportunity to draw on the experience of other practices that have successfully automated. And you can do this in the comfort of your home or office with a minimal time investment.

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Bertholon-Rowland, PMS insurance
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campaign. Members may contact their
Benefit Services Department to receive
an enrollment kit which contains a
coverage highlight sheet and enrollment
application. The number to call is
(215) 565-3450.

AIDS CONFIDENTIALITY
BILL CLOSER TO SIGNING

As controversy over HIV/AIDS testing sweeps through state legislatures na-
tionwide, a package of PMS-supported confidentiality protections for patients
and physicians edges nearer passage by Pennsylvania’s lawmakers. Of partic-
ular import to physicians is the AIDS confidentiality bill, SB 1163, which
passed unanimously in the Senate last fall. In early April, it passed in the
House as amended, and now awaits a vote for concurrence.

Sponsored by Senator John Peterson,
the AIDS confidentiality bill offers
several protections for persons faced
with HIV testing decisions. The bill
requires a patient’s informed, written
consent prior to testing, and requires
physicians to provide pre- and post-test
counseling. An exception to this re-
quirement allows health care profes-
sionals to proceed with testing in emer-
gency cases, such as comatose patients.

Other amendments to protect health
care workers within the confidentiality
requirements drew fire during House
deliberations. Health care workers who
receive significant exposure, such as
needle-pricks, to a patient’s bodily
fluids could obtain a court order if
necessary to permit HIV testing of
the patient’s blood.

The confidentiality requirements of
the bill also make it a civil liability to
disclose testing information to anyone
other than the patient, and prohibit
alteration of medical records. Sharing
of information within the health care
team is specifically protected.

Of importance to physicians is an
exception that allows physicians the
option to inform, under certain guide-
lines, a patient’s sexual or needle-
sharing partners of HIV-positive test
results. The bill states that physicians
are not obligated to inform partners.

The amendments were prompted by
concerns within the sponsoring coal-
tion, comprised of PMS, the Hospital
Association of Pennsylvania, American
Civil Liberties Union, bar association,
health department, insurance federa-
tion and organizations of other allied
health care workers. While the bill was
stalled in the Appropriations Commit-
tee over the winter, when it emerged from
committee in early April it was imme-
diately met with continued opposition
to the health care worker exposure
amendment.

Despite opposition, eventual passage
seems likely; concurrence in the House
moves the bill directly to the gover-
nor’s desk, and nonconcurrence sends
it to a joint conference committee,
where passage is still possible after
negotiation of amendments.

Speaking to the PMS Board of Trust-
nees meeting in April, State Health
Secretary N. Mark Richards, MD, lauded
the State Society for its leader-
ship in creating and guiding AIDS
related legislation.

PMS informs legislators
A conference jointly sponsored by PMS
and the Bar Association on April 17
updated legislators on AIDS and its
impact in Pennsylvania. Scheduled
prior to legislative session and located
conveniently inside the Senate cham-
bers, the conference educated legisla-
tive leaders on current medical, sci-
cific, epidemiological and legal
information on the status of AIDS in the
Commonwealth.

James Curran, MD, head of the Cen-
ters of Disease Control in Atlanta,
provided an overview of the epidemi-
ology of the AIDS epidemic. PMS assem-
bled a blueribbon panel of physicians
to discuss the medical impact of the
disease on sectors of the state’s popula-
tion. John Denney, MD, Geisinger
Medical Center, chairman of the PMS
Task Force on AIDS, described his
studies on AIDS in rural Pennsylvania.
Robert Sharrar, MD, Philadelphia, pro-
vided the alternate perspective of AIDS
impact within urban settings, and John
Dossett, MD, Hershey Medical Center,
a pediatric infectious disease specialist,
discussed the disease’s affect on infants
and children.

Following the medical panel, four
attorneys focused attention on work
place discrimination toward HIV and
AIDS infected persons.

One common note struck by the
experts was a need for blind testing of
blood serum within the Common-
wealth, as a determinant of the extent
of HIV infection within the population.
This controversial measure had been
struck early last year from the package
of AIDS legislation now pending, but
PMS and other health care organiza-
tions continue to support the need for
such testing.

PMS, HAP SPONSOR
DATA BANK USER SEMINAR

An overview of the long-awaited Na-
tional Practitioner Data Bank will be
provided May 25 at a seminar co-
sponsored by the Pennsylvania Medical
Society and the Hospital Association of
Pennsylvania. The seminar will be held
from 8:30 a.m. until 3:45 p.m. at the
Harrisburg Marriott.

Scheduled to begin operation some-
time this summer, the data bank will
collect and disseminate adverse infor-
mation about licenses and privileges of
physicians and other health care prac-
titioners. As mandated by the Health
Care Quality Improvement Act of
1986, the data bank will also affect
physicians by collecting information on
malpractice claim settlements and
judgments. Because the data bank’s
opening date has been pushed back
repeatedly, officials are unwilling at
this point to predict an official starting
date. However, progress was reported
in April with the approval of a finalized
version of the reporting forms.

A summary and overview of the
data bank’s potential impact on physi-
cians has been developed by PMS, to
be used at the seminar and subse-
sequently made available to members.
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**PMS INSURANCE COMPANY FILES FOR RATE DECREASE**

The PMS-affiliated Pennsylvania Medical Society Liability Insurance Company (PMSLIC) has filed with the Insurance Department for the largest rate decrease in its 13-year history. If the 15 percent rate decrease for all classes and specialties is approved by Insurance Commissioner Constance Foster, the third and fourth quarter bills of all PMSLIC insureds will reflect the downward adjustment.

PMSLIC insureds will also receive an appropriate credit for the reduced CAT Fund surcharge triggered by the rate reduction process.

The decrease was attributed not only to fewer paid claims, but also to a recent trend toward lower award amounts. PMSLIC Board Chairman Betty L. Cottle, MD, reported that the filing reflects PMSLIC's continued commitment to the company's original goal that rates be reflective of current experience.

The PMSLIC Board is also studying the feasibility of declaring a policyholder participatory dividend, to be credited as a renewal premium offset for each insured. This measure would provide equitable distribution of a portion of the company's 1989 retained earnings.

**AMA MEMBERS HOTLINE OPEN TO PMS MEMBERS**

PMS unification with the AMA provides special priority for all PMS members when they call the AMA toll-free hotline number, 1-800-AMA-3211. When calling the number, PMS members should mention that they belong to a unified society.

Members can request information on numerous AMA services or gain access to persons who can assist them. Information is available on membership benefits including continuing education, AMA meeting updates, conference and seminar schedules, JAMA subscriptions, AMA library search, programs for residents and medical students, publications, and medical studies and research. Callers can request information on medically related topics from legal, malpractice, and medical ethics issues to finances, practice management, peer review organizations, and statistics on medical economics. For a more complete listing of accessible information and departments, request an AMA Member Services Guide.

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to use the hotline as a quick, easy means not only to obtain AMA-related information but also to answer a wide range of medical or practice related questions. If an operator is unable to answer a specific question, callers will be connected with other persons knowledgeable in that area.

CHIEF APPOINTED FOR STATE AIDS BUREAU

The Pennsylvania Department of Health has selected Michael E. Carbine, a health policy adviser from Washington, D.C., to head the department's new Bureau of HIV/AIDS.

Carbine formerly advised several organizations, including the National Leadership Coalition on AIDS, the National AIDS Network, the National Association of People With AIDS, and other health care and hospital corporations. He was also executive editor of "The AIDS Reference Guide," an AIDS policy resource manual.

The state's Bureau of HIV/AIDS was established by executive order to coordinate all elements of the department's AIDS effort, including education and training, intervention care, and epidemiology. State funding to fight the AIDS epidemic has increased from $1 million in 1986-87 to $37.7 million in state and federal funds proposed for the 1990-91 budget.

NEW POLICY/RESEARCH AGENCY ESTABLISHED

A new agency of the U.S. Public Health Service, the Agency for Health Care Policy and Research (AHCPR), was established in December 1989. The purpose of the AHCPR is to enhance the quality, appropriateness, and effectiveness of health care services and to improve access to services. The AHCPR will establish a broad base of scientific research and promote improvements in clinical practice and in the organization, financing, and provision of health care services. The AHCPR builds on and expands the responsibilities of its predecessor, the National Center for Health Services Research and Health Care Technology Assessment.

The agency will conduct and support research, demonstration projects, evaluations, and training; facilitate guideline development for medical treatments; and disseminate information regarding a wide range of activities. These include the effectiveness, efficiency, and quality of health care services, health promotion, and disease prevention.

A major undertaking of the new agency is the Medical Treatment Effectiveness Program (MEDTEP), which focuses on improving the effectiveness and appropriateness of health care services by enhancing the medical community's understanding of which health care practices are most effective. Using improvement of the patient's functional status as the central criteria, MEDTEP's activities will attempt to improve the scientific basis of medical decision making. Results will be widely disseminated to health care providers.

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The Lane, A. (ACP) Information from AHCPR’s and Ration. 18-12, Selected of American 443-4100. MEDTEP Rockville, the to the Journal of the American Medical Association. For more information contact Maria A. Friedman, Chief of Publications and Information Branch, AHCPR, Room 18-12, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857; telephone (301) 443-4100.

ETHICS MANUAL AVAILABLE FROM ACP

The American College of Physicians (ACP) has published the second edition of its Ethics Manual, a guide to making ethical decisions in medicine and a code of professional ethics to assist doctors confronting difficult situations. The manual was developed by ACP’s Ethics Committee, composed of practicing interns, medical ethicists and educators.

Among issues addressed by the manual is the withdrawal of life support. The manual states that families of patients who are unable to make life-and-death decisions should work with physicians to reach the best decision in light of the patient’s condition, chance of recovery, nature of treatment, and wishes. Citing the manual, the ACP recently joined groups supporting the patient’s right to have life-sustaining medical treatment withheld in the case of Cruzan vs. Director, Missouri Department of Health, now before the U.S. Supreme Court.

In reference to ethical dilemmas raised by diseases such as AIDS, the manual says that it is unethical for a physician to refuse to see a patient solely because of medical risk, or perceived risk, to the physician.

On cost control, the manual states “No external factors should interfere with the dedication of the physician to provide optimal care.” It also says physicians have a responsibility to avoid unnecessary treatment expenditures.

Other topics reviewed by the manual include: conflicts of interest, confidentiality, criticism of a colleague, physicians and society, physicians and news media, public announcement of research discoveries, abortion and contraception, the impaired physician, advertising, and physicians and government.

The manual is available from ACP’s subscriber services for $7.00. To order, call (215) 351-2600.

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SORTING OUT PRIORITIES IS NEVER SIMPLE

Elaine S. Herrmann

Be friendly and open with your patients, John W. Mills, MD, advises. It not only gives you a good image, it gives medicine a good image. And it’s not as simple a choice as it seems, he says. Making a good image a priority is not without trade-offs: “I know it’s difficult to run a practice on time if you want to spend time with patients—you’ll always be late.”

Simple priorities and the paradoxes they entail have colored Dr. Mills 30-year career, since he chose to practice obstetrics/gynecology in Indiana, Pennsylvania. He will lend his perspective from Pennsylvania’s heartland to the PMS Board of Trustees, representing physicians in Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango counties.

Dr. Mills made his choice to be a rural physician at a time when, he says, “You set up your office, saw your patients, paid off your debts and made a living and tried to become involved in the community.” Change in the practice of medicine—even tucked behind the Pennsylvania mountains where modern entanglements are slower to encroach—has been “monumentous,” he says. “Now, there are so many restraints and restrictions on the practice of medicine that it’s difficult to do it the way you were taught.”

While he places high value on his easy, open rapport with patients, he knows it can’t protect him from the toll of outside forces. With more than 2,000 deliveries to his record, he delivered his last baby 12 years ago. “When I first started practice, my (malpractice insurance) premium for the year was $87. The last year I paid full obstetrics/gynecology insurance was ’86, and it was $35,000, even though I hadn’t done ob/gyn for 12 years.”

It is one of medicine’s most frustrating paradoxes: Dr. Mills says, “I don’t think patients have changed that much; but we look at patients a little differently from the way we did 30 years ago, because of the defensive posture under which we must practice medicine now.”

Organized medicine must be more active in this central issue of malpractice, he says. “In Pennsylvania we have been trying to make changes since Act 111 was passed in 1975 and we have been unable to budge the legislature.” The looming presence of malpractice issues is delaying implementation of change in national health care financing, he says, because “Congress does not want to deal with the malpractice issue—they don’t
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I'd do it again or not. In fact, I quit at one point and tried research for a year. I was delivering 30 babies a month, and I couldn't get any help. I think that's less of a problem now, because we do have more physicians, nationally." Dr. Mills returned to practice because he missed daily contact with patients.

Communicating needs
Despite the pressures today on physicians—and on their patients—it is patient contact that physicians need to nourish, Dr. Mills says. "Being human with your patients and giving them a break is the most important thing." He says this need for communication with patients encompasses a need for contact between the medical community and the public. "The average person doesn't even know the (state) medical society exists...I think we spin our wheels too much. I'm not a politician, but I think we have to become more visible and more vocal."

PMS and the AMA are not limited so much by lack of finances in enhancing their public image, Dr. Mills says, as they are hampered by "lack of bodies." The average physician who's trying to keep a practice running has a difficult time spending days away, because those days come out of time spent with family or on much-needed vacations. "Time with family seems to be more important to younger physicians than it ever was. I understand that; my family really didn't know me for the first ten years I was in practice. But I think the AMA, and PMS to some extent, are limited by that. It is another frustrating paradox, one not unique to medicine. Dr. Mills remains hopeful that young physicians can somehow be encouraged to become more active in organized medicine.

Small-town medicine
While some medical needs are harder to meet north of the state's burgeoning southern metropolitan belt, other aspects of medical practice are simpler. "We don't have any HMOs in Indiana County—that's one big difference. We're one of the few counties that have no pre-paid health plans; most of the surrounding counties do," Dr. Mills says. "There isn't the cut-throat competition. We have some, but there aren't even very many groups of more than two physicians."

The image of the self-sufficient small-town doctor may be fading, but it still harbors frustrations for rural medical communities. "I'm solo, have been for 30 years," Dr. Mills says, "but I don't know if

Engineers pastimes
"Trains have been my life-long love," Dr. Mills says. He collects, builds, models, rides. Feeding the rumble of the train yards in Hornell, New York, as a child may have been the spark, he says. He also enjoys gardening and restoring antique automobiles.

He and his wife, Jane, have four children and one grandchild. One son, John F. Mills, DO, practices family medicine with the Norland Family Practice Group in Chambersburg. His wife, Bonnie, a nurse, works in the obstetrics department of Carlisle Hospital. Three daughters are nurturing families and careers: Elizabeth, with a master's degree in criminal justice, is married to an attorney. They have a daughter, Caitlin, and live in California near San Diego. Susan, with a criminology degree, is teaching in Gettysburg and she and her husband John, an insurance loss-control agent, live in Middletown. The youngest, Stephanie, recently married Todd Bush, MD, a first-year resident in internal medicine at Lankenau Hospital. Stephanie teaches fifth grade in Wilmington, Delaware.
**CLINICAL HISTORY:** This is a 25-year-old female with complaints of left sided flank pain, nausea, and vomiting.

**FINDINGS:** Figure 1 represents a coronal T1-weighted image through the kidneys. A lobulated soft tissue mass conforming to the approximate shape of the left renal pelvis and the lower pole collecting system can be identified (large arrow). Signal intensity is intermediate and there is a central area of decreased signal intensity probably representing necrosis. Figure 2 is a sagittal image through the left kidney. In this projection, the soft tissue mass is comma shaped and can be identified extending from the left renal pelvis into the proximal left ureter (small arrows). Figure 3 is a T2-weighted image which exhibits increased signal intensity in the periphery of the mass and central decreased signal intensity. A curvilinear low signal structure lies medial to the mass and is felt to represent the left renal vein displaced by the mass. The vein appears to be patent as evidenced by the low signal intensity indicative of flowing blood (small arrows). No adenopathy is identified. There is no evidence of extension of the mass beyond the margins of the left renal pelvis or the proximal left ureter.

**MR IMPRESSION:** The location and shape of the soft tissue mass is typical for a transitional cell carcinoma.

**MR NOTES:** MR of the kidneys is a noninvasive procedure yielding both static and dynamic information about the pathologic process in question. In this case, the MR images defined the presence of the soft tissue mass in the left kidney, the confinement of the soft tissue mass to the left renal collecting system and the proximal left ureter, and the lack of invasion into the kidney and the adjacent pararenal soft tissue structures. In addition, the MR scan demonstrated that there is no evidence of thrombosis of the left renal vein nor is there evidence of tumor into the vein. MR imaging of the kidney is a noninvasive procedure allowing both anatomic identification of renal masses, staging of the extent of those renal masses, and determination of the presence or absence of renal vein involvement for surgical planning.

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BLUEMLE ERA LEAVES MARK AT JEFFERSON

What he doesn’t say tells the story of Lewis W. Bluemle Jr., MD, as much as what he does say.

On February 22, 1990, Dr. Bluemle, the retiring president of Thomas Jefferson University, was one of six recipients of honorary degrees at Commemoration Day ceremonies marking the 114th anniversary of The Johns Hopkins University and 100th anniversary of The Johns Hopkins University School of Medicine. Among those honored with him were two other alumni, two Nobel laureates, and the president of the United States. Although the material for this article was being collected at that time, and Dr. Bluemle was interviewed at length, his high honor was not revealed. None of his colleagues at Jefferson knew until the day the honor was bestowed and it was not mentioned in the course of a long and detailed interview. Lewis W. Bluemle Jr., MD, is a self-effacing man, but one whose accomplishments at Jefferson are so monumental that the last 12 years already are known as "the Bluemle Era" at the renowned facility for medical care, education, and research.

A Pennsylvania native, Dr. Bluemle was born and raised in Williamsport and recalls with a grin details of his boyhood there. Although Johns Hopkins claimed him for college and medical school, where he was Phi Beta Kappa and Alpha Omega Alpha respectively, he returned to the Commonwealth in 1946 to the Hospital of the University of Pennsylvania for internship and residency training. Dr. Bluemle stayed on at Penn in 1950-51 for a fellowship in the chemical section of the Department of Medicine, beginning a career in teaching and research there that lasted until 1968.

It was during this period that Dr. Bluemle, with his young assistant, later to become his wife, Dolores, established the first successful kidney dialysis program in Philadelphia. The story goes that Bill and Dee, as they are known to their friends, laid claim one night to a storage room at the Hospital of the University of Pennsylvania. They cleaned and painted, and with an odd assortment of parts—some from the doctor’s phonograph—they assembled Philadelphia’s first dialysis unit. Dr. Bluemle became the first chief of renal dialysis at Penn, and did research in fluid and electrolyte metabolism and diuretics and in designing and modifying early artificial kidneys. He remained chief of the dialysis unit at HUP until 1968, continued his work in clinical research, and from 1951 to 1968 was instructor, associate professor, and assistant professor in the Department of Medicine at Penn. He performed the first successful kidney dialysis in Philadelphia, the third in the nation, and coincidentally, helped to establish the kidney dialysis program at Jefferson in the early 1960s. He has written or coauthored more than 60 articles in the field.

During this period of teaching, research, and direct patient care, Dr. Bluemle also had his first experience in administration. From 1961 to 1968 he served as director of the Clinical Research Center at HUP, and from 1966 until he concluded his service there was associate dean at Penn’s School of Medicine. During this period he also filled the top three offices for the American Society for Artificial Organs, was a Markle Scholar in Academic Medicine, and received the Lindback Award for Distinguished Teaching.

In 1968 his growing interest in administrative affairs, which he attributes to his great respect and admiration for his father, who practiced his own administrative skills in real estate and insurance, led to his acceptance of the presidency of the Upstate Medical Center (Syracuse) of the State University of New York. He held that position until 1974, when he was called west to fill the same role at the University of Oregon Health Sciences Center in Portland.

While he was “putting SUNY Upstate on the map,” Dr. Bluemle reached out to the community by assuming leadership roles in widely diversified fields, including United Way, educational television,
music and the arts, and civic and community organizations. As Philadelphia Inquirer columnist Darrell Siffrd was to put it on Dr. Bluemle's return to Philadelphia, he finally took time to smell the roses when he gave up his medical practice and teaching and became an administrator. He also built a harpsichord, a color television, and two dollhouses, working so that he could be in the midst of his family, from whom the practice of critical care medicine had separated him during his years at Penn.

The move to Portland opened even more opportunity for community outreach to build support for the institution. Political activity, because of the multilayered decision making process for Oregon state schools, included the legislature, the chancellor of higher education, and the board of higher education. The University of Oregon Health Sciences Center also gave him the opportunity to institute modern management and fiscal systems from the ground up. Dr. Bluemle's completion of a job of this magnitude has been judged by associates in Oregon as his greatest accomplishment there. With an integrated fiscal management system, the professional schools control their academic affairs along the pattern of the nation's most modern academic health centers.

Lewis William Bluemle, MD, was inaugurated president of Thomas Jefferson University on September 7, 1977. It is significant that the inaugural parade was an academic procession through the streets of Center City Philadelphia, of which Jefferson is a pivotal part and to which Dr. Bluemle would give much of his time and talent. In his first public address as president, he expressed his delight at leading "an institution deeply rooted in the past to meet new demands and opportunities consistent with the basic concept of a medically oriented university." He spoke that night of the importance of training family physicians and of the role of the humanities in medical education. He said, "It is no easier to structure humanism into the curriculum (of medical school) than it is to structure the golden rule into our family or business lives. But we must do both if we are to make the human condition better. And making the human condition better, after all, has been the ultimate goal of the health care professions since their inception." He quoted Thomas Jefferson when he urged the Jefferson family, "Let us pursue a venture in quality."

In retrospect, he was a prophet. He said, "The difficult process of balancing health care costs with easy access to quality medical services (is) in the best interests of our citizens." Now, 15 years later, scholars write long treatises to express the same thought. And once again reaching into history, he spoke of Dr. Robley Dunglison, Thomas Jefferson's friend and personal physician: "Each reinforced the other's conviction that there must be a better way to treat sick people than with purges, emetics, and blood-letting. . . . Jefferson urged Dunglison to 'preach a crusade against ignorance.' This is exactly what Dunglison did for 32 years, but not primarily at the University of Virginia. He had the good judgment shortly after his arrival to accept the chair in medicine at the institution named for his mentor here in Philadelphia... establishing it as one of the best . . . institutions of medical learning in the country. . . The faculty at Jefferson has never lost it's orientation toward excellence in intelligent, humane medical care."

His accomplishments since he spoke those words have been prodigious. Administratively, the endowment fund has tripled; strategic real estate has been acquired for campus expansion; the institution now is the largest employer in central Philadelphia; the financial performance of the hospital has been outstanding with a double digit bottom line for five consecutive years; fundraising for the period stands at $100 million; workers enjoy a smoke-free environment, on-site day care, and a health awareness program; and the institution now has a historian, an archivist, and art researcher, as well as facilities to house their activities.

In the area of patient care and services, a new 400-bed hospital opened; consumer-oriented programs were initiated; additional facilities were acquired and affiliations arranged to provide appropriate care at locations throughout the city; the Level I trauma center and regional spinal cord injury center were opened; the liver transplant program was established; a hospital-based home health program was initiated; a critical care ground transport program began; and a number of new medical services were initiated, including the only extra-corporeal membrane oxygenation (ECMO) program in the region.

In the area of medical education, the Gibbon Scholars MD/PhD seven-year integrated program was developed for students with an early commitment to academic medicine; practice management and medicolegal courses were added; 126 new full-time faculty were hired; a nationally recognized Center for Research in Medical Education does critical studies on the impact of curriculum changes; and a code of professional conduct and commitment to concern for social issues in medicine is in place.

In the area of education in the allied health professions, Dr. Bluemle worked to establish the Jefferson School of Allied Health Professionals, an innovative graduate school of the Jefferson Health Sciences Center that bridges the gap between the fields of health sciences and the arts and humanities. The school now offers programs in medicine, nursing, pharmacy, and public health, and has established collaborations with the schools of music, fine arts, and dance. Dr. Bluemle's leadership has been outstanding and he has been an advocate for the integration of the arts and humanities into the medical curriculum. He has worked to create a climate where artists and scholars are valued and respected, and where they are encouraged to engage in creative pursuits.

Dr. Bluemle's commitment to the advancement of medical education and the institution has been demonstrated through his tireless efforts to ensure that the needs of patients, students, faculty, and the community are met. He has been a visionary leader who has guided the institution through challenging times and has helped to create a culture of innovation and excellence.

Paul C. Brucker, MD
Chairman-Department of Family Medicine
President Designate of Thomas Jefferson University

All of Jefferson's leaders contribute to the institution's success. As president, Bill Bluemle has never failed to express his appreciation. Because his attitude is contagious, everyone here has been willing to go the extra mile. They are building a church, not just laying bricks. I am grateful for these four months of transition. Dr. Bluemle is using this period to put in place a mechanism to continue the striving for excellence that has been the hallmark of his tenure. In choosing people he is careful; he is comfortable in trusting the people he chooses. His interest is to make the world better. His leadership in Physicians for Social Responsibility and in civic affairs are examples. The rest of us joke about trash, but it is an enormous problem. Yet it is the kind of issue on which Bill Bluemle is willing to apply his scholarly talents and abilities. Health care delivery research is a new dimension for Jefferson and has the responsible awareness of the entire Jefferson leadership under Dr. Bluemle's direction. I believe the federal government sees an important role for academic medicine in the search for efficient solutions. Any approach must include the elderly and the poor, two groups largely ignored by managed care systems. I believe the solution will include regionalization of care and specialization in levels of care and will have an impact on training programs. We should expect dramatic changes and must be able to respond quickly and with flexibility.
health sciences, there are new master’s degree programs in nursing, physical therapy, and occupational therapy; a career services center, the first in the nation; and record enrollments, increasing from 738 to 1,128 in the last 10 years. In the field of graduate studies, there are a large number of new courses, especially in molecular biology; improved quality has resulted from greater research strength and funding for faculty; and a seventh PhD program, in developmental biology, has been added. In research, public and private funding has doubled every two years since 1984 and stood at $40 million in 1989. The future is now at Jefferson in the early recognition of the need for a multidisciplinary approach to molecular biology. Establishment of the Jefferson Institute for Molecular Medicine and breaking ground for the latest facility, a Life Sciences Building, to house it, fills that need.

In the face of this, Dr. Bluemle says, “My role has been to help good people succeed. We aimed high and did a lot of recruiting. This meant spending money at a time when belt-tightening was the norm in medicine. Our emphasis always has been on quality.

“Fortunately for me, Jefferson was in a position to move forward—it was in solid financial shape when I arrived. When the decision was made to invest in first-class people on the cutting edge in their fields, we planned for a return on the investment several years out. But the financial returns came almost immediately and we reinvested in more people and the materials they need to do their jobs. We are investing our growing assets in good patient care, good people, and good research. We don’t anticipate growth as in ‘bigger,’ but as in ‘better.’”

Dr. Bluemle believes Jefferson acquired the related hospitals at just the right time. “Jefferson Park Hospital serves our need for more beds, and it has turned around financially since we acquired it. Methodist Hospital is aligned by management contract. It provides an additional teaching mechanism for Jefferson residents and medical students.”

Dr. Bluemle credits strategic planning for Jefferson’s progress. Spanning four education must be translated into clinical practice. Success in our education programs must be measured by the impact on patient care. This measurement is one of the functions of our Center for Health Services Research. With the support of Dr. Bluemle the center has continued the development of a severity of disease classification (Disease staging) and an analysis of economical costs of late hospitalization. Dr. Bluemle’s support for this work is typical. His strength is that he allows people to take risks and doesn’t spend time worrying about who gets credit. That attitude instills confidence and the proof is the record he has achieved.

From federal government sources. These funds support research by some 250 investigators. To make continued growth possible, a new research building with a price tag of $93.5 million is being constructed. Clearly the 287,000 square foot Life Sciences Building at Tenth and Locust Streets will be an important visible monument to the Bluemle era. The interdepartmental efforts resulting from the expansion of research, including the establishment of the Jefferson Institute of Molecular Medicine, will also benefit patient care and education.

I imagine a more outstanding leader for an institution such as this. He has an uncanny ability to get people to work together. Dr. Bluemle has set the framework for Jefferson to thrive in the years ahead and leaves a legacy of success in a strong, solid institution.

others for these achievements. The fiscal soundness of the hospital is due as much to excellence in research and patient care as to the cost efficient delivery of care. During his tenure the real focus has been on growth and quality as opposed to cost containment, but efficiency has been a direct result.

Joseph S. Gonnella, MD
Senior Vice President
Dean, Jefferson Medical College

The growth at Jefferson during the tenure of Dr. Bluemle is well documented. The research dollars from government, industry, and other private sources have been used well. As research grew, medical education kept up. There is an environment of excitement for all the students—medical, nursing, allied professional, and graduate students at all levels. This makes for better patient care. The linkages between the basic sciences and the clinical sciences have spurred the conveying of new knowledge to the bedside. Ultimately, whatever happens in

Jussi J. Saukkonen, MD
Dean, College of Graduate Studies

The numerous contributions to research during his tenure make the Bluemle era shine. The growth in scholarly activity and the training of new researchers are marks of a major change in direction during this period. Dr. Bluemle’s major contributions include increasing support for research, hiring excellent faculty, and blending research and patient care. External funding for research in 1976-77 was approximately $6 million. In 1988-89 it was $40 million, with $25 million coming

Willis C. Maddrey, MD
Chairman-Department of Medicine

Dr. Bill Bluemle sees the large picture, has clear goals, leads by example, and allows those working with him to move ahead to achieve workable goals once consensus has been reached. I cannot

Thomas J. Lewis III
Executive Director
Thomas Jefferson University Hospital

As a teacher and a consensus builder, Dr. Bluemle is responsible for both the growth and the excellence that have marked “the Bluemle era,” but he credits
and erudite, he is involved in all aspects of institutional life, including the preservation of its heritage through the institutionalization of the offices of historian and archivist and the establishment of the art gallery. His interest in the humanities has led to his involvement in the cultural as well as the civic life of the community at large.

Robert A. Peterson
Vice President-Administration and Finance
Under Bill Bluemle's leadership, the financial strength of Jefferson has enjoyed remarkable growth, especially in endowment resources and in physical resources. The campus has expanded and capital acquisitions have added significantly to the physical holdings. Such growth attests to Bill Bluemle's wisdom and sophistication in financial affairs. He has invested for the future in human resources, technology, and facilities, thus making provision for the long haul. In the last six years we have undertaken capital projects costing $200 million, the bulk of it without outside financing.

Lawrence Abrams, EdD
Dean, College of Allied Health Sciences
Dr. Bluemle's respect for nursing and the allied health professions have made the Bluemle era among the best for the College of Allied Health Sciences. He views these professionals as full partners with physicians in rendering health care to patients. Jefferson has avoided a crisis in staffing suffered in recent years by other institutions because many of the graduates of this college remain at Jefferson to work. The investment in this college has paid dividends in that respect.

Stephanie W. Naidoff, Esq.
Secretary and Corporate Counsel
The key to the success of Bill Bluemle is his secure ego and his modest view of himself. That allows him to keep his sights fixed on institutional goals, to which he brings not only great strategic vision but also a practical sense of what needs to be done to get there. He also has an extraordinary sense of balance—he encourages people to reach, to achieve, but he does not believe it is necessary to be the "first on the block" to try new things. He is a consensus builder—he always works in a collegial style—but remains decisive. Lastly, he has many interests and outstanding talents which he shares freely, and is a person of strong ethical principles.

Michael J. Bradley, CPA
Senior Vice President, CEO-Health Services Division
Dr. Bluemle has provided moral and ethical goals for Jefferson, believing that if the institution is to excel, its people must aspire to a higher standard. For example, Jefferson is a leader in United Way giving, and Bill Bluemle has been the catalyst for this. The hospital was in reasonably good condition at the time of his arrival, but the changes that occurred since then have been dramatic. For the year ending June 30, 1989, occupancy overall was 87 percent. On most days occupancy is 100 percent. Patients remain loyal to Jefferson. If they need medical care they want to be in the care of a Jefferson physician. This level of loyalty depends on attracting to Jefferson clinicians and researchers of the highest order. Dr. Bluemle has helped to create an environment where this can be done. Jefferson has experienced no material shortage of quality personnel at any level because the dignity of individuals is respected.
1989, for an increase of 323 percent. Full time faculty increased 72 percent; house staff was up 64.4 percent; gross square footage of the physical plant increased 25 percent; number of employees in 1989 stood at 7,103, up 46.5 percent over the 4,850 figure of 1977; the number of sponsored projects in progress at the end of 1989 was 743, up 174 percent over the 271 of 1977.

Even as he was leading Jefferson to new heights, Dr. Bluemle found the time and energy to provide leadership in civic and cultural affairs and in the difficult debate on cost and quality in the delivery of medical care. He is not afraid to say that there are too many hospitals, and an average occupancy of 60 percent in area hospitals is proof. He believes that competition might do the job of thinning them out, except that uncompetitive hospitals are rescued from time to time out of political expediency or for an emotional reason, such as community attachment. He believes government help to hospitals should be rendered by way of subsidies based on the percentage of free care given. He also believes that the nation needs a system to direct the use of medical technological advances so that the greatest good for the greatest number is achieved. The proliferation in the number of cardiac surgery programs is an example, he says. Mis-guided competition causes institutions to install such programs not because the public needs them but because they serve the perceived need of the institution.

Dr. Bluemle attributes these problems to the absence of any rational plan for the allocation of medical resources. While some of the problems of inner city hospitals are due to government cutbacks, he sees the failure to plan for the use of medical resources as the major problem. "Jefferson is financially healthy, but we have a high indigent load, and the risks are tremendous. If we don't hear an early answer to the problem of financing for the care of indigent patients, it is conceivable that liver transplant surgery (Jefferson's highly successful regional program) could be sacrificed." The crisis in health care for indigent people is one of the reasons Dr. Bluemle believes the odds for developing a national health care program are better now than ever.

International Physicians for the Prevention of Nuclear War has had the unstinting support of Dr. Bluemle through the years, and he rejoiced when the organization was awarded the Nobel Peace Prize for 1985. In 1988, Jefferson awarded an honorary degree to Bernard Lown, MD, co-founder of the group.

He foresees an orderly transfer of responsibility to his successor in the presidency, Paul C. Brucker, MD, chairman of the Department of Family Medicine at Jefferson. He is enthusiastic about the most recent of his many civic interests—he co-chairs, with William Donaldson, head of the Philadelphia Zoo, the Advisory Committee on Solid Waste Management for Philadelphia. He also plans to relax a little, he says, spend time with his other civic activities, and do a little work with a private company. With his gift for leadership and his creative thinking on medical care delivery, it is easy to prophesy a leading role for him in this area of endeavor. That he will remain involved is a given.

Francis E. Rosato, MD
Chairman-Department of Surgery

Jefferson has always been respected for teaching. Bill Bluemle’s gift has been in the recruitment of the right people. Peter Herbut (his predecessor in the presidency) will be remembered for expansion and physical growth of the university—Bill Bluemle for people and programs. There was no research in surgery when I arrived here in 1978—now every laboratory is filled. In the development of the liver transplant program, the first transplant created a debt of $284,000, but that never happened again and Jefferson now has the strongest liver transplant program in the region. We also do 70 to 100 kidney transplants a year, up from four in 1978. The ECMO program was pioneered here, and, like the other new programs, filled an area need. Dr. Bluemle is committed to filling needs as they are perceived and is dedicated to supporting the research required to make such programs successful. He makes the hard decisions but also is permissive in letting others express their ideas in full. He has built here an atmosphere of openness and leaves Jefferson in a very self-confident mode.

Trevor Fisk
Associate Executive Director
Marketing and Planning

Like hit shows, excellent medical centers result not from the efforts of one star but from the contributions of many stars. Lewis W. Bluemle has proved this at Jefferson. Always the director, he made his stars shine and built on their brilliance. That is his first success. His second real success is that he is as one with those serving under him because he shares their fields, whether research, teaching, administration, or direct patient care. He’s done it all. I have been here five years. It is remarkable that I was brought in at all—marketing was then a stranger in a place like Jefferson. Although he knew nothing about marketing, Bill Bluemle saw a need to institutionalize Jefferson’s

ability to change and grow, and he learned quickly. He funded the marketing effort fully, and has had remarkable results. Twenty percent of patients self-refer—they are people who want access to this hospital for medical care. There is a standard of excellence among institutions to which all aspire—Jefferson is now at the top. Across the board, department by department, Dr. Bluemle made improvements. His contribution is that he cast a great play with great players. Finally, in the last five years, we have reinforced the institution’s sensitivity to all its family and their wants and needs, including students and staff as well as patients. A great spirit has resulted. Jefferson’s tradition is one of excellence in patient care. Ultimately everything we do is aimed to that end.
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AN WE
MONITOR THE
MONITORS OF
MEDICAL COSTS?

Everyone is mad! Business says it can no
longer pay its employees health benefits
if it wants to remain competitive. The
public believes health care has become
unaffordable and that too many people have
become rich at the expense of the
unfortunate. Doctors are increasingly
badgered by politicians, and third party
payors are getting fed up. A recent report
says 50 percent of physicians feel
excessive paperwork is interfering with
their practice.¹ If you listen carefully, you
can hear a battle brewing. If you don’t
hear it, you are not listening.

Rapidly rising medical care costs are
attributed primarily to hospitals and physi-
cians raising their prices for providing
patient care. New technologies, chang-
ing patient demographics, and increased
capability to treat disease have no doubt
contributed. However, even all these fac-
tors do not adequately account for in-
creasing costs of care. A close examina-
tion of medical expenditures reveals that
a major portion of increased expense is
in so called “indirect costs” of care.

These “indirect costs” have burgeoned
in the past few years. It is easy to under-
stand costs allocated for personnel time
to deliver an antibiotic, or even an aspi-
rin. We recognize need for space utiliza-
tion, equipment, and personnel to do a
coronary angiogram or angioplasty, but
we have great difficulty understanding
the numerous “indirect costs” which
have little to do with patient care.

Primary among indirect costs are
those incurred in the collection of vol-
umes of information required to meet
the demands of regulatory or payment
programs. These “evaluation costs” are
assigned as medical care costs, but pri-
marily support the bureaucracy itself in
salaries and personnel.

The additional requirements these reg-
ulatory and bureaucratic agencies im-
pose on institutions, physicians, and
other health care providers, in demands
for records, summaries, and explana-
tions, are entirely different from those
required for interprofessional commu-
nications. They impose substantial medical
care costs, even greater than those to
support the bureaucracy itself. These
costs are not reported separately as ad-
ministrative or regulatory expenses.
Studies have calculated that 25 percent
of total medical care costs are spent on
these functions.²

Expensive paper pushing
Medical records employees now spend
57 percent more time preparing medical
records than before prospective pay-
ment.³ Over 50 percent of medical rec-
ords functions are under regulatory
mandate.⁴ One hospital that used to op-
erate with three people in the medical
records department now has over 60
people to meet data handling require-
ments. That institution must now also
have expensive computer programs to
compile excessive data into masses of re-
ports which, to date, result in informa-
tion of little use. To sort out the resulting
dichotomies and conflicts of information,
the institution and regulatory bureaucra-
cies require more personnel and more
equipment. Thus, another empire is
born. This compilation function has not
yet provided proven help in the diagno-
sis and management of patients’ ill-
nesses.

Health care administrators grew in
number at an estimated 171 percent
from 1970 to 1982 (and have probably
doubled since then), while the personnel
involved in actual patient care rose only
50 percent in this time period.⁵ This
growing bureaucratic empire has in-
creasing administrative requirements
which permit managers to solidify, ex-
tend, and justify their impact until the
process has become a congealed mass
totally under their control, but “out of
control.”

Administrative budgets are growing at
a faster pace than patient care expendi-
tures.⁶ In New York state, 56,000 hospital
employees devote all of their time to

Dr. Cooper is chairman of the
Department of Medicine at
Shadyside Hospital, Pittsburgh.
Dr. Shulkin is chairman of the
Pennsylvania Medical Society
Resident Physician Section, and
a fellow in the Department
of Medicine at the University of
Pittsburgh.
regulatory matters. Sixty-seven different agencies review administrative policies and procedures. The average urban hospital is reported to have 40 separate monitoring programs to assure regulatory compliance. In addition to the costs of the federal bureaucracies related to medicine, we are now developing burgeoning state bureaucracies which add yet another layer of regulations. The states seem determined to be tougher than the federal government on health care professionals and to get their share of these "medical care" funds diverted to them.

Another "indirect cost" relates to the paramedical/paraprofessional expenses that have wormed their way into reimbursement through the Medicare and Medicaid programs and are accepted as "medical care costs." Medical supply houses merchandise large amounts of medical equipment to patients at excessive rates, even if the equipment is not truly needed. Requests for items may show up at a doctor's office months later for "routine" signature for approval of something that has already been provided to patients. For example, chairs that raise a patient from a sitting-to-standing position costing up to $1,000 or more are merchandised on television and in newspapers, but have very limited use.

Some home care services of marginal value are funded as a result of political pressures while those of major benefit are ignored. Medicare and Medicaid laboratory mills sell services to physicians, dentists, allied health personnel, and other groups to provide studies sometimes not clinically indicated. Inadequate, but needed, Medicare supplemental insurance costs are classified as medical care costs, but these are paid for by the individual and are really a tax. The recently repealed catastrophic insurance tax was an attempt to impose costs upon all the elderly without serious study or discussion with the group involved. This occurred with the support of a major senior citizen organization.

The cost of PR

A particularly disturbing type of "indirect cost" is Madison Avenue type institutional image development. The primary beneficiary appears to be members of the advertising industry rather than patients or hospitals. For example, in a nearby hospital, the public relations administrative staff has increased 50 percent in a decade. Nothing contributed by any of these people has improved medical care for patients or the hospital census, but these increasing expenditures are part of "indirect medical care costs" and they reduce the money available for direct patient care.

Despite demands for explicit demonstration of cost benefit for medical procedures or care, these same requirements are not demanded of management, or of the advertising/public relations components of the system. If part of the system is subjected to intense evaluation, why not all of it? Where are the data to prove whether or not there is a cost benefit to those activities? Apparently, we are expected to accept without question the statement of regulators that their activity is valuable. The fact that rigorous review is forced on physicians, hospitals, and allied health care providers while regulators exempt themselves from scrutiny creates an inexcusable double standard. Moreover, the system appears to be driven by a form of paranoia based on the concept that physicians are greedy and will exploit the public unless scrutinized. With relatively rare exceptions, this behavior is not substantiated.

These ballooning "indirect costs" will be addressed only when the public recognizes the impact of "indirect costs" on their medical care. These expenses are now buried in overall cost figures and are not evident. There apparently is resistance by government and the bureaucracies to make available or identify such data. Cost accounting appears to extend only to direct provision of medical care and not to an explanation of these increasing "indirect costs." No commercial business enterprise could survive such mistreatment.

Seven suggestions for action

1. Demand accurate accounting of indirect costs through action by our professional societies.
2. Require that new regulations and requirements have cost estimates for compliance filed before approval.
3. Support public exposure through the media of information concerning the rise in indirect costs of medical care.
4. Encourage the adoption of standards by government and third party payers to limit regulation and practice interventions, and to simplify the reimbursement process.
5. Educate responsible legislators through collection and explanation of data on indirect costs.

6. Initiate cost-effective programs which focus on high quality care to offset the need for further regulations.
7. Speak out as individuals against those indirect costs which take funds away from patients. Be an advocate in the full sense of the word.

References
REPORTING INCOMPETENT PHYSICIANS

Recently physicians have found themselves facing requirements to report their fellow physicians. More traditionally, physicians have been required to report persons with communicable diseases or those whose behavior is criminal, such as the child abusers. Now the Federal Health Care Quality Improvement Act requires medical societies and hospitals to report those whose society membership or staff privileges have been revoked for quality of care reasons. Pennsylvania state law now also requires a physician to report a fellow physician who has active addictive disease and is not receiving treatment, or is diverting a controlled substance, or is mentally or physically incompetent.

These reporting laws arise from the perception that the profession is not doing a good job of policing itself. Such criticism, to be accurate, should be directed at medical licensure boards, wherein lies the legal responsibility and the power to ensure that only competent physicians are in practice. Seldom, however, are the criticisms so narrowly directed; rather, through ignorance or intention, a broad brush covers medicine in general.

Physicians have two practical reasons for reporting incompetent or impaired colleagues. The first is that in some circumstances the law requires it, and the second is that such reporting is one part of the answer to criticism that the profession does not police its own ranks.

Much more important, we must not forget that we are, above all, a profession. Although we have been battered by the Federal Trade Commission for our efforts to enforce our ethical codes, now we are told that competition is the watchword and that we should all behave like competitors. We remain a profession, however, and it is most important that our actions demonstrate professionalism. One benchmark for professional associations is that they hold their members to certain minimum standards of competence. That must begin with each of us.

The AMA Code of Ethics says it well: “A physician shall expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.” That admonition has not always been followed. Our obligations as physicians go beyond treatment of our own patients; however much we wish to avoid possible unpleasantness and complications, we must proceed without fear or favor.
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COMMENTS ON REGULATIONS FOR PHYSICIAN ASSISTANTS

Proposed regulations governing physician assistants in the Commonwealth have undergone extensive review and revision by the State Board of Medicine and in January 1990 the board approved them for publication.

During the review process, the board of medicine responded to input from the Pennsylvania Society of Physician Assistants, the four AMA-accredited physician assistant programs (Gannon University, Hahnemann University, Kings College and Saint Francis College), and from other practicing physician assistants. This input facilitated the development of regulations, including those governing the prescribing and dispensing of drugs by physician assistants. This is a significant step toward final implementation of Chapter 18, Subchapter D, the Medical Practice Act of 1985, which pertains to physician assistants.

The regulations provide for “more effective utilization of certain skills of physicians by enabling them to delegate various medical tasks to physician assistants when such delegation is consistent with patient health and welfare.” (§18.121). The regulations preserve the delegatory authority of physicians, and reinforce the role of physician assistants as dependent practitioners.

The delegation of medical tasks to physician assistants by the physician/supervisor may occur as direct supervision, such as in the hospital emergency room when the physician/supervisor must be present at all times directly supervising his physician assistant. Or task delegation may occur when “constant physical presence of the physician assistant supervisor is not required…” (§18.122), such as in an underserved area primary care facility. An “appropriate degree” of supervision of the physician assistant’s activities ranges from “active and continuing” direct on-site overview, to a “minimum weekly review by the physician of the records of patients upon which entries are made by the physician assistant” (§18.122), such as in a remote primary care office.

Certification of physician assistants
Physician assistants must be certified to practice in the Commonwealth. Board approval for certification as a physician assistant is contingent upon evidence of: (1) graduation from an AMA-accredited physician assistant program; (2) a passing grade on the NCCPA certifying examination, and (3) a completed application together with the required fee. (§18.141)

Physician assistant utilization
Physicians may use physician assistants to “augment the physician’s data gathering abilities in order to assist in reaching decisions and instituting care plans for the physician’s patients.” (§18.151)

Specific tasks delegated to the physician assistant may include, but are not restricted to, screening patients to determine need for medical attention; taking patients’ histories and performing physical examinations; recording pertinent patient data; initiating requests for lab studies; initiating appropriate evaluation and emergency management; performing a variety of clinical procedures (venipuncture, suturing, casting/splinting, administration of medications, etc.); and providing counseling and instruction about common patient problems.

Prescriptive privileges
The Medical Practice Act authorizes the physician assistant to prescribe drugs. The proposed regulations include a formula and specific provisions for the prescribing and dispensing of drugs by physician assistants (§18.159). The for-
Table I: Key Questions on Physician Assistant Regulations

1. Is physician assistant certification required? Yes (NCCPA)
2. Is physician assistant supervision required? Yes (MD)
3. Must physician assistant supervision always be direct? No
4. How many physician assistants may the primary physician assistant supervisor employ? A maximum of two
5. Can physician assistants perform a broad range of medical tasks? Yes
6. Can physician assistants prescribe and dispense drugs? Yes, with some exceptions
7. Can physician assistants execute and relay medical regimens? Yes
8. Can physician assistants deliver emergency medical services? Yes
9. Can physician assistants be utilized at satellite locations? Yes
10. Can recent physician assistant graduates work while awaiting certification exam results? No specific provisions in regulations.

Since physician assistant prescriptive privileges are based on a list of drugs submitted to the medical board, how comprehensive must the list be? For example, should every single antibiotic that the physician assistant might eventually prescribe be on the list?

The formulary cites classes of drugs that physician assistants may be authorized to prescribe. Therefore, if a physician assistant is likely to prescribe a variety of antibiotics within the scope of practice, then the list entry will simply be "anti-infective agents." In similar fashion, the list might name "antihistamines," "contraceptives," or "gastrointestinal drugs."

However, take care when entering drug classes, since a few classes have specific restrictions. For example, if a physician assistant supervisor designates that the list contain "blood formation and coagulation" agents, then he/she must be aware that coagulants, anticoagulants, and thrombolytic agents are specifically excluded from that class. Therefore, the physician assistant supervisor must have full knowledge of the formulary when developing the list of drugs that the physician assistant will be authorized to prescribe/dispense within the scope of the practice.

We suggest that the application submitted to the medical board identify each and every drug to be prescribed, rather than broad classes. This will avoid misunderstanding on the part of the physician supervisor and his physician assistant, as well as with the medical board.

Executing and relaying medical regimens

A critical issue for many physician assistant supervisors is whether the physician assistant may write orders for patients in the hospital setting when the supervisor is not on the premises, and whether such orders are to be considered valid by other health care personnel. The regulations are quite clear and specific on this matter: "The physician assistant may rely to other health care personnel, medical regimens as defined by a physician assistant supervisor who need not personally issue the order to execute the relayed medical regimen. (§18.153)

If the physician assistant supervisor was not present when orders were relayed or executed, the physician assistant must report such action to the physician assistant supervisor within 24 hours, indicating "the basis for each decision to execute or relay a medical regimen. Chart entries made by a physician assistant "must be countersigned by the physician assistant supervisor within a reasonable period of time, not to exceed seven days..." (§18.153(e). Many hospitals have developed their own regulations, often requiring that entries be signed within 24 hours.

Other health care personnel who need to confirm the validity of an order from a physician assistant should consult "the written agreement governing the physician assistant’s activities." (§18.153(b)) (see below)

Written agreements

The terms and conditions of employment of a physician assistant must "identify and be signed by the physician assistant and by each physician the physician assistant will be assisting. At least one physician must be a medical doctor. (§18.142(a)(1))

The written agreement must "describe the manner in which the physician assistant will be assisting each named physician," and must include a list of functions to be delegated to the physician assistant. These included "medical, therapeutic, corrective, or diagnostic measures to
The physician assistant supervisor must satisfy the medical board that criteria for physician assistant utilization at a satellite location have been met. Final approval for use of a physician assistant at a satellite location is contingent upon an on-site visit by a representative of the board, and submission of a favorable report of compliance with requirements for physician assistant utilization at the site. [§18.155 (b)]

Emergency medical services
The regulations state that a physician assistant "may only provide medical services in an emergency medical care setting if he has training in emergency medicine and is under the direct supervision of the physician assistant supervisor." (§18.158)

Direct supervision denotes the "physical presence of the physician assistant supervisor on the premises..." (§18.126). In many smaller community emergency medical care settings it is difficult to achieve round-the-clock physician coverage. Physician assistant coverage will not then be possible in those EMS settings where there is not "physical presence" of the physician assistant supervisor.

Physician assistant graduates
No provisions are made in the regulations for a probationary employment period for graduates of AMA-certified physician assistant programs, who must wait up to six months before they can sit for the National Certification (NCPA) Examination. The NCPA exam is given only once each year, usually in October. Results are not available for three to four months. Therefore, the employment status of recent graduates remains on hold for a considerable time.

Specific regulatory provisions should be addressed allowing a probationary period of employment for graduates who are waiting for certification examination results. This would alleviate potential hardship situations resulting from this regulatory oversight.

Conclusion
Proposed regulations are contained in Subchapter D (Chapter 18), implementing provisions in the Pennsylvania Medical Practice Act pertaining to physician assistants. The regulations preserve the delegatory authority of physicians in their utilization of physician assistants, including specific provisions for the assistants prescribing and dispensing of drugs, executing and relaying medical regimens, and use in satellite locations.

Potential problem areas in the regulations involve: (1) a requirement mandating the physical presence (direct supervision) of the supervising physician when physician assistants are employed in the emergency medical care settings, and (2) the lack of specific provisions for probationary employment between graduation and reception of NCCPA certification exam results.

The regulations are comprehensive in matters affecting the professional relationship between the physician assistant supervisor and the physician assistant. The regulations address particularly important areas of interaction between physician assistants and other health care personnel (e.g., prescribing and dispensing drugs, executing and relaying medical regimens, etc.) which was not included in previous regulations. The regulation regarding prescribing and dispensing of drugs is of particular significance.

The authors have attempted to anticipate some questions and concerns that may surface about physician assistant utilization once the proposed regulations receive the force of law. (Table I). For those physician assistants and physician assistant supervisors entering into written agreements in the future, there is no substitute for careful reading and thorough understanding of the original language of the regulations.

Reference
Pennsylvania State Board of Medicine: Draft of chapter 18 Practitioners Other Than Medical Doctors-Subchapter D, Physician Assistants, 1989

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PREPARING FOR YOUR NEW DOCTOR

The Health Care Group

The process of bringing a new associate into your practice is multifaceted and takes time. First, you assess your practice's needs and what kind of doctor you should bring in. Next, you recruit and interview candidates. Finally, you extend an offer and reach an agreement. Getting to this point can take anywhere from 12 to 24 months.

Before you declare the process complete and your efforts successful, there is one more step, the one which brings the payoff for all your hard work: getting your new associate off to a running start.

Your new doctor should be ready to practice, and in a position to be productive, from day one. That means the new associate should have a minimum amount of down-time, and should meld easily with your practice's regular routine. This will not happen automatically and requires careful planning and preparation. While the new doctor must take an active part in the preparation process, the primary responsibility for making things happen rests with the practice.

Attention required
Proper planning for your new associate's arrival is not just a luxury. Your diligence will directly affect his initial success; and potentially will determine the long-term advantages of the move.

Failure to prepare can lead to serious consequences for both the doctor and the practice, and the repercussions may be felt in both your office and your medical community. Those consequences could include paying a doctor who cannot yet see patients; angering patients who know nothing about the new doctor they are being examined by; alienating referral sources; creating dissension between your staff and the new doctor; forcing your new associate to be unproductive, despite his best efforts; undermining the doctor's confidence in his management or clinical skills.

As soon as you have signed an agreement with your new doctor, one person within your practice should be made responsible for coordinating the "new doctor process"—this could be the office manager or even the lead doctor.

Obtaining credentials
If your new associate is fresh from training or from out of state your first priority is assistance in obtaining the necessary credentials to practice. These include state and DEA licenses, and hospital staff privileges, and any other credentials necessary or valuable for your practice.

The licensure process is highly bureaucratic and very detailed. You and the associate will need to initiate the process immediately, and then keep track of it regularly. The coordinator should take an active stance: guiding the new doctor in gathering the appropriate documents and submitting applications; contacting the appropriate authorities at regular intervals to make sure the application is progressing; and responding immediately to any questions or information requests from the licensing agency. Do not assume that no news is good news, because, in the long run, no news means your new doctor cannot practice medicine until the good news arrives.

Determine steps necessary to gain hospital admitting privileges for your as-
sociate, and follow that process through to conclusion. Serving on a hospital staff committee is a good way to meet medical colleagues; so send a letter on behalf of the new doctor, recommending that he or she be appointed to a specific committee.

Third-party payors
You cannot assume that simply by joining your practice, the new doctor will be recognized by the third-party payors with which you deal. There may be accreditation or contractual arrangements necessary. Send a formal notice of the new doctor’s association with your practice to Blue Shield and the commercial carriers you deal with most often. Ask them to inform you of any steps necessary to bring your new associate into compliance with their guidelines.

Contact any managed care organizations with which you work; find out if special arrangements are necessary to include the new doctor in your service contract.

When you have determined if the new doctor has a Medicare profile, decide whether to add him or her to your existing profile or to establish a new one. Working with Medicare profiles can be complex, and you should consult your management/reimbursement advisors in making and implementing your profile decisions.

Insurance
There may be nothing more frustrating than having everything in place for your new associate—even a series of patient visits scheduled—only to have everything halted because malpractice coverage has not been granted. Remember, professional liability insurance is not umbrella protection for your practice; it is personal to the doctor.

Work with your new associate to complete the lengthy application and gather

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any supporting documentation. Have your coordinator closely monitor the application’s progress and respond immediately to any questions or problems raised by the insurer.

Be sure that your new associate has been added to the list for your practice’s casualty, health, life, and disability insurance programs as well.

Supplies and equipment
When the new doctor agrees to join your practice, begin an assessment of the necessary additions or changes to office supplies and equipment. Arrange for new super-bills, letterhead, business cards, and office signs. Make sure office space is ready, and desks, lamps, chairs, file cabinets, dictaphone, and beeper are all available.

On the clinical side, be certain that all necessary instruments and equipment are available—from lab coat and stethoscope to sophisticated machines. If your new associate is bringing new skills and procedures to the practice, you may need to acquire a major new piece of equipment; place your order in time to assure it arrives just before the new doctor does. And make sure you have the necessary personnel to handle the new equipment’s operations.

Finally, determine if the volume of your office’s clinical and pharmaceutical supplies is sufficient for an additional doctor’s needs. If it is not, make careful assessments of the additional numbers needed; err on the side of slightly too much supply volume, rather than too little. And, of course, check that your storage areas can accommodate the added supplies.

Management issues
It will be important to understand the financial implications of bringing in your new associate. If you have not already done so, informally review the first-year costs incurred for the new doctor, including salary, benefits, malpractice coverage, hospital staff fees, new equipment and personnel, and any personal costs. This review will give you a sense of the added dollars your practice must generate to cover the cost of a new doctor, and this, in turn, will help you set goals for the doctor’s performance and productivity.

It is important that the new doctor know what is expected. Therefore, you should communicate your first-year goals, and set up a monitoring system to see they are met. This system should include at least a series of regular meetings between you and the new associate. During these meetings you can assess performance, review and modify goals, and gain valuable feedback from the new doctor.

Prepare yourself mentally for practicing with a new doctor. This will be especially important for solo or small group practices, where a new body in the office represents a major change. Allot yourself some time to consider new issues and problems that come with having a new associate. Also set aside time specifically to manage and guide the new doctor. Perhaps the worst you could do is simply leave the doctor to learn and fend for himself, with no opportunity to check back with you on questions or problems.

Having another “boss” could be traumatic for your nursing and office staff; therefore, take the time to prepare them for the new doctor’s arrival. Let them in on your strategies and objectives, and on the kind of relationship you hope to see between them and the new physician. Make sure your staff understands the new office scheduling, on-call, and hospital coverage patterns.

Schedule specific times for the new doctor and individual staff members to meet. These sessions should serve as both get-acquainted sessions and opportunities for the doctor to learn about the office systems and procedures, including billing, charts and records, and CPT and ICD-9 coding.

Professional and patient relations
Create a plan and schedule for announcing your new associate’s arrival. Develop a specific strategy for communicating with each important group: colleagues, referral sources, patients, medical societies, and the health care community generally. This is an essential step in getting your new doctor busy, and in enabling him or her to begin drawing in new patients to the practice.

A formal announcement should be sent to anyone who has been a patient during the last five years. It should highlight the doctor’s training and skills, especially those that broaden the range of your practice. Many practices find that an “open house” for patients and colleagues is an effective way for the new doctor to meet people personally.

Arrange immediately for the new doctor to join the appropriate state and county medical and specialty organizations. Schedule appointments for your new associate with individual referrers, hospital administrators, and other health care leaders in the community. Send formal announcements to every medical professional in the community and at the area hospitals—including pharmacists, opticians, physical therapists, nurses, and others in a position to refer patients.

Consider preparing press releases to go to local newspapers, and radio and television stations. These should highlight the new doctor’s special skills and training, and any new expertise that he or she brings to your practice or the community generally.

An experienced practice-marketing consultant can help you develop your announcements and letters, and can prepare press releases for you. The consultant can also help you rework your existing patient-information brochures, to include your new associate and any new services your practice will now offer.

Finally, arrange for the new doctor to meet other professionals in the community, such as lawyers, bankers, architects. Getting to know them will allow your associate to become a part of the community. These people, whose personal opinions are usually respected by their own clients, can serve as a valuable referral network outside the medical profession.

Assist the new doctor
Whether the doctor is fresh from residency or has been practicing elsewhere for 10 years, the move to a new practice will be stressful—especially if it involves relocating home and family. Understand this, and try to be helpful on a personal level. Provide the doctor with useful names and addresses: real estate agents and attorneys; bankers and insurance agents; and schools or day-care facilities.

Remember that there may be a spouse involved, someone who could use help finding a job, finding a babysitter—or who just needs reassurance that the decision to join your practice was a good one for the family.

With good planning and teamwork, you can make sure that your new associate hits the ground running. That is important for the doctor’s self-confidence, and it is essential for the success and growth of your practice.
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors. Its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocoon is indicated as a sympathomimetic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases and patients sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral adrenergic blockade. These include, anti-diuretic, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. Also diziness, headache, skin flushing reported when used orally.1,2

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.3 4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, diziness or nervousness. In the event of side effects dosage to be reduced to 1 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

How Supplied: Oral tablets of Yocoon 1/12 gr. 5.4 mg in bottles of 100's NDC 53159001-01 and 1000's NDC 53159-001-10.

References:

Revised: 1/85

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HIV INFECTION AND AIDS: THE NUMBERS

George J. Pazin, MD

Having dealt with issues of transmission and acquisition of infection with human immunodeficiency virus (HIV) in the past five installments in this series, it is time to look at the impact of infection with HIV beginning with the extent of the epidemic.

In beginning to discuss the numbers in relation to the HIV/AIDS epidemic, I am struck with the immediate need to point out that the epidemic we will be considering is not portrayed accurately in bar graphs nor pie diagrams. Even absolute or cumulative numbers in a table do not portray an accurate picture because the numbers represent people, and in turn, the people experience an immense amount of suffering. Illness, pain, loss of abilities and well-being, and eventually death; these are the consequences of infection with HIV.

Also, before considering the numbers, I should also point out that we will not be discussing AIDS "victims," nor will we be describing risk "groups." Instead we will be considering AIDS sufferers and risk behaviors.

Why do people with AIDS prefer to be referred to as persons with AIDS or PWAs rather than AIDS victims? There are at least two reasons. First, the term "victim" is undesirable because it suggests that nothing can be done by or for the AIDS sufferer. PWAs are not helpless. Many can and are doing much to combat this epidemic. Secondly, the term victim is undesirable because it is often followed by an expression of concern for the unfortunate "innocent" victims. This in turn, implies that AIDS sufferers, other than children, hemophiliacs and transfusion-acquired persons with AIDS or HIV-infection, are in some significant degree "guilty" of having brought this infection upon themselves. Since no one desires to get infected with HIV, I believe it is fundamentally unfair to blame any persons with HIV-infection for having acquired the infection, regardless of the manner in which it was acquired.

The term "risk behavior" is preferred to the term risk group because it emphasizes the reality that people do not get infected with HIV because of the societal group in which they may be a member, but because of the "risky behavior"

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases of AIDS</th>
<th>Cumulative cases - U.S.</th>
<th>Cumulative cases - Pa.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>8 cases</td>
<td>(538)</td>
<td>8</td>
</tr>
<tr>
<td>1980</td>
<td>43</td>
<td>(512)</td>
<td>51</td>
</tr>
<tr>
<td>1981</td>
<td>220</td>
<td>(364)</td>
<td>271</td>
</tr>
<tr>
<td>1982</td>
<td>800</td>
<td>(251)</td>
<td>1,071</td>
</tr>
<tr>
<td>1983</td>
<td>2,007</td>
<td>(255)</td>
<td>3,078</td>
</tr>
<tr>
<td>1984</td>
<td>5,124</td>
<td>(161)</td>
<td>8,202</td>
</tr>
<tr>
<td>1985</td>
<td>8,249</td>
<td>(157)</td>
<td>16,451</td>
</tr>
<tr>
<td>1986</td>
<td>12,932</td>
<td>(163)</td>
<td>29,383</td>
</tr>
<tr>
<td>1987</td>
<td>21,070</td>
<td>(154)</td>
<td>50,453</td>
</tr>
<tr>
<td>1988</td>
<td>32,311</td>
<td>(109)</td>
<td>82,764</td>
</tr>
<tr>
<td>1989</td>
<td>35,238</td>
<td></td>
<td>118,002</td>
</tr>
</tbody>
</table>

Dr. Pazin is an infectious disease specialist and associate professor of medicine at the University of Pittsburgh School of Medicine.
which led to exposure, and most importantly, to inoculation of HIV into the body or onto a moist lining surface (mucosal membrane) of the body.

Having made these important caveats, let's turn our attention to a brief historical overview and then to the numbers, keeping in mind that the numbers represent people who are suffering.

The HIV/AIDS epidemic may be summarized as follows:

The HIV Infections/AIDS Epidemic
1959—Three of 1,000 (stored sera from) prostitutes in central Africa positive for antibodies to HIV on screening ELISA and confirmatory WB testing.
1968—Isolated case of 14-year-old boy in St. Louis with extensive Kaposi's sarcoma subsequently found to be HIV positive. (Fortunately, this infection was seemingly not spread to other persons.)
1970—Many unrecognized cases of HIV infection and AIDS in central Africa.

Late 1970s (1977)—HIV introduced into gay community in San Francisco or elsewhere and possibly into intravenous drug abusing persons.

*1981—First cases of opportunistic infections and tumors reported in June 5 and July 3 Morbidity and Mortality Weekly Reports (MMWR).
1982—AIDS recognized among intravenous drug users, transfusions recipients and hemophiliacs.
1983—First instances of HIV infection and illness among newborns.
*1983-4—Discovery of the etiologic agent, called LAV, HTLV-III, ARV, eventually HIV.
1985—Licensure of serological tests for blood transfusion services.
*1986-7—Development, licensure, and marketing of antiviral therapy—AZT, azidothymidine, now called zidovudine (ZDV, Retrovir).
1989—Beneficial effects of early intervention therapy with zidovudine (ZDV, Retrovir, formerly AZT) documented in large, placebo-controlled studies.

Note that the three major milestones (marked above with an asterisk), recognition of the disease, discovery of the etiologic agent with development of a diagnostic test, and demonstration of therapeutic benefits of antiretroviral therapy, have occurred in unusually rapid sequence over a relatively brief period of time. Nevertheless, the first decade of recognized AIDS has been the easy part. The period of tedious, slower progress has begun.

Now, let's look at the numbers. The following is my compilation of reported cases of AIDS as gleaned from CDC Morbidity and Mortality Weekly Reports (MMWRs), the Allegheny County Bulletin, news releases and the like. Reported numbers vary slightly from report to report, but they are generally reasonably close and reasonably accurate. The numbers lag 2–3 months behind and are 10–15 percent underreported at any point in time, but are satisfactory for our purposes.

Note that at least 50 persons with AIDS were recognized and diagnosed in retrospect to have existed before the first reports of PCP and/or KS in gay men were reported nationally in MMWR. These cases emphasize that it is not difficult to diagnose AIDS and also emphasize that AIDS (and antecedent HIV infection) is a new disease in the U.S. and not a disease that had been occurring for a long time without a diagnosis being made.

The second point is that the initial cases of AIDS were reported in mid-1981 and a cumulative number of 271 cases were diagnosed by the end of that year. Note that early in the epidemic the an-

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nual percent change in reported cases was 500 percent of the previous year, but the change in reported cases has gradually decreased over time until the 1989 cases were only about 109 percent of the 1988 cases. Thus, the annual incidence of reported cases is leveling off, but at an unacceptable, troublesome rate of 35–40,000 cases per year. The brief rebound in rate of increase noted in the 1987 numbers was due in part to a revision in the CDC case definition of AIDS in September 1987.

Although the ongoing cumulative mortality rate has remained relatively stable at approximately 58 percent at any point in time, the cumulative numbers of persons alive with AIDS is continuing to increase with approximately 50,000 persons with AIDS alive at the beginning of 1990. Advances in antiretroviral therapy will add to the reservoir of persons infected with HIV and ill with AIDS.

The numbers of reported cases of AIDS in Pennsylvania are increasing along with the national numbers. Approximately 75 percent of Pennsylvania’s cases are being diagnosed in Philadelphia and slightly more than 10 percent in Pittsburgh.

Throughout the first several years of the epidemic, the proportion of persons with gay and bisexual behaviors as their risky behavior remained relatively constant at about 63–65 percent. However, the proportion with this risk behavior between January and July, 1989 was 56 percent. This is a substantial decrease, but gay and bisexual men continue to account for more than half of newly diagnosed persons with AIDS.

Conversely, the percentage of AIDS attributed to intravenous drug use has increased from 18 percent early in the epidemic to 23 percent recently. This 5 percent increase represents a 28 percent proportional increase. The seriousness of this observation is magnified by the observation that this risk behavior is disproportionately represented by the Black and Hispanic communities who have less access to health care and this risk behavior provides ‘bridges’ to the larger population with generally less risky behavior.

The percentage with both gay or bisexual risk behavior and intravenous drug use has remained stable at 7–8 percent. Overall, gay or bisexual behavior, intravenous drug abuse, and the combination still account for 86–87 percent of reported cases.

The number of PWAs who have acquired the infection via heterosexual behavior is a major concern for many people, and indeed it should be because the number of people who have acquired HIV via heterosexual activity and have developed AIDS continues to increase more rapidly than the epidemic as a whole. (See December 1989 discussion in this series. One percent in ’83 to 4.4 percent in ’89.) Over 3,500 persons with AIDS have acquired HIV via heterosexual activity. Thus, it is AIDSpeak to say that HIV is exploding into the heterosexual population, but AIDSense requires that we recognize the progressive movement of the virus.

I continue to be amazed by efforts to downplay heterosexual transmission with statements such as, “People who acquire HIV via heterosexual behavior do so by having sex with someone within the usual risky behavior categories.” Of course, what do you expect? Viruses do not arise by spontaneous generation. For the time being the statement is expected to be true, but it will become less applicable as the virus continues to be transmitted into and within the heterosexual population.

Perhaps the unreported numbers of HIV-infected persons are the most frightening aspect of the AIDS epidemic. The knowledge that it takes time for AIDS-defining disease manifestations to develop suggests that there are many persons infected with HIV for every person diagnosed with AIDS. The validity of the concept of HIV-infected persons exceeding persons with AIDS was clearly shown by testing the San Francisco hepatitis cohort sera. It is reasonable to expect that the number of HIV-infected persons exceeds the number of PWAs by a factor of 10 times or more. Thus, although there is some controversy about estimates of the number of HIV-infected persons in the U.S., an estimate of 1,000,000 HIV-infected persons in the U.S. does not seem unreasonable.

Before closing, the following transformations of AIDSpeak into AIDSense with respect to the numbers of HIV infections and AIDS are suggested.

AIDSpeak:

1) The AIDS epidemic is leveling off.
2) Fewer gay and bisexual men are becoming AIDS sufferers.
3) AIDS is not exploding into the heterosexual population.
4) Since the number of persons with AIDS is not reaching the 1986 projections for 1991, the reservoir of HIV-infected persons may also be less than the previously estimated 1.0–1.5 million.

AIDSense:

1) The AIDS epidemic is leveling off, but at approximately 35–40,000 newly diagnosed cases per year. If you think about it, the ‘leveling off’ phenomenon is expected as persons with more risky behavior become infected more quickly earlier and persons with less risky behavior become infected at a slower rate later in the epidemic.
2) Gay and bisexual risky behavior continues to account for the majority of newly diagnosed persons with AIDS and the absolute numbers of new PWAs attributable to this risky behavior is higher than ever.
3) Persons with AIDS attributable to heterosexual acquisition are increasing at a rate greater than the epidemic as a whole. An expanding unrecognized reservoir of 35,000 or more heterosexual HIV-infected persons probably exists in the U.S. currently.
4) An unrecognized reservoir of 1,000,000 HIV-infected persons, plus or minus about 500,000, provides an ample number of people among whom AIDS manifestations will develop and from whom the virus may be transmitted to unsuspecting intimate partners, needle sharers, indirectly to newborns, and albeit rarely, to health care providers.

In conclusion, I am reminded of a poignant cartoon in which AIDS cases were depicted as a floating angular iceberg above the submerged portion shown as a large, partially obscured skull. Some persons prefer a more wishful, optimistic viewpoint; others express the more pessimistic, fatalistic perspective. I prefer to operate, teach, and counsel from the reasonably objective attitude of a realist. Regrettably, from this perspective the numbers are not comforting. Indeed, the growing number of persons with AIDS and the larger number of HIV-infected persons who may or may not be aware of their infection and infectiousness are troublesome, disturbing, and worrisome.
Symptomatic patients similar to Axid® subjects.

Contraindication:

Indications

Brief Summary. Consult the package literature for complete information.

References

1. USP/DI Update, September/October 1986, p. 120.

Additional information available for the profession on request.

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nizatidine capsules

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2. Maintenance Therapy—for healed duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. The consouquences of therapy with Axid for longer than one year are not known.

Contraindication:

Indications

Swift and effective H₂-antagonist therapy

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Nizatidine (Axid®, nizatidine)

Republic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) rarely or possibly related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 SUL in SGOT or SGPT and, in a single instance, SGPT was >3,000 IU). The incidence of elevated liver enzymes varied and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinue of Axid.

Anticoagulant—In clinical pharmacology studies, short episodes of asymptomatic vitamin B-thyroid occurred in two individuals administered Axid and in three unselected persons.

Rashes—Rare cases of morbilliform mental confusion have been reported. Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antidiabeticogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fetal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Intestinal—Swelling and urticaria were reported significantly more frequently in nizatidine than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hypersensitivity unassociated with rash or neurtihisms was reported; epistaxis, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdose occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for toxic patients has been associated plasma clearance by approximately 84%.

PV 2008 AM

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AXID® (nizatidine, Lilly)
During the past four and one-half years, we have from time-to-time conducted recruitment drives to obtain physician advisors to review for KePRO. Although a large number of physicians have applied and been credentialed, we continue to need physicians from certain specialties.

We have occasional inquiries from physicians who have applied and been credentialed but have never been called to do review. There are several reasons for this, including instances when the physicians may not have attended one of our physician advisor training sessions or may have had scheduling conflicts. Primarily, though, it happens because we have an abundance of certain specialists and a shortage of others.

Now more than ever, we need additional physician advisors representing certain specialties. One reason is, we no longer conduct first level physician review onsite at the hospitals, and are trying to match specialties at first level as well as at second level and for reconsiderations. This has been done mainly to improve our quality assurance review process. Also, we have opened a rural review office in Bloomsburg where cases from hospitals classified by HCFA as rural hospitals will be reviewed. We need physicians from the whole range of specialties at rural hospitals willing to travel to Bloomsburg to review in that office.

Since April, the board certified specialists most urgently needed by our area offices are:

**Blue Bell:**
- Neurological Surgeons
- Cardiovascular Surgeons
- Psychiatrists
- Gynecologists
- Nephrologists

**Harrisburg:**
- Cardiologists
- Neurological Surgeons
- Gastroenterologists
- Urologists

**Monroeville:**
- Orthopedic Surgeons
- Gastroenterologists
- Psychiatrists
- Neurologists

We can do true peer review only if we have a sufficient number of peers willing to take the time to review for us. I ask that even if your specialty is not listed above, you write to Liz Otto, Manager of Physician Review Operations, at our Central Office, or call her at (717) 564-8288. She can help determine the extent to which your particular specialty is needed for review at our office nearest you.

Remember, if you don’t participate in the review process, it will be that much harder for us to match specialties for review; this will reduce your chances of having a peer of your specialty review your own cases.

**Obituaries**

- Denotes PMS membership at time of death.

**Emma B. Bevan,** *King of Prussia*
University of Pennsylvania School of Medicine, 1930; age 86, died February 20, 1990. Dr. Bevan was an obstetrician and gynecologist. •

**Joseph A. Brady,** *Villanova*
Graduated 1943; age 71, died February 14, 1990. Dr. Brady was a neurosurgeon. •

**Frank J. Gregg,** *Pittsburgh*
University of Pittsburgh School of Medicine, 1933; age 82, died February 28, 1990. Dr. Gregg was a cardiologist. •

**Alice E. Gularski,** *Gibsonia*
University of Pittsburgh School of Medicine, 1922; age 93, died March 1, 1990. Dr. Gularski was an obstetrician and gynecologist. •

**R. James Kay,** *West Chester*
Cornell University Medical College, 1929; age 91, died January 26, 1990. Dr. Kay was a general practitioner. •

**Paul R. Myers,** *Ridgway*
University of Maryland School of Medicine, 1945; age 68, died January 25, 1990. Dr. Myers was a general surgeon. •

**Clement B. Potelunas,** *Mountain Top*
Jefferson Medical College, 1938; age 79, died January 29, 1990. Dr. Potelunas was a dermatologist. •

**Harold G. Scheie,** *Philadelphia*
University of Minnesota Medical School, 1936; age 80, died March 5, 1990. Dr. Scheie was an ophthalmologist. •

**Cyrus B. Slease,** *Kittanning*
Graduated 1937; age 81, died March 7, 1990. Dr. Slease was a general practitioner. •

**John J. Walsh,** *Voorhees, NJ*
Jefferson Medical College, 1934; age 84, died February 15, 1990. Dr. Walsh was an internist. •

**Sidney Auerbach,** *Quakertown*
University of Basel, Switzerland, 1936; age 77, died January 23, 1990. Dr. Auerbach was a family practitioner.

**Phillip R. Hamilton,** *Philadelphia*
University of Wisconsin Medical School, 1973; age 50, died February 3, 1990. Dr. Hamilton was an obstetrician and gynecologist.

**Ludmil A. Tinterov,** *Pittsburgh*
Graduated 1944; age 68, died January, 1990. Dr. Tinterov was neurologist.

The Educational and Scientific Trust of the Pennsylvania Medical Society provides you with a way to make a significant statement honoring the memory of and paying tribute to your colleagues who are deceased. Send your tax-deductible memorial gift to the PMS Educational and Scientific Trust, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.
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At Medical Protective, fighting for our doctors is our number one priority. We know we're not just insuring your finances. We're protecting your professional reputation, an asset no amount of insurance can replace.

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PHYSICIANS WANTED

Emergency physician — Full-time opportunities in the PA, NY, and NJ area. Must be experienced. Board eligibility and ACLS certification preferred. Salary range $80,000 plus malpractice insurance and benefits. Part-time positions also available. Send CV to AES, Inc., Box 2510, Wilkes-Barre, PA 18703; or call (717) 825-2500 collect.

ER physicians — Full-time/part-time positions available NJ, PA, NY. Emergency medicine experience preferred. Guaranteed compensation and paid malpractice. For more information call (215) 521-5100 (within PA), 1-800-TRAUMA6 (outside PA), or send CV to Trauma Service Group PC, Scott Plaza, Building Two, Suite 114, Philadelphia, PA 19113.

Family practice opportunities — Muncy Valley Hospital is seeking four individuals to establish practices in surrounding rural communities. Competitive, flexible financial assistance opportunities available. If interested, call George J. Geib, (717) 546-8282.

Family practice — Recently trained family physician seeking board certified or eligible family physician in well-established and growing practice in semi-rural community 30 miles from Pittsburgh. No OB. No HMOs to deal with. Enjoy country living with abundant recreation and proximity to cultural and sporting events of a major city. 80K. Reply to Box 277, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.


Pennsylvania, western. 400-bed teaching hospital designated Level II Trauma Center seeking career emergency physician, preferably board certified/prepared in emergency medicine. Sophisticated emergency care with nearly 30,000 visits per year, resident teaching and a busy hospital-based paramedic program. Excellent compensation for qualified physician. 70 miles east of Pittsburgh. Call or send CV to Richard M. McDowell, MD, FACEP, Department of Emergency Medicine, Conemaugh Valley Memorial Hospital, Johnstown, PA 15905, (814) 533-9769.

Excellent opportunity for BC/BE Ob/Gyn person. Solo or partnership. Ideal location to raise family. Excellent schools. Reasonable drive to cities—Philadelphia, New York, Washington, DC. Very modern hospital facilities. Send to Box 310, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

General/Vascular surgeon — BE/BC, immediate opening in prestigious private practice, rapid growth opportunity in north central Pennsylvania. Send CV to Box 323, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

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Board Certified FP seeking BC/BE FP or IM to join busy practice in a growing university town in central Pennsylvania. Excellent opportunity-competitive salary-no OB. Inquiries to Lewisburg Family Practice, 55 N. 5th St., Lewisburg, PA 17837.

Wanted: Family practice specialist or Board-eligible to join four-person group in south-central Pennsylvania. No obstetrics. Salary negotiable. Write Box 296, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.


Radiologist — Full or P/T for out-patient imaging center, suburbs of Phila. CT experience necessary. MRI experience desirable. Call Judy Weiss (215) 752-8080.

Seeking general and peripheral vascular surgeon — Fellowship-trained in vascular surgery, to join a group of general and peripheral vascular surgeons practicing in northeast Philadelphia, and the suburbs. Please send CV and a brief letter detailing expectations. Box 328, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Internist/Gastroenterologist wanted. Send inquiries to Box 329, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Pulmonary fellowship — Fellowship position available beginning July 1, 1990, at 320 bed tertiary care center in Philadelphia. This two year program provides 18 months clinical & 6 months research experience. Rotations include consultations, ICU, pulmonary function & exercise labs, pathology, radiology & outpatient clinic. Attending staff includes six pulmonologists. Candidates should contact Dr. James Shinnick, Pulmonary Section, Presbyterian Medical Center of Philadelphia, 51 N. 39th St., Philadelphia, PA 19104.

Western Pennsylvania practice-solo, with 4 other family practitioners for call. Cash collected first-year minimum income guarantee of $85,000, first 6 months office overhead full paid. 104-bed hospital, 43,000 annual admissions, 37-member staff. Call: Wanda Parker at (800) 221-4762, or collect (212) 599-6200, E.G. Todd Associates, 535 Fifth Ave., New York, NY 10017.


102-bed hospital in western New York, offering cash collected first-year minimum income of $80,000, 6 months office overhead, and malpractice. OB/Gyns provide subspecialty backup. Possible university affiliation. Call: Wanda Parker at (800) 221-4762, or collect (212) 599-6200, E.G. Todd Associates, 535 Fifth Ave., New York, NY 10017.

177-bed, south central Pennsylvania hospital seeking board certified/eligible emergency physician. 21,000 ED visits/year. Salary of $100,000, 4 weeks vacation, 2 weeks CME. Call: Wanda Parker at (800) 221-4762, or collect, (212) 599-6200, E.G. Todd Associates, 535 Fifth Ave., New York, NY 10017.

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Recruitment package includes relocation assistance, 1st year guaranteed income, referrals and practice set up guidance. New grads welcome.

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Associate to join solo, busy practice with arthroscopy skill, interested in sports medicine and general orthopedics. Rural setting close to large university center. Practices at two modern and progressive hospitals with a growing area of 350,000. Excellent opportunities. Very good area to raise a family with good schools and the benefits of cultural and amateur and professional sports activities in a large metropolitan area.

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Azetta J. Spicer
802 Perry Como Avenue
Canonsburg, PA 15317
(412) 745-0488 (home)
(412) 745-6100, ext. 5030 (office)

Internist/Family physician — Busy internist/family physician group practice located in Pittsburgh suburb seeking board certified physician for associate position leading to partnership. Send resume to Rudy Antoncic, MD, 2903 Skyline Dr., West Mifflin, PA 15122.

Emergency medicine positions available — Suburban Philadelphia emergency department group seeking emergency department physician for open position and also locum tenens for summer of '90. Candidate must be BC/BE in emergency medicine, internal medicine or surgery, and certified in ACLS/ATLS. Contact John D. Gorry, MD, FACEP, Chairman, Department of Emergency Medicine, Crozer-Chester Medical Center, 15th and Upland Ave., Chester, PA 19013, (215) 874-8177.

Family practice, BC/BE 3 person primary care, active hospital practice. No OB. Harrisburg area. Excellent salary + incentive bonus with early buy in. Send CV to: Box 334, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Williamsport — Solo psychiatrist with active general practice really needs an associate. Two hospitals with psychiatric units. The city is located in a peaceful rural area with 100,000 population served. Hunting, fishing, water sports. Excellent public schools and churches. Terms of association negotiable. Please give me a call (collect) (717) 323-4677. Dr. Williams.

Beaver, Pennsylvania — Seeking director, assistant director, full-time and part-time emergency physicians for 475-bed Level II trauma center. Double and triple coverage provided during peak periods. Outstanding compensation and paid malpractice insurance. Benefits available to full-time staff. Board eligibility or certification in emergency medicine or primary care specialty, and ACLS required. Contact: Karen Remai, Emergency Consultants, Inc., 12200 S. Airport Rd., Room 27, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Philadelphia — BC/BE pediatrician to join well-established primary care group practice affiliated with a diversified, dynamic, managed care system (prepaid and FFS). Excellent career opportunity for a mature physician with demonstrated aptitude in primary care. Potential opportunity for a subspecialty or medical administrative activity. Competitive financial package includes base plus bonus, malpractice, attractive benefits, and relocation allowance. Address inquiries and resumes to: Barbara Gold, MD, Delaware Valley Health Network, P.O. Box 21119, Philadelphia, PA 19114.

Pocono Mountains, NE Pennsylvania — Extremely busy family practice seeking BC/BE FP. Active hospital practice, peds but no OB. Good terms, excellent opportunity for potential partnership. Beautiful recreational area with close proximity to cultural events. Please respond to: Monroe Family Practice Associates, 1803 W. Main St., Stroudsburg, PA 18360, (717) 421-0170.

Northeastern Pennsylvania — Multispecialty group practice is seeking BC/BE physicians with background in: Family practice with obstetrics, gynecology—office and surgical, anesthesiology, urology, non-invasive cardiology. We are located in a beautiful rural area of Pennsylvania that has recently experienced an industrial buildup and community growth. Send CV to Box 335, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Philadelphia, PA area — Part-time or full-time position available for FP or IM in modern urgent care center. Excellent salary with incentive bonus plus benefit package. Reply: Box 336, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

POSITIONS WANTED


Certified radiologist seeks locum tenens work in conventional radiology, ultrasound, nuclear medicine for one week or longer. Send inquiries to Box 330, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Board prepared emergency physician recently relocated in Scranton. ATLS and ACLS instructor certified. Available for part-time/full-time ER or urgent care position. Call: (717) 344-4439.

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Professional office suite in northeast Philadelphia. Private entrance, located in apartment bldg. One block from shopping and transportation. Will renovate to suit ten-
ant. Call (201) 944-8700 or (215) 744-8271.

**Medical transcribing services** available from C & C Computer Services, 6035 Devonshire Rd., Harrisburg, PA 17112. Transcription by cassette and phone available. For information call (717) 652-5091.

**Very lucrative Cherry Hill practice** (internal and family medicine) available. Send confidential CV to Box 318, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

**Practice wanted** — Experienced family physician 15 years in practice, wants to buy general/family medicine practice in Chester, Montgomery, Philadelphia, Delaware, or Lancaster counties. Please call (215) 495-5414.

**Physicians** — Urgent mobile insurance exams. Highest $$$ pay, F/T, P/T, IM, FP, GP. (215) 563-3970.

**Professional office space available** in an established practice in the Quakertown area. Call before 8:00 a.m. or after 9:00 p.m. (215) 267-7900.

**For sale/for rent** — Modern medical facility in very residential S.W. Lebanon location.

Living quarters included or rent apartments if necessary. "Turn key" operation. Parking everywhere, quiet corner lot. Hurry! $126,000 call (717) 274-5669 evenings.

**Office space for physician in Erie, PA** available April 1st. Designed especially for needs of an ophthalmologist, but well-arranged for needs of any physician. Has been occupied constantly by ophthalmologists since 1949. Is in excellent condition, air-conditioned, good location, reasonable rent, parking available. Call (814) 452-2918.

**Active established primary care practice available.** Desirable location near four hospitals, northeastern Pennsylvania. Will assist in transition. Physician retiring. Building for sale optional. Write to Box 325, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

**York County** — Established family practice available. Home/office combination on approximately 1.5 acres of land. Physician to retire. Please reply to Box 333, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

**For rent** — Prime professional office space, Baltimore Pike, Media, PA 19063. Call (215) 565-0241.

**Family practice office equipment, supplies and furniture,** ideal for starting practice. 4 examination rooms, laboratory, pharmacy, physical therapy, reception and waiting room. $8,500. Call (717) 344-4439. Write 1616 Dickson Ave., Scranton, PA 18509.

For sale — Culposcope, Model MM 4000 on gravity base with 35 mm camera package with large stand. 1 year old. Price $5,000. Cryosurgical unit, approximately 4 years old. Price $825. Please call Dr. Bruce Montgomery at (215) 525-0810.

**Medical user building for sale.** Norristown, PA. Corner location near hospitals. 12,000 sf. Immaculate. Elevator. 30 plus parking. Two rental units. Excellent investment. $398,000. Tornetta Realty Corp. (215) 279-4000.

**Pleasant country practice** in rural community in south central PA. Spacious new building with lower level rented to radiology, physical therapy, and orthopedics. Reasonable on call schedule with other solo practitioners. An abundance of new equipment. Lease/buy options available. Send inquiry to Box 337, Pennsylvania Medicine, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

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Melvin Deutsch, MD, professor of radiation therapy at the University of Pittsburgh School of Medicine, has been selected the first Raul Mercado Professor in Radiation Oncology. The new professorship honors the former faculty member whose career was ended by lung cancer at age 49.

A sports medicine lecture series was inaugurated in March at the University of Pittsburgh School of Medicine, honoring Freddie Fu, MD, Blue Cross of Western Pennsylvania Professor of Orthopaedic Surgery and medical director of the Sports Medicine Institute. Dr. Fu is head team physician for Pitt athletics, executive medical director of the Pittsburgh Marathon, and company physician for the Pittsburgh Ballet Theatre.

Elias Schwartz, MD, has been named physician-in-chief of Children's Hospital of Philadelphia and chairman of the Department of Pediatrics at the University of Pennsylvania School of Medicine. Dr. Schwartz had been hematology director at Children's and a professor of pediatrics and human genetics at Penn.

Moreye Nusbaum, MD, has been named chairman of surgery for Presbyterian Medical Center of Philadelphia. Prior to joining Presbyterian, Dr. Nusbaum was chief of gastrointestinal surgery at the Graduate Hospital and professor of surgery at the University of Pennsylvania School of Medicine.

Leonard H. Finkelstein, DO, MSc, FA-COS, has been named chairman of the board of trustees and acting president of Osteopathic Medical Center of Philadelphia. Dr. Finkelstein is past president of Pennsylvania Osteopathic Medical Association (POMA) and currently serves as editor-in-chief of the POMA journal.

The Robert H. Ivy Society of Plastic and Reconstructive Surgeons has elected new officers for 1990-91. They are: president, Barabra Lundy, MD, Norristown; vice president, Richard Dabb, MD, York; secretary, Frederick R. Heckler, MD, Pittsburgh; member-at-large, Geoffrey G. Hallock, MD, Allentown; treasurer, Eric W. Blomain, MD, Dunmore.

Jeffrey Pilchman, MD, a Frankford Hospital gastroenterologist and internist, was recently awarded the Attending Physician of the Year Award. The recipient of the annual award is chosen by residents completing their training.

Simon Kramer, MD, was recently honored by Thomas Jefferson University Hospital with the dedication of the Simon Kramer conference room at the hospital's Bodine Center for Cancer Treatment. Dr. Kramer is distinguished professor emeritus of radiation therapy and nuclear medicine at the hospital.

Scott Brennan, MD, a plastic and reconstructive surgeon at Pennsylvania Hospital, recently spent two weeks in Liberia, Africa, training a local physician in new techniques developed in the U.S. The trip was sponsored by Operation Smile, a privately funded organization based in Norfolk, Virginia.

David J. Shulkin, MD, was selected as a member of the Journal of the American Medical Association's (JAMA) Editorial Board. Dr. Shulkin is founder and president of Physicians for Research in Cost-Effectiveness (PRICE). He is also currently a general medical fellow at the University of Pittsburgh School of Medicine and will be a Robert Wood Johnson Clinical Scholar beginning this summer. He also serves as chairman of the PMS Resident and Physician Section.

Edward S. Cooper, MD, is co-recipient with Wyeth-Ayerst Laboratories of the Heart of Philadelphia Award from the American Heart Association. The award goes annually to an individual or company whose leadership and dedication exemplify the giving spirit of Philadelphia. Dr. Cooper, of Philadelphia, is professor of medicine at the University of Pennsylvania and serves on a variety of the Heart Association's local and national committees.

Elise R. Broussard, MD, DrPH, Pittsburgh, was elected to membership in the Association for Child Psychoanalysis. Dr. Broussard is professor of public health psychiatry at the Department of Health Services Administration and associate professor of child psychiatry in the Department of Psychiatry, University of Pittsburgh School of Medicine.

Michael Johnson, MD, a surgeon at Misericordia Hospital, Pittsburgh, left March 30 to begin a career as a missionary physician in Kenya, Africa, under the auspices of the World Gospel Mission. He will be located at Tenwek Hospital, 250 miles from Nairobi, which has 300 beds but runs on a 110 to 120 percent occupancy rate and delivers 2,500 infants each year; one-fifth of the region's births. He and his wife, Kaye, served as short-term missionaries with the World Medical Mission twice before.
For the brain/bowel conflict of IBS*

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Antianxiety Antisecretory Antispasmodic

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

- "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
- Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin rashes, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy.

Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.
In IBS,* when it's brain versus bowel,

IT'S TIME FOR THE PEACEMAKER.

In irritable bowel syndrome,* intestinal discomfort will often erupt in tandem with anxiety—launching a cycle of brain/bowel conflict. Make peace with Librax. Because of possible CNS effects, caution patients about activities requiring complete mental alertness.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.
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Record turnout for timely program

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Dr. Stephen Dunn on the difference between the old St. Christopher's Hospital for Children and the new St. Christopher's Hospital for Children.

"With our June 9 move to our new location at Erie Avenue at Front Street in Northeast Philadelphia, I've been asked to compare the 'Old' St. Christopher's to the 'New' St. Christopher's. But that's like comparing apples to oranges.

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Seated: Mark Costantino, George Rawding, Catherine Colburn,
Richard Borgerson, Douglas Kreitzberg

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STATE DELEGATES BRING RESOLUTIONS TO AMA

A 41-member State Society delegation, including 20 delegates and 17 alternate delegates, will carry eight resolutions to the AMA annual meeting June 24-28 at the Chicago Hyatt Regency. Chairing the delegation is Joseph N. Demko, MD. Among other PMS members participating in AMA official business are PMS President-elect Gordon K. MacLeod, MD, chairing the Rules and Order of Business Committee; Doris G. Bartuska, MD, serving on the reference committee on hospitals; and William H. Mahood, MD, on the committee addressing cost containment, DRGs, and peer review. Among the resolutions: accelerated death benefits of life insurance to pay terminal illness costs; changing HCFA physician classifications from "non-participating" and "participating" to "non-contracted" and "contracted;" AMA lobbying for modification or repeal of the Federal False Claims Act and similar federal statutes; AMA investigation of differing policies and procedures among Part B Medicare carriers.

NEW KEPRO DIRECTOR BEGINS JUNE 11

John DiNardi III, deputy director of the Medical Society of Virginia Review Organization, has been named executive director of the Keystone Peer Review Organization. He begins his duties at KePRO on June 11, replacing former Executive Director Robert R. Weiser, who resigned.

HEALTH CARE COUNCIL RELEASES S.W. REPORT

The Pennsylvania Health Care Cost Containment Council has unveiled its "Hospital Effectiveness Report" targeting information about hospitals in Allegheny, Armstrong, Beaver, Fayette, Greene, Washington, and Westmoreland Counties. The report includes specific care data from 37 general acute care hospitals with more than 100 beds in the southwestern region of the state. This report covers hospital data from October 1 through December 31, 1988.

AUTO INSURANCE BATTLE IN COURT

The Society will step into Commonwealth Court on June 13 to argue the Insurance Department’s preliminary objections to the Society’s lawsuit against measures within the controversial new auto insurance law which directly affect physicians. The state has filed a motion to dismiss the case. The Society’s action challenges the constitutionality of the law’s caps on physician reimbursement for treating accident victims. PMS will issue a letter to all members explaining the law in more detail within the month.

PMSLIC RATE CUT EFFECTIVE JULY 1

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) has received final approval from the state Insurance Department for a 15-percent overall rate decrease, the largest in the company’s 13-year history. Effective July 1, 1990, the decrease will be applied to all insureds regardless of rating class or county of practice. It will also result in a decrease for the rest of 1990 in the surcharge for the Medical Professional Liability Catastrophe Loss (CAT) Fund.

AMA LAUNCHES YOUTH HEALTH PROJECT

The AMA, in conjunction with the AMA National Coalition on Adolescent Health, is implementing a new project to improve the health of the nation’s adolescents during the next decade. The three-year project, entitled "Healthier Youth by the Year 2000," is being funded by the U.S. Public Health Service’s Office of Disease Prevention and Health Promotion to promote the Year 2000 Health Objectives for the Nation. The objectives, to be released in September 1990, will recommend ways to reduce high-risk behaviors and prevent health problems in all age groups. The AMA project will include a National Adolescent Health Promotion Network (NAHPNet) to share information with health care workers caring for adolescents. "Target 2000," a quarterly newsletter, will channel NAHPNet information to and from those professionals.
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THE FIFTH COLUMN

J. Joseph Danyo, MD

My travels as your representative to professional gatherings in other states offer me an excellent opportunity to observe first-hand the problems facing physicians. Each state, each doctor, reports ongoing, burgeoning hassles: they boil down to accountability and regulations.

If the profession is to survive as a profession, we must look closely at these two seemingly laudatory concepts.

Accountability has a popular ring. It extends to teacher recertification, defense contractor bidding, and quality control of the actions of legislators and non-elected leaders and, of course, ourselves. There is nothing wrong with being held accountable; what is wrong is the method of determination.

Medicare enlists Peer Review Organizations for this. Hospitals must employ several weapons, including the Joint Commission on Accreditation of Healthcare Organizations, the state health department, blood bank agencies, the American Board of Medical Specialties, and on and on. That is, until we come to us.

In hospitals, the buck stops with the medical staff. At all levels, physician expertise in handling the guidelines and mandates is very much lacking. Doctors are simply not educated in the nuances and long-term effects of their actions. While we revile the mischief of the regulators, it is really the responses of the regulated that require scrutiny.

I know of no institution that offers instructions to doctor committee members. The need for that instruction is urgent, as we see ourselves, and the delivery of care—hindered by the paper chase. Innovation and the art of medicine are caving in to mediocrity and compliance. Hospitals are becoming an unhealthy environment for physicians.

Don't blame the administrations; look at the Fifth Column—your representatives in hospitals who jump the hoop and over-regulate by applying strict interpretations to nebulous admonitions. Physician, heal thyself.

I propose that each hospital medical staff set up a permanent standing committee called the Regulatory Review Committee. Before any proposals for change go to other committees, the RRC would review them and consider their impact on the institution and on practitioners. I have asked the PMS Hospital Medical Staff Section to produce a plan for implementing this concept, post haste.

Too much influence has been placed in the hands of non-health care folks who never see a patient. Their might emanates from skewed perceptions and smoke. There is nothing wrong with seeking information, but do not let them make medical decisions.

Contest every adfront; Appeal all adverse determinations. Those bodies manning the attack on the profession abhor meeting you on medical grounds. They do not possess the skills to compete on our level.

Several of my past messages to you dealt with reunification. PMS is committed to improving the lot of doctors, and I believe we have made bold advances since the October 1989 decision. The PMS that you see now is gearing up for the even tougher issues ahead. Leadership is primed. All we need is you to make the difference.

The day of the Lone-Ranger doctor is fertile material for a Saturday Evening Post cartoon a la Norman Rockwell. Our future is tied to PMS. This new scenario represents both enormous challenge and opportunity, within which non-involvement will be suicidal. Send your suggestions to us—we want to hear from the silent majority.
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"We've got to adapt," PMS President J. Joseph Danyo, MD, told physicians attending the PMS Leadership Conference on May 2. In his address concluding the event, he said the conference’s roster of thought-provoking speakers had caused him to realize that "there is a new reality out there; it's not just the doctor and the patient anymore."

This year's May 1—2 conference at the Hershey Lodge and Convention Center attracted nearly 100 more participants than last year—448 health care leaders, including 358 Pennsylvania physicians. They heard insights on "Medicine in Transition" from a wide variety of health care perspectives: a Washington, D.C.-based health care consultant; the chairman of the board of directors of the Canadian Medical Association; a representative of the American Medical Association; and a prominent medical economist. Tips on understanding risk management, dealing with peer review, surviving cost containment, and managing stress were offered during workshops on the conference's second day.

Rebuilding medicine's image
Keynote speaker Lawrence S. Lewin, president of ICF Inc., and senior vice president and director of American
what is happening in organized medicine, with respect to the ability to make things happen in the public arena," he said. Physician bashing has led to physicians’ loss of status, talent, autonomy, income, and—perhaps most serious of all—loss of influence, he told the gathering.

“The entire health industry has done itself a terrible disservice by presenting itself as being at least as concerned about income maximization as it is about the patient,” Lewin said. These threats to the status and influence of physicians have broad implications for our health care system, he said, and they are coming at a historic moment when key decisions are being made that will affect the practice of medicine for decades to come.

He recommended five steps for physicians to correct this battered image: lessen concerns with income and squarely face the access question; openly accept the legitimacy of economic reality—the most medicine is not always the best medicine; embrace practice guidelines; re-examine and improve methods of governance of the profession; and re-examine professional standards in light of the many changes impacting modern medicine.

Lewin concluded that while physicians “still have the high ground,” they need to seize this time of opportunity to change public perceptions.

**Secularization of medicine**

According to William L. Kissick, MD, “No society in the world has sufficient resources to provide all the health services its population is capable of using.” The American health care system is now facing the implications of this, “Kissick’s second law,” he said.

From his perspective as professor of public health and preventive medicine and chairman of the health economics institute at the University of Pennsylvania, Dr. Kissick described the secularization of health affairs now occurring in this country. “I can assure you,” he said, “that in the secularization of health affairs, society is off and running; the choice is ours to take the lead, or follow.”

In distilling 25 centuries of medical history, Dr. Kissick emphasized that medicine is no longer just a biomedical science, but has become a political, social, economic, and cultural as well as techno-scientific phenomenon. Medicine is caught between laws of economics and dictates of western medical practice: “We are taught as physicians that no cost is too great to save a human life or cure disease; but economists say that costs are finite. How do you reconcile the two?” At the same time, the number of players in the health care policy process has increased from three at the time Medicare was passed—the AMA, the American Hospital Association, and the American Nurses Association—to a host of health care institutions today.

“The golden age of American medicine,”—when physicians enjoyed autonomy, authority and prerogative with free choice, fee-for-service solo practice, voluntary hospital staffs, and retrospective cost-based...
reimbursement—is no more, Dr. Kissick said. That type of practice, which he dubbed the "Marcus Welby scenario" after the well-known television doctor, was implemented by Medicare using federal dollars. But now, expenditures are rising above receipts at such a rate that a Medicare deficit may occur within the 1990s.

In order to cope with rising expenditures, and Kissick's second law, there is an effort to modify the health care markets through cost containment, he said. This has instigated the development of a "Lilliputian scenario," according to Dr. Kissick; like Gulliver tied to the beach by miniature beings in Jonathan Swift's famous work, the strings binding physicians are "made up of the stuff of cost containment"—second opinions, prior authorizations, utilization review, resource based relative value scales, diagnostic related groups and therapeutic protocols. "So it will be much simpler: all the decisions will be made for us by HCFA in Baltimore. And we physicians, like Gulliver, will be bound to the beach," Dr. Kissick said. "We have the choice of organizing or being bound—by string—in a very dramatic fashion."

Dr. Kissick concluded by recalling what he had told President Bush in a recent meeting: "Our society cannot afford less than appropriate health care for each of our citizens; and we can afford no more."

The Canadian dilemma
Dropped into the emerging equation of American health care reorganization, the Canadian health care system can—like a prism in a window—help Americans visualize other possibilities, Judith C. Kazimirski, MD, said. A family practitioner from Windsor, Nova Scotia, she chairs the board of directors of the Canadian Medical Association.

By any yardstick, the Canadian system is not doing badly, she said. Under the system, which funnels control to a partnership of governments, health professionals, and voluntary organizations throughout the 10 provinces and two territories, the main objective is not to control costs but to remove barriers to health care. "In effect, there are no uninsured people in Canada. . . The Canadian population is overwhelmingly satisfied with their health care system," she told the Pennsylvania physicians.

But, referring to "Kissick's law," she described the increasing economic and societal pressures on her country's health care system: "The Canadian Medical Association has predicted problems because of the inherent conflict between four elements: universal coverage with increasing utilization and technology; patient's free choice with rising expectations; the need to protect physician autonomy; and the government's requirements to control budgets." The link between who pays the bill and who receives the services is completely broken in Canadian health care, Dr. Kazimirski said.

"What we have is good and cheap; what you have is good and fast. While the majority of Canadian doctors are satisfied with their life and with the system, they are fearful their system will deteriorate further until someone sees government and health care providers into developing a new era of collective, cooperative management, she said.

An American solution
Because of the differences in our historical development and in our resulting national mindset, Americans need a health care solution that is not a clone of the Canadian system, but rather a revamping of the best parts of our present system, Lonnie R. Bristow, MD, American Medical Association trustee, countered. "It is ironic to see this great [American] health care system so badly misunderstood by our nation's political leadership," he said, calling on organized medicine to fight misguided change and to build upon and extend that which is good about our system.

Dr. Bristow, pointing to increasingly strident attacks on the American health care system in the past 19 months, said six key factors have to be considered in seeking solutions: quality, cost, access, choice, the business community and incremental change. In dealing with these factors, the AMA's Health Access America program attempts first to deal with the question of access. The program is intended to reform, restore, and reinforce the American health care system, Dr. Bristow said.

He outlined the four major pillars of Health Access America: restructuring Medicaid to provide uniform benefits to everyone below the poverty level; requiring employers to provide health insurance for all full-time employees and their families, coupled with tax incentives and employer risk pools; creating state-level risk pools to make coverage available to the uninsured; and providing a sound financial base for the Medicaid program.

Dr. Bristow said, "We need to reform when it is needed those government programs that already accomplish much good, instead of treating them like unwanted step children."

Transitions talk show
To tackle the controversial subject of "Governmental transitions in medical care," the conference format changed to that of a television talk show. Alice G. Gosfield, Esq., Philadelphia, a health law attorney, former consultant to the Health Law Project of the University of Pennsylvania and founder of Teleosis, Ltd., served as host. Answering audience questions was a panel composed of Peter Braun, MD, one of the authors of the original Harvard study on Resource Based Relative Value Scales (RBRVS); Bernie Patashnik, director of the Division of Medical Services Payment of the Health Care Financing Administration, Baltimore; and Thomas J. Dehn, MD, immediate past president of the American Peer Review Association (AMPPRA) and a practicing radiologist from Milwaukee, Wisconsin.

Dr. Braun described the main features of RBRVS. He said the premise in the development of RBRVS is that in a competitive market, prices approach the cost of producing things. Therefore, a resource cost basis reflects estimates of the relative values of health services in a hypothetical health care market. He identified three major elements of cost: work the physician puts into the service; practice costs (overhead); and the cost of training a physician.

The RBRVS values are based on assessments of work by the physicians who perform these services, Braun emphasized. He said the main pattern that has emerged from surgeons' assessments is that evaluation and management by surgeons are paid less well than the basic procedures for those same surgeons.

Bernie Patashnick gave a brief overview of Medical Volume Performance Standards (MVPS) and changes that relate to them. He noted that HCFA
The sixth annual Toward 2000 Symposium is an opportunity to assess progress toward the goal of reducing cancer mortality in the United States. The symposium will be held at Fox Chase Cancer Center on October 12th and 13th. National experts will conduct seminars, workshops and informal dinner discussions focusing on common solid malignancies including lung, colon, and breast. Faculty will also discuss advances in autologous bone marrow transplantation and the role of immunotherapy.

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will be publishing a model fee schedule by September 1, 1990, which will give Congress and physicians an idea of how to proceed. Final regulations are expected by October 1991.

"It's important to recognize what MVPS is not: it's not the rationing of care," Patashnick said. If Congress accepts the HCFA recommendations and the growth rate continues at historic levels, there will be adjustments in price; "but those adjustments could be favorable to physicians if the increase goes below the recommended standard," he said.

Thomas Dehn, MD, representing AMPRA, emphasized that peer review is more appropriately known as consumer advocacy. "We are not here to make patients happy, or doctors or hospitals; we are operating on behalf of the biggest purchaser of health care, the federal government," he said.

Dr. Dehn pointed to three areas of greatest concern in peer review: Prior authorization, quality denials, and corrective actions plans. He told the physicians, "if you don't like how your PRO is reviewing, call KEPRO and ask to participate in their committees."

Following audience questions and the conclusion of the "talk show" session, a dinner was sponsored by the Pennsylvania Medical Political Action Committee. Speaker for the evening was Dick Flavin, political and social satirist featured on the Sunday Today Show.

The second day of the conference began with a breakfast sponsored by the PMS Liability Insurance Company (PMSLIC), with Edward R. Annis, MD, speaking on "The doctor patient relationship."

Wednesday morning workshops featured James W. Saxton, Esq., discussing risk management; Thomas J. Dehn, MD, of AMPRA, on how to deal with KEPRO; David B. Nash, MD, MBA, Director of Health Policy and Clinical Outcomes, Thomas Jefferson University Hospital, discussing how to survive the health care cost containment spotlight; and Jeff Boon, MD, medical director, the Institute of Stress Medicine, Denver, Colorado, instructing how to manage stress.

The conference concluded at noon Wednesday following Dr. Danyo's address.

**Special meetings**

While following a varied program from noon Tuesday to noon Wednesday, many Leadership Conference attendees also participated in special meetings in conjunction with the program. Among those meeting were the PMS Board of Trustees; PennsylvaniaAMA Delegation Executive Committee and the Committee to Nominate Delegates and Alternates to the AMA; the PMS-Hospital Medical Staff Section; the PaMPAC Board of Directors; the Young Physicians Section Governing Council; and the PMS Interspecialty Committee.

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**SYMPOSIUM ON AIDS ATTRACTS LAWMAKERS**

More than 200 lawmakers, community leaders, and other public policymakers were updated on the spread of HIV/AIDS in Pennsylvania during the AIDS Symposium on April 17. The event was co-sponsored by the Pennsylvania Medical Society (PMS) and the Pennsylvania Bar Association (PBA).

AIDS has now been diagnosed in more than 150 countries, according to keynote speaker James W. Curran, MD, MPH, director of the Division of HIV/AIDS, Center for Infectious Diseases, Atlanta. In his overview of the etiology of AIDS, Dr. Curran emphasized that because AIDS is a new disease nobody has a lot of experience with it, and it is "one of those health care problems which raises all kinds of other questions." He said the disease poses a fundamental challenge to health care professionals to care for people they are afraid of, and it presents them with the pressing question: Are health care workers obliged to care for people if that care places the workers in danger?

An alarming trend is emerging within HIV/AIDS epidemic statistics, Dr. Curran said, that points to women of childbearing age who are unaware that they are HIV-positive as the future focus of the epidemic. This trend highlights the need for blind serum testing in scouting the extent of the epidemic, he said: "HIV surveillance is the conscience of the AIDS epidemic." The question of blinded testing has attracted debate within the AIDS confidentiality legislative package. As now written, the bills do not permit infant blood drawn for hospital PKE tests to be tested for HIV/AIDS in blinded studies.

The epidemic is reaching into rural Pennsylvania, not just through persons who return from urban areas carrying the disease, but from within the rural communities themselves, according to John J. Denney, MD, director emeritus of the Geisinger Medical Center Department of Infectious Diseases. He reported that he is currently following 125 HIV-positive persons referred to the center, and that he suspects HIV/AIDS cases are present in every rural county in the state.

John H. Dossett, MD, associate professor of pediatrics and chief of the division of infectious diseases of the Department of Pediatrics at the Pennsylvania State University, Hershey Medical Center, discussed problems specific to treating HIV/AIDS in children. He noted that while quality of life for HIV/AIDS patients is improving with drugs, it is an expensive disease to treat.

The problems of the epidemic are especially acute in urban areas, and are magnified by the parallel crisis of crack addiction, said James Roberts, education program supervisor for the AIDS Activities Coordinating Office in Philadelphia. He called for more free and anonymous testing and more adolescent educators within urban and
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The second session of the symposium focused on the “Legal, judicial and public policy response” to the disease within the Commonwealth. Panelists were members of the PBA Special Task Force on AIDS: Martin Wald, Esq., John G. Whelley, Jr., Esq., and Richard Turkington, Esq. Audience comments and questions, following the panelists’ remarks, touched on aspects of the AIDS confidentiality legislation.

Also on hand to underscore the importance of the topic and of this joint venture were leaders from the state’s health and legal professions: Leonard Dubin, Esq., PBA president; Gordon K. MacLeod, MD, PMS president-elect; N. Mark Richards, MD, secretary of health; John White, secretary, public welfare; Senator John E. Peterson, chairman of the Senate Public Health and Welfare Committee; Senator Hardy Williams, minority chairman of the Senate Public Health and Welfare Committee; and the Honorable Emanuel A. Cassimatis, president of the Pennsylvania Conference of State Trial Judges.

**Allegheny CMS Focuses on Drug/Alcohol Abuse**

The Allegheny County Medical Society has issued a report synthesizing recommendations made during its fall 1989 conference, “Diagnosis ’89: Alcohol and Other Drugs.” The summary of 26 major recommendations made during the conference is available from ACMS by calling (412) 321-5030.

A working conference designed to explore issues and suggest solutions, Diagnosis ’89 brought together national, state and local experts in individual presentations and panel discussions. This group, along with the ACMS Substance Abuse Committee, prioritized the goals presented and ACMS has initiated projects based on these within the community.

Five major priorities include: 1) Expand physician training, from basic science to clinical application; 2) Support programs to curtail substance abuse among women, including county-wide maternal addiction projects; 3) Cooperate with industry and insurers to develop a comprehensive worker education program; 4) Establish clear boundaries to stem adolescent use of alcohol and drugs; 5) Urge the formulation of a coalition of professionals and volunteers in the field, led by county commissioners, to improve the efficacy of all programs.

Speakers at Diagnosis ’89 whose recommendations are included in the ACMS summary report include Daniel H. Gregory, MD, 1989 ACMS president; Peter Bell, executive director, Institute on Black Chemical Abuse, Minneapolis, Minn.; Leclair Bissel, MD, researcher, consultant; Judith R. Lave, PhD, professor of health economics, University of Pittsburgh; Mark R. Pubberker, MD, medical director, Chemical Dependency Services, HealthAmerica; James C. Higgins, PhD, superintendent, North Hills School District, Pittsburgh; Oscar G. Bukstein, MD, assistant professor of psychiatry, University of Pittsburgh; Ernest D. Preate Jr, state attorney general; Armand M. Nicholi Jr, MD, associate clinical professor of psychiatry, Harvard Medical School; Stacey A. Hinderliter, MD, director of neonatology, St. Francis Medical Center; and Robert W. McDermott, MD, medical director, PMS Physicians’ Health Program.

**Erie County Society Publishes History**

Slated for publication this fall is Reflections on Erie County Physicians, an account of 200 years of medical history in Erie County, Pennsylvania. Written by Erie County Medical Society Historian John Chaffee, MD, in a cooperative effort with the county society, the book details the experiences of 225 physicians who practiced medicine in that county and were born before 1900.

The 300-page, hardbound book will contain approximately 250 photographs and sketches, excerpts from the diaries of prominent Erie County physicians, descriptions of historic medical incidents in the county, a 200-year time graph of people and events, a repository of family histories, as well as indexed profiles of physicians.

Orders are being taken for the book, at $25 per copy, by the Erie County Historical Society. Write to: Reflections on Erie County Physicians, Erie County Historical Society, 417 State Street, Erie, PA 16501. For more information call (814) 454-1813 or 864-3682.

**Medical Equipment Scam Continuing HCFA Concern**

The Health Care Financing Administration reminds physicians not to sign certificates of medical necessity for any equipment that is not medically necessary and is not recognized by the physician as indicated by the patient’s condition. Unscrupulous medical equipment suppliers continue to mislead physicians as well as patients through telephone solicitations into executing false statements of medical necessity. The Pennsylvania Medical Society has adopted a position urging physicians to determine medical necessity before authorizing special equipment.

Some suppliers were found last year to be calling patients in a telemarketing scheme that advised patients of equipment available from Medicare at no cost to the patient, solicited the name of the patient’s physician, then checked the physician’s name against a list of doctors who would not approve unnecessary equipment. Physicians not on the list were contacted and told the patient requested the equipment and were sent a medical necessity certificate for signature.

HCFA Regional Administrator Maurice Hartman reminds physicians that they are required by federal law to assure that services or equipment they certify are medically necessary, of quality that meets professionally recognized standards, and supported by evidence of need and quality.

**State Society Opposes Lay Midwife Measure**

Physicians representing the State Society testified at a public hearing in April to voice opposition to a measure that would provide registration of lay midwives. Senate Bill 1528 would establish
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an advisory board within the Department of Health to set guidelines for lay midwife registration. Under current law, only registered nurses may be certified as midwives.

Testifying on behalf of the Society was Andre Blanzaco, MD, vice chairman of the PMS Council on Governmental Relations and a practicing obstetrician/gynecologist. Dr. Blanzaco outlined the critical need for professional obstetrical care due to the many complications that can arise from an otherwise normal pregnancy. Also testifying in opposition to the bill were representatives from the Pennsylvania Osteopathic Medical Association, the Pennsylvania Nurses Association, the American College of Nurse Midwives, and several private physicians.

Members of the Amish and Mennonite communities who favor the bill attended the hearing in large numbers. A companion bill has recently been introduced which the Society also opposes.

TRAAVA SOCIETY MEETING

FOCUSSES ON EDUCATION

Nearly 350 people from six states gathered at the Hershey Lodge and Convention Center in March for the fourth annual conference of the American Trauma Society (ATS), Pennsylvania Division. H. Arnold Muller, MD, former secretary of health in Pennsylvania, chaired the conference. The theme was "Trauma in the '90s: A Look into the Past, A Step into the Future."

Educating health professionals as well as the public toward better understanding of trauma prevention is the goal of ATS programs, according to John M. Templeton Jr., MD, pediatric surgeon at Children's Hospital, Philadelphia, and president of ATS, Pennsylvania Division. The Pennsylvania Division announced that it's new goal is to "reduce deaths due to trauma by 20 percent by the year 2000." Trauma permanently disables over 10,000 and kills more than 4,500 Pennsylvanians each year. It is the third leading cause of death in the U.S., behind cardiovascular disease and cancer. But because it primarily affects the young, it accounts for the highest number of years of life lost.

Doug Heir, a nationally-recognized figure in trauma prevention education and advocacy for the disabled, was keynote speaker for the conference. A practicing attorney, Heir is an accomplished athlete who became disabled by quadriplegia in a swimming accident at age 18. He offered an inspirational note to the conference, advocating that "it's not what happens to you in life that's important, but it's what you do with you life that makes a difference." Heir works with spinal cord injury and head trauma treatment organizations, is a nationally syndicated writer specializing in legal rights and liabilities of the disabled, is a media spokesperson, and has been a featured athlete in a breakfast food promotion of healthful living.

PMS TRUST LOANS $574,000 TO MEDICAL STUDENTS

The PMS Educational and Scientific Trust loaned $500,285 to medical students and $74,000 to allied health students for the 1990-91 school year. The funds are derived through money allocated from PMS member dues, repayment of student loans, interest income and individual contributions, and are distributed through the non-profit, tax-exempt trust.

To be eligible for the loans, applicants must be: a resident of Pennsylvania for at least 12 months before registration as a medical student; a fully registered medical student—loans are not granted to undergraduate or premed students; enrolled in an approved medical school in the United States. The PMS medical student loan program has been in existence since 1948, and has been administered by the trust since 1954.

ST. CHRISTOPHER'S OPENS NEW FACILITY

The new St. Christopher's Hospital for Children on Erie Avenue at Front Street in Philadelphia was dedicated May 12.

The $100 million, eight-acre medical campus has a six-level brick pallette hospital, an ambulatory care pavilion, and seven-level, 850-car parking garage. The three-story ambulatory care pavilion is contiguous to the new hospital and acts as its front door. A glass-enclosed elevator tower on the east side of the parking garage will offer passengers a full view of the new hospital complex.

St. Christopher's Hospital for Children, annually treating 160,000 children, is a non-profit, non-sectarian pediatric medical center that serves as the Department of Pediatrics of Temple University School of Medicine. It has the only pediatric burn center between Boston and Washington, DC, as well as other prominent departments.

KEPRO CAN NOW MAINTAIN PREFERRED ADDRESSES

The Keystone Peer Review Organization's (KEPRO) physician file programs have been upgraded to allow the retention of preferred physician mailing addresses, according to KEPRO President Donald E. Harrop, MD.

Dr. Harrop said that the change was made because directing KEPRO mail to the addresses which each of the more than 35,000 licensed Pennsylvania physicians prefer has been a continuing problem for KEPRO.

Previously, address change were made at each physician's request. However, problems arose involving KEPRO's method of obtaining current names and addresses: when KEPRO updated the physician file every quarter with the State Board of Medicine data tape, physicians' addresses reverted to those maintained by the medical board rather than the address preferred by the physician. To alleviate this problem, KEPRO area offices maintained manual files and checked them before sending mail to a physician.

Physicians who prefer to have KEPRO mailings sent to an address other than that now in use should send a written request to: Pat Jenkins, Director of Data, KEPRO, PO. Box 8310, Harrisburg, PA 18105.
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PHILADELPHIA CMS INSTALLS DR. FINK

Doris G. Bartuska, MD, will pass the gavel of presidency of the Philadelphia County Medical Society to Paul J. Fink, MD on June 20. Official installation will occur during the President’s Ball on that date. Dr. Fink, the society’s 129th president, is chairman of the Department of Psychiatry, Albert Einstein Medical Center, medical director of Philadelphia Psychiatric Center, and professor and deputy chair, Department of Psychiatry, Temple University School of Medicine.

Dr. Fink served as president of the American Psychiatric Association in 1988. He has been active in numerous county society posts since 1980, including a long list of committee chairmanships. In addition to membership on the PMS Council on Medical Practice, he is past president of the Philadelphia Psychiatric Society, vice president of the Psychiatric Alliance and has been an examiner for the American Board of Psychiatry and Neurology since 1975. In addition to a wide range of academic activities, consultations and advisory posts, Dr. Fink has served on six editorial boards and was editor of the Journal of Art Psychiatry and chief medical editor of Psychiatry. Other county society officers for 1990 are: vice president, Richard M. Gash, MD; secretary, Norman Makous, MD; treasurer, William S. Frankl, MD; and president-elect, Donald Kaye, MD.

ZIDOVUDINE APPROVED FOR USE IN CHILDREN

The Food and Drug Administration in May expanded indications for the antiviral drug zidovudine (Retrovir®) to include the treatment of children three months of age or older infected with the human immunodeficiency virus (HIV). Now, children who have HIV-related symptoms, as well as those without symptoms who have abnormal laboratory results indicating significant suppression of their immune system as a result of HIV infection, are included in the indications.

Previously, the drug had been indicated only for treatment of asymptomatic and symptomatic HIV-infected individuals over the age of 12 who have CD4 cell counts of 500/mm³ or less.

Clinical studies in pediatric patients began in 1986 and have involved more than 200 children, ages three months to 12 years. These studies were conducted by Burroughs Wellcome Company, the National Cancer Institute and the National Institute of Allergy and Infectious Diseases (NIAID) in a number of medical centers throughout the country.

Clinical, immunologic and virologic improvements were reported in children receiving zidovudine in the clinical studies supporting the expanded indications, as well as in other studies. Clinical improvements included weight gain in previously growth retarded children, a reduction in the size of enlarged livers and spleens, and improvements in I.Q. scores and other measures of brain function. There also was evidence of antiretroviral effect. The most frequently reported side effects were the development of anemia and neutropenia.
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PSYCHIATRY REVISITED

Charles S. Berlin, MD

One of the questions that psychiatrists talk about a lot concerns the perceptions of them held by colleagues in other medical specialties. Perhaps more than of any other medical specialty, there seems to be a lack of clarity about psychiatrists' training, skills, the work they do, and the scope of help they can offer to patients. Some of this is due to the entry over time of many nonmedical professionals (and nonprofessionals) into segments of the mental health treatment arena, occasionally accompanied by claims that there is little difference between what they do and what psychiatrists do.

In recent years, a particularly galling organizational assault on psychiatry along these lines has been conducted by lobbyists for psychologists at the national level. For example, on the one hand this group devalues the use of medications by psychiatrists, while on the other hand they are attempting to have legislation passed allowing themselves to prescribe psychotropic medications (asserting astonishingly that a single summer training course will qualify them to do so). This psychologist lobby claims that any argument by psychiatrists against these irresponsible assertions is simply a "guild issue" of economic self-interest (a clear example of "projection," to use a psychiatric term), and they refuse to acknowledge the real issues of scope of capabilities and adequacy of patient care.

However, just as there are vast differences between an orthopedist, a physical therapist, and a chiropractor—all of whom may be called upon to treat back pain—so there are differences, and substantial ones, between psychiatrists and the many others who treat or purport to treat those with emotional or psychiatric disorders.

To note the obvious, psychiatrists undertake eight or nine years (often more) of intensive and supervised post-bachelor's degree training which provides them with a multi-level core of understanding of the workings of personality and behavior, the neurophysi- cal substrate within which this takes place, the complexities of dysfunction which can occur here, and the avenues of treatment available. There is simply no other mental health discipline which includes this scope of training, knowledge, and clinical experience.

Early in my own career, coming from an undergraduate program with an extensive clinical psychology orientation, I was faced with the choice of whether to pursue graduate psychology or medical training. My opting for the latter proved to be one of the most important and productive choices of my life. Medical training provides an invaluable tool of understanding that I draw upon continuously in my work. In addition, the experience during medical training and beyond of accepting what are at times life and death responsibilities for the patients we care for inculcates an intensely profound respect, humility, and sense of responsibility in caring for patients.

So what is it that psychiatrists actually do? A lot of things, too numerous to mention of course, but ultimately they do the same thing as all other physicians: They try to understand the problems that people bring to them and intervene to relieve their patients' suffering. As I write this, some examples of patients I've seen recently in my own practice come to mind:

—A woman who, despite several years of psychotherapy with a non-psychiatrist, continued to experience immobilizing anxiety in her work and social relationships. When finally referred for psychiatric treatment and given effective anti-panic medication, she experienced "a miracle" within a month's time—freedom from anxiety
for the first time in two decades, and a new capacity to engage the world at large. She wondered (as did I) why she hadn’t seen a psychiatrist far earlier.

—A boarding home patient in her sixties who is brought to me for evaluation of some behavioral problems. In the course of my work-up I discover that this patient, who has a history of supposedly cured cancer, is hypercalcemic. It is only with difficulty that I convince her caretaker to have her further evaluated, and unfortunately, but not unexpectedly, she turns out to now have metastatic disease.

—A man who, despite being outwardly successful by all standards, managing a large enterprise, and having many friends and a fine family, has become a great expert at hiding his overpowering and ever-present feelings of failure and inadequacy. After a long course of grappling in psychotherapy with the figurative devils that inhabit him, he has finally been able to experience himself as a more intact person who can understand and accept his feelings, and not be compelled to feel like an inner house divided.

—I receive a desperate call from aging and frightened parents whose 30-year-old son has been convinced for several years that there are plots against him and conspirators who “track” him and influence him. His parents have taken to “guarding him” lest he do something impulsive. They worry at his social isolation and difficulties in sustaining a job, and most of all worry at his denial of any illness and resistance to getting help. This will be a tricky task, to be able to establish a trusting relationship with such a wary patient, to treat if he’ll allow me, and to help the parents to realistically come to terms with the psychiatrically malignant illness that their son most likely has.

—A severely disturbed patient who is a chronic self-mutilator develops pneumonia and immunologic abnormalities. Many calls take place between myself, her internist, a rheumatologist, drug companies, and the county veterinarian (she has a pet rabbit, and an elevated tularemia titer) to help sort out if she has an autoimmune disorder or a drug side effect. My literature search reveals a few such cases and pharmacologic changes are made. Extensive discussion is also undertaken with the large multidisciplinary staff involved in her care about the best way to engage her own motivation towards finding healthier modes of emotional expression than by slicing herself or banging her head.

All of these cases, which are typical of those seen by any psychiatrist, benefit from—indeed, demand—the skills inherent in the profession of psychiatry: a thoughtful, coherent, and scientifically broad-based theoretical understanding of human behavior from both psychological and biological perspectives; extensive training and experience to actively intervene at whatever systems level (pathophysiological, individual, family, organizational) is required to effectively help patients; the capacity to temper directive treatments with a less intrusive fostering of patients’ mobilization of their own strengths; and a broad range of therapeutic options and capabilities from which to choose, tailored to the individual patient’s needs, rather than the application of a few unidimensional skills to all patients whether appropriate or not. Among all mental health field practitioners, psychiatrists are uniquely fitted to offer this spectrum of care. This is what a psychiatrist is.

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PRACTICING THE MEDICAL SCHOOL BALANCING ACT

Elaine S. Herrmann

From within the fishbowl world of medical school, the outside world can appear to be whirling by in a blur of color. A few students manage to push their heads above water long enough to clear their vision. An even smaller number attempt to communicate with the fast-moving outside worlds of organized medicine, medical legislation, medical academia, and other medical schools. Bobbing long enough to raise your voice, while clutching onto a coattail of the "real world" is a delicate balancing act indeed.

Steven Nemerson, a second-year medical school student at the Penn State College of Medicine, Hershey, says he enjoys accomplishing the balancing act and challenges other students to attempt it. "I think the name of the game is communication, as it is in many other areas," he says.

As student representative to the State Society’s Board of Trustees, he has now turned to encouraging the statewide growth of the PMS Medical Student Section, working with the MSS governing council and its chairman, Robert Gainor, of the University of Pittsburgh School of Medicine.

Medical students are not an easy lot to inspire, he has discovered. They’re not willing to commit themselves to too many things beyond their studies, because those studies are all-consuming. "Your goal (as a medical student) has to be passing your courses; the time involved in that is extremely intensive," he says. Still, even those immersed in studies hear the realities shouted from daily newscasts and headlines, and most see the need to participate in change. "Things change so fast now, that if you’re not on top of them, you’ll have to struggle to keep up. I think it is naive to be totally uninvolved," Nemerson says. "The way that society is moving mandates that anyone going into clinical practice has to be aware not only about clinical medicine but what’s on the legislative agenda."

Increasing attendance at student section meetings is not only a sign of this awareness, but also of renewed vitality of section activities, Nemerson says. The ranks of the student chapter at Hershey have nearly doubled in the past year; a rise he attributes in part to more effective communication. "We’re becoming more effective in communicating to help students realize the importance of organized medicine in their future," he says.

Boosting interest at Hershey is a course on politics and organized medicine created by the Hershey section and PMS staff. Each Monday students can hear presentations by state legislators, PMS staff, or invited speakers.

Nemerson reports that the PMS Medical Student Section conducted a successful recruitment campaign throughout the past year, and sent nine student members to the AMA interim meeting in Hawaii. Through the AMA Outreach Program, conducted each fall, students at Pennsylvania medical schools earned a total of $10,000 to cover travel ex-
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expenses to the interim meeting and to the AMA annual meeting. Organ donation programs and student well-being programs are also in the works at many campuses. "Attendance at medical conferences is probably the most exciting experience for students who get involved in the organization," Nemerson says. "We'd love to be able to send everybody. We do a lot with our limited funds—we always travel on a shoestring—when one student goes to a meeting two others go along and sleep on the floor."

Nemerson is anxious to further networking between students and administrators at the seven Pennsylvania medical schools. "We need to see where our mutual interests lie," he says. Such a network is vital to coordinating action to legislation affecting medical students, Nemerson says, citing the helplessness of students to counter recent attempts to mandate substance abuse education in medical schools as one example.

Students are alarmed that the elongated tentacles of government regulation of physicians will reach into their affairs: "A lot of the same federal government burdens that physicians bear legislators may try to place on resident physicians. I don't know how they can put more on the students since we're already in debt up to our eyeballs."

Before targeting specific initiatives for use of limited student section resources, Nemerson wants direct input from fellow students. "We'd really like to do more for medical students than we have been," he says. "We'd like to reach out to students and cultivate a large volume of input into our organization; to find out what's on students' minds, in which direction they think we ought to be moving."

To facilitate this process, Nemerson treks from Hershey to Harrisburg to discuss possible research projects with the PMS Educational and Scientific Trust. He also instigated a project to incorporate the student section newsletter into PENNSYLVANIA MEDICINE. "I think that will be a huge start," he says of this cooperative publishing effort. "It allows us, in a cost-effective way, to reach audiences that we have never reached before—senior physicians, members of the PMS House of Delegates, general PMS membership, and our own members and as well as student nonmembers."

Losing faith
Asked what most concerns medical students these days, Nemerson is quick to set aside philosophical and political concerns and offer the bottom line: debt. "The thing to be concerned about—if I were a practicing physician or a medical faculty member or a health care administrator—is that society is creating an environment in which medical school graduates must abandon their ideals for the sake of repaying student loans and practicing defensive medicine."

That lurking spectre of debt closely follows physicians throughout their early careers, often showing its ugly head at crucial decision points, Nemerson says. While financial constraints ought to enter into medical career choices, students are becoming resigned to that necessity, he notes. Even those just beginning to consider careers in medicine may be deterred by the frightening debt carried by medical school graduates. "Graduating that much in debt mandates that, if you've had a focus in medical school on trying to graduate, then as soon as you graduate, your next focus has to be on performing well in your residency in order to repay your debt."

While trying to enlighten fellow students about the world of organized medicine and medical legislation, he warns: as students become more aware of third party reimbursement problems, attempts to remove the tax deduction of student loans during residency and other burdensome legislative initiatives, their disillusionment may grow.

Knowledge of the realities awaiting today's medical school graduates could be a dangerous state of mind for a pessimist. Though hecourts that awareness, Nemerson is not a glowing optimist but rather a steady-handed realist. "I would certainly love it if I could get out of medical school and not have to be concerned about owing more money to banks than I will earn over the first five to 10 years out of school. And I would like it if the educational process were less time-consuming. But there's something that's expected of a physician by his or her patients that these challenges help us fulfill... That kind of noble feeling is still there among medical students," he says. "It's an interesting balance to strike."

Pre-medical years
Nemerson recalls that, although he was not the type of student "born knowing he would be a doctor," he did have a strong interest in science throughout high school. In 1984, he won fourth place in the medical sciences division of the International Science and Engineering Fair.

He found his interest in biomedical engineering while an undergraduate at Brown University, where the program was "a very exciting place to become involved." The program at the time included exposure to many smaller research projects, including artificial organs and biomaterials. He received his ScB from Brown in 1985.

At Johns Hopkins as a graduate student, while working in anesthesiology and critical care medicine and in the division of pediatric intensive care, he began, he says, to feel "a real desire—-a need even—to add clinical medicine" to his education. He received his MSE from Johns Hopkins in 1988.

He has been interested and active in professional organizations throughout graduate and medical school. While at Brown University, he was chairman of the Association of Engineering Society Presidents and was founder and president of the Brown University Biomedical Engineering Society. At Johns Hopkins he was student representative for the MSE program in biomedical engineering. His first year at Penn State-Hershey he was president of the PMS student chapter.

While he has ruled out a number of things, he has not yet zeroed in on a particular medical specialty. He places his career priorities as: 1) practicing clinical medicine; 2) teaching; 3) active research. He says he's contemplating specialties in such areas as pediatric surgery or pediatric intensive care or reproductive endocrinology.

"I'm not all-consumed by medical school; maybe I should be," he says. Although he has no desire to practice in a rural area, he says he has enjoyed the setting in Hershey. He loves the outdoors and is an avid camper, hiker and skier. "It's easy to complain when school takes up so much of your time. But on nice sunny days when the wind's blowing in the right direction and it smells like chocolate out on my balcony, I start to remember why I came here in the first place."

He was raised in Potomac, Maryland, where his parents, and sister now completing college, still reside.
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an excessive and somewhat hematopoietic dose, with no evidence of a carcinogenic effect in rats, mice, and female macaques (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for AXID.

AXID was not mutagenic in a battery of tests performed to evaluate its potential to produce heritable changes, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects** —Pregnancy Category C—Oral reproduction studies in rats at doses up to 50 times the human dose and in Dutch Belts rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and decreased fetal weight. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac contractility, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anoxia, distended abdomen, spinax blinda, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.**

**Pediatric Use—Safety and effectiveness in children have not been established.**

**Use in Elderly Patients—** Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs. 0.2%), urtica (0.5% vs. <0.01%), and arthralgia (2.4% vs. 1.9%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

**Nizatidine—**

**Hepatic—** Hepatic injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT and/or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hematologic changes have been reported. All abnormalities were reversible after discontinuation of AXID.

**Cardiovascular—** In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered AXID and in three untreated subjects.

**OES—** Rare cases of mental confusion have been reported.

**Endocrine—** Clinical pharmacology studies and controlled clinical trials showed no evidence of antisteroidogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Synarcosomas has been reported rarely.

**Hemolysis—** Fetal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenia have been reported.

**Hypersensitivity—** As with other H₂-receptor antagonists, rare cases of anaphylactic shock following nizatidine administration have been reported. Because cross-sensitivity among this class of drugs has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and anaphylactoid) have been reported.

**Other—** Hyperuricemia unassociated with gout or nephro lithiasis was reported rarely. Eosinophilia, fever, and rashes related to nizatidine have been reported.

**Overdosage—** Overdose of AXID have been reported rarely. If overdose occurs, activated charcoal, emetics, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for the severe increased plasma clearance by approximately 84%.

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SECRETARY UPHOLDS
FDA ON GENERICS

N. Mark Richards, MD

I have reviewed the recent article on generic drugs by Gordon K. MacLeod, MD, FACP (Pennsylvania Medicine, January 1990) and have a number of concerns with his assertions, specifically as they relate to primidone/Ayerst Mysoline® use. The United States Food and Drug Administration (FDA) has published many articles on the therapeutic equivalency of approved generic drugs to dispel the doubts raised by brand name manufacturers. The Therapeutic Equivalence Action Coordinating Committee Report of the primidone incident is an example of how an incomplete study was used to oppose the appropriate use of generic drugs and generate confusion.

The FDA conducted an inspection at the Cleveland Clinic to verify the original 1987 Journal of the American Medical Association article on the alleged failure of generic primidone in controlling epileptic seizures. It was found that the total relevant history of the patient was not included as part of the study. The authors failed to record the patient’s complete history of seizures while on Ayerst Mysoline. It became apparent from clinic records that the patient in question could not be fully controlled with either Mysoline or the generic primidone.

I find the issue of ineffective generic drugs to be unsupported by the facts. The subject has been carefully monitored in our generic formulary process on an ongoing basis by staff and consultants to the Pennsylvania Department of Health. Dr. MacLeod’s comments on this issue will be made part of that review, along with a number of other letters and reports generated at my request, and found to be supportive of the FDA position.

To dramatize the use of cost-saving generic drugs as a “major public health problem,” is one to which we take exception. Rapid increases in drug prices over the past five years, at a rate double the cost of living, must surely fall within Dr. MacLeod’s definition of a major public health problem. Another public health problem was described in the Wall Street Journal of January 30, 1990. The article describes serious overprescribing of benzodiazepines by physicians in New York state. The rate of prescription writing for these drugs was rapidly reduced by regulations which permit the monitoring of individual physician’s prescribing habits by the New York State Health Department.

There are many other drug-related problems in society that affect public health and I am looking forward to working with Dr. MacLeod and the State Medical Society in finding needed solutions.

Dr. Richards is secretary of health in Pennsylvania, an office he has held since January 1987. He had served as director of the Allegheny County Health Department prior to assuming his current duties.

SECOND OPINION GIVEN
ON CANADIAN SYSTEM

Gerald L. Andriole, MD

All Pennsylvania physicians have read about and possibly studied in some detail the Canadian health care system. My purpose in this article is not to add to the confusion, but rather to put in perspective the main issues physicians should understand if our lawmakers introduce legislation akin to the Canadian health system model. Undoubtedly our proper role is to be the spokesperson so that an efficient and workable health care system will result.

Clearly, if costs are the main argument, the Canadian model wins hands down. Since adoption of the system in 1971 Canada’s health care costs have grown slowly, so that in 1987 those costs represented 8.6 percent of GNP. In the United States our health costs now exceed 11 percent of our GNP. On a per capita basis we spend $3 on all aspects of health care for every $2 Canada spends. Business is quick to point out the huge difference and asks rhetorically, “does more spending give better care?” No, say many advocates of change in America.

Another clear-cut difference is the provider relationship with government. In Canada the providers are fully regulated and the provincial government sets a fixed “global” budget within which providers must negotiate for their fixed fees. In the case of physicians, this fee is usually negotiated by the medical association. Think of the turf battles that ensue between surgical and nonsurgical specialties. Hospitals are similarly constrained in their budgets, and this creates a situation in which hospitals cannot compete for patients. Even though hospitals can be funded by multiple sources, ultimately the government has to approve of increased capital expenditures on the grounds that these extra funds will have an implication for future operating costs. Since the budget is completely controlled, hospitals must make their own decisions about which services survive and which should be restrained.

Not only are physicians’ fees negotiated in an atmosphere of limited dollars, but the government has the further ability to control any escalation of fees. In its quest to control costs, the government can limit residency positions or refuse to grant qualified new doctors an identification number allowing them to bill the government for services. A natural outgrowth of this control can be a stipulated decrease in specialties, or a severe limiting of fees for newly licensed physicians who do not choose to practice in remote underserved areas. The list of possibilities goes on and on for the controller of the purse strings.

Proponents of the Canadian model point to the high public and physician support in Canada. Perhaps Canadians trust their government more than we do; perhaps instinctively they believe in the “collective good over the individual good,” and are willing to pay to finance that system—as evidenced by the average 46 percent income tax they pay. Bear in mind that Canadian doctors remain in the upper 5 percent of the income ladder, averaging $77,000 annually. Very little of this income is expended for claims processing or eaten up by medical liability premiums. Despite the considerable constraints on practice activities, Canadian doctors generally approve of their system.

At this juncture it would be well to ask for an answer to a philosophical question—“Are Americans ready to put everything in the hands of one payer for their health care as Canada does?” Remember that potent forces are actively agitating for a “yes” answer. It seems to me that we must make the U.S. health care system manageable so that most Americans will come to consider their
health care a strong fundamental value! This will happen only if we, as responsible physicians, become vocal proponents of high quality care with almost universal access. We must tell business and government that we are not intransigent in seeking solutions, but that we insist on having responsibility as caretakers of that quality medical system. We cannot allow a "yes" to become automatic.

It is our duty to enter into the debate decisively and not to become solely a critic or cynic. We can by our individual effort and our association efforts become the major player in the health care policy agenda. Our course is clear. We have to decide if our objective is cost control or providing universal access—maybe a little bit of both. We have our challenge and now we must focus on results for an improved health care delivery system.

Dr. Andreole is immediate past president of the Pennsylvania Medical Society. He is a urologist in Hazleton and represents the State Society on the Pennsylvania Health Care Cost Containment Council. Refer to the article "Dissecting Canadian Health Care," beginning on page 40 in this issue for further discussion of this topic.

REPORTING ADVERSE DRUG THERAPY RESULTS

Commission on Therapeutics

When a physician prescribes a pharmaceutical agent with unexpected results both the patient and physician are dissatisfied. Probably the most common of such reactions are allergic ones; such reactions, although undesirable, are not unexpected. However, non-allergic drug reactions also frequently occur. A number of these reactions represent side effects and drug-drug interactions that are already documented in the "Physician's Desk Reference."

There are often, however, other undesirable results of drug therapy. A reaction not previously described in the PDR and/or scientific literature may be recognized only after a drug has been marketed. There are also anecdotal reports of therapeutic failures (attributed to a generic drug, for example).

The vehicle for bringing such events to the attention of the U.S. Food and Drug Administration is the Adverse Reaction Report of the Department of Health and Human Services. A copy of the Form (FDA 1639) required for filing this type of report can be found on the last page of the FDA Drug Bulletin that is distributed periodically by all licensed physicians in the United States. A facsimile is reproduced herewith. The 1639 Form is not difficult to use. The information requested on the form is vital in evaluating an Adverse Drug Reaction or other drug report. Items 1 through 12 describe what happened (or didn't happen as in the case of a generic drug therapeutic failure, for example). Items 14 through 21 provide more detail about the drug in question. Items 22 through 23 disclose information regarding concomitant drug use since many of our patients are receiving more than one drug. Items 24 through 25 can be ignored by the physician. Item 26 simply identifies the physician making the report.

Whatever the undesirable result, the FDA and pharmaceutical manufacturers take these Adverse Reaction Reports very seriously and both parties actively follow up each report. This usually involves a review of the patient's chart and pharmacy records. It is hoped that by understanding the purpose and scope of this form and the reporting process, physicians will provide much needed feedback to the FDA and pharmaceutical companies which will result in safer, more effective drug therapy.

John J. Deaneley, MD, Danville, is chairman of the commission. Other members are: Roxana F. Barad, MD; Richard T. Bell, MD; Paul C. Brucker, MD; Anthony J. Piraino, MD, and Robert G. Sauder, MD.
The physician executive is a liaison between physicians, other health professionals, health care consumers, and management. To be most effective, a physician acting in this capacity cannot represent any single viewpoint exclusively. Though job descriptions vary, the primary responsibility of the physician manager is to direct the development and implementation of clinical and organizational policies under which physicians must practice. Some of the major issues associated with this position are proper training opportunities, isolation, credibility, and job description development. Resolution of these issues can be assisted with (1) education of the physician and business communities about the role of a physician executive, and (2) development of nationally recognized training programs such as those offered through the American Board of Medical Management created by the American College of Physician Executives.

In the coming years, physician executives will be forging powerful partnerships to help make difficult decisions which will impact greatly on medicine. All physicians have a unique opportunity to influence the future course of medicine by supporting their physician colleagues who specialize and/or participate in medical management.

Evolution of the position

Without question, the delivery of medical care in Pennsylvania is undergoing considerable change, both clinical and socioeconomic.

Every day, medical technology becomes more sophisticated, is used more frequently, and, in many cases, is more expensive. Breakthroughs in medical research speed up the process of technical change and increase the rate at which hospitals and physicians seek to offer new services.

Socioeconomic developments also contribute to the changing medical environment. Government, industry, and consumers now want to share control over the provision of medical services. In the past, physicians were essentially in charge of medical procedures and the payment mechanisms for services rendered. Now, more often, consumers are participating in decisions about their health care. In addition, the payers (government, businesses and insurers) are heavily involved in controlling financial resources spent on health care. Prior authorization for tests and hospitalization, second opinions for surgeries, and concurrent case reviews are some of the mechanisms used to limit physician discretion in managing their case loads.

The consequence of these clinical and socioeconomic developments is increasing attention to the relationship between quality and cost. In Pennsylvania, for example, a Health Care Cost Containment Council was established by the legislature in 1986 to collect data on the cost and quality of medical services being rendered in the state. This information, though not viewed as the ultimate solution, is now being made public so that businesses and consumers can "shop around" for the best "deal."

Medicine has responded to these pressures by becoming more attuned to business objectives. Common business concepts such as product line management, market segmentation, and market share expansion are now part of the health care industry. In Pennsylvania, health care has evolved from a cottage ("mom and pop") industry consisting of solo practices and community hospitals to a big system industry with large group practices, multi-hospital systems, and managed care programs.

Hospitals, once content just to accept and discharge local residents, now work to increase market share and to offer
services that attract customers and generate revenue. Because of rising technological costs and stringent reimbursement policies, hospitals, by and large, no longer consider in-patient services the only source of income available. Many are developing successful new business and service strategies. In some areas, what was a hospital is now a "health system" comprised of various corporate entities created to broaden markets and facilitate diversification.

As corporate health care grows, so will the need for physician executives. Senior management in health care "businesses" is looking for executives who can speak the language of finance and management as well as the language of clinical care. For example, companies are hiring physicians to manage their employees' health benefits program; insurers and health maintenance organizations are employing physician managers, some of whom have the authority to decide what services will be offered and at what reimbursement levels; physician executives in pharmaceutical companies determine how to best communicate with physicians; and large group practices are designating one physician to be the medical director to manage the business side of the practice.

Nationally, the rise of physician executives has been meteoric. In 1975, the American College of Physician Executives (ACPE), formerly the American Academy of Medical Directors, began with 64 members. The membership in ACPE has since swelled to more than 5,000. In Pennsylvania, there are a significant number of businesses and health care facilities to support this new medical subspecialty: 300 hospitals, 22 health maintenance organizations, 105 pharmaceutical companies, and 34 Fortune 500 corporations.

Role of physician executive
In general, a physician executive carries out administrative responsibilities relating to the professional actions of physicians, or sometimes other health professionals, and directs the development of clinical and organizational policies under which physicians must practice. However, the scope of responsibilities associated with each medical director or physician executive position can vary greatly.

The actual job description for a physician executive depends on the individual organization or facility, its mission and its management. In some cases, the job description is not well defined. There are some common activities and responsibilities, however, that most physician executives share. They are:

Communicator: One of the primary responsibilities of a physician executive is to serve as a liaison between physicians, other health professionals, health care consumers, and management. Though this liaison role will be accomplished through different means, the physician executive as communicator will be called upon to:
• gain acceptance of change by both physicians and nonphysicians;
• foster an environment conducive to cooperation and mutual respect;
• meld, whenever possible, physician and nonphysician viewpoints;
• coordinate positive forces to ensure achievement of organizational goals; and
• encourage collective thought, as well as support independent judgment necessary for physicians to effectively treat patients.

Facilitator: In an institution, physician executives are usually involved in managing programs such as quality assurance, utilization review, peer review, risk management, medical education, and employee health benefits.

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Negotiator: A skilled physician executive knows well the path between conflict and collaboration. Because a physician executive can give input from both the clinical and managerial perspectives, he or she can play a key role in making critical decisions affecting both physicians and management. Medical managers are often required to have experience in conflict resolution, motivation techniques, and organizational problem solving.

Planner: Developing competitive strategies and taking an active part in strategic planning based on institutional and community needs can also be counted among the responsibilities of the physician executive position.

Educator: The physician manager takes the lead in educating both physicians and managers about developments in medicine and how they can be meshed with organizational objectives. In addition, physician executives are sometimes called upon to educate the community about the institution's programs and policies regarding health care delivery.

Physician: As the senior medical executive, the physician manager has the responsibility to monitor or direct monitoring activities for the purpose of evaluating new clinical developments and determining what impact the advancements will have.

Manager: The physician executive also participates in budgeting, policy-making, evaluation of programs and services, and all strategic decision-making.

Physician executive's concerns
As the demand for physician executives increases, some may contend that these medical specialists will have "the best of both worlds." However, physicians acting in managerial capacities are trailblazers with a particularly challenging assignment: helping medicine and business coexist as partners in the delivery of health care. While the number of management opportunities for physicians is increasing, there are corresponding risks and difficulties, such as loss of credibility, professional ostracism, conflicting interests, and lack of direction.

The issue of credibility is consistently raised in connection with the physician executive position; one must earn the respect and trust of both physicians and nonphysician managers.

It is generally accepted that physicians, as a group, tend to be more receptive to information supplied by other physicians and that business executives (or administrators) more readily trust individuals with formal training in business. Therefore, to be most effective, physicians in management positions (who are in those positions to act as a liaison between both groups), must be regarded as "true physicians" by their physician peers and also must be considered "organizational advocates" by those in administration.

Earning trust and respect from all professionals involved in health care is critical to the success of the physician executive. However, in many instances, the question of credibility directly relates to perceptions of "whose side" the physician executive represents. Changing "we/they" attitudes and educating both physicians and nonphysicians about the physician executive's liaison function can minimize or eliminate the issue of credibility. It can also be a very lengthy and difficult process.

Business and health care institutions in Pennsylvania are at various stages in the process of defining the responsibilities and functions of the physician executive position. In the medical executive position's earliest stages of development, nonphysician management and/or physicians: (1) recognized a general need for cooperation between physicians and managers; (2) established a physician executive/medical director position to accomplish this nonspecific goal; and (3) then asked the physician selected for the position to formulate a job description (i.e., "we need cooperation—figure out how to get it"). In more advanced stages of development, specific needs are identified such as benefits plan management, quality assurance, and peer review. A physician qualified to satisfy these defined needs is then hired.

Regardless of the job description, many physicians serving in executive positions are called upon to "develop" their role in order to make meaningful contributions to the organization.

Medical management is a new field that is rapidly changing within a profession that is rapidly changing within an industry that is rapidly changing. This state of flux makes the risk of entering medical administration multi-faceted. It includes not only the altering nature and expectations of physician executive positions, but the possibility that specific institutions employing physician executives may not survive.

Many physician executive positions are so demanding on time and energy that it is difficult to effectively practice medicine. As a result, entering medical management can mean the end of full-time clinical practice which could impact on credibility with physicians who practice medicine exclusively.

Physician executives play the roles of both physician and manager. As a result, the medical specialist's allegiances, commitments, and dedication are often questioned. Learning to balance these two roles and gain acceptance and trust from both the blue coats (administrators) and the white coats (physicians) is the challenge facing physician executives.

There are no generally accepted job responsibilities or performance standards exclusively for physician executives. This state of affairs reduces the chances of securing proper training for current and future executives. It also makes it more difficult to further define the physician executive role which is necessary to enable physicians-at-large to understand the position.

Many physician executives lack opportunities to meet and discuss common concerns with colleagues in similar positions. Such meetings would facilitate the development and enhancement of the physician executive position, thereby making it more attractive and acceptable to physicians.

Physician executive skills
The most important skill needed by physician executives is the ability to recognize and overcome misconceptions about "appropriate behavior" for this position. This often requires integrity, diplomacy, assimilating divergent viewpoints, searching for common ground between various factions, and demonstrating reliability.

The physician executive effects a split personality since it is often necessary to act in ways that may seem contradictory to both physicians and managers. For example, the physician executive is trained as other physicians to manage clinical problems from a patient standpoint. However, a physician executive is proactive and anticipates managerial requirements which go beyond the individual patient perspective. Physician managers, when practicing medicine, relate one-to-one with medical colleagues.
physician managers published in Group Practice Journal showing that 62 percent of those interviewed thought additional education in management would be advisable for physician managers; 22 percent said that formal course work or a graduate degree in management should be required.

Effecting change in health care
Though medicine and business are likely to have many unresolved issues, there is ever-growing recognition that the establishment of mutually acceptable goals is necessary to address the issues of quality, cost, and availability of health care. The proliferation of physicians serving in management positions, though not unanimously accepted by physicians and managers alike, is symbolic of new initiatives fostering collaboration, cooperation, and equality in the decision-making process which has great impact on the ability of physicians to practice medicine according to their beliefs.

As the liaison between practicing physicians and management, physician executives increasingly will find themselves in the influential, albeit difficult position of forging partnerships to make tough decisions impacting on and changing medicine in Pennsylvania. Since these changes will continue to occur in medicine and physician executives are likely to be at the center of this change, practicing physicians can best influence the future course of medicine by understanding, working with, and supporting their colleagues who choose to specialize and/or participate in medical management. It is through these efforts that the medical profession has one of its best opportunities to bring about positive change.

Organized medicine's role
As the professional organization representing physicians in the state, the Pennsylvania Medical Society is committed to providing assistance to all physician executives. The Physician Executives Liaison Committee, formed by the Society’s Board of Trustees, studies the needs of physicians serving in various administrative capacities and recommends strategies for addressing these needs.

If you’ve made the decision to move up, our four-day interactive career enhancement program for physicians will help you make the transition to administrative medicine. Adapt practical approaches to organizational challenges to fit your personal leadership style. Learn techniques that will help you control a meeting so goals are accomplished, and how to meet QA and Joint Commission requirements. Prepare to negotiate successfully and respond effectively to confrontation. Career counseling is available upon completion of the program. Class is limited to 24 participants, so call today for more information.

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Mark A. Kelley, MD, has been named vice dean for clinical affairs of the University of Pennsylvania Medical Center. In the newly created position, Dr. Kelley is responsible for all clinical programs at the medical center.

Edward J. Huth, MD, Philadelphia, editor for 19 years of the *Annals of Internal Medicine*, will retire June 30 after a 30-year affiliation with that journal. During his career, Dr. Huth helped improve medical journal publication standards.

Susan Bray, MD, has been elected to the board of trustees of Woodmere Art Museum, Philadelphia. She is president of staff at Chestnut Hill Hospital, president of the National Dialysis Association, medical director and chief executive officer of Chestnut Hill Dialysis Center, and a delegate to the PMS.

Marianne E. Feitl, MD, glaucoma specialist, recently joined Geisinger Medical Center Clinic as an associate in the Department of Ophthalmology. Feitl was previously associated with the Department of Ophthalmology at Scheie Eye Institute, Philadelphia.

Martin T. Orne, MD, PhD, has been elected to the Board of Scientific Affairs of the American Psychological Association. Dr. Orne is director of the Unit for Experimental Psychiatry at the Institute of Pennsylvania Hospital.

Young K. Yoo, MD, Hazleton, authored a medical paper published in the February issue of *Gastroenterology*. His immunological study involved the tumor infiltrating lymphocytes isolated from human colon cancers.

Isaac Djerassi, MD, director of research oncology and hematology, Mercy Catholic Medical Center, Darby, received the first Edwin Cohn-De Laval Award at the Third International Congress of the World Apheresis Association, Amsterdam. Named for the scientists who pioneered today’s haemapheresis technology, the award honors contributions in that field.

Loretta P. Finnegan, MD, has been appointed associate director, Office for Treatment Improvement, the Alcohol, Drug Abuse and Mental Health Administration, Washington, DC. She is taking a two-year leave of absence from her duties as director of the Family Center of Thomas Jefferson University.

L. Roy Newman, MD, was elected president of the Maimonides Society, an organization honoring physicians who have served the Albert Einstein Medical Center for 25 years or more.

Alan J. Wein, MD, professor and chairman, Department of Urology, University of Pennsylvania Medical Center, was elected to a six-year term on the board of trustees of the American Board of Urology.

Donald Kaye, MD, professor and chairman, Department of Medicine, Medical College of Pennsylvania, has received the title of honorary professor from the Federal University of Bahia in Salvador, Brazil. Dr. Kaye was recognized for his scientific accomplishments and his long-standing association with the Federal University of Bahia.

Bruce K. Branin, DO, of the American Society of Addiction Medicine, and Lorne R. Campbell Sr., MD, Erie, became members of the PMS Physician Task Force on Drug Abuse in April.

C. Jules Rominger, MD, chairman of the Department of Radiation Oncology at Mercy Catholic Medical Center, Darby, represented the Philadelphia Division of the American Cancer Society at the Sixth International Reach to Recovery Conference, Dublin, Ireland. Reach to Recovery is a world-wide program for rehabilitation of women with breast cancer.

Enrico Serine, MD, primary care internist, Lackawanna Medical Group, is chairman of the 1990 Red Cross auction at the University of Scranton.

Selma Kramer, MD, was awarded the 1990 Medical College of Pennsylvania (MCP) Commonwealth Board Award for outstanding work in child and adult psychiatry, psychoanalysis and research. The award is granted annually to a distinguished MCP graduate practicing in Pennsylvania.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubusae and related trees. Also in Rauwolfia Serpenina (L) Benth. Yohimbine is an indolealkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile flow, decreased penile outflow or both. Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors. Its effect on blood pressure, if any, would be to lower it; however inadequate studies are at hand to quantify this effect in terms of Yohimbine dosage.

Indications: Yocon* is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.1,2 Also dizziness, headache, skin flushing reported when used orally.1,3

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.1,3,4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

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References:
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Spinal Cord Injury: A Ten-Year Report

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On January 1, 1989, the Regional Spinal Cord Injury Center of Delaware Valley (RSCICDV) of Thomas Jefferson University marked its tenth year of service as a federally-designated model spinal cord injury (SCI) system. Sponsored in part through a grant from the National Institute on Disability and Rehabilitation Research (NIDRR) of the U.S. Department of Education, the RSCICDV is a cooperative program of Thomas Jefferson University Hospital and Magee Rehabilitation Hospital in Philadelphia, which is designed to minimize the devastating effects of spinal cord injury.

Under the direction of John F. Ditunno, Jr., MD, project director, and co-associate directors Jewell L. Osterholm, MD, Jerome M. Cotler, MD, and William E. Staas, Jr., MD, the RSCICDV has developed into a nationally recognized center of excellence for comprehensive spinal cord injury care, education, and research which meets or surpasses the standards established for a model SCI system. The directors of the RSCICDV have set the tone for collaboration, evidenced throughout the center program at Jefferson and Magee. Coordinated pre-hospital care, teamwork in acute care management, rehabilitation beginning at the time of injury, vocational evaluation, training and placement, and lifetime multidisciplinary follow-up care are the hallmarks of the RSCICDV program.

Physicians representing virtually every acute care hospital and medical center in the Greater Delaware Valley area have played a major role in the success of the RSCICDV by responding appropriately to the need for early referral to the comprehensive model SCI center program. Indeed, the physicians in the community hospitals and university medical centers represent the first step in the continuum of care which comprises the RSCICDV program, together with the Emergency Medical Services system. Physicians have been extremely responsive and supportive, referring 80 percent of RSCICDV patients within 72 hours of injury—the time recognized as the most crucial to promote optimal outcome.

In patient care, the RSCICDV has demonstrated that a comprehensive center program can achieve low mortality, reduced costs, and a return to independent community living for over 90 percent of the more than 1,000 persons with traumatic spinal cord injury served. Educationally, the RSCICDV represents an integral part of the nationally acclaimed training center at Jefferson Medical College and Thomas Jefferson University for physicians in nearly every medical and surgical specialty and for allied health professionals in nursing, occupational therapy, and physical therapy.

With Thomas Jefferson University and the Regional Spinal Cord Injury Center of Delaware Valley as its base, the first and only National Rehabilitation Research And Training Center in Neural Recovery and Functional Enhancement was federally designated in March, 1988. This effort utilizes the patient care programs of the RSCICDV, expands the educational efforts of the university-based program, and focuses research initiatives on the critical issues of motor recovery and therapeutic interventions to facilitate optimal functional outcome.

Although the accomplishments of the RSCICDV are significant, there are still goals to achieve. Significant strides are needed in prevention of traumatic spinal cord injury, early referral and admission for all persons with traumatic spinal cord injury, improved acute care intervention to prevent the severe secondary medical complications of spinal cord injury, and improved access for productive community living.

Prevention programs require an adequate surveillance base in order to be effective. Few states have designated spinal cord injury as a reportable condition, even though estimates of incidence range from 30 to 40 per million of population each year. Based on a population...
ETIOLOGY OF SCI
RSCICDV 1979–1988

ADMISSIONS BY YEAR
REGIONAL SCI CENTER OF DELAWARE VALLEY

ACUTE ADMISSIONS
RSCIDC 1979 – 1988

of 11,864,751, there are approximately 356 to 475 new injuries in Pennsylvania
every year.

Recent initiatives, with the support of the Centers for Disease Control, the en-
dorsement of the American Spinal Injury Association (ASIA), the Model SCI Sys-
tems program and other health care providers, could establish state-wide regis-
tries for spinal cord injury to document its specific impact. Regardless of the ac-
tual number of injuries, traumatic spinal cord injury is a devastating challenge
not only to the injured person, family and significant others, but also to the
health care community and society as a whole.

Despite the high percentage of early referrals experienced by the RSCICDV
program in the past 10 years, the need continues for early referral/admission to
the comprehensive SCI center of all persons with traumatic spinal cord injury.
Significant advances in medical-surgical intervention after SCI are only effective
if the patient is accessed early. RSCICDV patient care and research programs have
demonstrated effective reduction of life-threatening potential of deep vein
thrombosis, pulmonary complications, and pressure sores for early admissions.
These and other secondary complications require even further examination and
the establishment of effective therapeutic interventions. Early admission also results
in significant cost savings—an average of 29 days are saved by persons admitted to the RSCICDV within 72
hours of injury.

The costs of spinal cord injury may be measured in human terms: losses in mo-
tility, self-care function, human dignity, self-esteem, role relationships, commu-
nity accessibility and other potential complications and adjustments. Or, the
costs of spinal cord injury may be measured in dollars and cents: expenses for
initial acute care and rehabilitation; increased length of stay for complications
such as respiratory failure, deep vein thrombosis, gastrointestinal bleeding, pres-
sure sores, urinary tract infections, metabolic deficiencies, and psychosocial
dysfunction; equipment, medication and supply expenses which often last a life-
time; lost wages (and, therefore, lost tax revenue); and vocational evaluation,
training and placement costs.

Persons with spinal cord injury need full access to community living, through
a cooperative effort of center-based vocational programs and community-
based resources. Utilizing a cooperative approach, the RSCICDV has achieved
success in assisting more than 90 percent of the center's clients to return to the
community as socially active citi-
zens. Much more effort is required to
achieve vocational success.

Admissions by year
Serving 1,082 persons with new injuries in its first 10 years, the RSCICDV has
demonstrated the ability to consistently meet requests for referrals from nearly
every acute care hospital within the defined catchment area of southeastern
Pennsylvania, southern New Jersey and northern Delaware, as well as referrals
from outside the area. The number of ref-
errals has increased steadily since 1979,
as educational/outreach efforts have
gradually increased.

Demographics
The demographics of the spinal cord in-
jured population are telling, if not sur-
prising. A review of the first 1,000 ad-
missions to the RSCICDV reveals that this
center's population differs only slightly
from national statistics, reported to the
National Spinal Cord Injury Statistical
Center at the University of Alabama by
all federally-funded model SCI systems.

Age at injury: The average (mean) age at the time of injury for the first 1,000
admissions to the RSCICDV is 34 years
(slightly higher than the national mean
of 29.7 years), while the median age is
27 (compared to 25 years, nationally).
However, the most informative measure of average for the SCI population is the
mode of 18. The range of ages is 2 to 92
years. However, only six (<1 percent)
of the patients were less than 12 years old.
and only 20 (2 percent) were over the age of 80. Forty-two percent of admissions to the RSCICDV are between the ages of 15 and 30, compared to 61 percent nationally.

**Distribution by sex:** Males predominate the spinal cord injury population (80 percent at the RSCICDV and 82 percent nationally).

**Etiology:** The causes of spinal cord injury evidenced by RSCICDV patients illustrate the greatest statistical variation from the national data. Although motor vehicle accidents (MVA) and falls are major causes of SCI in both statistics, falls (29 percent) outnumber MVA (25 percent) at the RSCICDV, while nationally, MVA (47.7 percent) far outnumber falls (20.8 percent). At first glance, one might think that this variation can be attributed to a large urban elderly population. However, closer review reveals that, while the majority of the elderly admissions were injured in falls, falls account for spinal cord injuries at virtually all ages.

The RSCICDV also admits a far greater percentage of patients injured by gunshot wounds (13.3 percent), while nationally, all acts of violence combined (gunshot wounds, stabblings, and person to person contact) account for 14.6 percent of all reported cases.

Diving injuries account for 10.2 percent of all admissions at the RSCICDV, as compared to 9.5 percent nationally. In the Greater Delaware Valley, diving injuries occur almost exclusively between the months of May and September. Of significance for prevention efforts is the fact that nearly every person admitted with spinal cord injury from a diving accident was diving into water less than four feet deep.

Sports-related injuries (other than diving) appear to be changing over time. Football injuries are not as prevalent as they were 10 years ago—probably because of improved equipment standards, greater rules enforcement, and well-publicized professional and college athletic injuries.

Although falls, motor vehicle accidents, gunshot wounds, and diving accidents are the four leading causes of spinal cord injury, a close inspection of the data reveals that the causes of spinal cord injury are numerous. Virtually any activity which requires attention and care for the potential consequences can result in devastating lifelong injuries. The use of drugs and alcohol in the general population also contributes to many of the injuries that occur every year.

**Neurological impairment:** Persons with quadriplegia account for 55.6 percent of all RSCICDV admissions. This may be skewed slightly by the fact that clinicians in the community may be somewhat more likely to refer a patient with a cervical spinal cord injury to a spinal cord injury center.

The proportion of persons (of all levels) with neurologically incomplete lesions (preserved sensory and/or motor function below the zone of injury) has increased nationally from 38.1 percent in 1973-74 to 53.8 percent in 1983-84. At the RSCICDV, the proportion of incomplete lesions has not followed any trend over 10 years, but has ranged from 51 percent to 68 percent of annual admissions. The higher proportion of neurologically incomplete injuries may be explained primarily by improved methods of emergency medical management. For this reason, the RSCICDV has made a concerted effort to provide education to paramedical pre-hospital personnel.

**Referral pattern**

Eighty percent of all referrals in 1988 were from hospitals within the defined catchment area. Referrals from Pennsylvania accounted for 67 percent of all admissions, while New Jersey hospitals referred 28 percent. The remainder were referred from Delaware and other states. The majority of persons referred from states and countries outside the catchment area were Pennsylvania or New Jersey residents injured while out of state.

The executive committee of the RSCICDV is firmly committed to the regional concept of spinal cord injury care. That is, persons with traumatic spinal cord injury are encouraged to seek acute care and rehabilitation at the comprehensive spinal cord injury center nearest their homes, to ensure maximum involvement and support by family and friends in the rehabilitation process and to facilitate community reintegration. Although the RSCICDV does not refuse admission to anyone with an appropriate need, persons with a comprehensive SCI center program nearer to their home are encouraged to evaluate other programs as well as the RSCICDV.

**Entry interval**

The model SCI system program has demonstrated that persons with traumatic spinal cord injury have a greater opportunity for survival if they are referred to a comprehensive spinal cord injury center program within 72 hours of injury. Cost savings are realized through decreased lengths of stay, as well as the obvious savings of decreased complications and a quicker return to productive living in the community. In 10 years, the RSCICDV has improved its entry referral percentage significantly. In 1979, 30 percent of all SCI patients were admitted within 72 hours of injury, while in 1988, 69 percent were admitted within 72 hours.

The success of the RSCICDV in encouraging early referral can be attributed to two factors. First, a concerted effort has been made to provide ongoing education regarding optimal assessment, initial care and handling, and the resources and objective benefits of SCI center care to paramedical and emergency health care providers throughout the Delaware Valley.

The second factor has been the improved ability of the RSCICDV to respond appropriately to acute referrals. The administration of Thomas Jefferson University Hospital and the executive committee and staff of the RSCICDV have established mechanisms to meet acute referral requests promptly, efficiently and with the best interests of the injured person in mind. Methods include 24-hour-per-day nurse coordinator coverage to facilitate the referral, communication and transport process; a designated multidisciplinary acute spinal cord injury team to respond immediately to the arrival of an acutely injured person; and the willingness to waive pre-admission screening for acute injuries.

**Outcome benefits**

It is difficult to measure the benefits of care within any model SCI system program because of the inability to use a control group. It would be difficult—and unethical—to withhold "system" care from any group of patients in order to make direct comparisons, and it is virtually impossible to gather comparable data from "non-system" hospitals. Perhaps the latter will be more easily achieved if mandatory reporting comes to pass in Pennsylvania and other states.
Meanwhile, outcome must be measured by comparing persons who are admitted to the SCI center "early" (within 72 hours of injury) to those whose admissions are delayed.

Length of stay between injury and return home: The overall length of stay (LOS) from the date of injury to the definitive discharge to home for persons admitted to the RSCICDV in 1987 was 126.63 days. For all persons admitted within 72 hours of injury, the average LOS was 119 days—versus 148 days for all those admitted after 72 hours of injury. Therefore, the patient who is admitted to the RSCICDV within 72 hours of injury returns to the community an average of 29 days sooner than the patient who is admitted "late." Conservatively estimating costs at $1,000 per day, early admission saves approximately $29,000.

There is no effort to measure the direct benefits of decreased hospitalization that cannot be counted in dollars and cents. However, the data do imply that individuals are less likely to become hardened to a "sick role" and are more easily reintegrated back into the community, when time away from family and community is minimal.

Morbidity/Mortality: Although the statistics are incomplete at this time, SCI center care is designed to minimize the severe complications of spinal cord injury, and major strides for achieving this have been made. Renal failure, once the leading cause of death among persons with spinal cord injury, has been greatly reduced by comprehensive follow-up and prudent use of advanced antibiotic therapy. Gastrointestinal bleeding once meant a seeming majority of patients had to undergo gastric surgery. Today, with the advent of early initiation of H2 therapy, gastrointestinal bleeding is evidenced in only a negligible number of RSCICDV admissions.

Specialized SCI nursing care and technically advanced beds to facilitate early management of persons with unstable spines and insensate skin greatly decrease the incidence of pressure sores. This is significant because a pressure sore of grade II or greater is estimated to cost $30,000 per lesion—and the total cost of hospitalization is estimated to increase five-fold if plastic surgery is necessary.

Mortality statistics are significant. Although national estimates of mortality are as high as 20 percent, the mortality rate during the initial acute care and rehabilitation hospitalization at the RSCICDV is 4.2 percent (42 deaths out of 1,000 admissions). Not surprisingly, the mortality rate increases with age. Mortality for persons over the age of 60 is 19.1 percent (21 deaths out of 110 admissions), while the rate is 0.8 percent (5 deaths out of 561 admissions) for persons age 30 or less.

Summary
In the past 10 years, the RSCICDV has had a unique opportunity to serve and expand the bounds of knowledge regarding this most devastating injury. The RSCICDV has collaborated with other model SCI systems in research regarding the incidence of respiratory complications, the value of removing bullet fragments lodged within the spinal canal, the survival/cause of death following spinal cord injury, the cost of spinal cord injury care, and the recovery of motor strength after quadriplegia.

Key on-site research efforts have focused on preventing deep vein thrombosis and in documenting the course of motor recovery after spinal cord injury. The identification of electrical stimulation plus low dose heparin as a prophylaxis has been a major breakthrough in the prevention of deep vein thrombosis. The documentation of motor recovery after injury has led to the designation of Thomas Jefferson University as a federally-funded National Rehabilitation Research and Training Center in Neural Recovery and Functional Enhancement (1988–1993).

It cannot be stressed enough, however, that the accomplishments of the Regional Spinal Cord Injury Center of Delaware Valley would have been quite impossible without the cooperation and support of the many physicians who have referred their patients to this regional center program. Continuing and expanding this cooperative effort should result in even greater achievements for persons with spinal cord injury in the years to come.

Suggested readings

American humorist Robert Benchley once observed that the human race is divided into two types of people: Those who divide the human race into two types of people and those who do not.

To judge by the flurry of articles and letters in the New York Times and elsewhere recently, there are certainly two factions where a national health program for Americans is concerned. And the larger—or perhaps more vocal—side looks northward with envy, yearning, or whatever, to Canada's universal, comprehensive, government-sponsored and allegedly "free" health care system. Not since Nelson Eddy courted Jeannette MacDonald in a canoe in Rose Marie, or Oscar Wilde declared Niagara Falls to be a bride's second disappointment, has Canada been the object of so much international attention.

Before going on to say why I think the United States should have a national health system, if necessary, but not necessarily a government health system, let me note in passing that when physicians' prognostications go awry there is litigation and/or a funeral; when editors' and publishers' pronouncements prove misguided, there is a correction in four-point type in their publications. Let's begin with a word of history about national health plans or, as some have called them, socialized medicine.

In his History of Medicine, Volume 1, Henry Sigerist shows that organized practice carried on by a medical profession of a type recognizable to us today goes back in Egypt at least to the third millennium BC. Sigerist describes an inscription commemorating a physician by the name of Irj, who lived around 2500 BC, which would do justice to any eminent super specialist of today. Irj was superintendent of court physicians, palace eye physician, palace physician of the belly and the internal fluids—and a "guardian of the anus."

Even in those days, medicine, like the priesthood, was strictly hierarchical, and it's significant that at the top of the tree was a kind of minister of health called the administrator of the house of health and chief of the secret of health in the House of Thoth. In about 1700 BC came the first attempts to regulate medical practice by law. A scale of fees was applied to different surgical procedures, and these varied with the social standing of the patient—a notion that would be anathema in today's egalitarian western societies. More about that later. However, in the event an operation ended fatally or the patient lost an eye, the doctor's hands were cut off.

In 1511, the third year of Henry VIII's reign, parliament passed the Medical Act, which for the first time regulated the practice of medicine by the state, as opposed to a royal charter or a local agreement. State care of the sick in England continued under the Elizabethan Poor Laws of 1601. Contributory insurance schemes date from the 18th century, and in the 19th they developed rapidly, being operated usually by the so-called Friendly Societies, which in the 1870s had about 4 million working class members, who, in return for a weekly contribution, received a variety of benefits. According to Glyn Bennet in his book The Wound and the Doctor, the Friendly Societies employed their own doctors, and were rich and powerful organizations in their own right.

At about this time, canny old Otto Von Bismarck, having failed to quell the socialists by prohibiting circulation of their literature and empowering the police to break up their meetings, took a new "if you can't beat 'em, join 'em" tactic by introducing major social reforms providing for sickness, accident, and old age insurance. He also invented the retirement-at-65 principle, still in force today, although at that time few lived long enough to collect their pensions.

Meanwhile, back in Britain, when David Lloyd George tried to introduce his national insurance bill in 1911, he ran into opposition not only from the Friendly Societies but also from the med-
ical profession. When he told the Friendly Societies they could operate a health insurance scheme, they were amicable; the British Medical Association, however, predicted that the bill would result in fixed salaries or capitation fees for physicians, a lessening of freedom of choice of doctor, and control of medical practice moving out of the hands of the medical profession—a collective long-range prognosis that was right on the money.

Between the wars, William Henry (later, Lord) Beveridge proposed a social security system "from the cradle to the grave" for all British citizens. When, at the end of World War II, Britons elected a socialist government under Clement Attlee, that government nationalized the Bank of England, and the gas, electricity, coal, and steel industries as well as the railways, and introduced the National Health Service—the NHS—in 1948.

Pa Larkin, novelist H.E. Bates' ebulient Cockney hero, called it the National Elf Service. It's an apt mutation. The NHS has become a stunted and capricious creature. Stunted because successive UK governments have starved it of funds needed to replace or modernize antiquated facilities and equipment; capricious because an army of bureaucrats administrates by whim and at increasing distance from the realities of day-to-day medical practice, while militant unions employ wayward antics that regularly close down or threaten hospital services.

A capricious creature

After more than 40 years of steady decline in the NHS, it's no wonder British doctors are more and more disillusioned with it. Since 95 percent of them work in the public sector, the frustrations must be particularly acute; government control; the lowest percentage of GNP (about 6.2) devoted to health care of any advanced nation; patients waiting up to three years for surgery; and incomes failing to keep pace with those of other professionals.

The only serious option is to get out. In the past decade about 1,000 UK doctors emigrated each year, many of their places being taken by foreign-born practitioners who now make up 27 percent of Britain's physician population. A Royal Commission on medical education warned that "medical demand in Britain ought not to be met by permanent or semi-permanent immigration from developing countries whose own needs are enormous."

For the dwindling number who attended the birth of the NHS, it must be hard not to say "we told you so." Not that Lord Beveridge's baby was conceived in a bed of doctrinaire socialism: both the Conservatives and the Liberals, as well as the Labor Party, were generally in favor. World War II had, after all, spawned a coordinated emergency medical service designed to cope with thousands of casualties from bombed cities, and this was the progenitor for at least the hospitals segment of the NHS.

The story since 1948 has been one of chronic underfunding (despite the fact that public expenditures in the UK account for over 40 percent of GNP) compounded by massive inflation, tremendous advances in technology and pharmaceuticals, growing public demand for health care, and sluggish NHS management. Add to that a rapidly diminishing input by health care providers, particularly physicians, to decision making, and you have the recipe for disaster. No wonder the private health sector is growing rapidly; the myth that "The Health" will provide has been shattered.

In his July, 1948 message to the British medical profession, then Minister of Health Aneurin Bevan, a firebrand socialist ideologue, referred to the "lingering anxieties" of UK doctors about the NHS and to the "real professional opportunity" the service would afford them. Now, more than four decades later, the anxieties linger on and UK doctors seek such opportunities in a narrowing circle of hospitable overseas countries. It's a paradox, too, that the unions who cried out for government-sponsored health insurance in Britain now demand private insurance as a perquisite of employment.

In 1988, Prime Minister Margaret Thatcher acknowledged the deterioration of the NHS—a deterioration characterize in part by the fact that while the entire UK population is covered by government health insurance, over half a million people are on waiting lists for medical or surgical procedures, and are passed over in favor of those with private insurance.

As Thatcher erodes the principle of free health care for all, her government intends to expand by five-fold the role of private health care. HNS hospitals will be allowed to make a profit when serving private patients, and there's a proposal for government health vouchers that consumers might spend either on government or on private care. That the Iron Lady will meet resistance is inevitable if only because the NHS is Europe's second largest employer after the Soviet army.

Joan S. Lublin, writing last year in the Wall Street Journal, observed that the British system has persistently lowered costs to the point of penny pinching and rationing. Over 65s can't get dialysis in the UK, for instance. As a result, says Lublin, poor care and outdated technology beg the introduction of the private sector into the paralyzed health care system. A quick example of this will suffice: There are 19 MRI units serving the 57 million people in England and Wales; by comparison, the Philadelphia Metropolitan area has 21 units serving 4.9 million people.

Socialized medicine, British style, is truly ailing.

Canadian woes

Universal, government-sponsored medical care first achieved a toe-hold in Canada in the mid '60s under the socialist government of the province of Saskatchewan; universal medicare, as it's called, was enacted in the other nine provinces by 1971.

Please keep in mind, though, that Canadians are more amenable to government fiat than are Americans, whose inalienable rights include the preservation of life and liberty and the pursuit of happiness, and who are by and large convinced that the least government is the best government. Government—or, at least, too much of it—is an essentially malign force. Canadians, on the other hand, whose Constitution calls for 'peace, order and government' are generally more accepting of public enterprise, if that is not a contradiction in terms. Let me give you an example. It's estimated that 32 percent of the U.S. gross national product is consumed by federal, state, or local governments; by contrast, government spending in Canada absorbs about 43 percent of GNP. In a population of some 26 million, about 10 percent of Canadians work for the federal, provincial or municipal governments. Two decades ago the government telephone directory in Ottawa, the nation's capital, contained 200 pages; today, it contains more than 1,000. In the early 1980s, a retiring auditor-general averred that federal spending in Canada was quite literally out of control.

Remember, too, that medicine in Canada has never been as uncontrolled as it was in the United States in the mid-19th century. The number of medical schools in Canada was always limited by the
number that could obtain university affiliation; there was never the proliferation of proprietary schools that the U.S. had.

Following the depression era, various Canadian provincial commissions examined publicly-funded health insurance. The medical associations made a sharp distinction between a national health service, which they saw as payment by salary and state ownership of health facilities—and national health insurance. They were totally opposed to the former but reasonably receptive to the latter—provided they retained control of payment and administration.

In any event, Canadian medicare came into being with a promise of 40 percent in direct cost-sharing contributions to the provinces from the federal government on the condition that the mandatory health insurance plans meet these criteria: that they be comprehensive, accessible to all citizens, provide universal coverage, be portable from province to province, and be publicly managed and administered.

Since its birth some 18 or 19 years ago, Canadian medicare has endured a rather spotty and anemic adolescence. During the intervening period, there were a plethora of government and private studies and task forces on health care “problems,” selective withdrawal of services, and outright strikes by physicians—the government of British Columbia first publishing the incomes of all physicians in that province and later controlling the number of them allowed to bill the provincial government for their services, and Quebec simply refusing to pay full fees to MDs moving into “overserviced” areas. Passage of the Canada Health Act in 1984 effectively outlawed so-called extra billing by physicians for the difference between the professional’s fee schedule and the amounts actually allowed by the sole paymaster—government. The irony of this is that Canadian physicians, presumably members of a free profession, have their fees dictated neither by their own societies nor by the marketplace, but by government. No wonder that there was an exodus of them of the United States between the mid ’70s and the mid ’80s. As Canadian health care economist Robert Evans puts it: “When all dollars flow through one channel, you control costs. . .”

You sure do. The U.S. spends $550 billion (or some 11.5 percent of its GNP) on health care; Canada, with one tenth the population, spends less than 8.5 percent of its GNP. That’s easy when government simply gives hospitals a global prospective budget, then decides what physicians may charge in the year ahead. And those charges are certainly lower than in the U.S.: $500 to deliver a baby in Canada, upwards of $1,000 in the U.S.; a Canadian appendix is worth $200 for removal, and a U.S. one $900.

Interestingly, when both countries flirted with the notion of a government sponsored health care scheme in the post World War II years, Canada backed off for fiscal reasons and the U.S. for ideologic ones, the American Medical Association persuading Congress that such a scheme would hinder quality of care, provide for those who didn’t need to be provided for, tend to sap individual initiative, and supplant insurance programs already in existence.

In effect, though, the U.S. rations by money and by access, (allegedly 37 million Americans have no healthcare insurance) while Canada rations by time. Canadians wait two to three weeks to see a general practitioner, and a month or more to see a specialist. And, by the way, there are—pro rata—three times as many GPs in Canada as there are in the U.S. Moreover, no patients may go directly to a specialist, they must be referred by a GP. There are long waits for CT scans, lithotripsy (assuming you can find a lithotripter—there are only four in the entire country) and for such procedures as balloon angioplasty, and patients can wait up to two years for heart surgery or hip replacement.

And this has a great deal to do with differing investments in medical technology. The Canadian government spends roughly 50 percent of what the United States does per capita for research and development. Canada has one cardiac catheterization lab for every 800,000 people; the U.S. has one for every 160,000. There are 50 times as many lithotripters in the U.S. as in the Canada and 100 times as many magnetic resonance imagers. Another way of controlling costs: Canadian physicians earn roughly 25 percent less than their American counterparts, in addition to the lower-valued Canadian dollar.

With the overwhelming majority of Canadians satisfied with universal medicare, even Conservative federal governments dare not tamper with it—even though provincial health ministers now believe that steady cutbacks in federal funding could lead to deterioration in the quality of care, even greater rationing or, since provincial governments now spend some 30 percent of their total revenues on health care, the erosion of other services.

As Canadian Medical Association past president John O’Brien-Bell, MD, puts it: the high standards originally set by Canadian medicare are starting to fray at the edges. According to my former place of toil, the Canadian Medical Association Journal, O’Brien-Bell thinks universality, a major premise of the system, is coming unglued and the thing he finds most regrettable is that “the public has been taught to believe government is spending more and more money on health care.” He said this is not the case, and among the factors exacerbating the problem has been an $11.9 billion reduction in the amount of federal health care spending anticipated by provincial governments between 1982 and 1989. Most important, however, is the $322 billion federal debt. “When the government is paying 35 cents out of every dollar in interest to service the debt, the same amount of tax dollars just won’t go as far in providing services,” O’Brien-Bell said. “Government’s hands are tied.”

He thinks the provinces tend to use physicians as scapegoats when they have to cope with fiscal woes, and feels they could accomplish much more by working with doctors to solve difficult issues. For instance, he said, modest user fees charged at the point of service would do a great deal to make Canadians better informed and more aware consumers of health care. Hardy surprising that the Canadian system is seen to be “free”—only two provinces now charge any form of premium, and first dollar coverage (no deductible) is the order of the day. This can lead to overutilization by both users and providers.

Where the grass is greener

In sum, you have a Canadian health care system that is a source of overwhelming satisfaction to Canadians themselves, a source of envy, according to polls, for six out of 10 Americans, and characterized by generally high—but not the highest—standards, controlled costs of hospital and physician services, limited invest-
ment in research and development and high technology, a more or less co-opted medical profession and declining funding. And—something possibly overlooked by the Harris poll respondents—there is no such thing as "free" health care. Canadians pay $2.20 a gallon for their gasoline. Some common products are heavily taxed and anywhere from three to four times as expensive as they are here. Direct and indirect taxes are significantly higher.

As policy analyst John Iglehart put it in a three-part series on Canadian medicare in the New England Journal of Medicine: "Canada's Health Insurance Program resembles a pressure cooker that is building up steam on a hot stove. The federal government is reducing its financial commitment, the supply of physicians is increasing, and the physical plants of many Canadian hospitals—particularly the teaching institutes—are nearing obsolescence."

Now, what might Americans learn from all of this? The U.S. system is fragmented, expensive, bureaucratic (billions of dollars go into form filling for 1,500 different insurance companies) and 15 percent of the population has no insurance coverage. Life expectancy is roughly the same here as in Canada but infant mortality is considerably higher, which may have as much to do with urban ghettos and poverty as with health coverage. As Time magazine reports, when the American Medical Association conducts surveys of public attitude toward U.S. physicians, it finds a troubling loss of faith. Even people who esteem their own physicians, says Time, often deride the profession as a whole. Incentives to join prepaid, "managed" care plans have led to a doubling of enrollment in HMOs to 32 million people over the past five years. Hospitals spent more than $1.3 billion last year on marketing and advertising. As Time puts it: inflated expectations and consumers' attitudes have produced a treacherous legal reality confronting doctors today.

In short, the U.S. health care system is in a mess—but is the Canadian answer the answer?

Certainly CMA president John O'Brien-Bell doesn't think it is—at least in its present form. He would change the system dramatically to allow for significant user contributions in the form of premiums and deductibles, and would put in place mechanisms to create an awareness among both users and providers as to what things actually cost. And he would strongly review—and cut back on—many services now covered under universal medicare, services that include such goodies as massage therapy.

O'Brien-Bell points to the problems of trying to finance a system that nobody can really afford in the present economic climate. The Canadian government, he says, has encouraged a public deception that health care is free. However, he warns against shifting the burden of payment onto the backs of employers. By doing that, he says, the burden would come at a time when U.S. industry needs desperately to compete with the Orient and with an about-to-be united states of Europe. Already, he says, North America is starting 30-love down in the match against those countries.

Let me return for a moment to differences in national character. Canadians are different. They are moderate. Their country came into being not by revolution but by resolution, by compromise. As one wag put it: why did the Canadian cross the road? Answer: To get to the middle. Americans are interested in individualism, in getting the best, in reaping the benefits of a competitive marketplace system. Canadian patients are patient. Americans want the best in technique—and they want it now. As a committee report of the AMA put it: Canada's system is socialized medicine managed by an ever-enlarging and more expensive bureaucracy, financed by ever-increasing taxation and featuring rationing, shortages, health care waiting lists and an absence of private sector alternatives. An AMA brochure titled, "The American Healthcare System: Its strengths and weaknesses and a plan by physicians to improve it," notes that the Canadian system is less responsive to consumers than the U.S. system.

For example: In May, 1988, the wait in Vancouver for a psychiatric, neurosurgical or routine orthopedic opinion was one to three months; for a cataract extraction, six to nine months; for corneal transplantation, two to four years; and for admission to a long-term placement bed, six to 18 months. Waiting lists for angiograms in Quebec have been as much as six months long. More than 1,000 people were on waiting lists for bypass surgery in Toronto in January of 1989. At Toronto's Hospital for Sick Children, 40 children had open heart surgery cancelled and faced a delay of up to eight months for their surgery in January 1989.

Moreover, in Canada: Only 11 hospitals are capable of performing open heart surgery—one facility for every 2,364,000 Canadians. Only 14 hospitals are capable of performing organ transplants—one for every 1,857,000 Canadians. And only 12 hospitals offer magnetic resonance imaging—one for every 2,167,000 Canadians.

The AMA brochure purports to address the twin problems of access and costs, principally by maintaining a multifaceted delivery system and by reducing administrative costs.

Would or should Americans fund a national, comprehensive medical care system federally or through state governments? Yes, if Americans are prepared for large tax increases, diminished choice, lowered standards, eroded professional freedoms and the sort of dinosaur that only public enterprise can create. Can Americans learn from the British and Canadian experiments with universal, government sponsored health care systems? You bet.

How to finance it? Even at the present $550 billion, or more than $2,000 per head, there are alternative means of financing: by encouraging HMOs; by requiring that employers provide tax deductible coverage; by encouraging groups of physicians, particularly as we move further into an era of MD oversupply, to form comprehensive groups for insurance purposes; by urging hospitals to expand their ambulatory services and to "sell" in- and outpatient care to employers and individuals within the community. And then of course there's the hoary old notion about preventive medicine.

Nonetheless, the American public is calling for change—and there are some who believe that it has already made up its mind to have a state controlled system a la Canada. Prominent health care leaders in this country appear to be moving in the same direction. New England Journal of Medicine Editor Arnold Relman, MD, wrote recently: "There is now a growing sense that the time has come for a more basic and systematic realignment of our health system that will not only constrain costs but provide all citizens access to care and insure the quality and efficacy of services."

A noble ideal, and I wish Americans luck in achieving it. But to do so will require more than luck. It will require a willingness to learn from the British and Canadian experiences. And money. Lots of it. To leave the last words to Bismarck: "He who has his thumb on the purse has the power."
DON'T IGNORE RETIREMENT PLAN ADMINISTRATION

The Health Care Group

The topic of Retirement Plan Administration can be quite overwhelming in details and deadlines that need to be observed. Doctors and medical practice managers tend to be well in tune with the "bottom line" aspects of their practice retirement plans—i.e., how much is contributed and how much needs to be paid out. But when it comes to administration of the plan, their understanding is often not what it should be.

Unfortunately, this is a case in which what you don’t know could hurt you.

Given the large amount of money wrapped up in retirement plans, the federal government is very interested in how they are run. In fact, the government’s primary means of ensuring compliance with retirement plan laws is by examining how plans are operated or administered.

Administering a plan involves a complex collection of duties. These include: enrolling employees at the proper time; allocating money for participants; distributing information about the plan; and processing benefit claims. These activities can be very involved and they carry the potential for stiff penalties if handled improperly. Retirement plan administration is rarely performed by the physician or group practice sponsoring the plan—it is typically delegated to a professional administration or accounting firm.

This is where a little knowledge is valuable, because while you probably employ an outside professional to administer your plan, you are ultimately responsible that all legal requirements are met—and you could be penalized if they are not. To help ascertain whether your plan is being run properly, this article will review the basics of retirement plan administration.

IRS review

In most cases, a practice will choose to have the Internal Revenue Service (IRS) review a retirement plan. If the plan documents meet the tax qualification rules, the IRS will issue a positive “determination letter,” and the practice can move ahead with active funding and benefit accruals for the employees. Retirement plans are also routinely resubmitted when significantly amended—for example, when complying with changes in retirement plan law.

Before sending a new or rewritten plan to the IRS, you must notify all “interested parties” that you are requesting the review. These are generally all employees and any vested beneficiary. This notice must be delivered to each interested party, or conspicuously posted at each office location, within a specific time-period.

Plan descriptions

Plan sponsors must provide each participant with a “summary plan description” (SPD). This is a simplified explanation of the plan and the right of participants, and other information about the plan, its sponsors, and its fiduciaries. The SPD must be furnished to each participant and beneficiary within 90 days after becoming a participant or first receiving benefits. The SPD must also be distributed to all participants if it is revised to reflect an amendment to the plan.

Fiduciary bond

A plan sponsor is generally required to obtain a bond for the "fiduciaries" of the plan. A plan fiduciary is any person or entity who handles its assets. Thus, the bond coverage must be purchased for at least the plan administrator, trustees, and sponsoring employer. The minimum required bond coverage amount is the greater of $1,000 or 10 percent of the plan assets—which means that the bond must be increased as the plan’s assets grow.
Tax identification
It is generally advisable to obtain a separate tax identification number for the trust that holds the plan's assets. Obtaining this number will ensure that ownership of the plan's assets—and any income from it—will not be mistakenly assigned to the physician or practice sponsoring the plan. The tax identification number can be had by filing IRS Form SS-4.

Participation
The plan administrator must determine which employees are eligible to participate, by referring to and maintaining a current list of employees' birth and hire dates. Throughout the plan year, the list of eligible and participating employees should be updated regularly.

When contributions are made to the plan each year, the funds must be allocated among the participants. In the case of "defined contribution" plans, specific dollar amounts must be allocated from the overall contribution and credited to each person's plan account. This specific earmarking does not apply for "defined benefit" plans, since contributions are actually determined for all participants as a group, and no specific allocations are made for individuals.

Reporting and disclosure
Retirement plan sponsors must file an annual report with the government, commonly referred to as the Form 5500 series report. This reporting requirement applies to Keogh plans, as well as corporate-sponsored retirement plans. Unless an extension is granted, the appropriate Form 5500—there are several versions of it—is due by the last day of the seventh month following the close of the plan year (July 31 for calendar-year plans).

The penalties for late or incomplete filing of Form 5500 can be harsh: $25 for each day it is late, to a maximum of $15,000; and the plan administrator may receive a civil penalty of up to $1,000 a day for filing an incomplete form. In addition, if the form is rejected because of failure to provide material information, it will be treated as if it had not been filed—leaving the plan administrator subject to penalties for lateness and incompleteness.

The plan administrator must also give each participant a Summary Annual Report (SAR), a simplified version of the Form 5500. The SAR must provide information on: the value of the trust assets as of the first and last day of the plan year; the plan expenses incurred during the plan year; and information on any plan assets invested in insurance contracts. The plan administrator must also allow any participant to examine, at any time, the plan's full annual report.

Finally, the administrator must report benefit payments that occur during the year to the IRS, using either a Form W-2P or a Form 1099-R.

Married participants
Each participant must be provided with forms describing the death benefits mandated by the Internal Revenue Code within certain specific time periods—frequently, when an individual first becomes eligible to participate in the plan. But, there are special rules designed to protect a participant's spouse.

The law requires the entire death benefit of a married participant be paid to the surviving spouse. Therefore, a participant's spouse must consent in writing to any arrangement changing the form of payment or naming another person as beneficiary of the participant's funds. The spouse's consent must be made on appropriate forms provided by the plan administrator, the spouse's signature must be witnessed by a notary public or a plan representative. There is no limit on the number of times a beneficiary designation may be changed—but each require the spouse's consent if anyone else is named as beneficiary.

Given these special rules for married participants, it is important to maintain accurate records of each participant's marital status, and to ensure that the forms are provided in a timely manner. Failure to comply can result in penalties and legal liabilities to the plan.

Termination notices
When a participant with a vested interest in the plan terminates employment, the administrator should perform a variety of duties. A notice should be prepared for the terminated participant describing the amount of the vested interest. The participant may elect to have the vested benefit distributed immediately, or have the plan hold it until a later date—retirement age, for example. If the vested benefit is $3,500 or less, the plan may require the participant to "cash-out" within a reasonable time after employment ends. If the participant and spouse choose to a pay-out exceeding $3,500, they must consent in writing to the payment, and release the plan and plan administrator from any further claim for benefits.

The plan administrator must provide a notice of special tax rules which explains the right to "roll over" funds to another qualified plan or to an individual retirement account—or to elect favorable income tax treatment for the distribution. The notice should also explain the penalty tax on early distributions (i.e., 10 percent penalty on distributions prior to age 50-1/2). The plan administrator should furnish all of this information when the payment is a single sum which may be eligible for a rollover.

Federal law requires that the plan administrator withhold income taxes from distributions from the plan; the amount depends on the type of distribution. Ten percent is normally withheld from a lump sum distribution. However, periodic payments, such as annuity or installment payments, are considered ordinary wage income; and the amount of withholding depends on the size of the payments and the number of exemptions claimed by the recipient. Each year, recipients of periodic or annuity payments must be given an opportunity to change their withholding election.

Before paying any distribution, the plan administrator must provide the participant with a notice of withholding on payments and with IRS Form W-4P. These forms describe federal tax withholding from plan payments and the participant's right to waive withholding.

Divorce-related payments
A special rule applies where state courts mandate the distribution of retirement funds to a spouse, former spouse, child
or other legal dependent of a participant. These orders, issued in connection with divorce proceedings, are known as "Qualified Domestic Relations Orders" (QDROs); the plan administrator is required to send the QDRO to the participant and any other "alternate payee." A copy of the order should also be sent to the plan's legal counsel, to determine if the form and content of the order in fact meet the requirements for being a QDRO. The plan administrator, based on the opinion of counsel, should then adopt an approval of the QDRO, to be sent to all affected parties, describing whether and how the plan will pay benefits pursuant to the order.

Retirement plan investment

Although not specifically a plan administrator's duty, the plan's investment activities should be closely monitored, and in some cases implemented by the plan administrator. For the most part, investment rights and obligations are vested in the plan trustees or other fiduciaries. However, in medical practices the plan administrator, trustee, and fiduciary are often the same persons. The investment activities often include loans to participants and "directed" or "earmarked" investments.

Loans from a qualified retirement plan must be properly documented. As a result, participants requesting a loan should submit a written application to the plan administrator. The administrator should review the application and make a recommendation on it to the plan trustees. If the application is approved, the administrator should ensure that timely repayments on the loan are made (including principal and interest). Under current rules, in order for loans to be non-taxable to the recipient, they must be repaid within five years, with level repayments of principal and interest made at least quarterly.

The plan administrator should also facilitate directed investments for earmarked accounts—transmitting to the trustees any participant's written request for investment of particular account balances or portions thereof in selected investments. All investment direction requests should be retained with the permanent plan records should questions arise about losses sustained, investments actually made, etc.

Conclusion

We have only scratched the surface of a retirement plan administrator's responsibilities. They are, obviously, multifaceted and complex. But plan administration is also an area of significant legal and financial exposure, with potential large penalties for faulty performance. Therefore, you cannot turn a blind eye toward the operation of your retirement plan. A professional plan administrator's activities flow from your instruction and the information you provide. You must check in with the administrator on a regular basis and make sure each of the responsibilities is being fulfilled. In the end, the responsibility—financial and legal—is yours.
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Benjamin A. Gross, Philadelphia University of Michigan Medical School, 1929; age 84, died April 8, 1990. Dr. Gross was a dermatologist. •

Oliver E. Mattas, Sr., Altoona Jefferson Medical College, 1930; age 85, died April 14, 1990. Dr. Mattas was a general surgeon. •

James H. Parker, Jr., Wyomissing University of Pennsylvania School of Medicine, 1940; age 76, died April 2, 1990. Dr. Parker was an ophthalmologist. •

Paul J. Poinsard, Philadelphia Jefferson Medical College, 1941; age 75, died April 10, 1990. Dr. Poinsard was a psychiatrist. •

Timothy M. Ryan, Havertown Jefferson Medical College, 1978; age 37, died March 20, 1990. Dr. Ryan was a pediatrician. •

Charles L. Sacks, Palm Beach, FL Hahnemann University School of Medicine, 1941; age 76, died March 31, 1990. Dr. Sacks was a general surgeon. •

Carl A. Weller, Hummelstown Temple University School of Medicine, 1955; age 66, died March 10, 1990. Dr. Weller was a general practitioner. •

Nancy A. Boyer, Allentown Medical College of Pennsylvania, 1963; age 52, died March 17, 1990. Dr. Boyer was a cardiovascular surgeon. •

John F. Capiata, Philadelphia College of Osteopathic Medicine; died March 7, 1990. Dr. Capiata was a radiologist.

Henry L. Dean, Levittown Harvard Medical School, 1949; age 70, died March 1, 1990. Dr. Dean was a psychiatrist. •

Edward J. Fisher, Latrobe Jefferson Medical College, 1931; age 84, died March 16, 1990. Dr. Fisher was an obstetrician and gynecologist.

John A. Onderdonk, Sr., Wyckoff University of Pennsylvania School of Medicine, 1964; age 55, died March 13, 1990. Dr. Onderdonk was a cardiologist.

William B. Raycraft, Holland Loyola University of Chicago Stritch School of Medicine, 1926; age 95, died March 25, 1990. Dr. Raycraft was a pediatrician.

Louis C. Robinson, Philadelphia University of Pennsylvania School of Medicine, 1924; age 90, died February 12, 1990. Dr. Robinson was a family practitioner.

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